The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 **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 The Dalton Review – Examining New Options and Opportunities for providers of NHS Care

In December 2014 Sir David Dalton published his report into potential future options for health care providers. The report complements the Five Year Forward View and considers the means by which new care models can be delivered through a range of organisational forms.

The purpose of the review is to support the health system to reduce the variations in clinical standards, financial performance and patient safety. The report makes 22 recommendations to national bodies, clinical commissioning groups, NHS leaders and wider organisations across five themes:

- One size does not fit all
- Quicker transformational change and transactional change is required
- Ambitious organisations with a proven track record should be encouraged to expand their reach and have a greater impact across the sector
- Overall sustainability for the provider sector is a priority
- Change must happen – implementation must be supported

Key points to note are:

- Organisational forms should develop to deliver the models of care that best suit local circumstances, and not be centrally dictated
- Boards are challenged to consider wider system leadership and governance, and to shift from a mindset of ‘win-lose’ to one of ‘winning for patients and the community’.
- There are multiple options for providers to consider:
    - Federations
    - Joint ventures
    - Service level chains
    - Management contracts

    - Integrated care organisations
    - Multi-service chains
    - Foundation Groups
- The report suggests that in the future, organisations are likely to operate more than one organisational form for their service portfolio.

Specific recommendations for Trust boards include:

- As part of 2015/16 business planning process, Trust boards should consider their response to the NHS Five Year Forward View and determine the scale and scope of their service portfolios. They should consider whether a new organisational form may be most suited to support the delivery of safe, reliable, high quality and economically viable services for their population.
- Trust boards of successful and ambitious organisations should develop an enterprise strategy and should consider developing a standard operating model that could be transferred to another organisation or wider system.
- Trust boards should consider new operational and strategic leadership roles required in order to support the new organisational models, and put development plans in place accordingly.

The full report is available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf

The Board will have the opportunity to consider the implications of this report alongside the Five Year Forward View when the strategy refresh and 2015/16 annual plan is prepared.

2 Strategic Development of Organisational Capability

The Executive Team have been developing options to develop organisational capacity and capability in support of the agreed strategy.

One key strand of the strategy is the increased involvement of clinical leaders, in particular medical leaders, in the management of the Trust, to develop a shared leadership model. In order to support this ambition the King's Fund has been commissioned to undertake a diagnostic piece of work. The diagnostic is designed to elicit the views of current, past and future medical leaders within the Trust to enable plans to be made that best support the development needs of individuals and enable job plans to be appropriately structured.

The Kings Fund undertook their planned interviews in November and December 2014. Unfortunately not all consultant medical staff invited to interviews were able to attend and as a result it was agreed to extend the timeline for the project until the end of January to allow sufficient doctors to

contribute their views via a survey. The verbal feedback on the Kings Fund's findings is expected during February. The Trust Board will be appraised of the findings at the workshop in March.

3 Trust Business and Learning Day (TBALD) – Update

During 2013 the previous executive team introduced a monthly business and learning day, which was subsequently reduced to bi-monthly at the end of 2013.

The original objectives of TBALD were to ensure there was protected time for directorate discussions, clinical audit and a Q & A session with the CEO. Traditionally TBALD has always happened on a Friday and this brings with it some disadvantages in terms of fixed clinical sessions for some of the workforce.

We have taken the opportunity to review the effectiveness of TBALD in its current form with a view to improving how its objectives can be delivered with minimum disruption to patient services.

Feedback has been sought and there are a variety of views:

- "Please keep it; it's valuable"
- "Please drop it; it's not productive"
- "Rotate the day to spread the impact on clinical work"
- "Only half a day is needed"
- "Some consultants don't attend because they do private work on that day"
- "Some consultants can never attend due to split site contracts"

Based on this feedback and a continuing commitment to engagement and development, it has been decided to try an alternative approach from April 2015:

- Half day each month (8am – 1pm)
- 4th week of the month (except December)
- Rotate the day (Tuesday to Friday)
- Include Clinical Audit, directorate meetings and a CEO Brief/ Q&A session
- All consultant will be expected to attend except:
    - Dual contracts with direct clinical time at another Trust
    - Approved study/ professional leave
    - Annual leave

By rotating the day it is accepted it should be possible to achieve a wider coverage. These proposals are being consulted on in various settings and feedback so far has been positive.

4 Executive Management Team – January 2015

Key issues discussed and decisions taken include:

- Update on the issues that had been identified with regards to controlled drugs and the actions that were being taken to address these.
- Approved and/or ratified 13 policies or procedures, including 9 clinical policies
- Reviewed their risks and made amendments and comments where appropriate
- Richard Banks presented an update on the Transformation project around Inpatient Access. This included findings from the steps taken to deliver the additional RTT activity in October and November, and a position statement for the workstreams relating to capacity & demand, data quality, referral to first appointment and milestones 3 and 4.
- The MSK business case, relating to the appointment of a new MSK consultant to support growth and succession planning, was approved. It had originally been discussed at December's EMT, and was deferred with the directorate asked to revise the proposed job plan to ensure an appropriate financial contribution was generated.
- EMT discussed in detail the work that has taken place to understand the impact of implementing the 10 required standards for Seven Day Improvements. The Trust is required to include a plan for compliance against a minimum of 3 of these standards in our 2015/16 NHS contract. EMT approved the inclusion of Standard 3 (Shift Handovers), Standard 7 (Mental Health) and Standard 8 (Ongoing Review). It was noted that commissioners may be requiring an additional 2 standards to be included in the 2015/16 contract, and the Deputy Director of Nursing & Governance was asked to report back for EMT in February for further consideration of the standards if this was confirmed.
- EMT received the Patient Quality and Safe Staffing reports.
- EMT discussed in detail the current financial position and agreed an escalation in the approval route for agency staffing and the use of first class postage.

5 Stakeholder and Partnership Engagement

Key stakeholder and partnership engagement activities over the period include:

- A delegation from Bangladesh – doctors in training
- Chaired Academic Health Science Network Central Spoke meeting
- West Midlands Provider Chief Executive Forum
- HFMA CEO Forum
- Usual staff drop-in sessions

6 Recommendation

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Public Trust Board: 4th February 2015 **ENCLOSURE NUMBER: 4**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Andrew Pearson**
SUBJECT:	**Medical Director's Report**

SUMMARY

This report provides an update to Board members of key issues and activities since the last Public Trust Board 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 or being resolved since last report

1 Junior Doctor Forum

Mid-term meeting with GP trainees raised these issues:

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

1. SLA agreement with UHB switchboard is under review
2. Recent changes in the Research & Teaching Centre should allow progress towards a resolution to this longstanding issue
3. Awaiting report from Head of Pathology Services on ‘near patient’ testing

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 **ENCLOSURE NUMBER:5**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Anne Cholmondeley Director of Workforce and OD**
SUBJECT:	**Policy on the Fit and Proper Persons Test**

SUMMARY

This policy explains how the Trust intends to implement the new checks and tests necessary to fulfil the requirement for all Directors to be 'fit and proper' persons. This statutory requirement came into effect in November 2014.

This policy is presented to Trust Board for approval.

IMPLICATIONS

The new requirements will have the following implications:

- Increased time before postholders can take up their role to enable the necessary checks to be undertaken.
- Additional cost in undertaking credit reference checking.

RECOMMENDATIONS

The Trust Board is asked to agree this policy for implementation.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Fit & Proper Persons Test Policy

VERSION NUMBER	1
REVIEW DATE	28th February 2016
DATE PUBLISHED ON INTRANET	

Document Control Information

AUTHOR (POLICY FACILITATOR)	HR Associate
DIRECTOR / POLICY SPONSOR	Director of Workforce and OD
RATIFIED BY (Committee/ Group)	Trust Board and Council of Governors
DATE OF RATIFICATION	
NAME OF LOCAL GROUP / FORUM APPROVING THE POLICY **DATE OF LOCAL GROUP APPROVAL**	Trust Board and Council of Governors N/A

VERSION TRACKING

Version	Date	Author Name and Designation	Summary of Main Changes
1	26th January 2015	Kerry Pinker – HR Associate	Amendments as requested by Director of Workforce and OD

PROCEDURAL CHECKLIST

CONSULTATION COMPLETED	
CONSULTATION TRACKING SHEET COMPLETED	
VERSION CONTROL INFORMATION COMPLETED	
EXECUTIVE GOVERNANCE COMMITTEE CHECKLIST COMPLETED (APPENDIX M1)	
IMPLICATIONS FOR IMPLEMENTATION COMPLETED (APPENDIX M2)	
EQUALITY IMPACT ASSESSMENT COMPLETED AND DECLARATION FORM (APPENDIX M3)	
IMPLEMENTATION PLAN COMPLETED (APPENDIX M4)	
DATE SUBMITTED TO POLICY COORDINATOR	
APPROVED BY POLICY COORDINATOR	
DATE APPROVED TO RATIFICATION COMMITTEE	

CONSULTATION TRACKING SHEET

This document must be completed and accompany the policy procedure or guideline through the final ratification and authorisation process. A copy of this sheet should be included at the front of the final published policy.

Name of Policy, Procedure or Guideline: Policy on Procedural Documents

Name of person / team / committee asked to provide feedback	**Date request for feedback sent**	**Feedback received Y/N**	**Feedback incorporated into policy Y/N**
Director of Workforce and OD	26th January 2015	Y	Y
Company Secretary	28th January 2015		

Key Performance (compliance / success) Indicators (KPI's)

Describe Key Performance Indicators (KPIs)	**Target**	**How will the KPI be Monitored ?**	**Which Committee will Monitor this KPI?**	**Frequency of Review**	**Lead**
Compliance with Regulations 5 & 20 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014	100%	Annual Report	Nomination Committee of Trust Board and Council of Governors	Annual report And on appointment of Director	DofWOD

PERFORMANCE MANAGEMENT OF THE POLICY

Responsible for Producing Action Plans if KPIs are Not Met	Committee to Monitor These Action Plans	Frequency of Review (To be agreed by Committee)
Director of Workforce & OD	Nomination Committee of Trust Board and Council of Governors	As necessary

Contents

1. Executive Summary

Policy Description

This policy describes how the Trust will meet its regulatory requirements to ensure that all Directors and people performing "the functions of, or functions equivalent or similar to the functions" of a director are fit and proper individuals to carry out their roles, which includes compliance with the 'duty of candour' and the Nolan principles.

2. Introduction

As a Health service provider, the Trust currently has a general obligation to ensure that only individuals who are fit for their role are employed. The *Health & Social Care Act 2008 (Regulated Activities) Regulations 2014* has introduced an additional fit and proper persons requirement for Directors (FPPR) and people performing "the functions of, or functions equivalent or similar to the functions" of a director. The regulation came into force on 17th November 2014.

It will be the ultimate responsibility of the Chair to discharge the requirement placed on the Trust to ensure that all directors and 'equivalents' meet the fitness test and do not meet any of the unfit criteria.

3. Policy Objectives

The policy objectives are;

- To define the minimum standards for determining the fitness and propriety of individuals on appointment and on an ongoing basis [a 'Fit & Proper Person'] to serve in their respective position within the Trust.
- To explain to external regulators how the Trust intends to comply with the Regulations.
- To define the individuals and/or roles to which this policy applies
- To describe the procedures in relation to the policy
- To outline the evidence required to demonstrate statutory obligations
- To promote stakeholder confidence in the Trust and its officers

4. Scope

This policy applies to Directors and people performing "the functions of, or functions equivalent or similar to the functions" of a director. For the purposes of this policy the positions detailed in Appendix 1 within the Trust are defined as within the scope of this policy.

Any other new position specifically designated by the CEO or the Nominations Committee of Trust Board as being a role which requires the performing of "functions of, or functions equivalent or similar to the functions" of a director'; such a position is likely to involve:

i. High level decision making
ii. Implementing strategies and policies approved by the Board
iii. Developing and implementing processes or systems that identify, assess, manage and monitor risks related to regulated activities and operations; or
iv. Monitoring the appropriateness, adequacy and effectiveness of risk management systems

5. Duties / Responsibilities

5.1 Chair

The Chair has overall responsibility for compliance with the FPPR and will be required to confirm to the CQC that:

- the fitness of all new directors has been assessed in line with the regulations; and
- Declare to the CQC in writing that they are satisfied that all individuals within scope of FPPR are fit and proper individuals for their role.

5.2 Nominations Committee of Trust Board

- Review this policy to ensure fit for purpose
- Receive an annual report on application of FPPR to ensure ongoing compliance

5.3 Council of Governors

Receive an annual report on application of FPPR to Non-Executive Directors.

5.4 Director of Workforce & Organisational Development (DofWOD)

The DWOD is responsible for:

- Administering the policy; and
- Ensuring compliance with relevant obligations described within the Regulations and any changes to the requirements and recommending the appropriate policy amendments to the ***Nominations Committee of the Trust Board and Council of Governors***
- Ensuring that all appropriate documentation is completed, stored and ***available to the Care Quality Commission for inspection upon request.***

5.5 Affected Individuals

Individuals who fall within the policy are responsible for:

- The provision of their consent to the checks described in ***Appendix 4*** on request for the purposes of this policy
- The signing of the declaration that they are a fit and proper person at ***Appendix 2*** *on appointment and on an annual basis*
- The provision of evidence of their qualifications, experience and identity documents on appointment or on request to confirm the competencies relevant to the position at ***Appendix 4***
- The identification of any issues which may affect their ability to meet the statutory requirements on appointment and bringing their issues on an ongoing basis to the Chief Executive (for Executive and other Directors and Chief Information Officer) and the Chairman for NEDs. The Chair should raise any issues with the Lead Governor.

5.6 Members of Staff

Raise issues of concern via appropriate processes and/or policies i.e. Whistleblowing Policy or directly to Director of Workforce & Organisational Development

6. General Principles

6.1 What is a "fit & proper person"?

Regulation 5 of the Health & Social Care Act 2008 (Regulated Activities) Regulation 2014 sets out the criteria that a director and/or equivalent ***must*** meet. They must:

- Be of good character;
- Have the qualifications, skills and experience necessary for the relevant position.
- Be capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010;
- Not have been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider;
- Not be prohibited from holding the relevant position under any other law, eg under the Companies Act or the Charities Act.

6.2 Who approves a person as 'Fit & Proper'?

For a person to be "fit and proper" for the purposes of this policy, the Board and Council of Governors, delegate to individuals listed below to satisfy themselves that individuals are a "fit & proper person". The following table sets out the delegations: (***appendix 1***)

Identified Position	Who (the delegate) with authority to approve a person as "fit & proper"
Chair	***Lead Governor***
Executive Directors, Directors, Company Secretary	***Chair***
Non-Executive Director (excluding Chair)	***Chair***
CEO	***Chair***
Head of Communications and Chief Information Officer	***CEO***

6.3 Fit & Proper Person Test

This is defined in *Schedule 4* of the *Health & Social Care Act 2008 (Regulated Activities) Regulations 2014* in two parts; *good character(part 2)* and *unfit persons test (part 1)* and its purpose is to ensure that the Trust is NOT managed or controlled by individuals who present an unacceptable risk to the organisation or to patients.

Under Schedule 4, Part 1, a director will be deemed ***unfit*** if they:

- Have been sentenced to imprisonment for three months or more within the last five years, although CQC could remove this bar on application;
- Are an undischarged bankrupt;
- Are the subject of a bankruptcy order or an interim bankruptcy order;
- Have an undischarged arrangement with creditors;
- Are included on any barring list preventing them from working with children or vulnerable adults.

Under Schedule 4, Part 2 a director will ***fail*** the 'good character' test, if they:

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence;
- Have been erased, removed or struck off a register of professionals maintained by a regulator of health or social care.

6.4 The Nolan Principles

It is anticipated that this policy is operated alongside the Nolan principles Board members and equivalents are expected to promote and support these principles by leadership and example (***Appendix 6 - List of Nolan Principles***)

7. Policy Procedures

Director & 'Equivalent' appointments

All appointments will require appropriate approval for persons detailed in Section 6.2 prior to confirmation of offer of employment/office. An agreed signed off process with all relevant checks (***Appendix 4***) will be carried out prior to final checking by the designated person (see section 6.2 above) and unconditional offer. All conditional offers will be conditional on meeting the statutory requirements.

Disqualification

A failure or refusal by a candidate for appointment to comply with any of the procedures set out in this policy will immediately disqualify that person from the proposed appointment.

Decisions for Candidates

The Director of Workforce and OD will notify any prospective candidate for appointment as soon as is practicable if that person is determined to be ineligible under this Policy.

Existing Staff

Investigation

If a concern regarding an individual is brought to the attention of the Trust, an appropriate investigation will be carried out by an appropriately person/body dependent on the particular circumstances.

Where an individual's fitness to carry out their role is being investigated, the CQC states that "*appropriate interim measures may be required to minimise any risk to service users*". This may mean that an individual's duties may need to be temporarily varied or closely supervised pending investigation and in some cases suspension may be considered.

Any failure by an affected individual to co-operate with such an investigation without an acceptable (as defined by the Trust Chair) explanation, will result in suspension without pay/payment of fee until the matter is concluded.

If an investigation has concluded that an individual carrying out an identified position under this policy may no longer meet the requirements of the "fit and proper person test" the following 2 stage procedure will be applied:

Fit & Proper Person Hearing

If there is sufficient evidence that an individual carrying out one of the identified positions under this policy may no longer be a fit and proper person and the evidence is such that formal action may be required, then that person will be invited to a hearing to give them the opportunity to test the evidence and/or offer an explanation for consideration of the panel.

Fit & Proper Person Appeal Hearing

If an individual carrying out one of the identified positions under this policy has been determined to no longer be a fit and proper person, then that person may appeal that decision in writing within 10 days of receipt of notification of Trust's decision.

Evidence

The regulations require certain information to be available as evidence in respect of persons employed or appointed by the Trust. The information required is described in *Schedule 3* of the Regulations (***see appendix 3***).

Based on the regulations and cross-referenced with the guidance provided by the CQC a simple check sheet (***see appendix 4***)has been developed in order to ensure all appropriate information has been gathered and is available for inspection.

Confidentiality

All information provided by a person in accordance with this Policy will be kept confidential in accordance with the terms of the Trust's confidentiality and privacy policies. However, a person seeking to demonstrate that they are a 'fit and proper person' in accordance with this policy consents to the Trust disclosing, to Regulators, the extent that is necessary any personal information (as per Data Protection Act 1988) and confidential information for the purpose of undertaking the checks required by this policy and for the related purposes of this policy.

8. Dissemination Process – all policies

Documents will be disseminated via written notification to staff covered by this policy, prospective candidates and published on the Intranet.

9. Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity both within our workforce and in service delivery. This policy will be implemented with due regard to this commitment.

An Equality Impact Screening Assessment will be completed and the outcome noted on Appendix M3 of all policies

10. Supporting References

CQC Guidance for NHS Bodies November 2014	Regulation 5: Fit & Proper persons: directors and Regulation 20:duty of candour
Health & Social Care Act 2008 (Regulated Activities) Regulations 2014	SI 2014/2936, reg 20; SI 2014/2936, reg 5
NHS Guidance	NHS Employers Employment Checks etc

Professional Standards Authority	Standards November 2013
Charities Commission Guidance	2013/14
Disclosure & Barring identity Check Guidance	July 2014
Equality & Human Rights Commission	Employment Statutory Code of Practice
NHS Standard Contract 2014/15:	Updated Technical Guidance (Appendix 5: Contractual requirements relating to duty of Candour
NHS Patient Safety Agency, being Open Framework	Provision of guidance on communicating about patient safety incidents with patients, families and carers
National Patient Safety Agency, Seven Steps to Patient Safety	Definitions of levels of harm
CQC (Registration requirement) Regulations 2009	Regulations 16-18 outline the notifications required by CQC
NHS Litigation Authority	Saying Sorry
General Medical Council Guidance	Good Medical Practice 2001, Guidance on 'duty of candour'
Trust policies	Whistleblowing Policy Safeguarding Policy Incidents Policy Recruitment & Selection Policy

11. Training

The approved policy will be promoted via the Trust intranet for all staff and detailed briefings will be carried out with all affected individuals.

Coaching will also be available to managers on a 1-2-1 basis for individual cases.

12. Appendices to this policy

APPENDIX 1 – LIST OF EQUIVALENT POSITIONS CURRENTLY IDENTIFIED *(subject to annual review)*

All Directors in attendance at Trust Board positions irrespective of voting rights:

- Chair
- Non-executive Directors
- Executive Directors
- Director of Workforce and OD
- Director of Strategy and Transformation

Equivalent Positions

- Company Secretary
- Head of Communications
- Chief Information Officer
- Chief Pharmacist
- Responsible Officer for the Human Tissue Authority

APPENDIX 2 – SELF-DECLARATION FORM AS PER SCHEDULE 4. To be completed by all applicants.

Fit & Proper Persons Director/Equivalent Declaration

Regulation 5 of the Draft Health & Social Care Act 2008 (Regulated Activities) Regulation 2014 sets out the criteria that a Director must meet, to ensure unfit persons do not become or continue as directors (or those performing similar or equivalent functions). As part of our assurance process we ask that all individuals in identified positions complete a self-declaration on appointment and on an annual basis.

PART 1 Unfit person test

I hereby confirm that I am **NOT**

i. An undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
ii. Subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
iii. A person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
iv. A person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
v. Included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
vi. Prohibited from holding the relevant office or position, (or in the case of an individual from carrying on the regulated activity, by or under any enactment).

PART 2 Good Character

I hereby confirm that I am a person of good character and;

i. Have NOT been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.
ii. Have NOT been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

PART 3 General

i. I am NOT subject to any investigation, or have been notified of such or under any performance management regime for any reason.
ii. I am NOT aware of any incident or issue in my previous employment which may affect my status as a fit and proper person to fulfil my role.
iii. I am NOT aware of any incident or issue which may affect my status as a fit and proper person to fulfil my current/potential role.
iv. I have read, understood and will adhere to the Trust's FPP Policy.

Date: _____ **Signature:** _____

Print Name: _____

APPENDIX 3 - SCHEDULE 3: INFORMATION REQUIRED IN RESPECT OF PERSONS EMPLOYED OR APPOINTED FOR THE PURPOSES OF A REGULATED ACTIVITY

1. Proof of identity including a recent photograph.
2. Where required for the purposes of an exempted question in accordance with section 113A(2)(b) of the Police Act 1997, a copy of a criminal record certificate issued under section 113A of that Act together with, after the appointed day and where applicable, the information mentioned in section 30A(3) of the Safeguarding Vulnerable Groups Act 2006 (provision of barring information on request).
3. Where required for the purposes of an exempted question asked for a prescribed purpose under section 113B(2)(b) of the Police Act 1997, a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults.
4. Satisfactory evidence of conduct in previous employment concerned with the provision of services relating to—
    (a) health or social care, or
    (b) children or vulnerable adults.
5. Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended.
6. In so far as it is reasonably practicable to obtain, satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.
7. A full employment history, together with a satisfactory written explanation of any gaps in employment.
8. Satisfactory information about any physical or mental health conditions which are relevant to the person's capability, after reasonable adjustments are made, to properly perform tasks which are intrinsic to their employment or appointment for the purposes of the regulated activity.
9. For the purposes of this Schedule—
    (a) "the appointed day" means the day on which section 30A of the Safeguarding Vulnerable Groups Act 2006 comes into force;.
    (b) "satisfactory" means satisfactory in the opinion of the Commission;
    (c) "suitability information relating to children or vulnerable adults" means the information specified in sections 113BA and 113BB respectively of the Police Act 1997.

APPENDIX 4 – INDIVIDUAL CHECK SHEET

On appointment	Existing Staff
Pre-employment Checks New Starter Form Right to work documentation Form Asylum & Immigration Form Occupational Health & Exposure Prone Procedures (EPP)Clearance Professional registration ID checks of original documentation including photo (retain copies) Right to work checks Check of original qualifications (check v person specification) Enhanced DBS Check References Self-declaration	Enhanced DBS Check (annual) Self-declaration (annual) Appraisal Information Absence Record (Occ Health referral as necessary) Compliance with appropriate policies e.g. FPPR, Incidents, safeguarding etc Professional Registration Check
Recruitment & Selection Recruitment & selection based on values as well as qualifications, skills etc Conditional Offer Letter (subject to above checks) Unconditional Offer Letter Contract to include additional FPPR requirements	As appropriate i.e. on new role Mutual variation of the contract: Contract to include additional FPPR requirements
Provider Checks Provider Checks e.g. provider whose registration has been suspended/cancelled, public inquiry reports about provider, disqualification from professional regulatory body, serious case reviews, homicide investigations for mental health trusts, criminal prosecutions against provider, ombudsman reports, CQC inspection reports & actions taken	
Unfit Person Criteria Checks Check for bankruptcy, sequestration, insolvency, insolvency and arrangements with creditors Check that not prohibited from holding office e.g. Companies Act 2006 or Charities Act Where any evidence found which suggests person unfit, evidence should be reviewed and decisions documented.	Where any evidence found which suggests person unfit, evidence should be reviewed and decisions documented.

APPENDIX 5 – CQC GUIDANCE ON EVIDENCE TO MEET FPPR REGULATIONS

Component of the regulation	On appointment	Existing Personnel
5(3)(a) the individual is of good character	NHS Employment Checks Previous employer references (last 3 years) DBS Checks Values Based Recruitment & Selection Self-declaration (appendix 2)	NHS Employment Checks (on file) Previous employer references (last 3 years) – on file (where not available – appraisal documentation) DBS Checks (annual?) Self-declaration (appendix 2)
5(3)(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position for which they are employed	Evidence to confirm individual meets 'Person specification', original to be seen, signed off and copies retained Check of relevant professional register Values Based Recruitment & Selection Appraisal information from previous/current employer where available Self-declaration (appendix 2)	Check that individual meets documented 'Person specification' Professional registration checks Appraisal information Self-declaration (appendix 2)
5(3)(c) the individual is able by reason of their health, after such reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or for the work they are employed	Occupational Health Clearance	Occupational Health referral as necessary Absence record
5(3)(d) the individual has not been responsible for, been privy to, contributed to or facilitated, any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity	References covering last 3 years employment to cover serious misconduct or mismanagement Provider Checks e.g. provider whose registration has been suspended/cancelled, public inquiry reports about provider, disqualification from professional regulatory body, serious case reviews, homicide investigations for mental health trusts, criminal prosecutions against provider,	Appraisal information Compliance with Trust policies including: • FPPR Policy • Safeguarding Policies • Incidents Policy Incidents/concerns raised via: • Whistleblowing Policy • Professional registration Referrals

	ombudsman reports, CQC inspection reports & actions taken Professional Registration/Regulator checks DBS Checks Self-declaration (appendix 2)	
5(3)(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual	DBS Checks Check for bankruptcy, sequestration, insolvency, insolvency and arrangements with creditors Check that not prohibited from holding office e.g. Companies Act 2006 or Charities Act Where any evidence found which suggests person unfit, evidence should be reviewed and decisions documented.	DBS Checks Self-declaration (annual) Professional registration checks
5(6) where an individual holds an office or position referred to in para 2(a) or (b) no longer meets the requirements in para (3) the service provider must- Take such action as is necessary & proportionate to ensure that the office or position in question is held by an individual who meets such requirements & (b) if the individual is a health care professional, social worker or other professional registered with a health care or social regulator in question	DBS Checks Self-declaration Professional registration checks References covering last 3 years	DBS Checks Self-declaration Professional registration checks Appraisal Any relevant investigation & outcome to be properly recorded with any relevant interim measures
20(1) a health & service body must act in an open and transparent way with relevant persons in relation to care & treatment provided to the service users in carrying on a regulated activity	Incidents & Openness Policy FPPR Policy Safeguarding Policies Disciplinary policy Whistleblowing Policy PDR Policy with appropriate training	
20(2) As soon as is 20(2) As soon as is reasonably practicable after becoming aware	DBS Checks Professional Registration Checks	Appropriate review, monitoring and follow up regarding any issues, concerns or incidents in

that a notifiable safety incident has occurred a health service body must– (a) notify the relevant person that the incident has occurred in accordance with paragraph (3)and 20(3) The notification to be given under paragraph (2)(a) must– (a) be given in person by one or more representatives of the health service body, (b) provide an account, which to the best of the health service body's knowledge is true, of all the facts the health service body knows about the incident as at the date of the notification, (c) advise the relevant person what further enquiries into the incident the health service body believes are appropriate, (d) include an apology, and (e) be recorded in a written record which is kept securely by the health service body.	Pre-employment checks References Self-declaration	relation to: Incidents Policy FPPR Policy Safeguarding Policies DBS Checks Professional Registration Checks Self-declaration
20(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must– (b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.	Provider Checks Professional registration Check FPPR policy self-declaration	Incidents Policy Professional registration Checks FPPR policy self-declaration
20(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing— • The provider must ensure that written notification is given to the relevant person following the notification that was given in	N/A	Compliance with following policies: • Incidents Policy • FPPR Policy

person, even though enquiries may not yet be complete. • The written notification must contain all the information that was provided in person including an apology, as well as the results of any enquiries that have been made since the notification in person. (a) the information provided under paragraph (3)(b), (b) details of any enquiries to be undertaken in accordance with paragraph (3)(c), (c) the results of any further enquiries into the incident, and (d) an apology.		
20(5) But if the relevant person cannot be contacted in person or declines to speak to the representative of the health service body– (a) paragraphs (2) to (4) are not to apply, and (b) a written record is to be kept of attempts to contact or to speak to the relevant person.	N/A	Compliance with following policies: • Incidents Policy • FPPR Policy • Safeguarding Policies
(6) The health service body must keep a copy of all correspondence with the relevant person under paragraph (4).		Compliance with Incidents Policy

APPENDIX 6 – LIST OF NOLAN PRINCIPLES

The Seven Principles of Public Life, known as the **Nolan Principles**, were defined by the Committee for Standards in Public Life. They are:

1. **Selflessness**: Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.
2. **Integrity**: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.
3. **Objectivity**: In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.
4. **Accountability** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
5. **Openness**: Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands it.
6. **Honesty**: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership Holders of public office should promote and support these principles by leadership and example.

12. Mandatory Appendices Bundle

APPENDIX M1: Executive Governance Committee checklist for new or renewed policies

Name of Policy: Fit & Proper Person and Duty of Candour Policy
Date Form Completed: 26th January 2015

Name of Policy Facilitator / Policy Sponsor: Anne Cholmondeley

Question	Response Y/N
Does the policy have the appropriate approved front cover layout including the ROH NHS Foundation Trust Logo	**Y** **Y**
Is the policy written in 12 point Arial font	**Y**
Is the Document Control Information Bundle complete o Author/ Sponsor/ Committee information o Version Tracking o Procedural checklist o Consultation tracking sheet o Compliance monitoring o Performance management o Contents page	**Y**
Has the policy had an EqIA done?	
Have Mandatory Appendices M1-M4 been completed and provided to the group?	
Has a review date that is a maximum of 2 years from the date of ratification / approval been included in the document control information?	
Are the pages in the policy numbered?	**Y**
Is the policy name included in the footer?	**Y**
If this policy replaces a previous document, have the results of a previous audit of compliance (undertaken in the previous 2 years) been provided to the group	**N/A**
Does the policy include references	**Y**
Has the EMT submission sheet been completed (See Policy on procedural documents **Appendix 2**)	**Y**
Has the Memo to Managers been completed (See Policy on procedural documents **Appendix 3**)	

Additional comments from the group approving the policy	
Name of group approving the policy	**Board and Council of Governors**
Chair of the group approving the policy	**Chair**
Signature on behalf of the group	

APPENDIX M2: Implication for implementation of this policy

This document must be completed and accompany the policy, procedure or guideline through the final ratification and approval process.

Date: 26th January 2014

Name of Policy, Procedure or Guideline: Fit & Proper Persons Trust Policy

Name of Policy Facilitator: HR Associate

Name of Policy Sponsor: Director of Workforce & OD

The following points include those aspects that need to be considered prior to the authorisation of this policy:

Staffing issues arising from implementation of this policy:

- For all staff covered by policy to be aware of their responsibilities in relation to 'serious issues' or concerns and the mechanism for raising their concerns.
- Check that all statutory requirements are met in relation to all positions outlined in the policy & any arising staff issues are properly addressed

Training issues arising from implementation of this policy:

- Dissemination of new policy and responsibilities to all relevant personnel
- The training of recruiting managers in relation to checks required for 'affected positions' and appropriate recruitment & selection methods.

Funding/Cost Issues arising from implementation of this policy:

- Compliance with policy
- Training in relation to policy and values based recruitment

Barriers to implementation of this policy:

Reliance on external bodies to supply appropriate information and difficulty in determining whether an individual is a fit and proper person where their current or previous employer is subject to external scrutiny.

Implications on other services or processes from implementation of this policy:

This policy should be operated alongside other key Trust policies, for example, *Safeguarding Adults and Families at Risk Policy* (V4Sept16), *Safeguarding Children Young People and Families Policy* (v5 Jan-17), *Incident Reporting, Event Investigation, Analysis and Improvement and Being Open Policy* (0114) and *Whistleblowing Policy* (Aug2016).

APPENDIX M3: Equality Impact Assessment Form

Equality Impact Assessment
Form A – Policy Screening Impact Assessment

Fit & Proper Person Test Policy	
The completion of appropriate checks to ensure that new appointments and existing personnel is essential to ensure that the statutory requirements (*Health & Social Care Act 2008 (Regulated Activities) Regulations 2014)* are met and that members of the Board and equivalent positions are carried out by fit and proper persons to safeguard quality of care.	
Name and details of those involved in the screening equality impact assessment	
Date of screening assessment	

Negative Impact		
Could the policy or strategy have a significant negative impact on any of the protected characteristics? Could the policy or strategy: • Presenting any problems or barriers to any staff, community or group • Excluding people as a result • Worsening existing discrimination and inequality • Having a negative effect on relations with staff or the community	Yes	No
All equality strands listed below		✓
Age		✓
Disability		✓
Gender Reassignment		✓
Marriage and Civil Partnership		✓
Pregnancy and maternity		✓
Racial Group		✓
Religion or Belief		✓
Sex		✓
Sexual Orientation		✓
Please give any relevant information / details:		

Positive Impact		
Could the policy or strategy have a significant positive impact on equality by reducing inequalities that already exist? Could the policy or strategy help meet our duty to: • Promoting equality of opportunity • Eliminating discrimination and harassment • Promoting good community relations • Promoting positive attitudes towards disabled people • Encouraging participation of disabled people • Considering more favourable treatment of disabled people • Promoting and protecting human rights	Yes	No
All equality strands listed below		✓
Age		✓

Disability		✓
Gender Reassignment		✓
Marriage and Civil Partnership		✓
Pregnancy and maternity		✓
Racial Group		✓
Religion or Belief		✓
Sex		✓
Sexual Orientation		✓
Please give any relevant information / details		

Evidence
What is the evidence for the above What does any research say What additional research is required to fill any gaps in
The implementation of the policy is required to ensure that the statutory obligations introduced by the *Health & Social Care Act 2008 (Regulated Activities) Regulations 2014* are met.

Full impact assessment		
In light of the above does the policy or strategy require a full equality impact assessment (refer to the flowchart on page 3)	**Yes**	**No**
Is a full Equality Impact Assessment required		✓
Please rate the priority High / Medium / Low	LOW	

APPENDIX M4: Implementation Plan – Fit and Proper Persons Policy

No	Objective	Responsible	Deadline	Status
1	Policy sign off	Board	4th Feb 2015	
		Council of Governors		
2	Policy briefing to affected individuals	DWOD	End Feb 2015	
	Checks for existing postholders v statutory requirements	DWOD	End Feb 2015	
	Appropriate actions on any matters arising	DWOD	End March 2015	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 ENCLOSURE NUMBER: 6

DRAFT REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Jo Chambers, Chief Executive**
AUTHOR(S)	**Jo Chambers, Julian Denney**
TITLE	**Governance Declaration – Quarter 3 2014/15**

SUMMARY

To provide assurance on behalf of the Trust Board in relation to the Governance Declaration for Quarter 3 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 licence.

RECOMMENDATIONS

It is recommended that the Board note the following submissions to Monitor made on its behalf by the CEO and Chairman:

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 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 3 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 Q3 submission was due on the 31st January 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 October 2014 to 30th December 2014 is contained in the Trust's Corporate Performance Report.

The Trust is below the 85% threshold for capital expenditure threshold for Quarter 3 and as such is required to resubmit a revised capital programme for Quarter 4. The main variances relate to the e-Prescribing system, which is currently going through the procurement stage and is therefore slipped into 2015/16 and the Data Warehouse. The Trust is currently reviewing the requirement for a Data Warehouse following the successful migration of our databases to SQL2014.

The Board is required to declare that it anticipates that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the reforecast plan. It is recommended that the Board signs this declaration, as the remaining expenditure largely relates to Estate and Radiology schemes that are already in progress.

2. Service Performance Targets

The table of Monitor requirements and evidence is Appendix One of this report. All targets have been met except for the 18 week RTT standard for admitted and non-admitted patients as explained below.

The Trust has breached the RTT standard in Q3 in line with the national initiative to reduce long waits as forecast in the Q2 report. This was agreed and funded nationally with a contract variation in place and agreement to not levy the usual contractual fines for breaches. The Trust returned to compliance in December. This position is agreed with Monitor and Commissioners.

The Trust is at risk of breaching the 52 week RTT target in Quarter 4 – note this is not a target included within Appendix A

The ROH also provided assistance to a number of other Trusts regarding their own RTT targets.

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 Director of Strategy and Transformation who took up appointment in November 2014. The Trust also approved the formation of a Transformation Committee Chaired by a NED; a workshop was held in December by members of the Committee to underpin the initiation of the Transformation Programme
- In January 2015 the Director of Nursing and Governance (an Executive Director) resigned. An interim Director is expected to be appointed and to take up appointment in February
- The Council of Governors has initiated the process of recruiting an additional non-executive Director with a clinical background. This appointment is intended to support the input of the existing medically qualified NED and to strengthen clinical governance across the organisation.
- There were elections completed in the following constituencies:
    - Birmingham & Solihull (2 seats) -Sue Arnott, Anthony Thomas
    - Rest of England & Wales (1 seat) - Alan Last
    - Staff: Non-clinical (1 seat)- Alison Braham

The report of voting for the above election, which closed at noon on Friday 7th November, was as follows:

Public: Birmingham and Solihull
Number of eligible voters: 3,783 Total number of votes cast: 623 Turnout: 16.5% Number of votes found to be invalid: 11 Blank or Spoilt No declaration form received 11 0 Total number of valid votes to be counted: 612
Result (2 to elect)
The following candidates were elected (in order of election):
ARNOTT, Sue THOMAS, Anthony

Public: Rest of England and Wales
Number of eligible voters: 1,923 Total number of votes cast: 373 Turnout: 19.4% Number of votes found to be invalid: 3 Blank or Spoilt No declaration form received 3 0 Total number of valid votes to be counted: 370
Result (1 to elect)
The following candidate was elected: LAST, Alan Thomas

Alison Braham was uncontested

- 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 twice during the quarter and reviewed the relevant assurances that risks to compliance are being managed.
- Following the publication of the CQC Inspection report on 17th October 2014, the report specified the compliance actions the Trust must take relating to regulated activities as well as actions which the Trust should take relating to non-regulated activities. 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. 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,
    -
- There has been a review of medicines management in the Trust which has identified a number of areas for improvement which are being addressed. Board members have been kept up to date through briefings and key contacts at CQC and Monitor have been informed. Monitor have confirmed that an exception report is not required in respect of these activities.
- Expenditure on agency staffing has increased from £1.0m in Quarter 2 to £1.5m in Quarter 3. This continues to be driven by the challenges of providing a compliant junior doctor service, with additional locums appointed in Quarter 3 to support this. We have also seen an increase in the use of agency staff on the wards as a result of an increase in the acuity of patients and the corresponding steps taken to ensure safe staffing levels. The Trust are currently reviewing a revised medical workforce model and ward staffing model with a view to attracting substantive staff into new roles to reduce the reliance on agency staff.

- The Audit Committee met once during the period in respect to this declaration and can offer the following assurance:

    - 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.

- 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 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 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 SFI's 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.

APPENDIX ONE

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 3 CQC published their formal report; the Trust accept the overall rating and has an action plan to address them as described above.

In Quarter 3 an election was completed as described above.

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

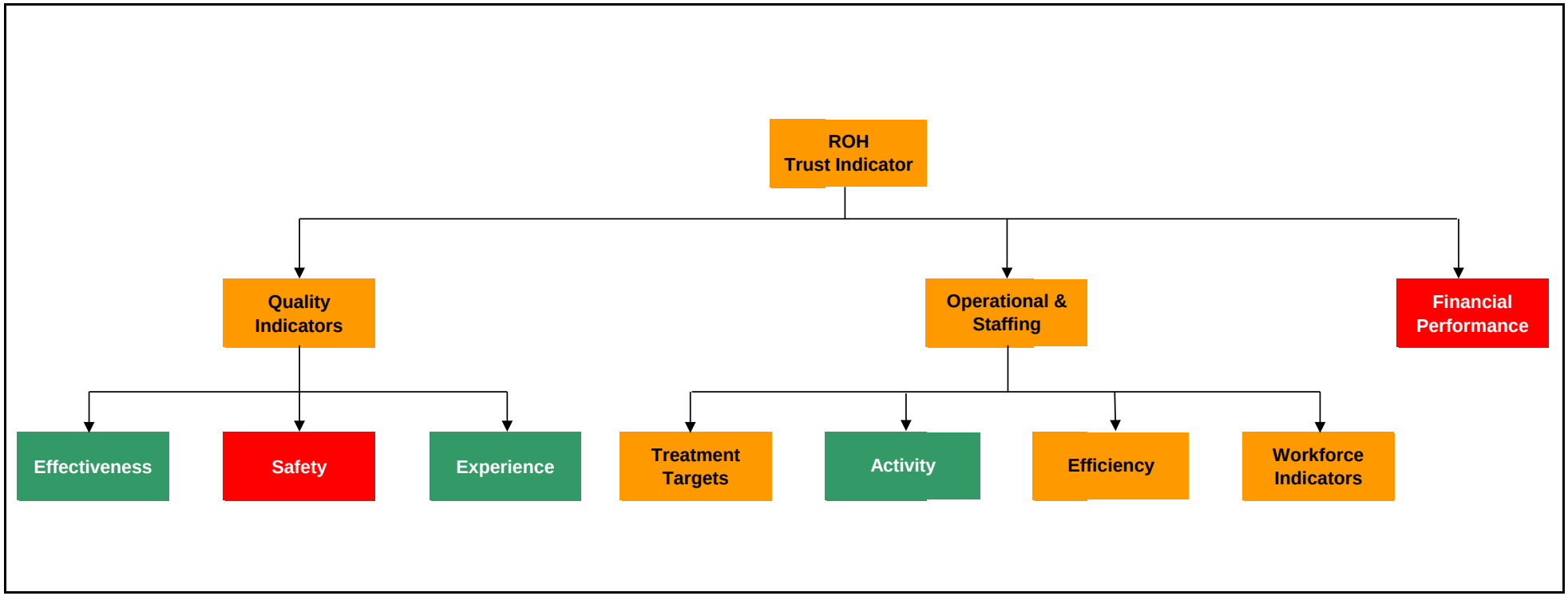
Targets and indicators with thresholds for 2014/15

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	Not achieved (86.3%) – See Section 2 for rationale
Referral to treatment time, 18 weeks in aggregate, non-admitted patients	95%	1.0	CPR	Not achieved (92.7%) – See section 2 for rationale
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	N/A			No

submission)				
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.

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



Quarterly Detailed Report

Executive Summary as at December 2014

Headlines

- The Trust had a never event in the month, relating to a wrong site spinal procedure.
- For the year to date the Trust made a surplus before impairments of £546k compared to a planned surplus of £838k.
- Backlog increased by 52 cases, and there was a 52 week breach.

Monitor Compliance Framework Targets	December 2014 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	95.52%	92.65%	1	6
Referral to treatment time - Admitted %	90%	93.05%	86.32%	1	6
Referral to treatment time - Incomplete Pathways %	92%	95.20%	95.28%	0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	75%	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%	97%	99%	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	1 never event in month				

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

Key Trust Targets		December 2014 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	1	↓	3
	Complaints	<=12	5	↓	4
	CQUINS	100%	90%	→	11
	Total Unexpected Hospital Deaths	0	0	↓	5
Efficiency & Workforce	Total Backlog Patients	<400	342	↑	6
	Incomplete 14 - 18 Week Waiters	<450	520	↑	6
	Total Admitted Patient Care Patients vs Plan	100%	94.7%	↑	7
	Unused Theatre Sessions	<44	21	→	8
	Sickness	3.7%	5.4%	↑	9
Financial	Surplus	£838k	£546k	↑	10
	CIP	£1,315k	£1,250k	↑	11
	Agency Expenditure	£91k	£322k	↑	10
	Locum Doctor Expenditure	£46k	£206k	↑	10

Trust Summary

There has been a 52 week breach in December, with a further 2 confirmed breaches in January. The cases are spinal deformity patients who were due to be operated on at BCH within 52 weeks, with BCH cancelling the theatre availability.

Backlog has increased by 52 cases in month.

All 3 RTT targets were met in month. However, the Trust has recorded in its Q3 return that it had breached both the non-admitted and admitted targets for the quarter, and hence these targets are showing as red above. These breaches are as a result of the planned breaches in October and November in order to reduce the backlog in line with the national initiative. In reality, as the breaches were nationally agreed, this will not impact on the Trust's governance rating, and this therefore remains green.

For the year to date the Trust made a surplus before impairments of £546k compared to a planned surplus of £838k. This represents an in-month deficit of £224k against a planned deficit of £67k. Within this position is a c £100k loss incurred by treating a number of spinal patients at Cromwell in during November and December in order to reduce the waiting list, driven by a complication in one patient that incurred significant private paediatric intensive care costs. The Trust is currently pursuing commissioners to cover this shortfall.

Both elective and day case performance was 103% of plan.

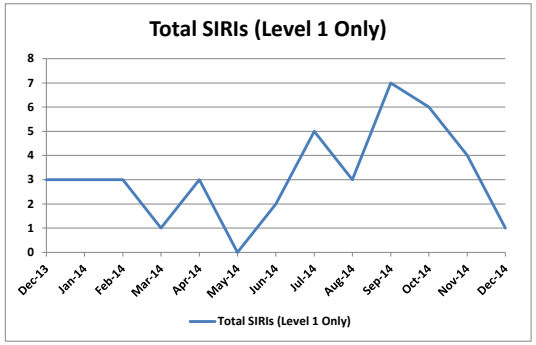
Sickness absence has remained red rated, and has decreased in month. However, this in line with expected seasonal trends.

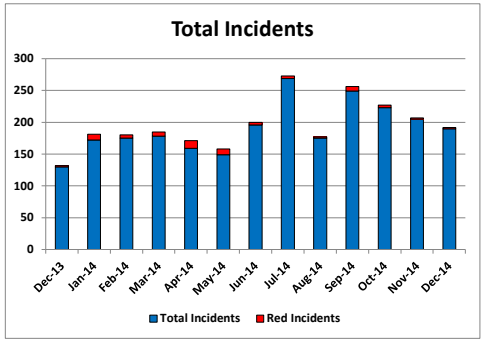
Quarterly Detailed Report
Safety Indicators as at December 2014

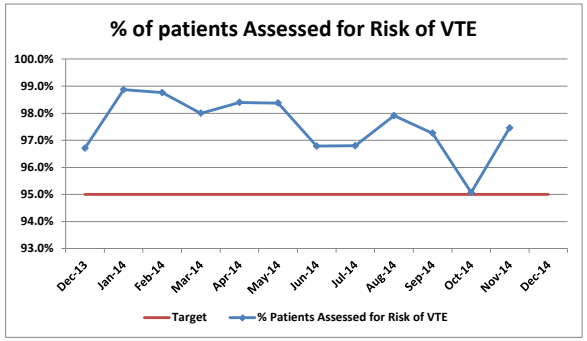
Headlines

- There has been a never event in month - this was a wrong site spinal procedure.
- The number of reported incidents has decreased and has become amber rated.
- Patient falls and SIRIs have decreased in month.

	Monitor	National	CQC Standard		Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	14/15 Full Year Position
Safety		N	4,16	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	1	1
			4,16	Total SIRIs (Level 1 Only)	3	3	3	1	3	0	2	5	3	7	6	4	1	3
			4,16	SIRI per 1000 bed days	1.01	0.90	0.85	0.27	0.89	0.00	0.56	1.30	0.86	1.90	1.58	1.07	0.31	0.94
			4,16	Total Incidents	130	172	175	178	159	149	196	269	175	249	223	205	190	202
			4,16	Incidents per 1000 bed days	43.61	51.71	49.30	47.94	47.04	41.98	54.87	69.74	50.23	67.52	58.73	54.71	59.69	56.06
			4,16	Red Incidents	2	9	5	7	12	9	4	4	2	7	4	2	2	5
			9,16	Total Medicine Incidents Reported	8	11	18	18	19	17	12	22	17	12	16	16	20	17
			9,16	Medicine Incidents Reported per 1000 bed days	2.68	3.31	5.07	4.85	5.62	4.79	3.36	5.70	4.88	3.25	4.21	4.27	6.28	0.52
				Medicine Incidents with Harm	2	1	3	3	3	2	4	7	6	4	0	5	5	4
		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	96.71%	98.87%	98.76%	98.00%	98.40%	98.38%	96.78%	96.80%	97.91%	97.27%	95.07%	97.46%		97.21%
			9	Incidence of Hospital Related VTE	1	1	1	1	1	0	1	2	2	3	2	1	1	13
			4	Patient Falls - Inpatients	6	3	6	12	6	7	5	6	5	13	12	7	5	7
			4	Patient Falls per 1000 bed days	2.01	0.90	1.69	3.23	1.78	1.97	1.40	1.56	1.44	3.52	3.16	1.87	1.57	2.73
				Avoidable Patient Falls with Harm					0	0		2	2	2	0	0	0	1
			4,16	% Harm Free Care	97.50%	97.41%	100.00%	97.71%	89.90%	99.02%	96.91%	95.88%	98.25%	98.04%	97.96%	94.50%	91.95%	95.91%







Safety Commentary

VTE Risk Assessment - Reported one month in arrears

There has been a never event in month - this was a wrong site spinal procedure and is discussed in more detail in the Quality Report.

There was 1 SIRI, in comparison to last month's 4.

The percentage of harm free care dropped from 94.5% to 91.95% and therefore remains amber rated.

Total incidents have decreased from 205 to 190.

There have been 2 red incidents in month, consistent with last month.

Medicine incidents have increased, although medicine incidents with harm have remained static at 5.

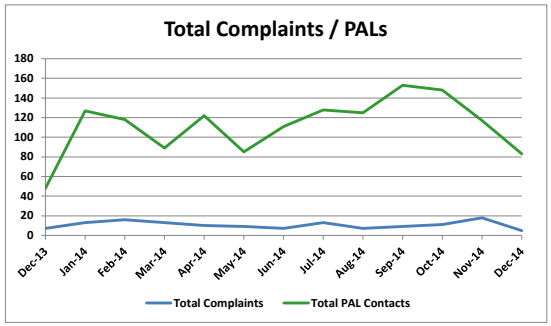
Additional information on all of the above is included in the Quality Report.

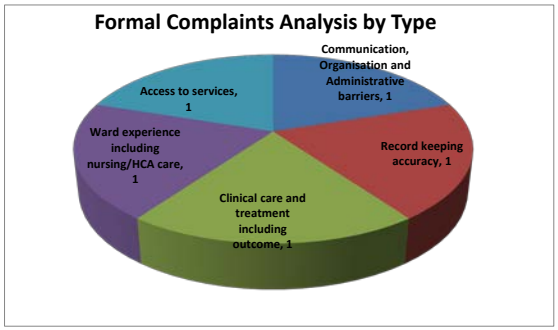
Quarterly Detailed Report
Experience Indicators as at December 2014

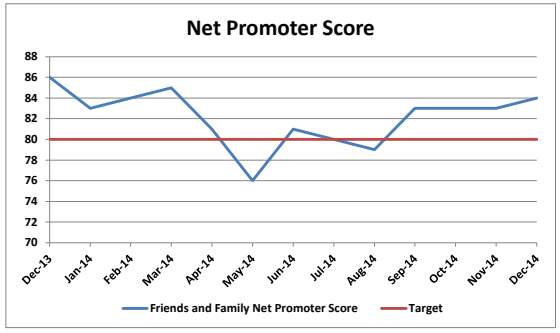
Headlines

- Complaints are down from 18 to 5 have become green rated again.
- PALs contacts decreased from 117 to 83, but the percentage of concerns continues to rise.
- Total compliments increased from 522 to 534.

	Monitor	National	CQC Standard		Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	14/15 Full Year Position
Experience			17	Complaints to Compliments Ratio	1:63	1:37	1:27	1:42	1:46	1:48	1:60	1:31	1:73	1:31	1:42	1:29	1:107	**1:45**
			17	Total Complaints	7	13	16	13	10	9	7	13	7	9	11	18	5	**10**
			17	Complaints reverted to informal <48 hrs	0	0	0	0	0	0	0	0	0	1	1	0	0	**0.2**
			17	Formal	7	13	16	13	10	9	7	13	7	8	10	18	5	**10**
			17	Complaints per 1000 bed days	2.35	3.91	4.51	3.50	2.96	2.54	1.96	3.37	2.01	2.44	2.90	4.80	1.57	**2.73**
				Complaints Response Time (Average No of Days)	49	45	53	25		46	59	41	24		109	67	69	59.29
			17	Total PAL Contacts	48	127	118	89	122	85	111	128	125	153	148	117	83	**119**
			17	PALS Contacts per 1000 bed days	16.10	38.18	33.24	23.97	36.09	23.95	31.08	33.19	35.88	41.49	38.98	31.22	26.08	**33.11**
				Total PALS Concerns		65	65	56	80	59	49	88	73	84	68	67	52	69
			17	Total Compliments	440	481	439	552	455	436	423	409	511	276	465	522	534	**448**
			17	Compliments per 1000 bed days	147.61	144.62	123.66	148.67	134.62	122.85	118.42	106.04	146.67	74.84	122.47	139.31	167.77	**125.89**
				Food - Real Time Patient Survey	96.60%	95.0%	93.0%	98.2%	97.2%	90.6%	97.7%	94.2%	95.0%	95.5%	98.3%	96.8%	96.5%	**95.8%**
			17	Friends and Family Net Promoter Score	86	83	84	85	81	76	81	80	79	83	83	83	84	**81**
				Friends and Family Response Rate	44.0%	40.0%	43.0%	46.0%	53.0%	39.0%	40.0%	53.0%	52.0%	46.5%	51.7%	58.0%	50.3%	**49.3%**







PALS
PALs contacts decreased from 117 to 83, but the percentage of concerns continues to rise, from 57% to 63%.

COMPLAINTS
Complaints are down from 18 to 5 have become green rated again.

COMPLIMENTS
Total compliments increased from 522 to 534, which is significantly higher than last year's December figure.

Further information on experience is included in the Quality Report.

Quarterly Detailed Report
Effectiveness Indicators as at December 2014

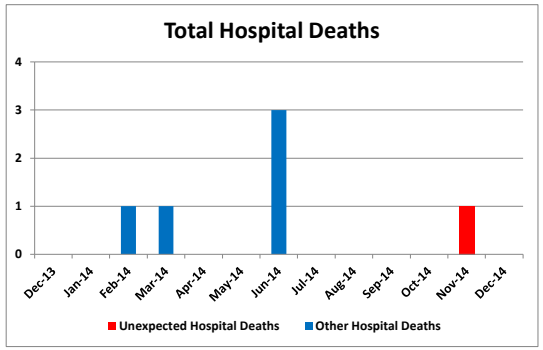
Headlines

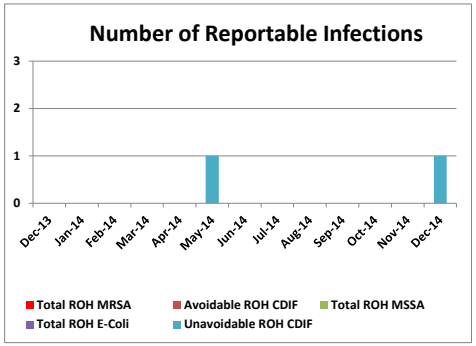
There were no deaths in month.

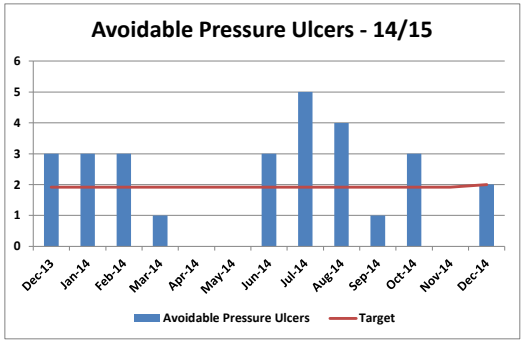
There was one case of C. diff, but this was tested as unavoidable.

There has been a slight decrease in the completion of the WHO checklist.

	Monitor	National	CQC Standard		Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	14/15 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	0	1	1	0	0	3	0	0	0	0	1	0	0.4
			4,18	Hospital Deaths per 1000 bed days	0.00	0.00	0.28	0.27	0.00	0.00	0.84	0.00	0.00	0.00	0.00	0.27	0.00	0.1
			4,18	Unexpected Hospital Deaths	0	0	0	0	0	0	0	0	0	0	0	1	0	0.1
				Other Hospital Deaths	0	0	1	1	0	0	3	0	0	0	0	0	0	3
			8	MRSA % Screened	100.10%	135.40%	102.00%	109.00%	115.00%	118.00%	126.00%	122.20%	107.00%	103.00%	124.90%	125.30%	111.00%	118%
	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	0	0
				Unavoidable ROH CDIF						1	0	0	0	0	0	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	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	1	0	0	0	1
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	1	0	0	0	0	0	0	1	0	0	2	0	0	0
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	2	3	3	1	0	0	3	4	4	1	1	0	2	2
			4	Avoidable Pressure Ulcers per 1000 bed days	1.01	0.90	0.85	0.27	0.00	0.00	0.84	1.30	1.15	0.27	0.79	0.00	0.63	0.55
				% Completion of WHO Checklist	100.00%	100.00%	100.00%	100.00%	98.69%	96.88%	97.88%	96.23%	97.69%	95.92%	97.96%	98.23%	97.81%	97.48%







Effectiveness Commentary

All indicators are green with the exception of the WHO checklist, which has declined slightly and remains amber rated.

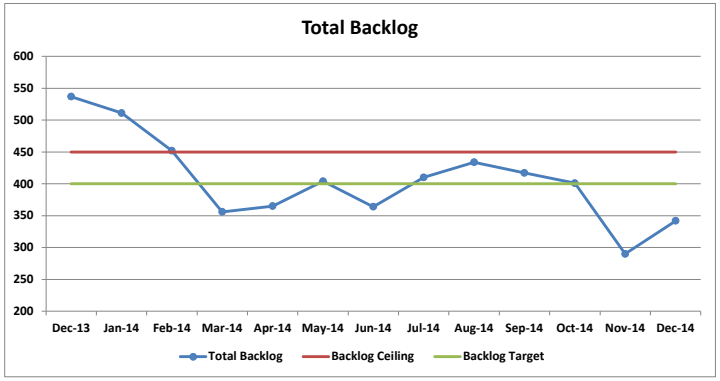
Further information on effectiveness is included in the Quality Report.

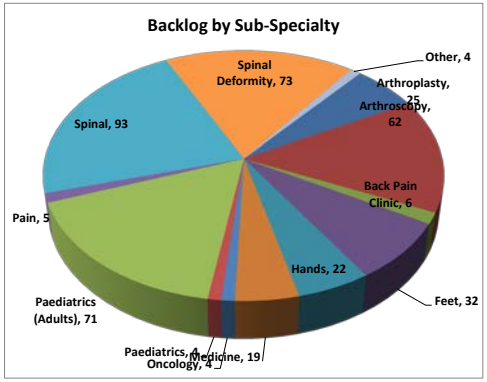
Quarterly Detailed Report
Treatment Targets as at December 2014

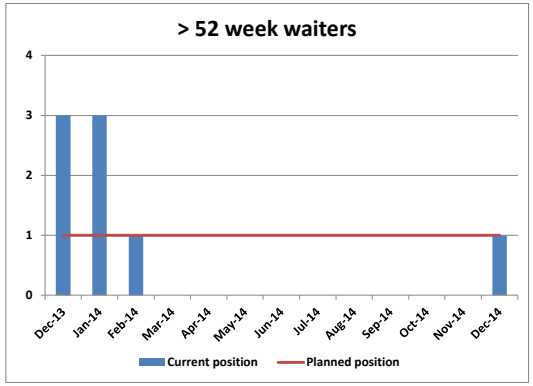
Headlines

- The backlog has increased by 52 cases
- There has been a 52 week breach in December, with a further 2 confirmed cases in January. The cases are spinal deformity patients who were due to be operated on at BCH within 52 weeks, with BCH cancelling the theatre availability.
- The 62 day cancer target has been missed, although overall performance for the quarter has been met.

	Monitor	National	CQC Standard		Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	14/15 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	3	3	1	0	0	0	0	0					1	1
				Referral to treatment waits over 45 weeks	6	6	5	7	5	4	5	4	4	8	11	6	12	12
	M	N	4	Referral to treatment time - Non Admitted %	95.12%	95.13%	95.00%	95.01%	95.32%	95.48%	95.15%	95.75%	95.24%	95.05%	92.68%	92.65%	95.52%	94.76%
	M	N	4	Referral to treatment time - Admitted %	83.25%	83.65%	88.76%	88.37%	91.12%	92.51%	91.74%	93.21%	91.57%	91.96%	91.63%	86.32%	93.05%	91.16%
	M	N	4	Referral to treatment time - Incomplete Pathways %	87.49%	92.71%	93.21%	94.63%	94.75%	94.43%	95.10%	94.52%	94.09%	94.26%	94.67%	95.96%	95.20%	94.72%
			4	Non admitted Backlog - Pathways waiting >18 wks	259	260	199	152	156	211	174	173	168	168	137	110	118	118
			4	Admitted Backlog - Pathways waiting >18 wks	278	251	253	204	209	193	190	237	266	249	264	180	224	224
			4	Total Backlog - 18 week pathways waiting >18 wks	537	511	452	356	365	404	364	410	434	417	401	290	342	342
			4	Incomplete 14 -18 Week Waiters	721	721	520	475	379	574	547	536	471	594	531	438	520	520
				Non Admitted Median Wait (Weeks)	7.96	8.54	8.53	7.91	7.80	8.46	8.90	8.39	8.46	9.00	8.92	8.10	8.45	#N/A
				Admitted Median Wait (Weeks)	11.06	11.23	10.67	9.95	9.20	9.29	9.49	9.54	9.69	10.64	10.06	10.79	10.61	10.61
				Incomplete Median Wait (Weeks)	7.09	7.10	6.02	5.62	5.90	6.65	5.71	5.81	6.24	6.30	5.63	5.44	6.40	#N/A
	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%	97.30%	99.69%
	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%	100.00%	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%	94.10%	100.00%	100.00%	100.00%	100.00%	100.00%	99.07%
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	66.70%	81.80%	100.00%	100.00%	100.00%	100.00%	90.90%	93.10%	85.70%	90.90%	83.30%	100.00%	75.00%	90.14%
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	99.37%	98.90%	99.82%	99.57%	99.15%	99.58%	99.15%	99.09%	99.58%	99.06%	99.33%	99.25%	99.79%	99.33%
		N	4	Cancelled Ops Not Admitted within 28 days	1	0	0	0	0	0	0	0	0	0	1	0	0	1
			1,21	Data Quality on Ethnic Group - Inpatients	95.47%	96.19%	96.16%	96%	95.58%	95.50%	96.00%	95.75%	97.23%	96.74%	95.67%	95.12%	TBC	95.60%







Treatment Targets Commentary

There has been a 52 week breach in December, with a further 2 confirmed breaches in January. The cases are spinal deformity patients who were due to be operated on at BCH within 52 weeks, with BCH cancelling the theatre availability.

Backlog has increased by 52 cases in month.

All 3 RTT targets were met in month.

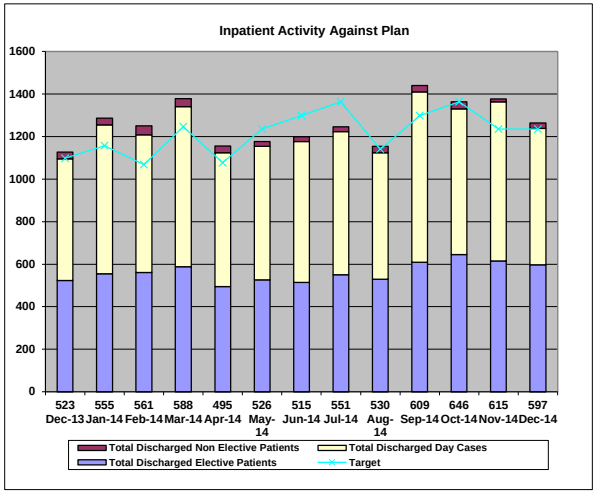
The 62 day cancer target was missed for the month, but has been met overall for the quarter.

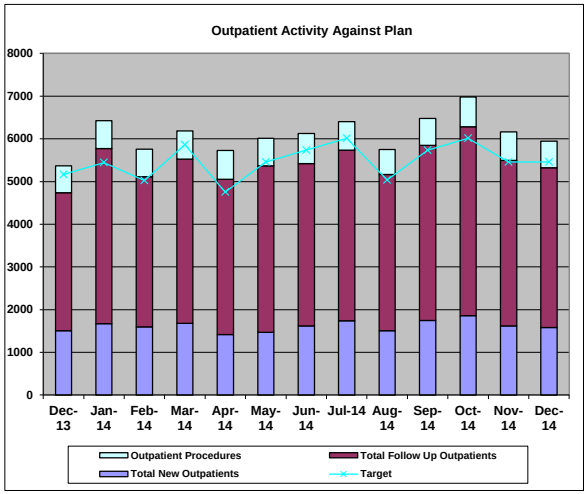
Quarterly Detailed Report
Activity Targets as at December 2014

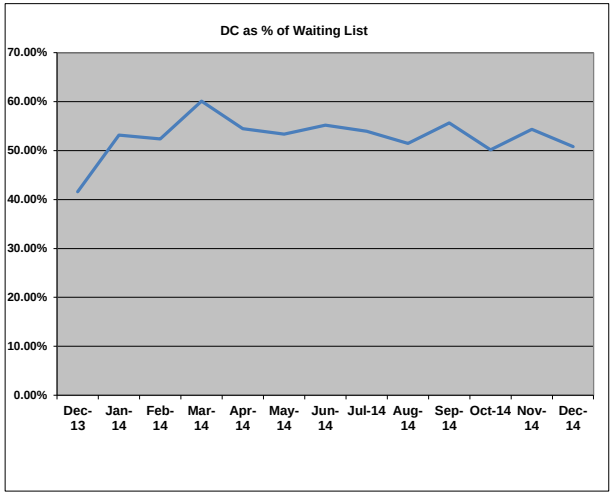
Headlines

- Day Case and elective activity were above plan this month.
- Outpatient activity remains strong.
- Non elective activity was significantly below plan, although improved from last month.

	Monitor	National	CQC Standard		Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	14/15 Full Year Position
Activity			4	Total Discharged Elective Patients	523	555	561	588	495	526	515	551	530	609	646	615	597	**5084**
			4	Total Discharged Non Elective Patients	31	32	43	38	31	23	22	23	30	30	34	14	25	**232**
			4	Total Discharged Day Cases	573	700	647	753	629	628	662	672	594	801	684	748	642	**6060**
			4	Total New Outpatients	1503	1672	1593	1682	1415	1467	1618	1742	1506	1746	1857	1617	1579	**14547**
			4	Total Follow Up Outpatients	3237	4101	3519	3840	3636	3902	3802	3993	3656	4101	4424	3876	3741	**35131**
			4	Outpatient Procedures	627	652	643	663	675	646	707	671	585	634	697	671	623	**5909**
				DC as a % of WL	41.58%	53.15%	52.39%	60.10%	54.46%	53.36%	55.21%	53.93%	51.47%	55.63%	50.15%	54.32%	50.79%	**53.27%**
			4	Elective as % Against Plan	93.5%	94.2%	103.1%	92.6%	98.4%	91.2%	84.8%	86.5%	99.4%	100.3%	101.4%	106.6%	103.5%	**96.7%**
			4	Non Elective as % Against Plan	87.3%	85.5%	124.5%	94.3%	110.7%	71.9%	64.7%	63.9%	100.0%	88.2%	94.4%	43.8%	78.1%	**78.9%**
			4	Day Cases as % Against Plan	113.9%	132.0%	132.2%	131.9%	115.2%	100.3%	100.6%	97.4%	102.8%	121.7%	99.1%	119.5%	102.6%	**106.4%**
			4	% New Outpatients Against Plan	114.8%	121.1%	125.0%	113.1%	107.9%	97.5%	102.3%	105.0%	108.4%	110.4%	111.9%	107.4%	104.9%	**106.2%**
			4	% Follow Up Outpatients Against Plan	99.6%	119.7%	111.3%	104.1%	124.8%	116.8%	108.2%	108.4%	118.5%	116.7%	120.1%	116.0%	112.0%	**115.5%**
			4	% Outpatient Procedures Against Plan	103.4%	102.0%	109.0%	96.3%	127.0%	106.0%	110.3%	99.9%	104.0%	99.0%	103.7%	110.1%	102.2%	**106.5%**







Activity Commentary

Day case, elective and outpatient activity has been strong in month, although non-elective activity was below plan.

Quarterly Detailed Report
Efficiency Indicators as at December 2014

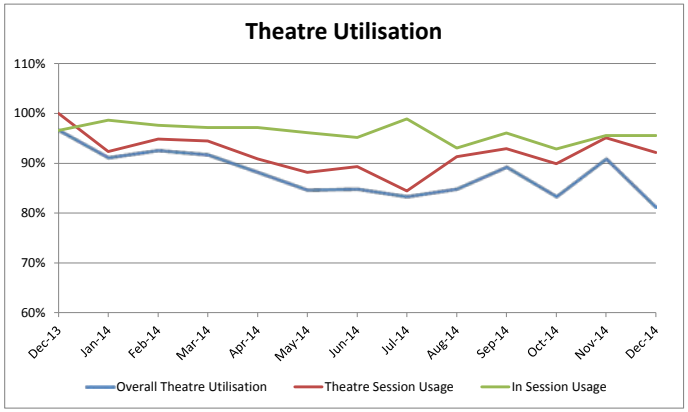
Headlines

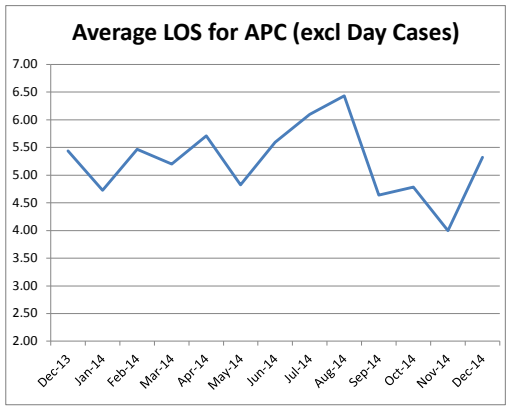
The theatre metrics have been largely positive this month.

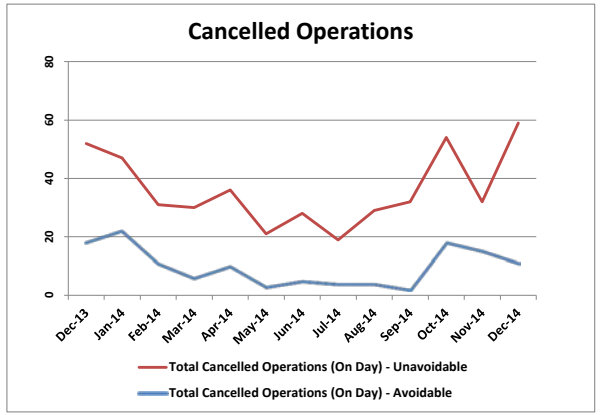
Cancellations are high, but those cancelled by the hospital have decreased.

AVLOS has increased and is again red rated

	Monitor	National	CQC Standard		Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	14/15 Full Year Position
Efficiency			4	Overall Theatre Utilisation	96.58%	91.13%	92.59%	91.74%	88.30%	84.76%	84.98%	83.48%	84.97%	89.30%	83.47%	90.91%	81.38%	85.73%
			4	Theatre Session Usage	100.00%	92.37%	94.88%	94.44%	90.88%	88.17%	89.30%	84.42%	91.29%	92.94%	89.88%	95.12%	92.14%	90.46%
			4	In Session Usage	96.58%	98.66%	97.59%	97.14%	97.16%	96.14%	95.16%	98.88%	93.07%	96.09%	92.87%	95.58%	95.58%	95.61%
			4	Unused Theatre Sessions	0	36	21	25	33	51	46	74	33	32	50	21	21	40
			4	Number of Cases per Theatre Session	2.97	2.83	3.10	3.11	3.31	2.98	2.98	2.97	3.15	3.27	2.88	3.20	2.92	3.07
			4	Total Cancelled Operations (On Day or Day Before)	84	78	71	58	67	53	61	54	56	39	54	74	88	61
			4	Total Cancelled Operations (On Day) - Avoidable	18	22	11	6	10	3	5	4	4	2	18	15	11	8
			4	Total Cancelled Operations (On Day) - Unavoidable	34	25	20	24	26	18	23	15	25	30	36	17	48	26
			4	Total Cancelled Operations by Hospital (On Day)	10	9	3	5	5	8	6	8	8	11	15	11	7	9
			4	% Cancelled Operations by Hospital	0.94%	0.73%	0.25%	0.38%	0.46%	0.71%	0.52%	0.67%	0.73%	0.80%	1.17%	0.84%	0.59%	0.08%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.30	2.58	2.44	2.50	2.76	2.78	2.49	2.43	2.54	2.40	2.48	2.38	2.43	2.52
			4	Pain Review-To-New Ratio	3.38	3.72	3.85	3.64	4.74	4.26	4.07	2.63	4.33	3.52	3.34	2.85	3.69	3.71
			4	Outpatient DNAs	8.61%	9.59%	8.18%	8.65%	8.42%	8.40%	8.48%	8.78%	9.21%	8.13%	8.23%	8.13%	9.34%	8.57%
			4	Bed Occupancy - Adults	79.80%	83.60%	88.61%	80.72%	80.32%	81.21%	86.15%	86.40%	80.63%	84.25%	83.17%	79.45%	69.20%	81.13%
			4	Bed Occupancy - Paediatrics	53.18%	63.80%	65.87%	82.80%	69.26%	50.87%	54.44%	89.96%	88.17%	50.00%	44.44%	60.74%	55.36%	62.60%
			4	Bed Occupancy - HDU	84.62%	87.45%	86.89%	91.40%	69.88%	75.10%	77.05%	69.85%	63.64%	73.39%	68.15%	70.46%	55.70%	69.35%
			4	Bed Occupancy - Private Patients	64.94%	80.28%	68.88%	78.80%	65.52%	81.57%	83.25%	84.33%	76.04%	82.86%	80.65%	84.33%	83.67%	80.19%
			4	Admissions on the Day of Surgery	386	421	415	445	358	383	396	392	393	477	502	477	455	3833
			4	AVLOS for APC (excl day cases)	5.44	4.72	5.47	5.20	5.71	4.83	5.60	6.10	6.43	4.64	4.79	4.00	5.32	5.27







Efficiency Commentary

Average length of stay has increased in month and become red rated.

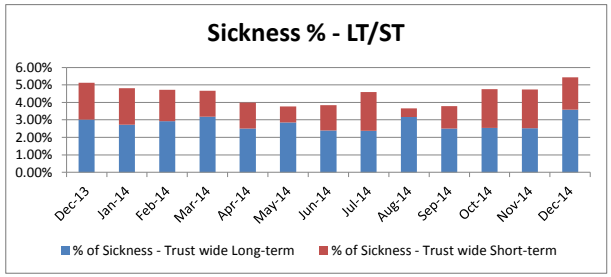
However, due to the increased activity in month, the theatre metrics have been largely positive.

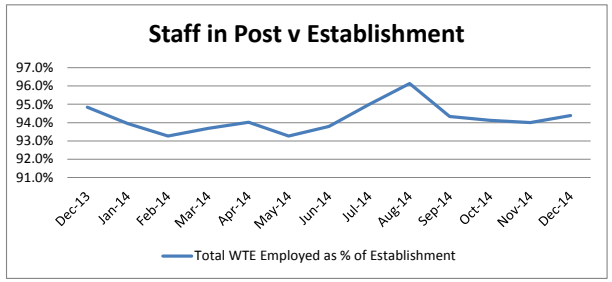
Monthly Report
Workforce Indicators as at December 14

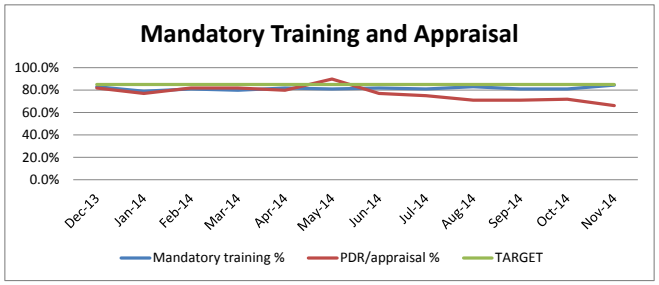
Headlines

- Increase in mandatory training to a 12 month high
- 10% improvement in appraisal position since November.
- Worsening in sickness absence

	Monitor	Contract	CQC Standard		Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	14/15 Full Year Position
Workforce				Total WTE Employed as % of Establishment	94.8%	94.0%	93.3%	93.7%	94.0%	93.3%	93.8%	95.0%	96.1%	94.3%	94.1%	94.0%	94.4%	94.3%
				Staff Turnover (%) - Unadjusted	13.1%	12.2%	11.8%	11.3%	11.6%	11.3%	11.9%	12.7%	12.8%	10.8%	11.4%	11.8%	10.6%	11.7%
				Staff Turnover (%) - Adjusted	8.6%	8.0%	7.4%	7.1%	7.7%	7.7%	9.5%	8.4%	8.4%	7.1%	8.9%	9.5%	9.3%	8.5%
				% of Sickness - Trust wide	5.1%	4.8%	4.7%	4.7%	4.0%	3.8%	3.8%	4.6%	3.7%	3.8%	4.8%	4.7%	5.4%	4.3%
				% Staff received mandatory training last 12 months	83%	79%	81%	80%	82%	81%	82%	81%	83%	81%	81%	84%	86%	82%
				% Staff received formal PDR/appraisal last 12 months	82%	77%	82%	82%	80%	90%	77%	75%	71%	71%	72%	66%	76%	75%
				Staff Friends & Family Test - Care & Treatment														
				Staff Friends & Family Test - Great Place to Work														







Workforce Commentary

The sickness absence position worsened in line with expected seasonal trends. This is due to a spike in long term sickness absence. There may be a slight over-reporting this month due to the transition to ESR self-service and the need to close a small number of staff absences on the system.

The vacancy position taken from the ledger suggests a vacancy level of under 6%. This indicator has been green for some 16 months now.

The turnover figure decreased to under 11% in December and was no cause for concern, showing a marked improvement versus the December 2013 position.

The mandatory training position went green for the first time in 13 months - this is good progress.

The appraisal position, whilst still a cause for concern, showed a marked improvement since November in the light of increased operational focus on data quality and activity.

Monthly Report

Finance Dashboard as at 31st December 14

	Surplus £	Cash £	Capital spend £
Plan	838k	14,672k	4,692k
Actual	546k	17,011k	2,530k
Forecast for next month (YTD)	43k	16,861k	2,680k

	Year to date		
	Actual	Plan	Risk Rating
Capital Servicing Capacity	2.8	2.7	4
Liquidity Ratio	65.9	58.9	4
Overall Continuity of services ratio			4

The capital balance is behind plan largely due to the delay in spend for EPMA and data warehouse, and due to the phasing of spend across the year.

A Q3 capital reforecast has been submitted to Monitor to confirm that the spend is likely to fall into 2015/16.

Cash is higher than plan as a result of capital spend being lower than expected (offset by increase debtors).

Both the Trust's Capital Servicing Capacity and Liquidity Ratio are 4 for the month.

The pay expenditure is significantly higher than Monitor plan for the fourth consecutive month, with the gap increasing.

When compared to budget, the actual pay is nearly £2.3m higher. Management represents £948k of the overspend, although in reality £888k of this relates to Junior Doctors.

In addition, theatres make up a significant proportion of the variance (£723k). The vast majority of this variance against budget is agency pay, which is not budgeted for.

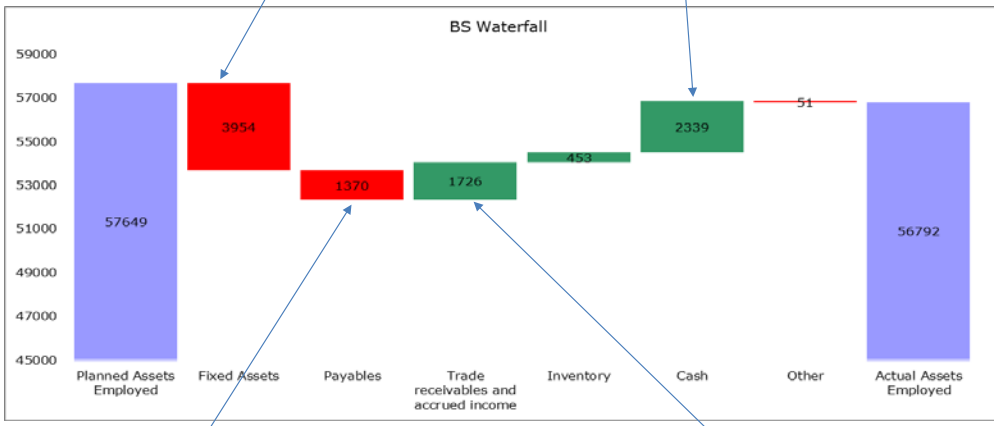
When reviewed against prior month, locum payments have been largely in line with prior month. Agency spend has been significantly higher in month (£322k compared to £240k). Nursing agency has been £86k higher than last month (with bank being lower over the Christmas period) and the remaining increase is in management, and is in line with expectations due to the Transformation Projects.

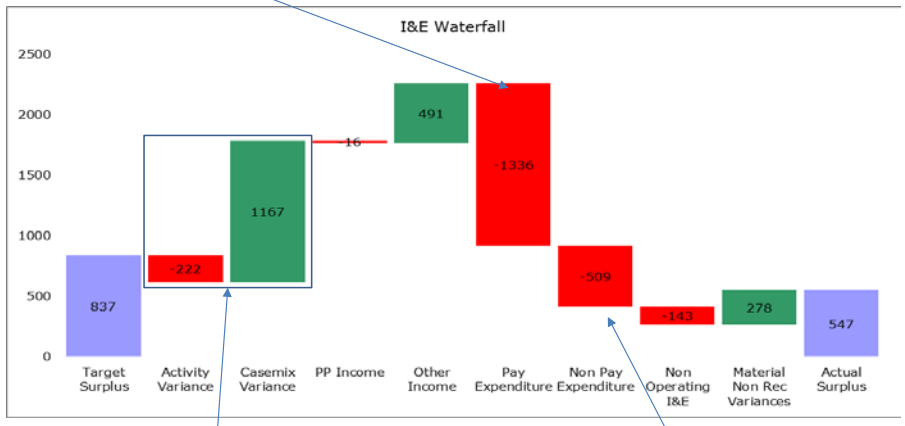
The predicted impact of impairments in the year was calculated for the Monitor plan, and spread throughout the year.

The planned and actual results include the first 3 quarter's elements of the expected impairment (£641k).

The underlying plan was therefore a surplus of £838k, compared to an actual of £546k.

	Plan	Actual
Surplus before imp.	838k	546k
Impairments	(641k)	(641k)
Surplus/(deficit) after imp.	197k	(95k)





Creditors are higher than plan as a result of;
- Expenditure being much higher than expected as explained in the I&E waterfall.
- Accruals are significantly higher than plan as a result of the additional activity performed and transformational spend.

Debtors are higher than plan as a result of a number of different factors;
- £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.
- Accrued income (income which has not yet been invoiced), which includes year to date overperformance, Clinical excellence awards and R&D funding, amongst others.

December is historically a lower activity month due to the Christmas break and theatre closures, and the plan reflects that expectation.

Taking this into account, the Trust overperformed against the elective and day case activity plans for December, narrowing the negative activity variance.

Overall case mix continues to be richer than expected, and as a result income is above plan.

There has been a significant 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 are costs incurred in relation to treating long waiting spinal deformity patients at Cromwell. These costs have not been fully offset by the income received, with a c.£100k cost pressure.. The Trust is currently pursuing commissioners to cover this shortfall.

Monthly Report

CIP Dashboard as at 31st December 2014

Plan for YTD	£1315k
Actual for YTD	£1250k
Difference	-£65k

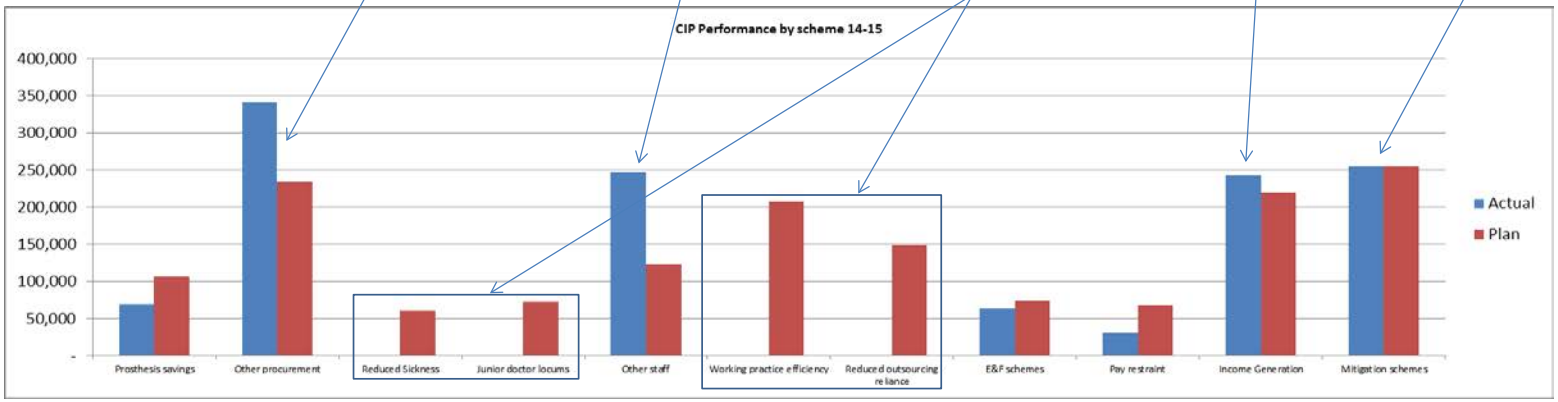
Negotiation of better rates on SLAs accounts for the majority of this performance, with £58k relating to agreeing a lower PACs service contract, and £47k relating to the Orthotics contract. In addition there are theatres savings for power tools of £48k.

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.

Increased use of locums and agency, in addition to outsourcing work to Cromwell have meant that it is not possible to recognise CIP savings in these schemes. However, this underperformance has been largely offset by some overperformance on other schemes.

A significant proportion of the performance in this area is from paediatrics physio and botulinum clinics, in addition to the increase in car parking and catering charges in the Trust.

The mitigation CIP recognised to date relates to improvements in cancellations, in addition to pay restraint savings.

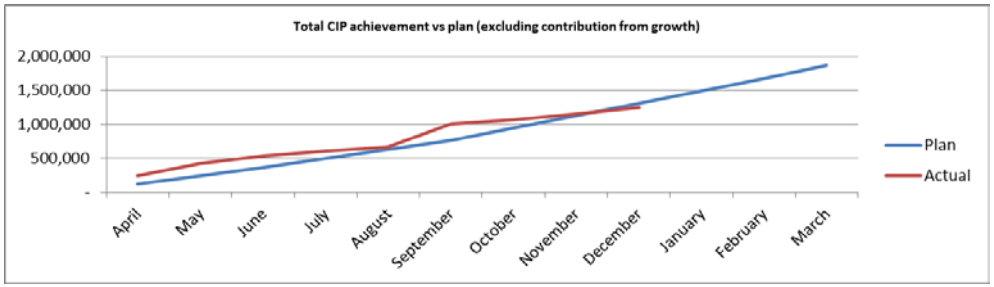


Overall performance against plan has dipped below plan for the first time this year, and must be carefully managed going forward to minimise the risk of non-achievement of the plan.

The strongest performance to date has been in 'other procurement', 'income generation', 'other staff' and the 'mitigation schemes'.

As part of the Annual Planning process, plans for 2015-16 CIPs have been reviewed. These will need to be further refined, added to and owned by the relevant directorates.

In addition, in January's CIP programme board, consideration will be given to the process for QIA completion for 2015-16 schemes.

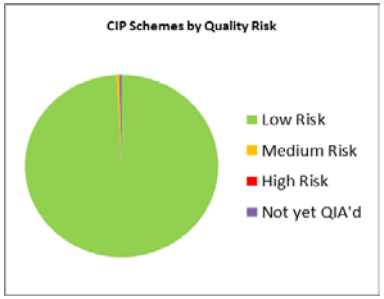


Overall performance by category

	£'000
Completed recurrent	632
Completed non-recurrent	364
Completed mitigation scheme	255
Planning/Implementation	189
Scheme Ideas	79
Mitigating Schemes	79
Unidentified	421
Total CIP target	**2019**

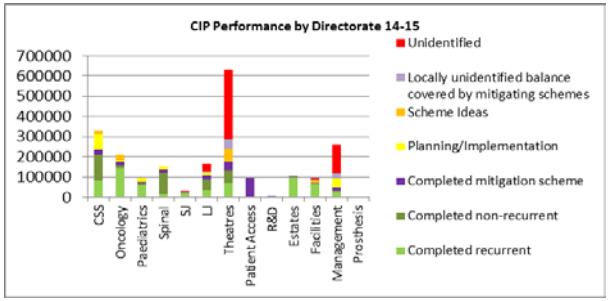
There is a gap between the CIP target for the year, and those schemes currently identified locally, or felt to be achievable as a mitigating scheme.

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.



99% of schemes have been QIA assessed.

The Directorates with outstanding schemes which have yet to be QIA'd are Oncology and R&D.

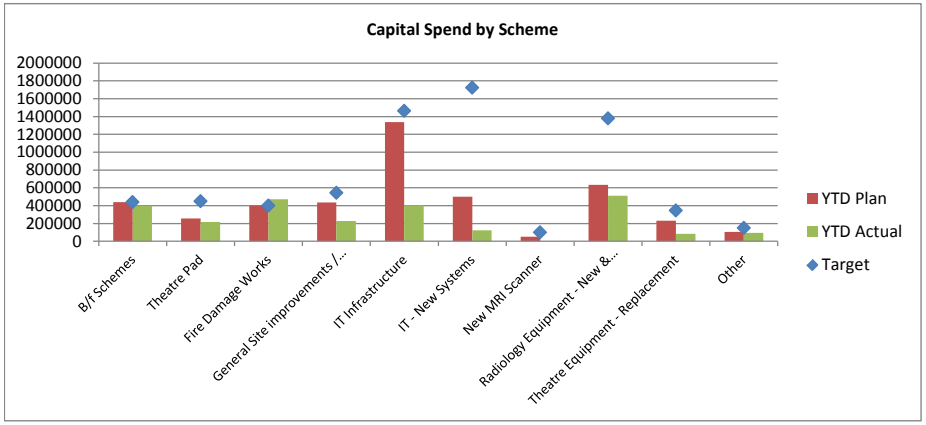


CSS continues to have the strongest performance to date in terms of completed schemes, although a significant proportion is non-recurrent performance. Paediatrics have the highest recurrent achieved balance.

Theatres continue to have the largest unidentified balance.

Quarterly Report

Quarterly finances as at 31st December 2014



Capital spend is lower than plan, with there being small underspends or slippages on a number of the schemes.

The most significant underspends against plan at present are in relation to 'IT infrastructure' and 'IT- New Systems'. Within these schemes were an expected £600k spend for the data warehouse, and £500k in relation to EPMA.

The spend on these schemes is now likely to occur where required in 2015/16, and as such, the Trust would expect to continue seeing significant underspends against plan for the rest of the year. Monitor have been informed through the monthly DEL returns submitted to them.

It is expected that where there is slippage in other schemes, that they will largely be on plan by year end.

Theatres has the largest overspend at present (£1.5m), with paediatrics having the biggest underspend (£111k).

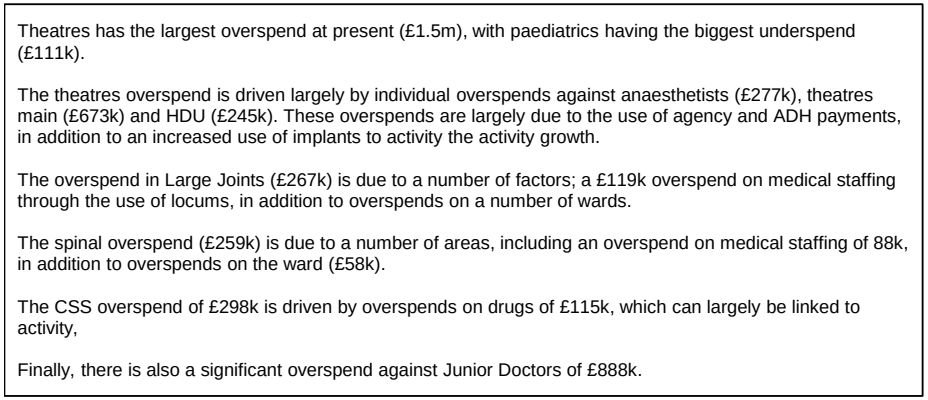
The theatres overspend is driven largely by individual overspends against anaesthetists (£277k), theatres main (£673k) and HDU (£245k). These overspends are largely due to the use of agency and ADH payments, in addition to an increased use of implants to activity the activity growth.

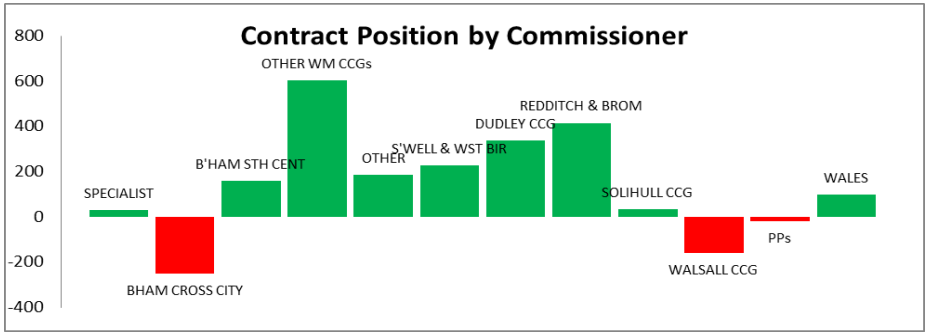
The overspend in Large Joints (£267k) is due to a number of factors; a £119k overspend on medical staffing through the use of locums, in addition to overspends on a number of wards.

The spinal overspend (£259k) is due to a number of areas, including an overspend on medical staffing of 88k, in addition to overspends on the ward (£58k).

The CSS overspend of £298k is driven by overspends on drugs of £115k, which can largely be linked to activity,

Finally, there is also a significant overspend against Junior Doctors of £888k.





There is generally strong performance against contracts at present.

The largest overperformance is with Other West Midlands CCGs (£604k), although several of the other CCGs are also overperforming.

The largest underperformances are with Walsall CCG (£158k) and Birmingham Cross City (£249k).

In addition, contract discussions for 2015-16 have begun.

Note: Under and overperformance here are measured against signed contract values, and not the Trust's internal activity plan, which assumes overperformance of c.£1m against these values.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 **ENCLOSURE NUMBER: 8**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	Director of Nursing and Governance
NAME OF AUTHOR	Lisa Pim. Deputy Director of Nursing and Governance
SUBJECT:	Patient Quality Report

SUMMARY

This paper provides an update on patient quality, safety and experience activity during December 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 Trust Board in bringing together key quality issues for debate, assurance and information.

Key areas of note this month:-

- Following the conclusion of an investigation into a surgical error incident (originally reported in September 2014) this has now been escalated to, and confirmed as Never Event in December 2014.
- The WHO checklist compliance figure for December was 97.81 against a revised and agreed target of 98%.
- There has been 1 case of reportable C Difficile Infection this month. An initial RCA undertaken by the IPC Team indicate that this case was unavoidable. The Trust is pending agreement from the Commissioners on this.
- There were 2 pressure ulcers (grade 2) during December, 1 was deemed avoidable and the other unavoidable.
- The key concern for CQUIN delivery is Dementia screening, achieving only 63% compliance in November against a target of 90%. Whilst we achieved over 90% compliance in October and December, the trust will have failed its quarterly target of 90% compliance due to the poor compliance figures in November. This will result in a loss of £26,000 for the trust.
- The Trust has failed for the second month to have met the agreed target for National Safety Thermometer achieving 91% against a target of 95%. An initial review of the information would appear to indicate that pressure ulcers sustained by patients in other transferring trusts may be adversely affecting the National Safety Thermometer compliance.

RECOMMENDATIONS

Trust Board are asked to:

- note and discuss the Patient Quality Report
- 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 - December 2014

REPORTING REQUIREMENT: National Incident Reporting Requirement & Quality KPI Contractual Requirement

There was one Serious Incident reported during December 2014 and Appendix 1 outlines details of all ongoing Serious Incident Investigations.

It should also be noted that, following the conclusion of an RCA investigation into the Surgical error SI in October 2014, this has now been escalated to, and confirmed with the commissioners as, a Never Event. This will require the Trust to monitor progress through Clinical Goverance Committee with monthly updates given to the Commissioners as part of the monthly contract meetings.

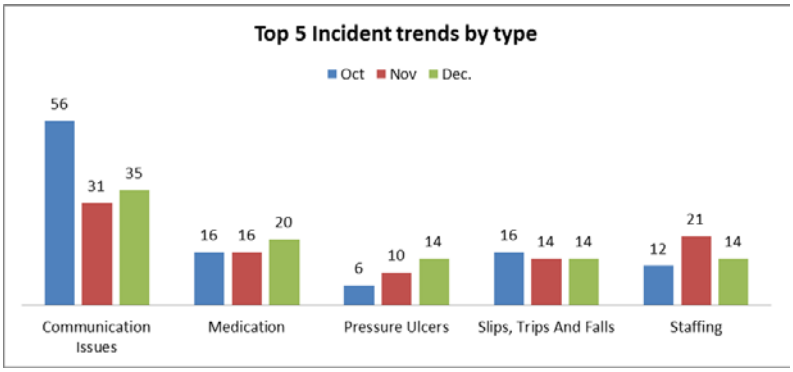
1.2 All other incidents requiring an investigation

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

A total of 190 incidents were reported during November, compared to 205 incidents reported during November and represents a 7% decrease in reporting from the previous 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:



1.3 Deaths

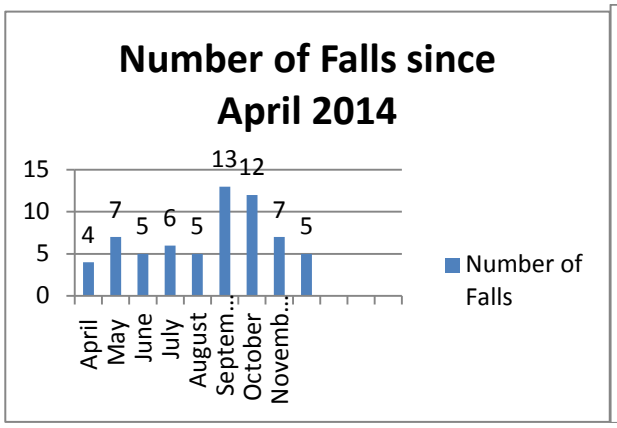
There were no deaths reported in December.

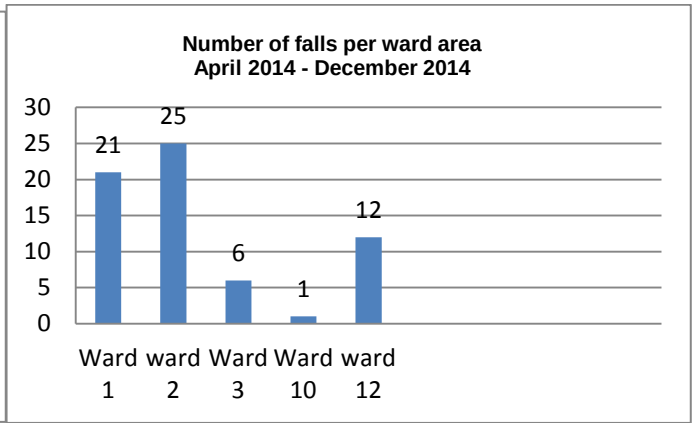
1.4 Falls

REPORTING REQUIREMENT: National Incident Reporting Requirement & Quality KPI Contractual Requirement

The graph above (section 1.2) reflects **all** falls reported within the organisation (eg. this includes non-patient falls and falls in the outpatient department). There were 9 additional falls that were reported in this incident category, however this section covers adult in-patient falls only.

There have been 5 unavoidable (adult) inpatient falls for the month of December 2014.





- Despite increases in patient falls during September and October, reportable falls continue to decrease to an average level.
- All reportable falls have been individually reviewed and all 5 were unwitnessed by staff.
- In December, 3 patient falls occurred during the night and 2 occurred in daylight hours with recommended safe staffing numbers in place.
- Two falls were in hospital toilets and 3 patients fell at or around the bedside.
- In 2 cases, patients had low haemoglobin (requiring transfusion) which may have been a participating factor.

Harm suffered as a result of inpatient falls

As an organisation, we continue to see the majority of falls resulting in no to minor physical harm. Of the 5 falls reported during December, none of these resulted in any harm to the patient.

Actions for Improvement

The following are additional organisational actions that are now in place to support falls prevention and care of patients:

- The Trust is now monitoring the number of 'harm free' days between falls via the use of a visual tool known as the 'Safety Stick'. Red on the Safety Stick indicates a fall with harm (categorised as low and above), orange indicates a fall with no harm and green indicates fall/harm free days. Avoidable falls are also marked with an "A". This is a helpful way of monitoring "harm-free" days and Ward managers display this information in patient facing areas.
- Sessions on falls awareness, prevention, reporting and risk assessing continue as part of the Clinical Skills Update days for both qualified and non-qualified staff. Training has become more in-depth for trained staff, including common falls medical risk factors, such as orthostatic hypotension.
- It is envisaged that as ongoing work progresses with the Throne Project, training will also commence on non-clinical training days to capture the attention of housekeeping staff and the role they have in falls prevention.

Falls Risk Assessments & Care Planning - Quality indicator requirements

Qu1.	Has the falls assessment been completed within 6 hours of admission? Yes/No N/A	December 2014	91%
Qu2.	If the patient is identified as high risk is a care plan in place? Yes/ N/A	December 2014	91%
Target = 91% compliance per ward			

1.5 Infection Prevention and Control and Tissue Viability

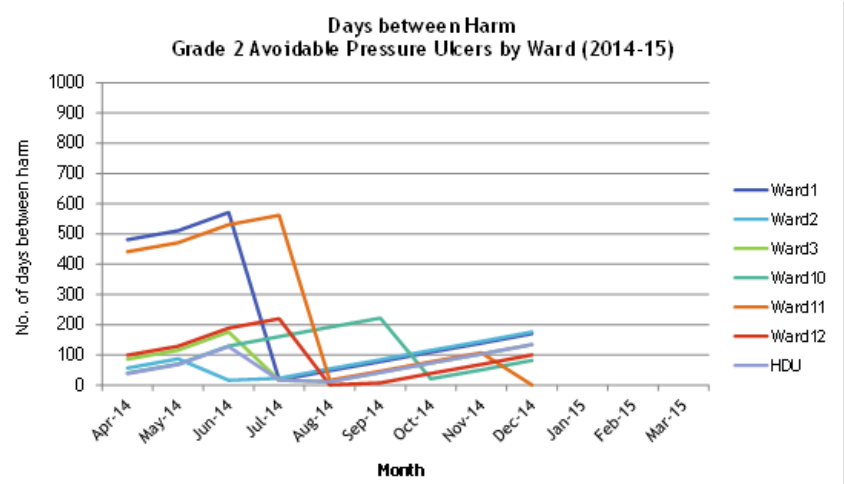
REPORTING REQUIREMENT: Contractual Quality KPI requirement, National Safety Thermometer CQUIN and National Reporting requirement

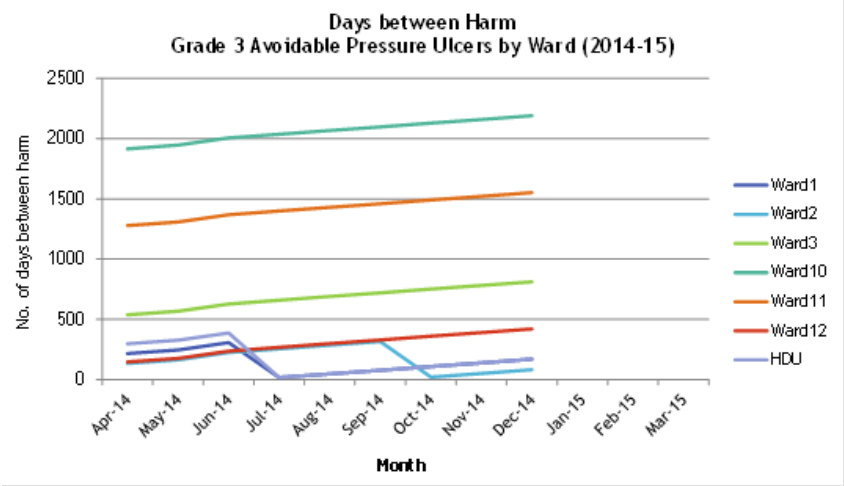
1.5.1 Infection Prevention and Control

There have been no MRSA bacteraemias this month. There was a case of *Clostridium* difficile which is reportable however following a Post Infection review the IPCT feel the case was unavoidable although agreement from the commissioners regarding the status of the case is outstanding. The case occurred in a child who underwent surgery for a bone tumour during a 4 week window in their chemotherapy regime. All antimicrobial use was within Trust guidance and necessary to reduce the risk of infection in an already vulnerable patient. This case has therefore been deemed unavoidable following internal scrutiny.

1.5.2 CQUIN Scheme: Safety Thermometer

Route cause analysis is utilised to ensure practice is scrutinised and improved wherever possible. The Committee are asked to consider the information below as it provides information on the nature of pressure ulcers and associated decisions regarding avoidability following investigation.





The Trust is compliant with the hygiene code and adherence to the annual plan is on target.

1.5.3 Tissue Viability

There were 2 pressure ulcers (grade 2) during December, 1 was deemed avoidable and the other unavoidable. Each case is investigated and the status (avoidable or unavoidable) is determined following the route cause analysis.

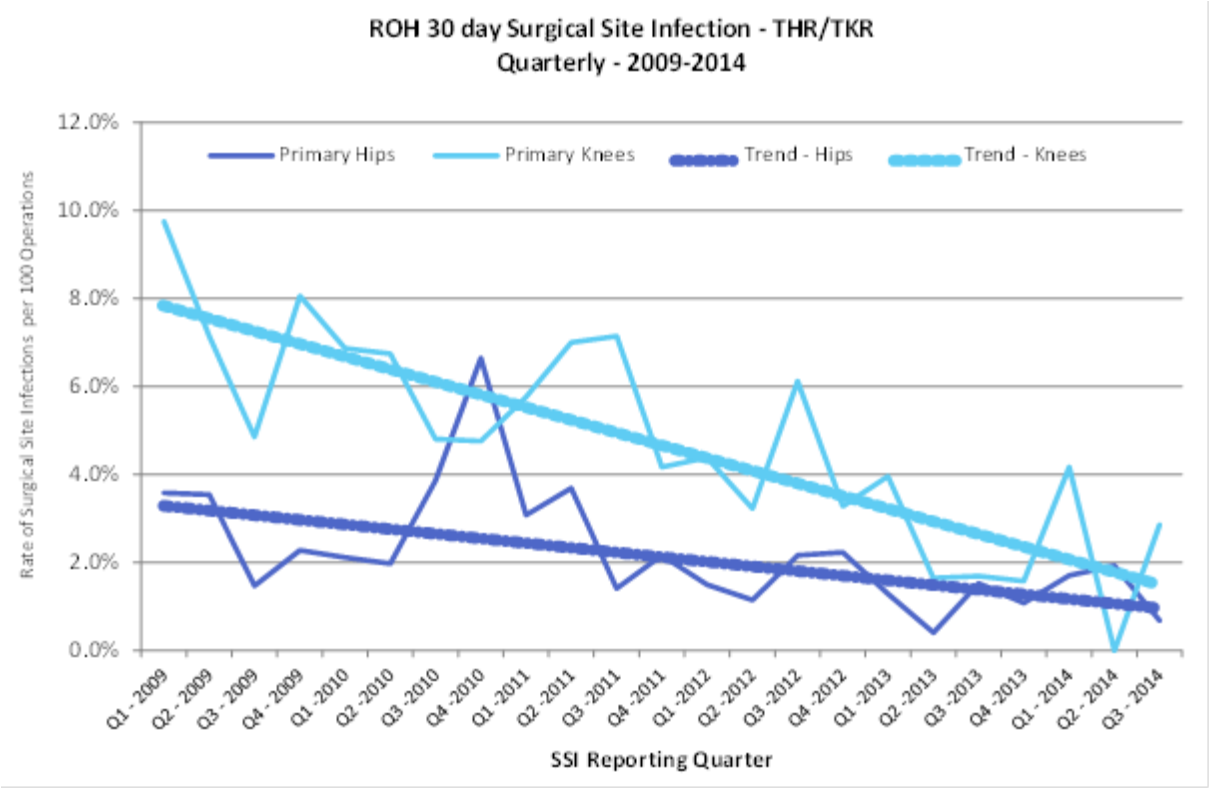
The unavoidable case occurred on Ward 12 – a patient shuffled off the bed to get onto the commode and the friction caused the injury, it is not a true pressure ulcer. All necessary risk assessments and equipment were in place and the documentation well completed.

The avoidable case is shared between Theatres and Ward 11. A plaster was put on in theatre; but removed on the ward when the patient complained it was painful - there was little padding present and it appeared the redivac tubing had caused a blister on the patient's malleolus.

The tables below show the number of pressure ulcers by ward. Please note that there are incidences where there are apportioned cases across more than one clinical area and so these are highlighted in yellow. These figures are not to be used for total incidence reporting as these are provided elsewhere separately. The tables are to illustrate the clinical areas where hospital acquired pressure ulcers have occurred within the trust.

1.5.4 Surgical Site Infection

In December 3 patients were readmitted with infection, none of these were primary arthroplasty patients. 1 was an ACL reconstruction, 1 was readmitted following hip revision surgery and the third after shoulder surgery.



The above graph details the rates and shows a rise in the rates for Primary knee arthroplasty but a reduction in primary hips. Analysis by quarter offers minimal statistical value however annual analysis provides a clearer view of the situation. SSI surveillance is monitored in a calendar year, not a fiscal year so analysis of 2014 30 day data will be available at the beginning of April 2015 after submission of Oct – Dec data to Public Health England on 31st March 2015.

1.5.5 Bone Infection Unit

Activity within the unit continues to be high with 56 patients under the care of the team, 10 of whom are inpatients.

1.5.6 Flu vaccination

The flu vaccinations have been undertaken by Occupational Health this year, supported by HR and IPC. So far uptake is 38% of frontline staff. The national target is to vaccinate 75% of all frontline staff. There are also a significant number of staff who have been vaccinated elsewhere and we are awaiting clarification as to how these are reported as this will increase the uptake if we can include them as part of the Trust's data.

The detail of those vaccinated at ROHFT is in the table below (it is reported cumulatively):

	Total	Oct	Nov	Dec	% uptake
Doctors	108	17	20	22	20.30%
Qualified Nurses	226	63	75	79	34.90%
Professionally Qualified - clinical	242	34	57	61	25.20%
Support to clinical staff	181	115	136	139	76.70%
Overall uptake end December 2014 = 39.7%					

There have been no cases of flu in patients this month.

1.5.7 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 in October 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. Work is underway to identify a core of around 55 clinical staff to undertake thorough training in the application and removal of PPE. The Trust has so far had approximately 22 staff offer to join, but more nurses and doctors are required. The lead Nurse for IPC attended a train the trainer event held by Public Health England on 10th December to ensure the Trust's training is in line with Government recommendations. Difficulties continue with ordering the necessary PPE following the updated guidance published in December. As soon as the suits arrive training can commence; this is a challenge nationally and is not just an issue for ROHFT.

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 for **December 2014:**

Adult Safeguarding Training

- Adults Level 1 (Basic Awareness) – 92%
- Level 1 Safeguarding Adults (includes SG, MCA, DoLs, Learning Disabilities) MCA 88%, DOLS 89%
- Level 2 – Enhanced (External provider) – 85.34%
- Level 3/4 – For Leads = 100%

Concerns possible alerts reported to team = 7
Incidents reported = 3
Deprivation of Liberties application submitted – 0

Children Safeguarding Training

- Children's Level 1 (Basic Awareness) –92%
- Level 2- Enhanced Child Protection – 87%
- Level 3/4 – For Lead and Named Nurse/Doctor – 100%
- Concerns reported and possible alerts to team: 8

1.7 Patient Safety Alerts
REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement

A total of 9 Patient Safety alerts were closed during December 2014, 7 of which required no further action by the Trust.

The Trust is currently assessing the relevance of the following alerts:

Alerts with assessing relevance status

Reference	Alert title	Issue Date	Status	Deadline
EFA/2014/003	Window restrictors of cable and socket design	10-Nov-14	Assessing Relevance	31-Mar-15
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
NHS/PSA/D/2014/010	Standardising the early identification of Acute Kidney Injury	09-Jun-14	Assessing Relevance	09-Mar-15

Alerts with on-going action status and remain open beyond deadline.

Reference	Alert title	Issue Date	Status	Deadline
NHS/PSA/D/2014/006	* Improving medical device incident reporting and learning	20-Mar-14	Action Required: Ongoing	19-Sep-14
MDA/2014/044	* Mains power lead used with Omnifuse syringe pumps (all models).Part number 0151-0651.Manufactured by ...	26-Nov-14	Action Required: Ongoing	24-Dec-14

Actions taken:

NHS/PSA/D/2014/006 – Meeting to take place in January 2015 between Medical Director and a Senior Consultant to discuss residual actions required to address closure of this alert. It is anticipated that closure of the alert should be possible by the end of January.

MDA/2014/044– Planned maintenance of Graseby Omnifuse syringe pumps taking place throughout January 2015. Alert to remain open pending completion of maintenance works.

1.8 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 compliance figure for November was 97.81% against a revised and agreed target of 98%. This indicates

we have not met the agreed and revised target as part of the remedial action plan with Commissioners. We are currently pending a response from the Commissioners.

1.9 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). Raising awareness of blood safety in general across the organisation remains a focus to maintain the improvements seen this year.

There was 100% traceability for December.

1.10 CQUIN Schemes

REPORTING REQUIREMENT: National and Local CQUIN Requirement

CQUIN requirements have now moved into Quarter 3. Evidence has been submitted for the month of November. The key concern for CQUIN delivery is Dementia screening, achieving only 63% compliance in November gainst a target of 90%. Whilst we achieved over 90% compliance in December, the trust will have failed its quarterly target of 90% compliance due to the poor compliance figures in November. Areas of non compliance have been identified and discussion taken place with the Senior Sister and Matron for the area with monitoring of performance commenced.

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 83, down by 34 or 29 % on last month's total of 117.

Of the 83 contacts, 31 were general enquiries (37%) and 52 were concerns (63%) which is 6 percentage points different to last month's split of general enquiries 43% and concerns 57%.

Greatest area of concern continue to be:

- what's happening with care and treatment plans; lack of info/clarity; chasing update and progress; no follow up booked post-surgery etc.

Highest volumes of general enquiries were:

- Work Experience
- PP enquiries
- How to contact colleagues enquiries

2.1.2 COMPLAINTS

Number of complaints received this month is 5, down considerably from 18 last month.

Areas of concern:

- Communication, Organisation and Administrative barriers x 1
- Record keeping accuracy x 1
- Clinical care and treatment including outcome x 1
- Ward experience including nursing/HCA care x 1
- Access to services x 1

% of complaints resolved within timeline was 78% (14/18) against KPI of 80% . Average length of time to close complaints in December was 69 days, up very slightly on previous month's figure of 67. There is now one outstanding old complaints which has been delayed due to patient reasons. All open complaints apart from this one relate to those received in Q3 of 2014/15.

2.1.3 COMPLIMENTS

Number of compliments received this month is 534 up by 12 or 2% on last month's total of 522.

2.1.4 Friends and Family Test

The Friends and Family Test for December is 84 and meets the CQUIN requirements for the month. The detractor rate for the month is 2.2% which remains low.

Reporting requirements are changing from April 2015 to a more straightforward % promoter and % detractor. The CQC intelligence monitoring report published in November 2014 required the Trust to provide a % change difference in quarter results over the short and long term from 1st August 2014. A change of 6% in score would indicate a risk and a 12% change would indicate a high risk. The data has been reviewed retrospectively. The Trust can take assurance from these results as the lowest recorded score using the new system shows 96.8% as promoters with the greatest change in results being a 0.8% increase in score in the last year's results.

.

2.1.5 Child Patient Experience

The December FFT Score for Ward 11 (under 16) is 80, which is four points below the Trust average . The increase in data collection has been maintained.

The Wi-Fi activation points have now been installed which should enable the electronic collection of Patient Experience data from January 2015.

2.2 Litigation

REPORTING REQUIREMENT: ROH NHSFT Good Practice

New Cases

Three new potential clinical negligence cases were received in December 2014.

Ref	Description	Directorate
T475	Infection following elbow replacement,	Large Joints
T474	post op infection in knee replaced in December 2013, also a complaint	Large Joints
T473	delay in diagnosis and treatment of spinal abscess, infection management. Also claim against GP, HoEFT, RJAH	Large Joints

Closed Cases

The following ongoing claims were closed:

Ref	Date of notification	Details	Settlement	Directorate
T416	7.8.13	punctured bladder during surgery Oct 2010	Formal claim lodged with Court but no particulars of allegations received: closed owing to inactivity	oncology
T293	18.3.11	Treatment to realign knee cap and arthroscopy Nov 2009 and ongoing	Partial admission of liability Final Damages: £30k Claimant Costs: £30k Defence Costs: £11.5k	oncology

The following potential clinical negligence claims were closed: these did not proceed beyond disclosure of the patients' notes to solicitors

Ref	Date of notification	Details	Directorate
T405	18.6.13	Surgical blister	Oncology
T396	18.3.13	cardiac arrest & transfer out of Trust following surgery 2012	Spinal
T433	17.12.13	?delay in diagnosis and treatment of cauda equina. Numerous potential defendants including UHB, HoEFT, GP, etc.	Spinal
T397	25.3.13	Hip surgery.	Large joints
T384	14.2.13	metal on metal - ?product liability claim	Large joints

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 December.

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	Nov-14	Dec-14
% Compliance	100%	96%	96%	93%	95%	85%	95%	89%	93%	88%	89%	90%

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	Nov-14	Dec-14
% NJR Consent compliance	81%	87%	88%	80%	91%	91%	91%	96%	91%	95%	88%	82%

Current 2014 Consent compliance: 88% average, against the target of 95% (and Best Practice Tariff target of 75%).

Note: The cut-off point for submission of the NJR overall compliance is February 2015. The cut-off point for the Consent compliance is June 2015. The NJR national report is then scheduled for publication in September 2015.

Action: The Deputy Director of Nursing and Governance has scheduled an urgent meeting with the Matron for POAC to unpick the reasons why all patients do not appear to have been given access to NJR consent process. Accurate filing of forms also requires improvement as on ocaasions NJR consent forms are completed but cannot be easily sourced in medical notes.

3.2 Patient Reported Outcome Measures (PROMs)

REPORTING REQUIREMENT: National Requirement & ROH NHSFT Good Practice

During November the 90% target compliance rate for completed questionnaires for both hip (90.7%) and knee (92.4%) replacement surgery was achieved.

3.3 Safety Thermometer
REPORTING REQUIREMENT: National Reporting Requirement

2014-15		Dec-14
Pressure Ulcers	All	6.9%
	New	0%
Falls with harm		0%
CAUTI		0%
New VTE		1.15%
Total Harm Free		91.95%

Action – An initial review of the information would appear to indicate that pressure ulcers sustained by patients in other transferring trusts are adversely affecting the National Safety Thermometer compliance. The Deputy Director of Nursing is to investigate this further and will feedback findings at the next committee meeting.

3.3 Matron KPI
REPORTING REQUIREMENT: ROH NHSFT Good Practice

The following is a brief summary of the Ward KPI's.

Paedeatric Directorate – Overall Amber. Sustained performance is noted. Currently have an acting Senior Sister in post. Activity levels have been variable in month.

Spinal Directorate – Overall Amber. Sustained performance noted.

Support Services – Overall Amber -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). OPD have sustained (Amber) performance. Excellent performance against KPI's in the Pain Team and ROCS.

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. As identified within the November report, a meeting has been held with Ward 2 Senior Sister and Matron for the Directorate and the Deputy Director of Nursing and Governance to review identified concerns around pressure area care, complaints, and fluid balance management. The action plan developed continues to be monitored and sustained improvement in these metrics is noted. For Ward 12/10, there has been sustained performance.

Theatre/Anaesthetics/Critical Care Directorate – Overall Amber. The KPI's for Theatre/Anaesthetics/Critical Care Directorate are split into HDU, (Amber rating), ADCU (Amber rating), CCO (Amber rating), and Theatres (Amber Rating). Continued high focus remains on training within the Directorate areas and this can be seen with improved training metrics. Most team members booked into essential training if not already complete. HDU have seen improvement in most metrics.

Oncology Directorate – Overall Amber. Sustained improvement is noted.

APPENDIX 1a – Ongoing Serious Incidents Requiring Investigation (SIRI) - December 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
14134 STEIS 2014/37077	06/11/14	13/11/14	Deteriorating patient	Moderate harm	Large Joints	Investigation underway	20/01/15
14238 STEIS 2014/37877	04/11/14	20/11/14	DVT	Moderate harm	Large Joints	Investigation underway	27/01/15
14156 STEIS 2014/38639	10/11/14	26/11/14	Grade 3 pressure ulcer	No harm	Theatres & Anaesthetics	Investigation underway	02/02/15
14268 STEIS 2014/38843	24/11/14	28/11/14	Consent	No harm	Theatres & Anaesthetics	Investigation underway	04/02/15
14453 STEIS 2014/41609	15/12/14	21/12/14	DVT	Low harm	Large Joints	Investigation underway	26/02/15

APPENDIX 1b - Closed Serious Incident investigations

Ref	Incident date	Description	Directorate	Deadline for submission of RCA investigation report	Progress/ Date submitted
13912 STEIS 2014/33034	07/10/14	VTE	Oncology	11/12/14	Report submitted 09/12/14.
13837 STEIS 2014/33461	10/09/14	Surgical error	Spinal	16/12/14	Report submitted 16/12/14.
13982 STEIS 2014/33836	15/10/14	Grade 3 pressure ulcer	Paediatrics	19/12/14	Report submitted 18/12/14.
13944 STEIS 2014/34206	20/10/14	Grade 3 pressure ulcer	Large Joints	23/12/14	Report submitted 22/12/14.
14048 STEIS 2014/35097	23/10/14	Drug incident	Theatres & Anaesthetics	02/01/15	Report submitted 31/12/14.
13795 STEIS 2014/30724	22/09/14	Transfer/ death	Large Joints	19/12/14 (Deadline extended from 24/11/14)	Report submitted 24/12/14.
13853 STEIS 2014/31822	29/09/14	VTE	Large Joints	02/12/14	Report submitted 02/12/14.
13856 STEIS 2014/31828	29/09/14	VTE	Small Joints	02/12/14	Report submitted 02/12/14.
13568 STEIS 2014/27185	19/8/14	Treatment delay	Theatres, Anaesthetics & Critical Care	6/11/14 (Deadline extended from 23/10/14)	Report submitted 03/12/14.

Appendix 1c Quarterly summary of findings from Serious Incident RCA investigations:

Ref	Incident date	Description	Directorate	Date report due/sub mitted	Outcome of review
13634 (STEIS 2014/29006)	29/08/14	Suboptimal patient care	Large Joints	07/11/14 Submitted 07/11/14	**Findings and Lessons to be learned** ▸ Initial deterioration was due to increased opiate side effects as a consequence of deteriorating renal function ▸ Whilst the dose prescribed/administered was not unreasonable, with hindsight in view of patient age/history a lower dose could have been prescribed. ▸ Frequency of obs and monitoring on Ward not increased on recognition of deterioration ▸ Full holistic review not carried out by medical staff ▸ Ineffective communication and escalation of concerns on Ward ▸ Inadequate level of supervision & support provided to the nurse caring for the patient in HDU ▸ Documentation overall was good but there were a number of areas of non-compliance with expected standards, this related to both junior and senior medical and nursing staff. ▸ Inexperienced staff must be provided with appropriate levels of supervision/training & development ▸ Escalation guideline should be disseminated to all staff and form part of local induction ▸ Communication regarding Trust and professional body documentation requirements should be sent to all clinical staff ▸ Training needs of relevant individual(s) to be reviewed and addressed
13678 (STEIS 2014/29080)	06/09/14	Attempted suicide	Large Joints	10/11/14 Submitted 10/11/14	**Findings and Lessons to be learned** ▸ Patient was verbally aggressive, non-compliant with treatment (wound infection), alcohol dependent/frequently intoxicated, and regularly absconded from the ward despite all efforts made to maintain the apteimts safety and well-being. ▸ Numerous incident forms completed about patient's behaviour prior to incident. ▸ No red flag signs of potential suicide risk.

					▸ Discharge delayed owing to home circumstances and lack of compliance with treatment. ▸ Patient received excellent nursing care and support. ▸ Awareness to be raised of requirement to adhere Trust policy on managing violent and aggressive patients, including withdrawal of treatment if necessary. ▸ Review of SLA for mental health support required ▸ Discharge policy to be reviewed with regard to patients needing help with housing. ▸ Medical team to implement management plans for non-compliant patients.
13717 (STEIS 2014/29738)	11/09/14	VTE	Oncology	14/11/14 Submitted 14/11/14	**Findings and Lessons to be learned** ▸ In their current format, there is no capacity to allow reassessment of DVT risk on the drug chart. Indications for clexane may change throughout the in patient stay. As is seen in this case, the initial risk of bleeding was high and therefore clexane was not appropriate. However, this risk has change and it was felt that clexane should be given. However, this conflicts with the initial assessment and has been flagged by the pharmacist. It appears that the change in clexane prescription was not discussed with the pharmacist and hence, clexane was not prescribed on the new drug chart.
13520 (STEIS 2014/26461)	13/08/14	VTE	Oncology	17/10/14 Submitted 10/10/14	**Findings and Lessons to be learned** ▸ VTE assessment done and followed as per Trust protocols. ▸ Despite standard chemical and mechanical DVT/PE prophylaxis instituted and all documentation completed, patient still had a PE which in this case would have been unavoidable.
13523 (STEIS 2014/26463)	09/08/14	VTE	Oncology	17/10/14 Submitted 17/10/14	**Findings and Lessons to be learned** ▸ The investigator believes this VTE to be unavoidable. However a recommendation would be that the Oncology team consider liaising with other oncology centres and review management of oncology patients undergoing major surgery who are also of increased bleeding risk. This may identify further pre-operative preventative measures that could be employed/considered in these high risk cases.
13205 (STEIS 2014/24850)	03/07/14	VTE	Spinal	03/10/14 Submitted 07/10/14	**Findings and Lessons to be learned** ▸ Patient appears to be doing well at his most recent follow up on 3rd July 2014

					▸ Whilst there were gaps in documentation noted it is not likely that these contributed in any way to the VTE.
13211 (STEIS 2014/21906)	03/07/14	Wrong side block	Theatres & Anaesthetics	08/09/14 Submitted 08/09/14	**Findings and lessons to be learned** ▸ This event resulted from a momentary lapse in concentration, by an experienced Anaesthetic registrar. ▸ The occurrence of this incident shows the importance of rapid cascading of recommendations to all staff. ▸ Recommend to move the printer in Theatre 6, minimising interruptions. ▸ A recommendation in the updated Standard Operating Procedure (SOP) encourages a minimum of a total of 3 staff in the anaesthetic room.
13290 (STEIS 2014/23040)	13/07/14	Grade 3 pressure ulcer	Spinal	17/09/14 Submitted 17/09/14	**Findings and Lessons to be learned** ▸ From carrying out the root cause analysis it has been identified that in this particular case the history of pressure damage was not identified on this particular admission so there was no awareness of the history. This was identified after the deterioration in skin had occurred. ▸ The assessments were not always carried out at the appropriate time this is to include the must and pressure prevention care plan. ▸ Documentation was a big issue across the whole patient journey 09/07/2014 care plan had incorrect documentation on it (wrong mattress stated foam but soft premier active are on all beds). Documentation on skin inspection stated that the patient was on gel pads but this was incorrect as the patient was on troughs.
13912 STEIS 2014/33034	07/10/14	VTE	Oncology	11/12/14 Submitted 09/12/14	**Findings and lessons to be learned** ▸ Upon reviewing this case, decision to withold post-op clexane would still be taken due to the significantly risk of bleeding and hematoma formation (and secondarily wound healing problems and subsequent deep peri-prosthetic infection). ▸ Mechanical prophylaxis (TEDS and SCD) and early mobilization are recommended to decrease the risk of DVT/PE.
13837 STEIS 2014/33461	10/09/14	Surgical error Confirmed Never Event	Spinal	16/12/14 Submitted 16/12/14	**Findings and lessons to be learned** ▸ All patients undergoing spinal surgery should have levels to be operated on accurately identified in clinical notes and published operating list ▸ Where transitional segmentation exists, this is identified in the

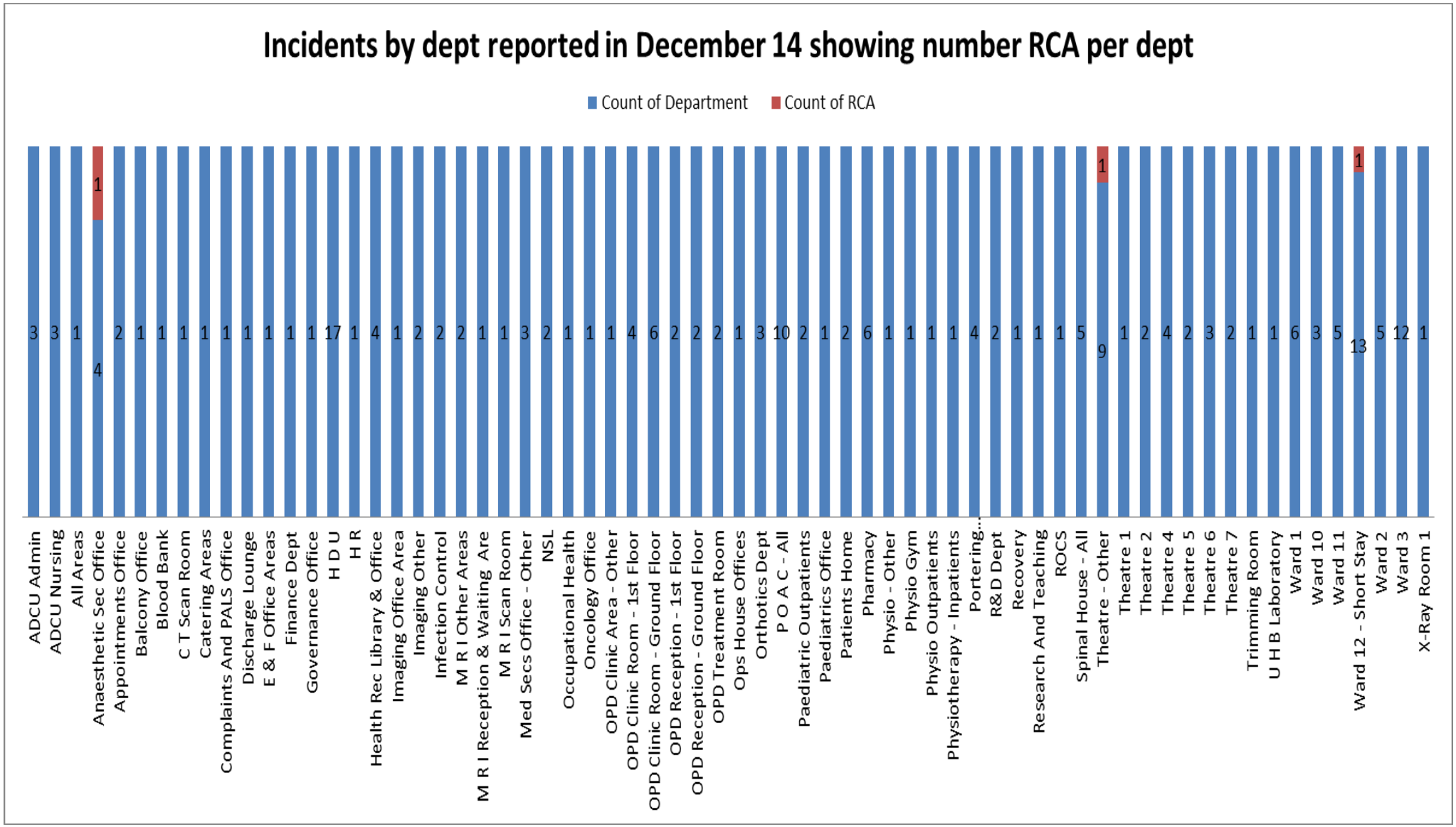
					notes and published operating lists ▸ Pre-operative skin marking should be undertaken according to the consultant surgeons preference but a well centred lateral X-ray is performed prior to opening the canal for standard interlaminar decompression or discectomy, or prior to taking down the intertransverse membrane for intertransverse approaches, and these images are saved onto PACS. ▸ Review of radiology support for theatres. ▸ Clinical protocols to be implemented to support clinical decision making.
13982 STEIS 2014/33836	15/10/14	Grade 3 pressure ulcer	Paediatrics	19/12/14 Submitted 18/12/14	**Findings and lessons to be learned** ▸ A very complex case, having extensve surgery to correct marked flexion deformity to improve positioning and quality of life. All preventative measures evidenced, clear consent discussing pressure ulcer risk with this type of surgery on 25/9/14, and at cast changes 9/10/14 and 15/10/14. ▸ Documented evidence of advice given to parent regading off loading heels and reporting any concerns. Parent well informed that this could have occurred and we are monitoring it closely. ▸ Communication is a barrier as patient is unable to verbalise or understand any language. ▸ This was a very high risk case due to extent of corrective surgery and repositioing requirred therefore as measures and education were present this can only be deemed as unavoidable
13944 STEIS 2014/34206	20/10/14	Grade 3 pressure ulcer	Large Joints	23/12/14 Submitted 22/12/14	**Findings and lessons to be learned:** ▸ Patient developed grade 3 pressure damage to heels post operatively. Risk assessments had been carried out pre and post operatively and pressure relieving measures were in place. However in hindsight due to the patient's history of autoimmune skin condition on long term steroid medication and poor mobility admitted for a total hip replacement the equipment was inadequate. Patient should have been considered for a breeze mattress and heels off loaded from point of admission. Skin inspections were carried out regularly and SSKIN tool implemented. However there is no documented evidence that when the early signs of skin damage (red, blanching heels) which was noted post operatively in HDU and then on the ward that any action was taken to off load heels. Gel pads continued to be used which do not off load the heels from all pressure. Trust protocol was followed on detection of the pressure damage and measures immediately put in place.

					Pressure ulcers were healing on discharge and referrals and equipment provided for care at home.Given conclusions it is deemed possible that grade 3 pressure damage could have been avoided. Preventative measures were not adequate for risk factors identified and should have been implemented from point of admission.
14048 STEIS 2014/35097	23/10/14	Drug incident	Theatres & Anaesthetics	02/01/15 Submitted 31/12/14	**Findings and lessons to be learned:** ▸ Syringe swaps are common in anaesthesia and probably account for more than 30% of anaesthetic drug errors. NPSA and RCOA/AAGBI via Safe Anaesthesia Liaison Group have explored two methods for reducing such errors – second person checking and barcode checking; ▸ Second person checking is considered impractical and has been shown not to reduce errors ▸ Barcode checking is well received but is associated with significant cost implications ▸ Distraction is known to be a contributory factor in anaesthetic drug error and methods of reducing distractions in the anaesthetic room at the time of induction of anaesthesia should be explored. ▸ Anaesthetist involved has completed a reflection exercise on this incident.
13795 STEIS 2014/30724	22/09/14	Death following transfer	Large Joints	19/12/14 (Extended from 24/11/14) Submited 24/12/14	**Findings and lessons to be learned:** There are numerous references in the notes to the regular care from the Bone Infection Unit. There are however some issues which have arisen from this case, which, whilst not affecting the outcome, are indicators of where there could have been improvements. ▸ At the moment, patients are referred to individual consultants for complex infections. I know this hospital has a Bone Infection Unit, this is run by the nurse specialists and Dr B and there is no formal MDT where all the consultants involved in infection sit down together to discuss the case, as for instance happens in the Oncology Service. I believe it would be a huge benefit to this hospital if such a process took place so that opinions from more than one consultant could be obtained and decisions hence made in a multidisciplinary setting. ▸ It is apparent from the records that Mr W was seen by a multitude of different consultants and junior doctors over the period of time he was in the hospital. Although his care was under the responsibility of Mr A, his input on a day-to-day basis is not always apparent and there were frequent references to him being away when decisions needed to be made. I would therefore strongly

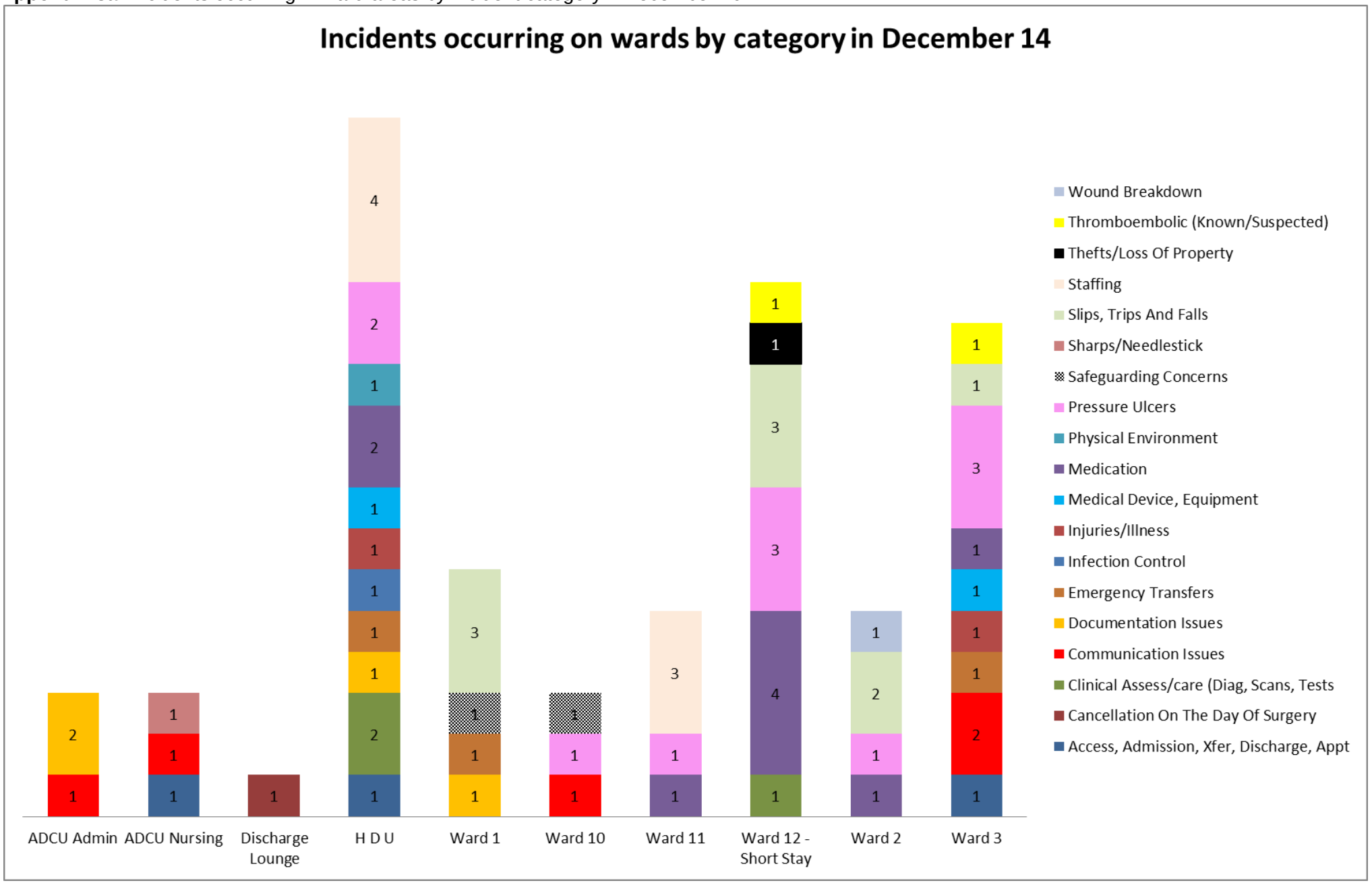
					recommend that any patient with a complex infection should be under the care of a team and not just one individual. There should be a nominated consultant who is familiar with the case who cross covers and if there was an MDT that existed for infection this would then take care of that. ▸ Junior doctor involvement for operations. Whilst many operations can be carried out by junior doctors there is no doubt that if a consultant is involved to carry out the operation, the Fces of a successful outcome are slightly improved. ▸ While Mr A did all of the major operations, the repeated washouts and packings were done by juniors and it is not clear if Mr A was present for any of these. ▸ There were repeated references to operations being cancelled and this is a problem with infection. These tend to go down at the end of the operating list and sometimes there is a relatively junior anaesthetist only left to do them who may cancel the case and secondly, the consultant surgeon may not be available to do them either. Cancelling cases like this is detrimental to their care and a patient with infection should be a priority, not one that is tacked on the end of the list. I would strongly recommend therefore that there should be availability of operating lists at least twice a week for infected cases if this hospital is to have a service for infection. ▸ Dealing with expectations. It is not entirely clear on what Mr W was counselled about the likelihood of success at various stages and the risks of proceeding with attempts to control the infection. In general, repeated first stage procedures have a lower Fce of success but they do not usually lead to major morbidity and mortality problems. In an elderly patient however repeated operations and repeated hospitalisation and repeated courses of antibiotics are likely to weaken the immune response and this is something which does need to be considered when counselling the patient. It is possible therefore that earlier amputation may have saved his life but not his leg. This is something which an Infection MDT would be able to monitor and advise on.
13853 STEIS 2014/31822	29/09/14	VTE	Large Joints	02/12/14 Submitted 02/12/14	**Findings and lessons to be learned:** ▸ It may be worth considering a longer period of anticoagulation in some patients but apart from a first degree relative with VTE, this pt had no riskfactors in addition to NWB in POP which is similar to many of our patients. I note that the physicians at the QE have investigated the pt for risk factors. Nothing had been found

					though some investigations were outstanding at discharge. A recent study (presented at BOFAS 2014) suggested that the calf pump mechanism functioned well despite a full below knee plaster in ambulant patients. I can find no evidence to suggest that we should start to use LMWH in patients who are allowed to fully weight bear 6 weeks post op. It seems that there will always be a risk of DVT/PE after surgery. If rebound hypercoagulability exists in some patients then there will never be a good time to stop chemical thromboprophylaxis.
13856 STEIS 2014/31828	29/09/14	VTE	Small Joints	02/12/14 Submitted 02/12/14	**Findings and lessons to be learned:** ▸ Procedure is high risk for a VTE event - local policy followed appropriately.
13568 STEIS 2014/27185	19/8/14	Treatment delay	Theatres, Anaesthetics & Critical Care	6/11/14 (Extended from 23/10/14) Submitted 03/12/14	**Findings and lessons to be learned:** ▸ It would be advisable to assign two anaesthetists to manage the case which will enable more efficient management of difficult situations. ▸ Pre-booking an ITU bed at QEH would be desirable in these types of surgery. ▸ Prior to extubation, an acceptable blood gas needs to be documented and discussed with anaesthetist (especially for out of hours procedures). ▸ It would be recommended that the theatre anaesthetist liaise with the on call consultant anaesthetist (for complex and prolonged surgeries finishing out of hours) to update and agree on a plan for post-op care. ▸ All complex and high risk procedures should have appropriate invasive monitoring as a routine. ▸ Discussion required as to a second opinion when decision to refrain from return to theatre when continuing resuscitation indicates that bleeding is still on-going. ▸ Discussion required for a skilled and experienced base protocol for surgeons to follow in the future.

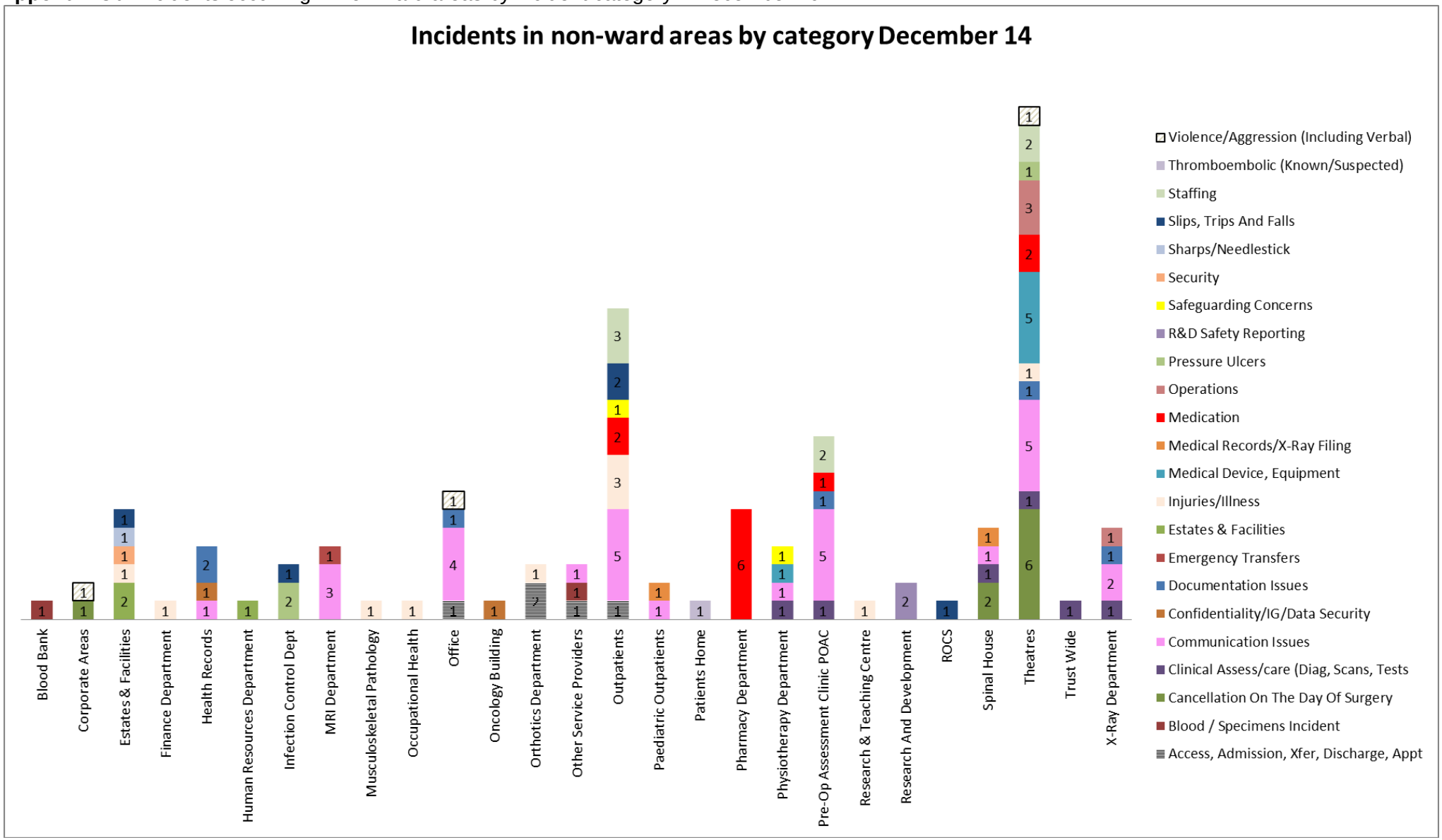
Appendix 2: No. of Incidents requiring an RCA investigation by department – December 2014



Appendix 3a: Incidents occurring in ward areas by incident category – December 2014



Appendix 3b: Incidents occurring in non-ward areas by incident category – December 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	12	5	7	74	129	0	12	3	257
Corporate	11	9	2	151	55	0	7	18	209
Large Joint	22	9	13	81	123	1	28	176	1301
Oncology	8	3	5	27	46	1	5	52	296
Paediatrics	6	2	4	6	45	1	3	92	389
Small Joint	4	1	3	22	36	0	6	0	31
Spinal	20	2	18	39	186	2	20	89	746
Theatres	0	0	0	12	34	0	6	104	953
TOTAL	**83**	**31**	**52**	**412**	**654**	**5**	**87**	**534**	**4182**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 **ENCLOSURE NUMBER: 9**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	Director of Nursing and Governance
NAME OF AUTHOR:	Lisa Pim. Deputy Director of Nursing and Governance
SUBJECT:	Safe Staffing

SUMMARY

In December there was SEVEN incidents reported relating to safe staffing, with 2 reports relating to the same incident. Proactive use of incident reporting continues to require focus to improve awareness and accurate reporting. Details as follows:-

14355, 14380, and 14402 – Three incidents were reported from HDU, they were all rated green. The incidents varied from lack of suitably trained paediatric nurse, only 1 member of staff on site for night shift and staff sickness. A breach of minimal safe staffing occurred when only 1 member of staff arrived for night duty; of note, the unit had no patients in place and no planned admissions. The Matron has been asked to investigate the reason why 1 member of staff only turned up for duty.

14343, 14331 and 14330 - Three incidents were reported from Ward 11, of these 2 were rated green and 1 was rated amber. 2 of the reports related to the same incident. All reports relate to short term sickness meaning staffing levels fell below safe staffing minimal levels. All actions were taken to ensure safe staffing of the area. The ward had very small numbers of patients at this time and the bleep-holder who is supernummary based herself on the ward to support care of the patients.

14416 – An incident was reported from Theatre 4, where considerable delay was caused to patients due to a lack of 2nd ODP practitioner to support workload. Safe staffing levels were not breached on this occasion.

Noted breaches of minimal safe staffing standards have occurred this month. In all instances escalation took place with the Matrons safe solutions sought. Patient safety was maintained at all times.

Twice weekly Matron/Senior Nurse Quality Debriefs continue. Monthly Safe Staffing Briefings continue.

It is recommended that monthly information shared with the Board is broadened to include data indicating the overall percentage of bank and agency usage for ward areas. A 6 month review of nursing establishments will also be included in next month's papers

IMPLICATIONS

Patient safety and experience
Staff satisfaction
Organisational reputation

RECOMMENDATIONS

Trust Board are asked to;

- Note and accept the recommendation for additional data relating to safe staffing.
- Explore the risks noted and support mitigation plans to maintain patient safety and staff wellbeing
- Acknowledge the ongoing work by Senior Sisters/Charge Nurse, Matrons and Project Manager
- Recognise and acknowledge the importance to ROH NHSFT of the national guidance in regards to our patient welfare and future strategy

APPENDIX 1: BOARD ASSURANCE FRAMEWORK 2013/14 (updated: 26.1.15)

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	16	8	16	6	9	12	16	10
				Exec Lead	DNG	Fin	DNG	Ops	Ops	WFOD	WFOD	Fin
					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 of engagement 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										
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
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							
32	Surgical Site Infection Rate		8	Medical Director (As DIPC)	Lead Committee				Supporting Committee			
33	Insufficient assurance around robust implementation of infection prevention strategies in theatres.		8	Medical Director (as DIPC)	Lead Committee				Supporting Committee			
30	Non-compliance with CQC safety domain 'management of medicines'	Potential harm to patients. Breach of CQC essential standards of quality and safety	16	Director of Nursing & Governance	Lead Committee	Supporting Committee	Lead Committee		Supporting Committee			
738	Failure to meet regulatory activity as specified within the CQC Inspection report published on 17.09.14, which detailed 6 compliance actions associated with failure to meet regulatory activity.	Risk of: theft or misuse of controlled drugs; electrical harm to staff and visitors; fire; privacy and dignity not maintained; IG breaches; poor patient experience of Outpatients, poor reputation, poor use of resources within the department; patient information not shared in a timely manner resulting in potential delays in care	16	Director of Nursing & Governance	Lead Committee	Supporting Committee	Lead Committee		Supporting Committee			
770	New Dec 2014: Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure.	Plant failure would cause significant operational impact on clinical services	20	Director of Operations				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	16	8	16	6	9	12	16	10
				Exec Lead	DNG	Fin	DNG	Ops	Ops	WFOD	WFOD	Fin
					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 of engagement 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.	12	Director of Operations				Lead 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				
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				
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 leadership development needs particularly in the management of change	Care for patients that is less than the best; Lack of organisational sustainability	16	WFOD							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

					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	16	8	16	6	9	12	16	10
				Exec Lead	DNG	Fin	DNG	Ops	Ops	WFOD	WFOD	Fin
					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 of engagement 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										
Risks downgraded- to be monitored												
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			
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
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	Lead 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
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

	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**

Enc. 10 - Appendix 2
Board Assurance Framework Update – Quarter 3 2014-15
(updated: 26th January 2015)

Summary

New risks aligned to the BAF
As new Trust-wide red/high amber risks these risk have automatically been escalated for BAF monitoring. EMT/CGC have been asked to review these risks and advise on monitoring arrangements.
770 'Theatres' engineering plant'

New red/high amber Trust-wide risks
788 'No H&S advisor/LSMS in post: previous postholder left December 2014 and new postholder due to start April 2015 ' – This was a new 'high amber' risk in December 2014, however assurance has been received from the Director of Operations that appropriate mitigation is in place and the risk can be managed locally.

Escalating risks:
30 'Management of Medicines'
738 'CQC compliance'
414 'PROMS'
178 'WHO' checklist
27 'Use of temporary/agency medical staff'

De-escalating risks:
EMT/CGC have been asked to review these risks with to provide assurance relating to possible de-escalation from monitoring via the BAF.
32 'Surgical Site Infection Rate'
33 'Infection Prevention in theatres'
669 'Point of Care Testing'

BAF Theme 1: Standards of Care (i.d. 260).

Update January 2015: Risk rating has been increased from yellow '6' to red '16' due to identification of organizational-wide non-compliance with safe controlled drugs practice, including prescription, administration and documentation.

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
Dec 2014 (re-instated)	(i.d. 414) ROH shows low position for health improvement as measured by PROMs on national Information Centre figures.	Reputational damage, for example, if Trust deemed to be an outlier.	MD	• Safe • Effective	16	12	PROMs remains a significant outlier for the Trust. This is the case for many specialist Trusts and might reflect the complexity of some of these cases. Ongoing work in analysing these cases.	Jan 2015: no change in position December 2014 Previously de-escalated but following review at November CGC meeting, this risk is to remain under current monitoring via the BAF due to lack of coherent process for monitoring and acting upon data collected in order to successfully effect change.	CGC
March 2014	(i.d.178) Poor completion of WHO safety procedure. Mitigation: Working partly in place. 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	December 2014 Following review at November CGC meeting, this risk is to remain under current monitoring via the BAF due to continued failure to assure the organisation of peri-operative safe process and in failing to meet contractual arrangements with the Commissioners November 2014 Revised action plan agreed with lead Commissioners.	CGC

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**
Tbc	(id 32) Surgical Site Infection Rate* *note change of title (previously SSI within arthroplasty)	Although the actual numbers are low the ongoing monitoring will from time to time show an increase. If this were sustained it could have a significant reputational impact on the Trust.	MD	• Safe • Effective	16	8	Current risk downgraded from 12 to 8 (Dec 2014) Surgical Site Infection Rate remains a background risk for the Trust given the high number of operations performed. Ongoing 12 month surveillance of all arthroplasty cases in place.	December 2014 SSI rate reduced by 65% over last 12 months. Consideration to be given to local management and de-escalation of management via BAF as risk mitigation and controls in place. Mitigation: 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	8	Current risk downgraded from 12 to 8 (Dec 2014) A number of SOP's have been introduced and embedded in the Theatre complex. There is daily monitoring of these standards by the Theatre lead for Infection Prevention	December 2014 Consideration to be given to local management and de-escalation of management via BAF as risk mitigation and controls in place.	CGC

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**
Jan 2015	(id 30) Non-compliance with CQC safety domain management of medicine	Potential harm to patients. Breach of CQC essential standards of quality and safety	DNG	• Safe • Effective	6	16	Current risk increased owing to concerns highlighted by trust-wide audits	Mitigation put in place Dec/Jan 2015: Trust-wide internal audit undertaken reviewing documentation of controlled drugs (CDs). External review by KPMG commissioned to look at documentation and prescription/administration of CDs. Zero tolerance letter sent reminding registered practitioners of their roles and responsibilities in the administration and documentation of CDs. SOPs produced to support practice in the administration and documentation of CDs. Matrons commenced spot audit checks on CDs. Joint quarterly audits by pharmacy and theatre staff commenced Sept/Oct 2014. Results show concerns re completion of documentation in theatres re CD registers and Fridge monitoring. Theatres management group led by consultant anaesthetist set up to address these issues.	CGC

De-escalated risks aligned to this theme (awaiting assurance from lead committee on mitigation)		
i.d.	**Description**	**Lead Committee**
12	KPIs	CGC

275	Learning from serious events/claims/complaints	CGC
621	Delays in MRI imaging and reporting	CGC

BAF Theme 2 Monitor Licence (i.d. 261)

Update on progress

January 2015: Overall risk rating increased from 3 'green' to 8 'amber' owing to link with BAF theme 3 'CQC' registration which has increased to red. Failure to meet regulatory activity as specified within the CQC inspection report published on 17.09.14 and associated risks (see risk 738) are indicative that further work needs to be done to ensure systems and processes re quality of care are robust.

BAF Theme 3 CQC Registration (i.d. 262)

Update January 2015: current risk rating increased from yellow '4' to red '16' due to identification of inconsistencies in controlled drug practice, specifically in relation to accurate documentation. A legally enforceable compliance action was issued by the CQC in June 2014 in relation to controlled drugs (HDU).

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
Jan 2015	(id 738) Failure to meet regulatory activity as specified within the CQC Inspection report published on 17.09.14, specifically management of controlled drugs.		DNG	• Safe • Effective	6	16	Following a Trust-wide audit reviewing documentation of controlled drugs, inconsistent practice was discovered within specific areas and poor compliance with expected standards identified.	Mitigation put in place Dec/Jan 2015 (same as for risk 30 'CQC compliance') Trust-wide internal audit undertaken reviewing documentation of controlled drugs (CDs). External review by KPMG commissioned to look at documentation and prescription/administration of CDs. Zero tolerance letter sent reminding registered practitioners of their roles and responsibilities in the administration and documentation of CDs. SOPs produced to support practice in the administration and documentation of CDs. Matrons commenced spot audit checks on CDs.	CGC

BAF Theme 4 Business continuity (i.d. 263)

Update on progress

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.

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
Dec 2014	(i.d. 770) Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure,	Significant operational impact on clinical services	Dir Ops		20	20		Jan 2015: Discussed with Dir Ops and Head of Estates. Requires review of Trust wide Estates Strategy at EMT, and previous investment decision into proposed new Theatre block Potential impact: The plant is beyond its normal life expectancy and has a high risk of failure, with significant operational impact on clinical services. Currently, 3 theatres share single, and oldest engineering plant, equivalent to 30% of the Trusts overall theatre capacity. Current controls and mitigation: Continue with annual rolling theatre maintenance programme. Introduction of temporary theatre would be limited to single replacement theatre due to limited on-site space available - dependent on demolition of decommissioned ward block in 2015.	EMT

								New risk December 2014 – agreed at EMT in Dec 2014 to be added to risk register with a score of 20	
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**
Aug 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	12	Jan 2015 current risk rating - confirmed as amber (12)	Jan 2015 Current risk rating - confirmed as amber (12) ; training for INR machines arranged for Jan 2015. ?continue monitoring via EMT until use of new INR machines well-established and training embedded. Dec 2014 Two meetings of the Blood Safety Committee sub-group have been held. New INR machines have been procured for clinical areas (Coaguchek). EQA will be added. Inventory has been brought up to date and QMS established. KH & MA attended training for new ISO standards. SOP to be written Confirmation being sought from EMT regarding possible de-escalation from management via the BAF.	EMT

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**
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..	Aug 2014 Increased number of lists available to treat patients at ROH Use of Cromwell Hospital for patients requiring ITU 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		Jan 2015: Formation of a Data Quality Group underway comprising a Stakeholder panel to review & escalate data issues and a technical panel charged with the rectification of data quality issues Technical staff fix issues as they arise. Informatics Manager is covering technical issues when short staffed. Longer term - infrastructure needs reviewing.	EMT

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**
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 GP trainees or FY2	Increasing locum and agency costs and potential successful banding claims. Following EMT discussion, awaiting further update from Medical Director.	MD/ WFOD	• Well led • Safe • Effective	20	20		**Dec 2014** Costs still escalating. MD advises rating increased from 16 to 20. New control in place: Director of Operations approves request for locum doctor appointment Planned assurance: appoint project manager for medical workforce project Work on recruiting physicians' assistants being progressed by Dr Minas and Prof Begg: update to be requested Spring 2015. 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.	EMT

De-escalated risks aligned to this theme (awaiting assurance from lead committee on mitigation)		
i.d.	**Description**	**Lead Committee**
269	Activity targets	EMT
51	Medical Records	CGC

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.

De-escalated risks aligned to this theme (awaiting assurance from lead committee on mitigation)		
i.d.	**Description**	**Lead Committee**
625	Spinal database data corrupt	EMT

BAF Theme 6 Staff Engagement (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 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. 582) Risk of non-delivery of strategic objectives due to leadership development needs particularly in the management of change Note: risk description updated (previously	Care for patients that is less than the best; Lack of organisational sustainability	WFOD	• Well led • Safe • Effective	16	16		Dec 2015 Kings Fund report due end of December and leadership strategy to be developed in Jan 2015	EMT

	"management of change")								

BAF Theme 8 Long term viability (i.d. 440)

Update on Progress (Jan 2015)

- CQC reviews: downgraded from 'adequate' to 'requires improvement' as there are some improvement actions included in the latest review, which rated the Trust as 'requires improvement'.
- Tariffs for 2015/16 released for formal consultation in Dec 2014. Lobbying has reduced the impact for the ROH from a £5.5m loss to a £1.2m loss. This is still a significant risk for the Trust.
- Operational and financial plan for 2015/16 is being updated for formal submission to Monitor on 10/4/15.

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
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		Jan 2015: likely impact of the tariff changes currently being modelled into the overall financial position for 2015/16 as part of the workings for the Annual Plan. High level revised plans to be taken to the Board in February 2015. Dec 2014: Final version released for formal consultation on 27th Sept. Likely impact for the ROH is a loss of around £1.2 million. A 50% marginal rate has also been introduced for specialized services, which could have a significant impact on our growth strategy.	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
782	Compliance with Equality Act	tbc
779	Bank staff holiday pay	tbc

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 **ENCLOSURE NUMBER: 10**

NAME OF DIRECTOR	Director of Nursing and Governance
SUBJECT	Board Assurance Framework (BAF) report
AUTHORS	Lisa Pim, Deputy Director of Nursing and Governance Jane Moore, Litigation Assistant and Governance Facilitator

SUMMARY

This report covers the period Quarter 3 2014/15 (1st October to 31st December 20014).

The frequency of reporting on the Board Assurance Framework has moved from monthly to quarterly. EMT and CGC continue to receive monthly reports on all risks they oversee and will also receive the quarterly BAF report.

The attached information shows:

- Appendix 1: The 8 BAF themes and Trust-wide red and high amber risks aligned to those themes.
- Appendix 2: A summary of new, escalating and de-escalating risks; details of the current status of the 8 BAF themes; and a commentary on the Trust-wide risks aligned to those themes, including mitigation and gaps in control.

BAF Themes

Three of the over-arching BAF themes are currently rated 'red':

a) Standards of Care,
b) CQC registration.

Both these themes have been escalated from yellow/amber to red in December 2014 owing to concerns relating to compliance with the CQC safety domain 'management of medicines' (see risk 30) and non-compliance with safe controlled drugs practice (see risk 738).

c) Organizational Leadership: risk '582' relating to the management of change remains red but will be reviewed in light of the Kings Fund report (due end of December 2014) and the leadership strategy to be developed in January 2015.

Overall risk rating for BAF theme 3 'Monitor Licence' has been increased from green to amber owing to the link with BAF theme 3 'CQC' registration.

Strategic Risks

Work has been undertaken by the Company Secretary and Director of Nursing and Governance on new corporate risks associated with implementing the Trust's strategy following a Board workshop in November 2014. These risks will be added to the Trust's risk register, and reported to the Board in due course.

Further work is to be undertaken reviewing potential risks associated with the Clinical Audit Programme.

IMPLICATIONS

Patient Safety, Contractual, Legal, Reputational

RECOMMENDATIONS

Trust Board is asked to:

- Note the paper
- Discuss

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 **ENCLOSURE NUMBER: 11**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers**
SUBJECT:	**Care Quality Commission (CQC) Action Plan**

SUMMARY

This report provides Board members with an update on progress to implement the action plan arising from the Care Quality Commission inspection in June 2014.

The Board is asked to note the timescales proposed for achievement of compliance and improvements, some of which conclude in mid-2015.

Progress is being made in all areas, however, additional actions have been identified in relation to the management of medicines as a result of further scrutiny and internal checks against compliance requirements.

IMPLICATIONS

The Trust is required to meet the standards required to provide high quality care and comply with legal and regulatory requirements. Failure to achieve the necessary standards may result in sub-optimal care for patients and result in conditions being imposed on the Trust's licence to operate.

RECOMMENDATIONS

The Board is asked to note the contents of the report, in particular the additional risks identified and discuss items as appropriate.

Report To	Trust Board
Report Of	Chief Executive
Purpose of the Report	To update Board members on progress against the action plan developed following the CQC inspection in June 2014
Recommendation	The Board is asked to note the contents of the report, in particular the additional risks identified and discuss items as appropriate.

This report provides Board members with an update on progress to implement the action plan arising from the Care Quality Commission inspection in June 2014 and report received on 17 October 2014.

Attachment 1 sets out the agreed actions and timescales for achievement as agreed by the Board in November 2014.

The attachment provides an update on progress against each item and confirms the director responsible for action. The Director of Nursing and Governance has overall responsibility for delivery of the plans.

Internal checks have identified additional risks in relation to medicines management. Additional steps have been taken to ensure that all staff are aware of the Trust's policy, which is consistent with legal requirements and individual professional body standards.

An external analytical and governance review has been commissioned, spot checks are being undertaken and a review of practice and compliance is nearing completion, which will provide advice to support improvements going forward. External assurance has been sought which confirms compliance by the due date (December 2014), however, more regular management oversight will be required to ensure updated practice becomes embedded. The Care Quality Commission have been informed of the latest position and further actions.

Further work is underway to review and strengthen internal controls, governance and reporting arrangements.

A number of activities are due for completion in mid-2015 and therefore further reports will be provided to the Clinical Governance Committee and Board.

Recommendation

The Board is asked to note the contents of this report, in particular the additional risks identified and discuss as appropriate.

POSITION STATEMENT ON CQC ACTION PLAN AS AT 28 JANUARY 2015

Action	Date	Responsible for Action	Responsible Director	Please review detailed actions set out in Action Plan and provide a position statement as at 19 January. Action should be complete if date agreed has passed
Compliance Actions – Must Do				
Unsafe management of medicines because controlled drugs were not checked in accordance with legislation. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Medicines Management	December 14	Matron for HDU	Director of Nursing & Governance	All actions in place including; • Team briefing from DON • Medicines policy re-issued • Sharing of learning experience at Nurse Leaders and Senior Nurses • Random spot checks • Performance Management of staff • Unit based medicine management training has been given informally and post new CD book/SOP with plans to formalise training records in development (clinical Nurse Tutor. As part of additional review work we have identified other areas of non-compliance separate to the observations made during the CQC inspection. CQC have been informed and the risk register revised to reflect increased risk. In response to these findings further actions have been taken to ensure full compliance in theatres: • Policy re-issued to all relevant staff & specific reviews • New CD registers issued • Additional training and reinforcement of standards • Spot checks, including independent assurance checks

				• Review and reinforcement of controls and governance arrangements
Unsafe equipment as electrical safety checks were not routinely undertaken. Regulation 16 91)(a) GSCA 2008 (Regulated Activities) Regulations Safety, availability and suitability of equipment	Rolling compliance	Head of Estates and Facilities	Director of Operations	• The process of rolling review continues to be the primary assurance tool. Estates are however working through a refresh of the electrical Asset Register to maintain a clear schedule of our circa 7000 electrical items. Education regarding the risk assessment of non-moveable items continues.
Arrangements to ensure the dignity, privacy and independence of service users. Regulation 17 (1)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users	January 2015	Matron for Outpatients and Senior Nurse Lead for Privacy and Dignity	Director of Nursing and Governance	• Communication complete with OPD staff via team meeting. CD informed ESP/Physio. Volunteers advised. ANPs made aware from Senior Nurse Meetings and Clinicians during conversation in OPD. Corporate Communication Team to support wider workforce outside of Matrons remit. • New policy being developed in draft format as of Jan 2015. Awaiting Corporate steer on expectations- i.e. Chaperone by Default or by Request of chaperones as a Trust. NB this option will influence if further workforce review/Business case required in OPD. • Posters displayed throughout OPD and baseline audit of chaperone awareness compiled through Listening Event in Nov 2014 and further review due February 2015. • New documentation approved by Documentation Committee and DDON in December 2014 and being

				rolled out 20/1/15. This will be audited in due course in February 2015 • Clarity system due to be upgraded in February and Chaperone question will be incorporated at this point too. • Spot checks being completed in OPD by Triumvirate on awareness of Chaperones and auditing once paperwork in full use. • Incidents/Complaints sent to Matron for HDU and referred to Matron for Outpatients - to date none since Action Plan.
Paper or electronic forms are kept securely. Regulation 20 (2)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Records	On-going	Matron for Outpatients Dept.	Medical Director (Caldicott Guardian)	All actions in place including: • Two new notes trollies arrived and in action December 2014 • Brief all permanent staff who work within or use the Outpatient Department of the requirement to appropriately secure confidential patient information • Ensure all Bank or agency staff, within local inductions, are informed of the requirement to appropriately secure confidential patient information • Provide appropriate, closed and lockable medical notes storage within public areas • Senior Sister, Matron, Clinical Director undertake random, documented spot checks and to feed back to staff their findings. Dependant on the outcome of the

				spot checks local actions are to be taken, as appropriate • Consideration of the appropriate use of the disciplinary policy will be taken should individual staff members persist in inappropriate management of confidential patient information • Brief all staff across the Trust of the importance of appropriate management of confidential patient information, using existing forums and communication methods • Corporate Communication required for all staff groups awareness.
Letters to GPs and other referring bodies are sent out within set timescales to ensure effective communication. No regulation identified. Action Trust must take.	July 2015	Divisional Manager for Patient Access	Director of Operations	• The current process of turnaround monitoring to the Activity Review Group continues on a weekly basis with any concerns being highlighted and actioned. • The accelerated timeline for the operationalization of Digital Dictation and voice recognition software installation suggests a go live from Mid April 2015. Regular project updates are being received. Once installed this will allow for real time monitoring of all turnaround times via the ICT platform.
Action the Trust Should Take				
Resuscitation equipment is routinely checked in accordance with the Trust's procedures and records of the checks are kept in outpatients	1 December 2014, with on-going vigilance	Senior Sister, Out Patients Dept. and Matron for Out Patients Dept.	Director of Nursing and Governance	All actions complete and robust checking system in place in OPD
Assessing and monitoring the quality of service provision – Trust did not have a system of	July 2015	Head of Out Patients	Director of Operations	• A patient Listening into Action event was held over 5 days during November. Circa 400 patients contributed to this event, broadly 20% of the week's OPD attenders.

monitoring the quality of services in OPD. Regulation 10 (1)(a)(b) HSCA 2008 (Regulated Activities) Regulation 2010 Assessing and Monitoring the quality of service provision				Automated monitoring continues to be a challenge and is largely still paper based. This situation will continue until the In touch with Health solution is operationalised during latter spring. During the intervening period the Interim Head of Outpatients continues to work with individual clinical colleagues and with the GooRoo planning tool to more evenly balance patient volumes.
Discharge arrangements to identify availability of beds for patients admitted on the day of surgery are improved	April 2015	Directorate Manager for Patient Access	Director of Operations	• The introduction of enhanced 7 day working during November has continued following its positive assessment upon patient flow. The work has resulted in a smoothing of admissions. A business case is being considered to mainstream this pilot. Work continues to better schedule patients to ward beds, both by way of improved information sharing and the merger of the bed management and discharge functions.
There is managerial oversight of all outpatient services to ensure the efficient and effective operation of the department and to ensure patients' experiences of care of improved	1 November 2014 (initial actions) Additional actions up to and beyond April 2015	Director of Operations	Director of Operations	• The Interim Head of Outpatient Improvement started with the Trust on 1st November. This individual is working to an extensive GANTT Improvement time line. The substantive post will go to national advert during February 2015.
Implementation of Enhanced Recovery Programmes to reduce patient length of stay in hospital and promote greater patient involvement in their care	Review of approach by June 2015	Directorate Manager, Patient Access	Medical Director	• The Medical Director has taken the chair of the Enhanced Recovery working Group, being supported by the General Manager for operations. Best practice scoping is underway together with an assessment of quick win opportunities. The developing work plan

				focuses on primary Hip and Knee patients.
When the reception desk is closed, there is clear, visible signage to direct patients and visitors from the main entrance to other departments	December 2014	Head of Estates and Facilities	Director of Operations	• The Trusts Mini Reception desk is now open Monday to Friday 0800 to 1700 with a business case to extend to 0700 to 1900. Enhanced signage has been installed to aid way finding out of hours. Further new hospital site maps are currently being produced for installation during February. Enhanced information will then be added to patient's appointment letters. Additional patient car parking has been secured adjacent to ADCU following patient feedback.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 **ENCLOSURE NUMBER: 12**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	Director of Nursing and Governance
AUTHOR	Evelyn O' Kane. Matron.
SUBJECT:	Children and Adults Safeguarding Report

SUMMARY

The annual report details progress made by the Trust in:

- Developing adult and children safeguarding systems and process
- Identifying key areas that form part of the ongoing work for the safeguarding team.
- Evaluation of achievement against set objectives.
- It highlights objectives and focus for 2014/2015

Key areas of note:

- The trust has made significant progress in all levels of training for eligible staff
- There is further focus required in the area of mental health and application of the mental capacity act and best interests.
- The Trust has had several external reviews including the CQC and our Commissioning Partners. Both inspections found noted that safeguarding knowledge throughout the Trust was sound.
- Implementation of the Care Act 2014 poses significant challenges for the organisation moving into next year, putting adult safeguarding on a statutory footing.
- The Lead Nurse and Named Nurse continue to develop their partnership working with Birmingham Children's and Adult Safeguarding Boards and the CCG Leads, alongside relevant charities/agencies.

- Patient experience and welfare
- Contractual
- Financial
- Reputational

RECOMMENDATIONS

Trust Board are asked to:

- Note and discuss the Safeguarding Report
- identify areas of risk requiring further assurance
- identify any other children and young people/adults issues for inclusion in future reports

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHILDREN AND ADULTS SAFEGUARDING ANNUAL REPORT

November 2013-2014

Contents

Summary

The annual report details progress made by the Trust in

1. Developing adult and children safeguarding systems and process
2. Identifying key areas that form part of the ongoing work for the safeguarding team.
3. Evaluation of achievement against set objectives.
4. It highlights objectives and focus for 2014/2015

Introduction

The report evaluates the objectives set for 2013/2014 and makes recommendations to improve practice in safeguarding children and adults at risk for the forthcoming year.

The Trust was inspected by the Care Quality Commission during 2013-2014; this took the form of an announced inspection in June 2014. In addition to this the CCG undertook an unannounced inspection on safeguarding services care and provision in July 2014. Positively, the CCG report stated that all members of staff demonstrated a good understanding of safeguarding. Recommendations for improvement from the visit related to information being available easily and accessible for the public in out-patients area, encouraging staff to work in partnership across agencies by supporting them to independently perform lateral checks, and improved liaison with other safeguarding colleagues.

There have been significant changes in safeguarding over the past year, following recommendations from new guidance and shared learning from serious case reviews nationally .The safeguarding agenda from a trust perspective is driven by several different reports, Birmingham Safeguarding Board guidelines, and legal rulings. Perhaps of greatest significance is the introduction and implementation of the Care Act 2014, which comes into force April 2015, placing for the first time adult safeguarding on a statutory footing.

The Trust is engaged with the safeguarding adults and children and young adult's agenda, including representation at the Birmingham Safeguarding Boards and relevant operational subgroups. This ensures partnership working and shared learning from case studies as well as sharing the work being undertaken as health providers.

The focus this year has been greater staff awareness on education and its application to clinical practice, robustly demonstrating safeguarding in action. Other areas of focus include implementation of reasonable adjustments to support adults and children at risk, and the empowerment of staff to be accountable, to take action ensuring protection of vulnerable adults and children.

Promotion of Right Services Right Time and partnership working with local charities, social service providers and support groups to help support and sign post the right services to patients and families has also been a key priority.

The Lead Nurse and Named Nurse have continued to ensure the six principles that underpin safeguarding are addressed through training and contact with staff. These are as listed below:-

Key Principles

- Empowerment
- Protection
- Prevention
- Proportionality
- Partnership
- Accountability

Cases reported, including concerns raised, are reviewed against these principles when internally and externally reporting on Trust activity in relation to safeguarding of our patients

Disclosure, scanning and Barring System

The Royal Orthopaedic Hospital scanning and barring system is a robust system for all employees and prospective employees, safeguarding concerns screening is included in reference request for all new staff employed by the Trust.

Education and training

Safeguarding protection training continues to be in-house, the training programme having been developed by the Named Nurse is regularly reviewed by the safeguarding team and changed as required to ensure lessons from serious case reviews and research is incorporated. This is externally reviewed by CCG Designated Safeguarding Leads.

Induction training for Adult at Risk Safeguarding (level 1)
Level 1 - Basic awareness consists of a leaflet given to staff annually. Identified staff members outlined within the training strategy are expected to complete either an e-learning package module or attend face to face training.

Enhanced Training (level 2)
The adult protection enhanced training session which is required by bleep holders and identified staff members is delivered by external providers, continuing to work in partnership with the Community Health Trust.
For children, enhanced child protection is required by all health care professionals who work on a regular basis with children. This training has been provided in house by the Named Nurse, supported by the Consultant Paediatric Physician from Birmingham Children's Hospital.

Level 3
Adult at Risk training for named and lead nurse and named doctor is provided by the Birmingham Safeguarding Board externally.

Annual Adult Safeguarding Figures for 2013-2014

Level	Percentage completed	Target
Level 1	94%	90%
Level 2	85%	85%
Level 3	100%	85%
Mental Capacity Act	88%	85%
Deprivation of Liberties	89%	85%

This information was collated October 2014.

Annual Child Safeguarding Figures for 2013-2014

Level	Percentage completed	Target
Level 1	94%	90%
Level 2	85%	85%
Level 3	100%	85%

This information was collated October 2014.

Prevent	Percentage completed	Target
Health WRAP 2	72%	50%

This information was collated October 2014.

Prevent trainers for the Trust have undertaken the required update in Oct 2014 to enable them to deliver the required new WRAP 3 training , which is required to implemented from Jan 2015.

Safeguarding Issues/activity

During the year the Trust received the following safeguarding issues;

External

- Eleven Domestic Homicide Reviews, with a nil response for the Trust on each.
- Two Deprivation of Liberties Applications submitted , one, following review was not required, the other was passed by supervisory body
- One Internal Management Review request, following possible service concern with a nil response for the Trust.
- Three Safeguarding Alerts made, one for a patient with undiagnosed vascular dementia, one for mental health concerns, one for a patient with special needs care concern in residential care.
- One Freedom of Information request received in relation to (FGM) Female Genital Mutilation.
- One referral to Aquarius accepted to support patient in preparation for surgery.

Internal

- Eleven Mental Capacity Assessments have been completed , concerning consent for surgery and ongoing treatment

- Six Best Interests meeting were undertaken in preparation for admission and care needs.
- Twenty four incidents reported of possible safeguarding concerns by staff, discussed at link professionals group.

There has been an expected increase in concerns formally raised and this is perceived to be as a result of greater awareness. The named nurse and lead nurse record advice calls and contacts made to allow for monitoring of these issues, which did not require action. These are reviewed for trend analysis to identify learning needs internally and shared with commissioning designated leads for children and adult safeguarding.

Protection Cases

Serious Case Reviews

The named and lead nurses are working with members of the Birmingham Safeguarding Board Operational Subgroup to ensure that learning is being implemented into practice for The Royal Orthopaedic Hospital.

Learning Lessons

The lessons that have been learnt within 2013-14 are as follows;

- Training. The Trust has expanded training for many members of the multi-disciplinary team to ensure that knowledge is embedded within all professional groups -"safeguarding is everyone business".
- The need to ensure action and pursuit of concerns with other providers, to protect and prevent potential issues for patients/carers ensuring early identification and prevention strategies to safeguard children and adult patients from harm or possible abuse.
- Improvement and access to mental health intervention and assessment for patients is needed, particularly in relation to substance abuse along with required provision of level of care and support patients and staff.
- Mental Capacity and best interest is not fully understood and undertaken, this are similar issues faced by other Trusts and health provider organisations, and is recognised by local and national reports and Birmingham Safeguarding Board as an area of focus in 2015.
- Further work with consent is required, specifically with regard to delegated responsibility for looked after children (LAC), including early identification of parental responsibility and enhancing parents understanding of this with regard to consent.

2013-14 Challenges

- Supporting patients with mental health needs, accessing and assessments of needs , service level agreement review
- Recruitment and retention of Named Nurse post with demands on role and current funded hours
- Ring fence protected time for Safeguarding Lead to undertake duties effectively.
- Review of staff eligible for training to ensure Trust staffs are appropriately trained in order to ensure all patients at risk are safeguarded.
- Mental capacity assessments being fully integrated into patient care pathway by both medical and nursing teams.

- Accessing information in a timely manner from other partner agencies , in order to realise potential concerns
- Data cleansing /accuracy with regard to (ESR) Electronic Staff Records for safeguarding training competence.

Summary of Work Completed in 2013/2014

- Learning disabilities awareness training incorporated into adult /children staff training
- Formulation of Learning disabilities action plan, in partnership with Clinical Lead for Health Facilitation team, CIPOLD plan.
- Video of patient/family experience with special needs undertaken and agreement from family to use as part of training and to share with senior managers/board.
- Participation in health provider quarterly learning disabilities group, to ensure care and practice is up to date and share learning and improve patient outcome
- End of Life Care- reviewed and partnership working with St Mary's Hospice
- Link professional meeting set up, to share learning and improve practice across the Trust, supported by CCG designated leads, offering clinical supervision time for staff.
- Raising awareness of Female Genital Mutation (FGM) with charitable organization, training provided for leads in theatre team. Training updated by clinical tutor with regard to catherisation training to include FGM awareness.
- Purple edge care plans for safeguarding concerns produced, launched as part of Nursing Day May 2014; to gain staff feedback on these and audit practice, to evidence care provided and concern action. To provide central record for safeguarding documentation.
- Terms of reference and work plan reviewed draft for the Trusts Safeguarding Committee.
- Participation in Local Safeguarding board operations subgroups, attendance at required meetings and working on project work for example annual assurance review.
- Policies updated and ratified
    - Adult and children safeguarding
    - Mental Capacity and Deprivation of Liberties
    - Equality in Access – Learning Disabilities
    - Missing Persons
- Bimonthly review meeting with CCG lead nurse adult safeguarding to ensure provider feedback and challenge.
- Serious Case Review learning – included into staff training and BSAB update provided, Case studies shared at link professionals meeting and via safeguarding group members.
- Executive and Non-Executive clinical governance committee observation of practice and discussion with staff via executive walkabouts.
- Staff attended practitioner workshops, arranged by BSAB and facilitated by sub group members, with very positive feedback in relation to improving practice and application of the key principles.
- Trust has supported increased training for name nurse and discharge sister for patients with learning disabilities and special needs.

- Participation in Section 11 audit tool peer review and challenge undertaken in November 2014 for both children and young adults safeguarding.
- Provision of bespoke training for theatre and preoperative assessment department staff to ensure training is embedded and accessible
- Evidence submitted and updated- Section 11 portfolio web based tool reviewed by quality and assurance group of the children's safeguarding adult's board and CCG.
- Reviewed process of assessing young people's competency and implemented tool following lessons learnt from untoward incident and staff feedback.
- Regular meetings with theatre link nurse and Named Nurse, with very positive feedback. Improved patient experience has been reported for children and young people.
- Medical Director Involvement in improving the medical team's engagement with required level of safeguarding training for role, this includes reinforcement at PDR and for revalidation evidence of competence in practice.
- Training at Level 2 –enhanced training undertaken by a number of on call executive managers

Update on Objectives set for 2013/14

Objective set	Progress/ update
Continue to review training strategy as required and increase % eligible staff trained using all training media forms available, with internal and external support	Completed
Safeguarding Level 1training - increase the number of face to face training sessions per month.	Completed Offered weekly , and min of 2 per month also evening sessions for medical /consultant staff
Safeguarding Level 2 (Alerter/Referrer role higher level) –further training to ensure staff are trained to support junior staff and consistent process applied safe practice and procedures followed for on call managers and Trust bleep holders/site managers for the Trust.	Completed
Supervision training to be undertaken by Lead Nurse and Named Nurse planned for early 2014	Partially completed Name Nurse for Children and Adults has attended. Lead Nurse to complete 2015/2016
Lead and Named Nurse to receive regular clinical supervision and review supervision guidance and policy and supervision offered to staff	Partially complete This continues to be supported by CCG lead
To work in partnership with operational groups on the review of MCA assessment and risk assessments and to actively participate in formulation of new procedures and processes.	Carried forward BSAB have appointed project team for 12 months commencing Jan 2015,

Improve communication throughout the trust monitor effectiveness, complete spot checks question staff on process and staff knowledge	Complete To audit Feb 2015
Flow chart for all areas within The Royal Orthopedic Hospital for staff members to improve knowledge of who to contact	Completed To be updated Feb 2015, in line with Local Safeguarding Boards and legal changes.
Shadowing experience with other safeguarding leads in health and other partner providers to develop networks and bench mark current the Trust training and practice to be undertaken by named and lead nurse.	Completed Two visits in 12 months period to Heart of England and Sandwell /Dudley Trust safeguarding Leads
Completed documentation audit and evaluation to review effectiveness and provide report to committee meeting for audit.	Completed Jan 2014
Mental Health Care and training with Criminal Justice System/Court Orders for the Trust.	Not completed Carried forward ,in line with new Care Act 2014 and review required of SLA for psychological care provision for the Trust with UHB
Increase the number of approved Prevent trainers for the Trust to deliver on training sessions required as part of contractual requirement	Completed 3 approved trainers
Provide prevent training for all members of staff as part of the mandatory training days.	Completed One hour to one and half hour training Wrap2 /3 undertaken on clinical and non-clinical days
Update safeguarding website regularly, Intranet for staff members and external Trust website for patients.	Ongoing
Undertake audit of MCA application and understanding and of care plan and documentation of safeguarding care in practice	Completed Snap shot audit, to work with project team from BSAB to improve compliance and learning and best practice.
Quartile report to be completed and submitted. Report to be evaluated by Lead Nurse and Matron to ensure information captured and quality effectiveness.	Ongoing
Cases of safeguarding to be reported and evaluated complete data sheet for reporting the cases monthly	Completed Further work required on putting this into data base to improve reporting internally and externally.

Risks

The current risks identified within The Royal Orthopedic Hospital are:

1. Robust documentation of Mental capacity assessments and best interest discussions
2. Mental health access and service provision via University Hospitals Birmingham NHS Foundation Trust
3. Use of Care plans for safeguarding children/adults at risk.
4. Numbers of staff receiving safeguarding training – sustaining this level of training at the target required
5. Clinical supervision is not currently formally offered to all members of staff, and documented in safeguarding records
6. Recruitment and retention of Named Nurse post with demands on role and current funded hours.

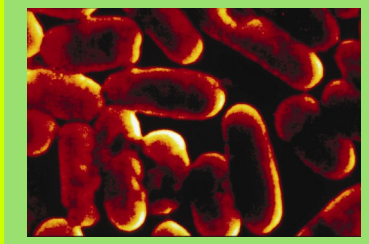
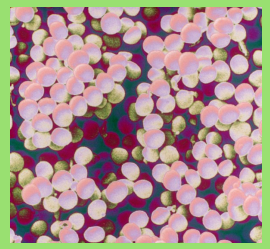
Objectives for 2014/15

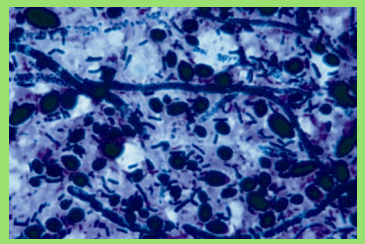
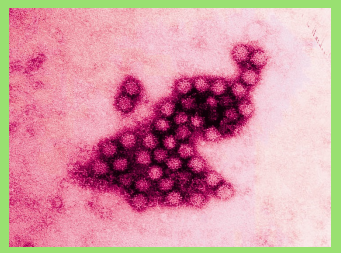
- Demonstrating an individual personalized approach to safeguarding, ensuring the child and patients voice is heard, including safeguarding patient journey reviews.
- Six principles of safeguarding being applied in everyday practice and care by all staff members, making every contact count, working with staff to ensure they fully understand how to apply these.
- Feedback form for patients with learning disabilities to review care and service provision in relation to reasonable adjustments, and ensuring patients/careers voice is captured.- April 2015
- Completion and submission of Learning disabilities self-assessment form – March 2015
- Completion and submission to the BSAB assurance framework –March 2015.
- Participation in the project being supported by BSAB with regard to (MCA) Mental Capacity Act and (DoLs) Deprivation of Liberties application and practice due to commence -Jan 2016 to support demystifying and empowering staff and patients
- Clinical supervision module completed by the Lead Nurse –Nov 2015
- Named and Lead Nurse to ensure training as required annual is completed and applied into Trust practice and guidance /policies-
- Ensure policies under group responsibilities are updated.
    - Restraint policy for the Trust, overdue – Feb 2015
    - Safeguarding policy – updated in line with guidance of the Care Act 2014 which comes into force April 2015.
    - Supervision Guidance – for safeguarding – May 2015
- Revise purple edge documentation and care plans following feedback – staff member to be supported to do work required to improve these and roll out use in the Trust – April 2015.
- Provide information for inclusion to new staff handbook being introduced by Trust learning and development team, to update staff on safeguarding and Prevent.-Feb 2015
- Review of safeguarding Trust Committee in line with governance review Trust is undertaking “knowing we are safe”, by Trust company secretary including work plan and terms of reference and reporting- March 2015
- To look to secure funds for improving information and raise awareness for staff and the public - Charitable fund application to be made to promote mental capacity principles and best interest checklist- banners and leaflets and staff handout. Care Act guidance update- April 2015

- Training strategy for all staff levels reviewed- due Feb 2015
- Birmingham Children's Safeguarding Board, chair assurance visit which will include notes audit –awaiting new date
- Update of staff and patient Safeguarding Leaflet awareness – Annual review and update due June 2015
- Update safeguarding website regularly –intranet for staff members, website for patients.
- Completion of clinical supervision guidance for staff and evidence to be submitted to section 11 audit tool.
- Domestic Violence lead for the Trust to be included in named nurse children's safeguarding duties, to raise awareness and educate staff on required actions and support and signposting for patients.
- Participation and evidence action with regard to Child Sexual Exploitation (CSE) working in partnership with local group and charities. Ensuring information and education for staff.
- Snap shot audit of staff understanding and awareness and confidence and competence in safeguarding patients, findings reported back to Trust Committee and Clinical Governance Committee six monthly.

December 2014

Infection Control Annual Report 2013-2014


A full list of images used in this report can be found in Appendix 2

Contents Page

Introduction

The Infection Prevention and Control team at the Royal Orthopaedic Hospital is a nurse-led service and is unique in that it incorporates Infection Control, Tissue Viability, Nutrition, Surgical Site Infection (SSI) surveillance and a wound care service. It also runs the Bone Infection Unit (BIU) which provides treatment and care to patients with complex bone and soft tissue infections; specialising in the management of prosthetic joint infection. The BIU accepts tertiary referrals and has increased in size dramatically since its inception in 2011.

The corporate requirements for Infection Prevention and Control are led by Mr Pearson, the Trust's Medical director and Director for Infection Prevention and Control and by Sarah Mimmack, the lead Nurse for IPC and BIU.

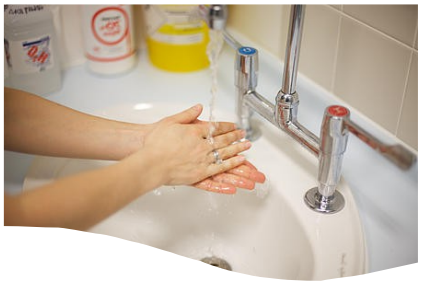
Despite several attempts to think of a name that incorporates all of the services the team provide, it continues under the inadequate title of Infection Prevention and Control Team - Under the IPC 'umbrella'. Tissue Viability and Nutrition are led by Jody Thompson and the team are able to manage many complex wounds both in Hospital and in the community by working closely with the Royal Orthopaedic Community Scheme (ROCS). ROCS are an integral part of the Bone Infection Unit and the Surgical Site Infection wound management service – and their input is pivotal to the continued success of these services.

Director of Infection Prevention and Control & Medical Director
Mr Andrew Pearson
BIU IPC Lead Nurse – Sarah Mimmack
IPC Specialist Nurse - Helen McCoy
IPC Nurse—Sarah Wood
Tissue Viability Specialist Nurse—Jody Thompson
Tissue Viability Nurse— Julie Bennett
Clinical Microbiologist & Infection Control Doctor
Dr Pauline Jumaa
Office Manager—Lyn Hindley
Epidemiological Data and Information Analyst—Nia Reeves
IPC Administrator—Bridget Dunbar

The whole team have worked incredibly hard over the past year developing the services; and the addition of a data analyst and additional administrative help has enabled the BIU in particular to grow. Presenting at the Oxford Bone Infection Conference, with analysis of the vast amount of data collected by the team was a particular highlight.

Patient satisfaction with the services remains very high and the team are deeply committed to continuing to develop and adapt to the ever changing climate as science enables us to learn how best to meet our patient's needs.

Key Achievements 2013-2014



- Mandatory Targets met
- Corporate responsibilities maintained
- Reduction in SSI rates
- Reduction in pressure ulcer incidence
- Procurement of additional equipment – VAC machines and specialist mattresses
- Increased BIU activity – tertiary referrals made direct to the team

Budget and Structure

The budget for Infection Prevention and Control is amalgamated with Tissue Viability and the Bone Infection Unit:

The pay budget for the team is: £302,552

The total budget including non pay is: £421,268

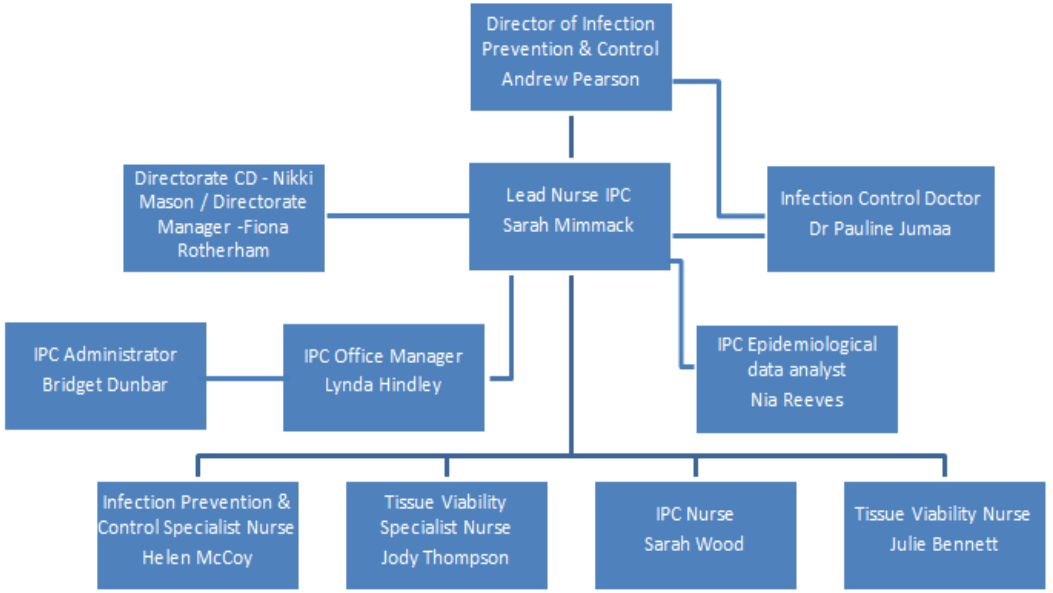
This includes funding for mattress hire, Vac consumables for the Trust and Dressings required for the Bone Infection Unit.

The Infection Control Doctor and Consultant Microbiologist for the Bone Infection Unit is Dr Pauline Jumaa. The services of Dr Jumaa and the on call microbiology service are secured via a service level agreement with the Queen Elizabeth Hospital Birmingham. 4 PA's of Dr Jumaa's time are funded.

The team is made up of the following whole time equivalent (WTE) posts:

- 1.0wte Band 8b - Lead Nurse
- 1.8wte Band 7 - Specialist Nurses
- 2.0wte Band 6 - Nurses
- 1.0wte Band 6 - Data analyst and epidemiologist
- 1.0wte Band 4 - IPC administrator

The team structure is shown here:



Reporting Arrangements

The Trust Infection Control Committee (ICC) meets every 2 months and the attendees were:

Director of Infection Prevention and Control / Medical Director – Mr Andrew Pearson (Chair)

Clinical Microbiologist / Infection Control Doctor – Dr Pauline Jumaa

Lead Nurse – Sarah Mimmack (Deputy Chair)

Consultant Orthopaedic Surgeon – Mr David Dunlop / Mr Robert Grimer

Consultant Anaesthetist – Dr Da Silva

Birmingham Cross City CCG, Infection Prevention Practitioner – Linda Raybould

Public Health England representative

Head of Estates and Facilities - Stuart Lovack

Decontamination Lead - Glyn Curley

Theatres Representative - Alan Arkell / Lis Richards

The committee reports to the Clinical Governance Committee which in turn reports to the Trust Board.

An Operational Group meeting is held every two months and is chaired by The Lead Nurse for Infection Prevention and Control.

The Operational Group consists of link workers from all clinical departments and representatives from facilities.

An out of hours and on call service is provided by the Queen Elizabeth Hospital Birmingham, this provides access to a 24 hours on call Microbiologist and is managed via the service level agreement.

Mandatory Surveillance of Healthcare Associated Infections (HCAI)

Reporting

The Infection Prevention and Control Team (IPCT) at the ROHFT are required to report on a number of different Healthcare Associated Infections (HCAI) through a number of mandatory surveillance schemes which includes monitoring of meticillin-resistant *Staphylococcus aureus* (MRSA) and meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias as well as *C.difficile, E.coli and* glycopeptide-resistant enterococcus (GRE). There is a surveillance scheme for monitoring Surgical Site Infections (SSIs) and this is covered in more detail overleaf.

In 2013-14 all targets were achieved for mandatory surveillance. There have been no cases of MRSA bacteraemia at the Royal Orthopaedic Hospital, this is the sixth year with no reported cases at the trust. There have been no cases of GRE. There were a total of two *C.difficile* cases at ROHFT both of which were categorised as unavoidable as both patients were under the care of the BIU and required antibiotics for a deep infection. Certain antibiotics can increase the risk of *C.difficile* infection more than others.

MRSA Screening

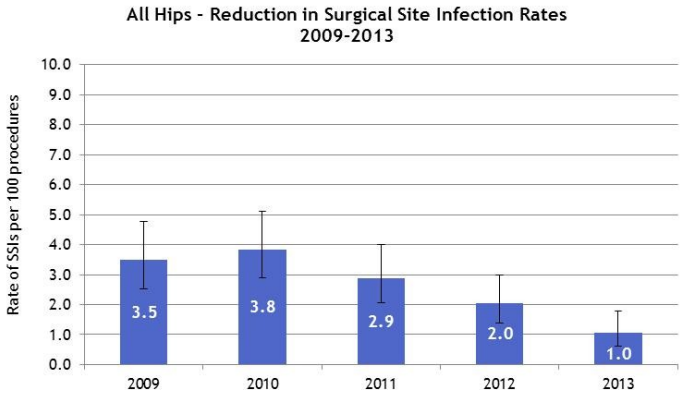
Screening for all admissions was mandated in 2009. 100% of elective admissions were screened prior to or on admission and from March 2010 all emergency admissions were also included in this target. The Trust has met this target throughout the year.

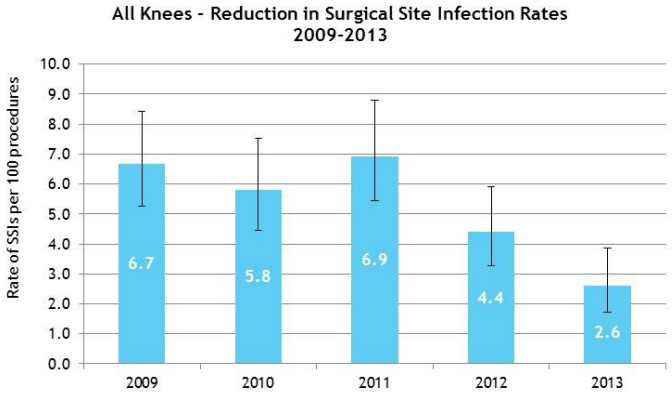
In 2010-11 there were 87 positive MRSA Screens identified and this had reduced to 47 in 2013-14. The IPCT have changed the way they screen patients for MRSA and now use an assessment tool which was introduced in June 2012 following a 2 year audit. This is a risk based screening method to eliminate unnecessary screening while maintaining the Department of Health requirements for MRSA Screening. The tool itself errs on the side of caution and any patient with an overnight stay is automatically screened and patients who have metal work inserted such as Hip and Knee replacements. It also considers their social circumstances and all other contributory risk factors.

This has resulted in a 50% reduction in the number of patients who are screened for MRSA from 14,245 in 2010-11 to approximately 7,000 in 2013-14. Each MRSA screen costs £6.75 and patients require two swabs of nose and groin. Since the introduction of the MRSA risk assessment screening tool there has been a significant financial saving of approximately £97,800. There has been no evidence of acquisition of MRSA or MRSA bacteraemias being an issue since the introduction of the screening tool and these markers are closely monitored by IPCT. A risk assessment tool is set to be adopted across the region as it has been so successful in reducing screening and in a time of financial pressure on the NHS, substantial cost savings without putting patients at unnecessary risk.

> **There have been no cases of MRSA Bacteraemia at the Royal Orthopaedic Hospital since May 2008**

Surgical Site Surveillance





> There was approximately a 65% reduction in the number of Surgical Site Infections for both Hips (64.9%) and Knees (64.6%) between 2009 and 2013

Surgical Site Infection (SSI) Rates are monitored through the national mandatory Surgical Site Infection Surveillance[1] System, which is co-ordinated by Public Health England (PHE). Under the current system patients are monitored for 30 days post-operatively following hip or knee surgery to see whether they develop a SSI via a questionnaire.

A significant amount of investment and effort has been put into reducing SSI rates at ROHFT since 30 day rates were first monitored in 2009. This has led to the reduction shown in the graph above and is multi-faceted but effective. Initial figures show the Trust has achieved a statistically significant reduction of approximately 65% in the number of SSIs for both hips (64.9%) and knees (64.6%) between January 2009 and December 2013[2].

There is a need to quantify our true infection rate by utilising better criteria than the 30 day SSI monitoring is currently able to offer. Discussions are required regarding the use of CDC criteria although these are currently under review and are due for final publication this autumn. IPCT propose to continue reporting of 30 day data to PHE and then further investigate all cases that meet the PHE criterion against a more robust criteria such as the CDC. This will help elicit the true SSI rate in a more scientific way than we are able to undertake at present.

The Trust has agreed to extend surveillance to 12 months minimum for all patients with a Hip or Knee prosthesis for 2014-15, which is recommended by PHE and CDC. Patients will be followed up at agreed intervals of 2 weeks, 4 weeks, 3 months, 6 months, 9 months and 12 months and information will be collected to ascertain whether a patient had a superficial or deep infection. This information will allow the IPCT to gain further understanding regarding Surgical Site Infection here at ROHFT and to continue to work towards lowering rates of infection across the board.

[1]Further Information on the Mandatory Surveillance of Surgical Site Infections can be found: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SurgicalSiteInfection/SSISurveillanceProgramme/

[2]A full breakdown of SSI Data can be found in Appendix 1.

Bone Infection Unit (2011-2014)

The Bone Infection Unit (BIU) is a specialist unit at the Royal Orthopaedic Hospital for the treatment of bone, joint and spinal infections. This includes infected prosthetic joints and infected metalwork such as endoprosthesis, plates and screws.

There have been significant advances in orthopaedic treatments including arthroplasty, endoprostheses and the surgical correction of deformities. Prosthetic joint replacements are widely performed. Deep infection of prosthetic joint replacements is a major complication. The overall incidence of prosthetic joint infection is rare and recent data from the mandatory surveillance of surgical site infection suggests that the incidence is around 0.5 to 2% . The number of joint replacements being performed is increasing and this means that the absolute number of prosthetic joint infections is increasing.

The development of a Bone Infection Unit (BIU) was driven by the desire to improve the quality of care and experience for patients undergoing treatment for bone infection. There are reputational benefits to enabling patients to return home rather than endure extensive hospital stays. The BIU operates as a 'virtual' unit and manages patients both in the hospital and in the community. The population of infected patients already existed in the hospital and it was identified that existing expert resources could be used differently to manage patients in a way that would improve their recovery.

The management of prosthetic joint infection can be particularly challenging. Diagnosis is often delayed as symptoms are generally variable and non-specific. Such infections are complex, and most centres will only see a small number of cases. A multidisciplinary approach to managing prosthetic joint infections is considered best practice to provide the patient with optimal care.

"The multidisciplinary team at the Royal Orthopaedic Hospital NHS Trust comprises of the following:

- Consultant Orthopaedic Surgeon
- Consultant Microbiologist
- Infection Prevention and Control Lead Nurse
- Tissue Viability Specialist Nurse
- Royal Orthopaedic Community Scheme (ROCS)
- Antimicrobial Pharmacist"

The pathway for each BIU patient is determined at the multidisciplinary meeting held every Tuesday morning. Prior to the introduction of the BIU all patients received a 6 week course IV antibiotics. Treatment of patients with and without prosthesis did not differ. Under the care of the Bone Infection Unit a patient specific plan is made and it is usual for patients without prosthesis to receive 6 weeks of antibiotic therapy and those with a retained prosthesis a 3 month course of antimicrobial therapy. The complexity of dealing with biofilm is the primary reason for the differentiation.

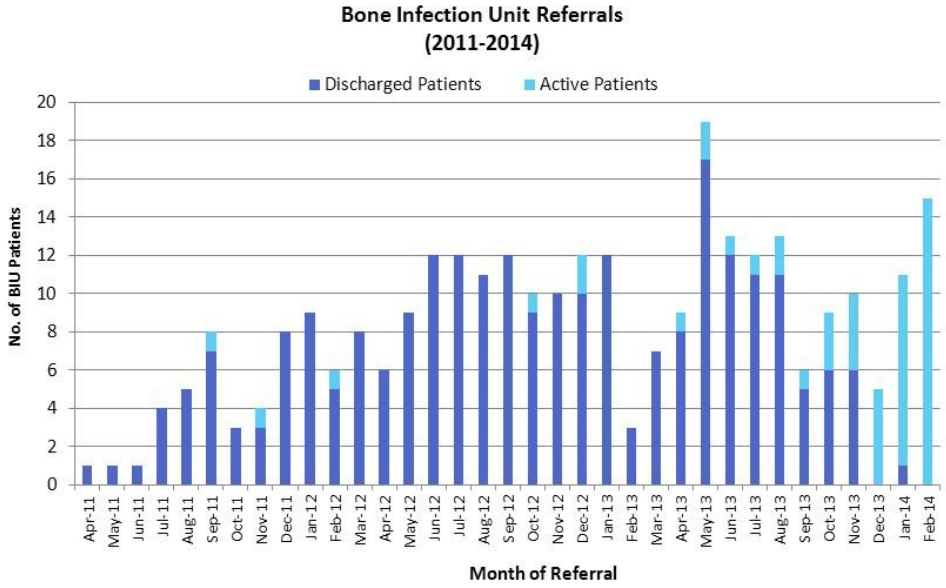
The success of the Bone Infection Unit relies on forging close working relationships between consultants, nurses, microbiologists, pharmacy and other medical professionals in ensuring that patients are referred and treated appropriately. It is important that patients with infection are identified early and appropriate antibiotic regimes are in place based on the microorganisms that are grown from tissue samples.

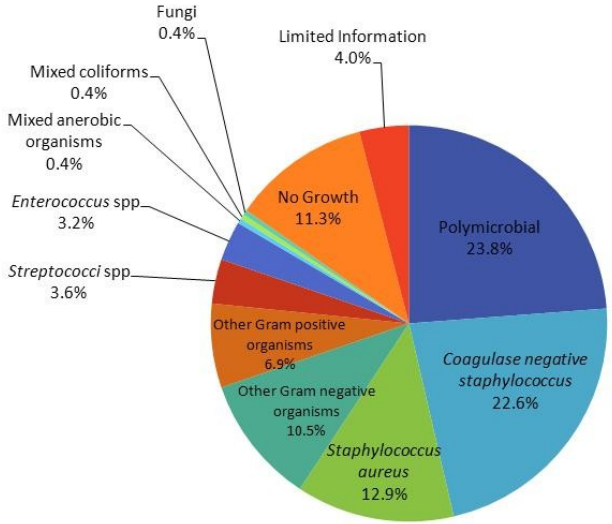
The Bone Infection Unit presented three separate pieces of work at this years Oxford Bone Infection Conference (OBIC) to share knowledge with other colleagues working in Bone Infection which included:

- *The safety and tolerability of oral linezolid to treat prosthetic joint infections*
- *Pre-operative aspirate culture in patients with suspected prosthetic joint infection undergoing two stage arthroplasty revision*
- *Modified Lautenbach procedure in patient with an Multi Drug Resistant Pseudomonas*

Bone Infection Unit

Activity to Date





There were a total of **296** patients who were under the care of the Bone Infection Unit (BIU) between April'11 and February'14. **248** patients were discharged from the BIU during this time period. At the time of producing this report, **51** patients were receiving ongoing care from the BIU. **25** (49%) of these patients were new referrals to the BIU in January and February 2014. There has been a steady upward trend in patients who are referred to the BIU.

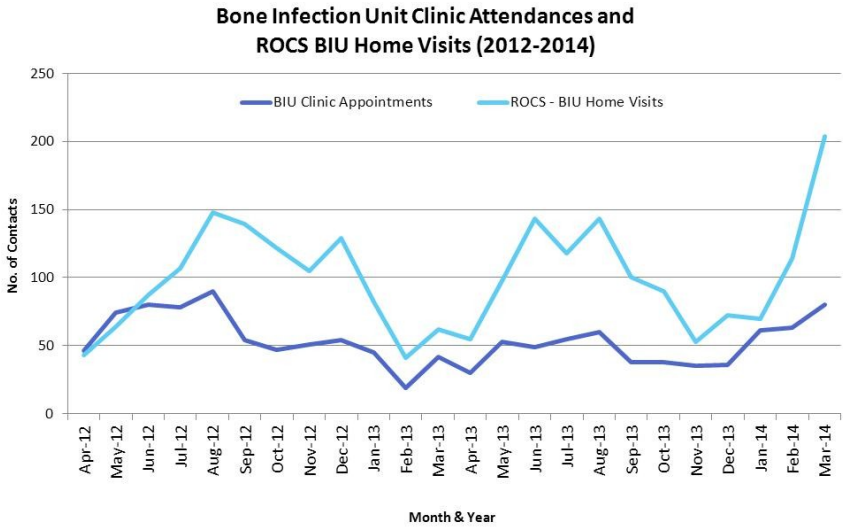
Key Facts:

- There are significantly more male (61.1%) than female (38.9%) patients seen in the Bone Infection Unit.
- There are significantly more patients in the 60-69 (26.3%) and 70-79 (25.1%) year old age group compared to other age groups.
- Over a third (34.8%) of all patients referred to the Bone Infection Unit had a history or probable history of chronic infection.
- Approximately 20% of patients had their referral to BIU within one year following their primary surgery.
- There has been an increase in the range of organisms that have been identified within the Bone Infection Unit from 24 individual organisms in 2011-12 to 52 in 2013-14.
- There are differences in the organisms identified in patients from different specialties (i.e. oncology, spinal, arthroplasty).
- The Bone Infection Unit has seen an increase in the number of rare or unusual microorganisms isolated from tissue samples from patients.

An in-depth report has been produced which provides a variety of data from the and is the first detailed report to be produced by the Bone Infection Unit. The discussion section at the end of the report sets out number of items for future consideration, which were beyond the scope of the initial report and a number of suggested items for discussion with different medical professionals who are involved in the care of patients referred to the Bone Infection Unit.

The ROH leads a regional meeting instigated to enable development of Bone Infection Management within the area and influence the national plans for this complex problem.

Royal Orthopaedic Community Scheme (ROCS)



The Royal Orthopaedic Community Scheme has a team of specialist nurses - all of whom are independent prescribers, and physiotherapists based within the hospital who cover a wide radius of up to 30 miles from the hospital. The scheme provides a service 7 days a week for 365 days a year and includes 24 hour support for the patients. ROCS was initially set up in 1999 to facilitate early discharge, the service has grown extensively over the years and the team are able to cater for a wide variety of complex orthopaedic conditions at home.

ROCS does not accept referrals exclusively for home IV therapy, in such instances referral of the patient, to the Bone Infection Unit is required and if home IV therapy is required as part of a patients treatment plan, ROCS will administer it at home wherever possible.

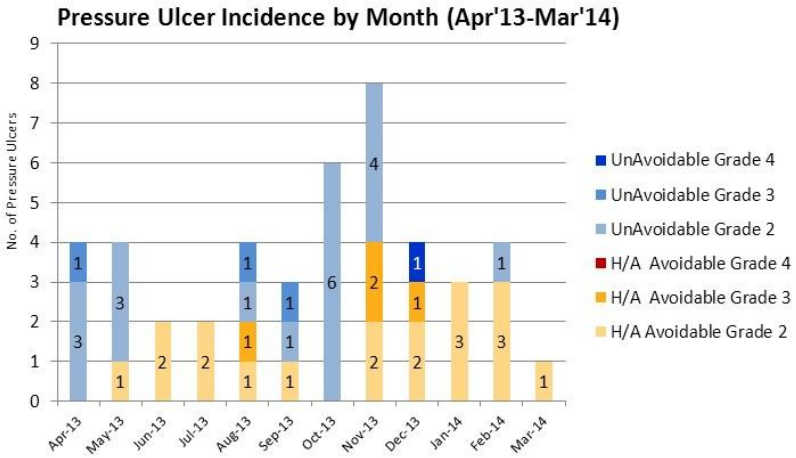
ROCS is an integral part of the Bone Infection Unit (BIU) and provides specialist care for this complicated group of patients following their surgery. The wound care required for some of these patients is complex and may require input for a period of months.

Since the Bone Infection Unit was set up in 2011, there has been an increase in the number of patients who are seen by ROCS as part of their treatment with the BIU and cared for in their own homes. In the first half of 2014 there has been a huge increase in activity. There are currently around 50 active patients under the care of the BIU. This has seen a significant increase in ROCS home visits from an average of 71 visits for October to December 2013 to 130 visits per month between January and March 2014. March 2014 saw some of the highest activity on record with 204 home visits being carried out by the ROCS team for BIU Patients in a single month.

A selection of services Provided by ROCS

- Supported early discharge following orthopaedic surgery
- Physiotherapy assessment and treatment at home
- Complex wound care including VAC therapy
- IV therapy (Outpatient)
- Community care for patients with bone infections
- Specialist treatment of surgical site infection
- Post-operative support via a telephone helpline
- Pre-operative support for patients with wounds requiring healing prior to surgery
- MRSA decolonisation

Tissue Viability & Nutrition



> The Tissue Viability Team procured new pressure relieving equipment in January 2014, every patient in the trust now has the use of specialist pressure relieving mattresses during their stay.

The Tissue Viability (TV) and Nutrition team is a nurse led team at the Royal Orthopaedic Hospital which provides a variety of services including specialist advice on wound care as well as advice and support for patients, families and their carers. The team offers guidance on appropriate treatment plans for patients who are considered to be high risk and provides expert knowledge to other health professionals within the trust. All staff are encouraged to contact the Tissue Viability team if they have any concerns about a patient and to seek appropriate advice on the use of dressings and care of patients.

Pressure Ulcers

In 2013-14, there were a total of 22 avoidable pressure ulcers, "Avoidable[1]" means that the person receiving care developed a pressure ulcer and the provider of care did not do one of the following: evaluate the person's clinical condition and pressure ulcer risk factors; plan and implement interventions that are consistent with the persons needs and goals, and recognised standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. There were 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 despite all preventative strategies being put in place. It must also be noted that this is a specialist Trust that performs complex orthopaedic surgery, which in some instances can mean that patients spend a total of 9 or more hours on the operating table. There was one grade 4 pressure ulcer at the ROHFT which resulted from patient who was admitted with pressure damage. This deteriorated post operatively after the patient had palliative surgery. A mini-root cause analysis was carried out and findings indicate this was unavoidable deterioration. At the time of writing this report Ward 11 had 383 days since their last avoidable pressure ulcer and Ward 1 has had 216 days since their last pressure ulcer.

Common factors were identified from both avoidable and unavoidable incidents. Malnutrition was a key risk factor in around a third of all pressure ulcer incidents (29%) and around 40% were oncology patients. Approximately 1 in 5 patients who had a pressure ulcer were diabetic. Other risk factors included the type of surgery a patient had, particularly complex hip revisions and also whether a patient had a plaster cast fitted.

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. This is also provided monthly and alternates between HCA's and RGNs. Feedback is positive about these sessions. Attendance is monitored through the learning and development department.

Appendix 1:

ROH 30 day Surgical Site Infection - PHE Criteria

Table 1: 30 Day SSI Data for The Royal Orthopaedic Hospital (2009-2013)

SSI Rate	2009	2010	2011	2012	2013	% Change from 09-13
Primary Hips	**3.5%**	**3.8%**	**2.9%**	**2.0%**	**1.0%**	**-64.9%**
LCL	*2.5*	*2.9*	*2.0*	*1.4*	*0.6*	
UCL	*4.8*	*5.1*	*4.0*	*3.0*	*1.8*	
Primary Knees	**6.7%**	**5.8%**	**6.9%**	**4.4%**	**2.6%**	**-64.6%**
LCL	*5.3*	*4.5*	*5.4*	*3.3*	*1.7*	
UCL	*8.4*	*7.5*	*8.8*	*5.9*	*3.9*	
No. of SSI	**2009**	**2010**	**2011**	**2012**	**2013**	
Primary Hips	37	44	33	26	13	-
Primary Knees	65	52	61	41	23	-
No. of Procedures	**2009**	**2010**	**2011**	**2012**	**2013**	
Primary Hips	1063	1144	1153	1274	1240	-
Primary Knees	974	896	880	932	887	-

Confidence intervals have been calculated using the Wilson Score Method as per APHO Technical Guidance: **Technical Briefing 3: Commonly Used Public Health Statistics (APHO, 2008)** Available from http://www.apho.org.uk

Statistical significance/Statistical test: to test a given hypothesis, we initially proceed on the assumption that it is true. If, on this basis, an observation as extreme as that obtained would have been very unlikely to arise by chance, we then 'reject' the hypothesis. The cut-off point or 'significance level' below which we consider to be too small is arbitrary, but is traditionally set at 0.05 (5%). Results which lead to the rejection of the hypothesis are said to be 'statistically significant' (APHO,2008).

Appendix 2:

Image Credits

Table 2: Report Image Credits

Page	Image	Credit
Front Page	5 Images	Provided by UHB—Wellcome Images—http://wellcomeimages.org/
Page 5	Top Right Hand Side	NHS Photo Library (www.photolibrary.nhs.uk)
	Bottom Left Hand Side	ROH In-House Photo
Page 6		ROH In-House Photo
Page 10		NHS Photo Library (www.photolibrary.nhs.uk)
Final Page		NHS Photo Library (www.photolibrary.nhs.uk)

The table above provides a list of all images used in this report including the website links where appropriate

Contact Us:

Infection Prevention and Control Team

0121 685 4354

Tissue Viability

0121 685 4000 extn: 55891

Bone Infection Unit

0121 685 4354 or e-mail: roh.boneinfectionunit@nhs.net

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Private Trust Board: 4th February 2015 **ENCLOSURE NUMBER: 13**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Andrew Pearson DIPC**
SUBJECT:	**Infection Prevention Annual Report**

SUMMARY

This report provides an update to Board members of key issues and activities since the last Infection Prevention Annual Report

IMPLICATIONS

Failure to ensure a high level of infection prevention and control has serious financial and reputational risk for the organisation

RECOMMENDATIONS

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: Wednesday 4th February 2015 **ENCLOSURE NUMBER: 14**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Anne Cholmondeley** **Director of Workforce and OD**
SUBJECT:	**ANNUAL EQUALITY REPORT 2014**

SUMMARY

As part of the Trust's requirement to comply with the Public Sector Equality Duty, the Trust is required to publish annual equalities information.

The report summarises the activity and progress made during 2014 towards achieving the objectives and the priority areas for action.

RISKS

PAS does not currently provide the functionality for the Trust to record all 9 protected characteristics of our patients. The plan is for this to be included in the PAS upgrade in March 2016. Our commissioners may seek further assurance that this will be achieved.

The new requirement to implement Equality Delivery System is likely to require re-allocation of existing resources (workforce capacity and financial investment).

RECOMMENDATIONS

The Trust Board is asked to:

- Discuss and note the content of the paper, particularly the areas of focus for 2015.

The Royal Orthopaedic Hospital NHS Foundation Trust

The Royal Orthopaedic Hospital NHS Foundation Trust

Publication of Equalities Information and update on Equality Objectives January 2015

CONTENTS

Equality and Diversity Annual Update 2015

Foreword

I am delighted to present the second Equality and Diversity Annual Update for The Royal Orthopaedic Hospital NHS Foundation Trust.

The aim of the update is to inform patients, public, Foundation Trust (FT) Members and staff of the work we have undertaken in the past year to promote and support equality at the hospital. It also shows the areas we will be focussing upon as long term objectives.

The Trust has agreed a set of objectives as the basis for delivering better outcomes for patients and communities and better working environments for our staff, which are personal, fair and diverse.

As part of our desire to become a more inclusive organisation we will be implementing the Equality Delivery System 2 (EDS2) during the 2015/16 year. Using the EDS, will allow us greater access to talk to and listen to, our local community, so that they are able to support us in the ongoing development of our services, which we intend to do through the participation of our foundation Trust membership and elected Governors.

We would like to encourage members of the public to become Foundation Trust members, especially people from Black & Minority Ethnic groups. If you would like to join you can do so by:

- telephone on: 0121 685 4000 x 55811
- email:lisa.kealey@nhs.net

Finally, I would like to thank everyone involved for all their hard work in this important area, and look forward to continued progress in 2015.

Anne Cholmondeley
Director of Workforce and OD

SUMMARY

Overview

The Trust continues to make good progress towards the effective implementation of its Equality Objectives which were established in April 2012, and reviewed and updated in January 2014. 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, our future direction, and a detailed analysis of our patient and staff equalities information.

1.0 Progress on Equality Objectives during 2014

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.

During 2014 a "Monitoring Patients Protected Characteristics Improvement Group" has been established and met bi-monthly during the year.

The aim of the group is to identify short term actions and long term plans to enable the robust reporting of patient protected characteristics in the future where reasonably possible, in line with the timescales of the equality objective.

The group identified a short term action to immediately improve current reporting using a standalone equality and diversity monitoring form. The form has been developed and a pilot has taken place within one service, which identified concerns around manually transcribing of data and confidentiality of separate paper records. A further meeting has been organised to streamline the process and seek the appropriate signoff before full implementation.

The group has also identified a longer term strategic solution to enable monitoring of all patient protected characteristics through the further development of PAS, and the Learning, Development and Equalities Manager is carrying out research among other Trusts in the region to identify whether there is a more appropriate solution immediately available to us which avoids the use of paper records.

The Chief Information Officer has included the requirement to record patient protected characteristics within the specifications for the development of the replacement PAS system.

This is planned for implementation in July 2016 and will continue to be managed as part of the Electronic Patient Record (EPR) Project.

Equality Objective 2:

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

Equality Impact Assessments (EQIAs) are now an integral part of the policy development process and the programme board for business projects. Since January 2014, either an initial impact assessment, a service impact assessment or a full impact assessment has been completed on new policies including:

- Corporate Induction
- Mandatory Training
- Equality and Diversity Policy
- Harassment and Bullying Policy
- Learning Disabilities Policy
- Interpretation Policy
- Missing Patient Policy
- Policy on assessing mental capacity and complying with the Mental Capacity Act.

All EQIAs are published on the Trusts Intranet and Internet.

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.

During 2014 we have maintained our focus on an increased awareness of equality and diversity. During the last quarter of the year we appointed a Learning, Development and Equalities Manager to refocus our efforts and to develop initiatives to move to a fully inclusive organisation.

The 2014 staff survey saw a 75% favourable response in staff confirming that they had received Equality and Diversity training in the last 12 months, which is above the national average. Overall, 90% of staff report that they have received training in equality and diversity.

Equality and Diversity training continues, with a refreshed session delivered in Corporate Induction, an eLearning module, and a new, dynamic standalone presentation which is being offered to all staff.

The Trust held its second Annual Equality and Diversity Awareness event on Friday 5th September 2014. The event provided a range of information, interactive activities and suggestion schemes.

Together with representatives from the Equality and Diversity Group, our Contact Officers and additional support from our external partners BRAP (a national

equalities charity) and the Andrea Adams Consultancy (harassment and bullying specialists) we continued to develop awareness around the Equality Act 2010, promoted the contact officer network and engaged with staff and patients for suggestions on enhancing the working environment.

During 2015 we intend to implement EDS2 and to hold further inclusion initiatives involving the whole organisation.

Equality Objective 4:

1.0 The Trust is able to monitor and report on all personal protected characteristics for staff.

The implementation of ESR self-service across the Trust is now 98% completed and will be fully completed by the end of January 2015. This facility is enabling staff to update and amend their own personal details within ESR. In order to further develop Equality monitoring and reporting, the ESR self-service project will continue to enhance the collection of data relating to staff Personal Protected Characteristics.

2.0 Equality and Diversity Policy

The Equality and Diversity Policy was signed 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 2014. An essential part of the policy implementation plan during 2015 will include ongoing training and awareness on the effective completion of Equality Impact Assessments.

3.0 Recruitment & Selection Policy Review

To ensure the Trust maintained robust recruitment procedures, the Employment Checks Policy has been updated to ensure it is aligned to the NHS National Recruitment checks Standards. The new checks support safeguarding patients whilst ensuring that equity and fairness is transparent within the recruitment process. The Recruitment and Selection Policy is due to be reviewed and updated by April 2015 and the revised policy will include “Values Based Recruitment”, which will allow the recruitment of people whose own values are aligned to the Trusts agreed values.

4.0 Staff Friends and Family Test Roll Out

The Staff Friends and Family Test (Staff FFT) is a simple survey which asks whether staff would recommend their NHS Trust to their friends and family.

Our first Staff FFT was carried out in April 2014 with a further test taken in July 2014. The Trust is performing strongly with 84% of staff saying they would recommend the Trust to their 'friends and family' as a place to receive treatment, and 67% of staff recommending the Trust to their 'friends and family' as a place to work.

5.0 Flexible Working Policy Review

The Trust's Flexible Working Policy has been updated following changes to legislation regarding for example, maternity and paternity rights in 2013. The policy is accessible to all staff and requests for flexible working arrangements have not increased following the changes to legislation. It is the intention of the Trust to further harmonise the Flexible working policies and procedures to make them more user-friendly.

6.0 NHS Staff Survey Results 2014

From the initial draft unweighted scores of the NHS Staff Survey 2014, the Trust again achieved some positive results. For the third year running, positive responses have been received in relation to personal development and training received within the Trust. There has been a modest increase in staff believing that their training and development has helped them do their job more effectively and also to deliver a better patient/ service user experience. Staff are seeing the increased focus from senior management on involving them in decision making and acting on feedback received. 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. The Trust has recently appointed a Head of Communications to lead on improving communication channels and the Chief Executive has introduced "Jo's Journal", an initiative which allows her to share her thoughts with staff. Involving staff in change is a key area of focus in the transformation programme to deliver our five year strategy, and special events are being planned for the first quarter of the 2015-16 year.

In addition, work continues to encourage staff to report incidents. The Trust needs to increase confidence in staff that it will act on incidents reported, and will do so with 'fair blame', holding people to account for their actions where appropriate

The percentage of staff feeling secure about raising concerns about unsafe clinical practice, and indicating that they would be confident that the organisation would address their concerns, are broadly in line with national averages.

There was a small increase in the number of staff experiencing harassment and bullying by service users, their relatives or other members of the public, or from colleagues, but both are lower than national averages.

The numbers of staff reporting that they have experienced discrimination from service users, their relatives or members of the public saw a small rise, and there was a reduction in those reporting discrimination from colleagues, which suggests that the work we have undertaken to address these issues in the Trust is having some positive results.

The numbers of staff who in 2014 sense that the Trust may not act fairly with regard to career progression and promotion has remained fairly static compared to 2013.

Following a further detailed review of the 2013 Staff Survey outcomes, a difference in the responses from staff of black and minority ethnic origin in relation to some specific questions were identified. The percentage favourable responses for some questions were lower for our staff from a BME background; however the participation rate for this group was lower than for the majority groups.

The Trust is taking steps to increase involvement among the BME group, including particular emphasis on participation in surveys, so that their voice and views are heard.

As a first step, to enable us to identify areas of concern, and make changes to enhance their experience at work, a letter was sent to all BME staff during August 2014, to explore the reasons behind this different perspective. The Trust is keen to identify if this is due to communication and perception issues within the organisation, or are there actual issues where the Trust can take steps to address. Staff were invited to contact in confidence, and without any judgement, the Director of Workforce and OD or the Head of Learning and OD (Equalities Lead) by email or by phone to arrange a suitable time to talk or to forward an anonymous communication should they feel unable to approach in person.

At the date of this report some staff have come forward but not in sufficient numbers to enable reliable analysis. As a result the Learning, Development and Equalities Manager, appointed in November 2014, has encouraged BME staff to attend one of a number of focus groups set up to identify trends and perceptions, the results of which will be compared against the results of all NHS Trusts due in March 2015, and will inform actions to be integrated into a Staff Survey Action Plan, allowing the development of initiatives to improve the experience of staff working in the Trust.

7.0 Findings from this year's Equalities information review:

7.1 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;
- Workforce profile remains static with a slightly younger ager profile as in 2013;
- Disabled people are still 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);
- There was a similar breakdown of the gender of employees in 2014 as there was in 2012 and 2013, that is, that men continue to be underrepresented compared to our overall local population; however compared to other NHS Trusts there is a higher representation of men within our workforce profile.

7.2 Promotions

- Despite our continuing efforts in this area staff between 26 and 45 are still 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, although there has been an increase in staff who feel the Trust acts fairly with regard to career progression and promotion, regardless of their protected characteristics;
- No LGB staff were promoted in 2014 (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);
- The Trust will be measuring metrics for white and BME staff linked to the Workforce Race Equality Standard (November 2014) which we will be adopting during 2015, and will be based on a two year rolling average measuring the percentage of BME staff in Bands 8-9 and at Very Senior Manager level compared to the overall workforce. Currently we are underrepresented at Band 8-9 level and have no representation on the Board.

7.3 Disciplinary Investigations

- Between January 2014 and December 2014 10 disciplinary investigations were undertaken. The staff had an age range of between 29 and 60. Two were disabled, four were married, six were women, and six disclosed their sexuality as heterosexual, while one recorded their religion as Islam, one as Christianity and one as Atheism.

7.4 Gender Pay Gap

- On average the gap between men and women (with men being paid more than women) has remained relatively unchanged between 2013 and 2014;
- 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. We will be implementing actions to undertake an equal pay audit during 2015.

7.5 Recruitment

- 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 are still more likely to be appointed during 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 and is mandated through the Equality Delivery System 2 (EDS2) which the Trust will be adopting during 2015;
- The Trust has recently refreshed its strategy and values in consultation with staff. This has led to the need to adopt new recruitment processes in line with the Trusts' values. The “working for us” section of the website will be update in line with the new values approach to reflect the Trusts aspiration to attract the best available talent. These initiatives will be implemented by April 2015.

7.6 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.

7.7 Leavers

Exit questionnaires are being sent out to all leavers between October 2014 and March 2015. All nurses are being offered an exit interview with the HR Manager.

The purpose of the exit questionnaire/interview is to:

- Enable the Trust to understand why members of staff leave the organisation;
- Provide you with the opportunity to provide feedback on your employment and put forward suggestions for improvements;
- Identify training and development needs;
- Alert the Trust to any concerns or issues.

We have achieved a modest start as between October and December (2014) we sent out 21 exit questionnaires. Of this 3 were nurses who were offered the opportunity to have an exit interview with the HR Manager.

- Proportionally more leavers where in the 26-40 year old age range and as with last year we have seen 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. Disabled people are no 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 2013 too, but is less pronounced in 2014. Pakistani, Irish, Black African and Filipino employees are again 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.

7.8 Experiences of Discrimination

- There has been a small increase in percentage of staff who, in the last 12 months, report that they have personally experienced discrimination at work from patients/ service users/ relatives/ members of the public;
- There has been a small improvement in the number and percentage of staff who reported in the survey that, in the last 12 months, they have personally experienced discrimination at work from Manager/Team Leader/other colleague;
- Majority of discrimination is on the grounds of ethnic background (38%) (which is lower than the 57% reported in 2013). There has been a significant decrease in proportion of discrimination on grounds of gender, sexual orientation but a small increase with perceived age discrimination;
- When tested with BME staff, a significant number of staff indicated that they had not been discriminated against and that in fact the perception is that ROH is a fair employer.

8.0 Patient Information

We surveyed 1426 patients in the period Dec 13-Dec14:-

- 99.9% felt we treated them with respect and dignity overall;
- 98.8% felt they were given enough privacy when discussing their condition or treatment;
- 96.6% felt they were involved as much as they wanted to be in decisions about their care & treatment;
- There was no great increase in the proportion of ethnic minority inpatients between 2013 and 2014 (around 35% of inpatients in both years). 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 (77% White British);
- Most patients (inpatients and outpatients) did not specify their religion or belief. Where this is recorded, most patients are Christian;
- In 2013 and 2014 most patients were between 62 and 81;
- A review of 'Serious Incidents Requiring Investigation' (SIRIs) indicates that in 2014 there appeared to be relatively few noticeable inequalities. In 2014, White British patients were more likely to experience a SIRI than would be expected given their proportion in the overall patient population.

9.0 Conclusions/Actions:

From the analysis undertaken and continued delivery of the equality objectives the following conclusions and actions will be taken during 2015:

Action	By When	Progress
In order to further develop equality monitoring and reporting; effectively implement the ESR Self-Service Project, to continue to enhance the collection of data relating to staff Personal Protected Characteristics.	March 2015	ESR Self Service Project on plan for full Trust implementation by end of January 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 Trusts Values to ensure a fair and equitable approach; developing interviewing skills, equality awareness of line managers and considering the diversity of interview panels.	Q1 2015/16	Trust values agreed in July 2014. Values based recruitment processes to be implemented.
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.	December 2015	Updated Equality and Diversity Policy – including EQIA procedures signed off in February 2014, and implemented during Q1. EQIA is now normal practice throughout the Trust and we will continue to monitor and sustain during 2015.
To further assist in eliminating discrimination in the Trust, develop and enhance 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.	December 2015	Harassment and Bullying Policy signed off in April 2014. Contact Officer recruitment occurred during May 2014. 12 Contact Officers identified. Contact Officer training delivered in June 2014, with a follow up in September. Promotional materials produced during July / August. Leaflets and Posters distributed during August. Harassment and Bullying awareness

		event took place during September 2014. We continue to embed the philosophy of contact officers throughout the Trust.
To identify if there are any areas of concerns in the identified gender pay gap, complete an Equal Pay Audit.	May 2015	The Workforce and OD Committee have commissioned an Equal Pay Audit with the intention of: • Identifying any gender pay gaps in each of the pay bands across the organisation • Developing an action plan for the Trust based on the outcomes of the audit with the aim of addressing any anomalies that cannot be legitimately justified. The audit has been completed and a draft report is currently being reviewed. The Trust will obtain expert advice in this specialist area to ensure the final report represents best practice.
Conduct additional research into exit interviews and leavers information to identify any trends or themes in reasons for leaving, and identify any actions required.	April 2015	The Director of Workforce and OD commissioned a review of the turnover of staff in the Trust and the stability of the workforce in terms of duration of employment. A key element of this was to review the Trust's termination process with particular emphasis on the action taken following staff resignations. As a result of the review an Exit Policy has been agreed which includes a robust exit questionnaire. All staff leaving receive an exit questionnaire. All nursing staff are being offered an exit interview for the 6 months October 2014 – March 2015 to identify any underlying trends. If following the interviews or receipt of questionnaires there are causes for concerns, appropriate steps will be taken. Information obtained from the questionnaires and interviews, such as protected characteristic classification

		and reason for leaving will be (anonymously) fed into the data presented to the Workforce and OD Committee, to allow greater and better scrutiny and subsequently for any negative trends or issues to be identified and addressed.
The Trust will introduce the EDS2 (Equality Delivery System 2) during 2015. As part of our new contract the Trust will be required by the CCG to implement EDS2. The Equalities Lead will ensure the implications are understood and then co-ordinate the transfer process of existing reporting mechanisms and ensure robust report is in place to meet these requirements as appropriate.	December 2015	Work has started to identify the requirements and impact on current processes. The four goals and 18 outcomes of the EDS2 which the Trust will be adopting are outlined in ***Appendix 1.***
The Trust will adopt the metrics of the Workforce Race Equality Standard (November 2014).	December 2015	Work has started to identify the requirements and the impact on current processes. The standard has three indicators comparing the metrics for white and BME staff. The standards are outlined as ***Appendix 2.***
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.	Ongoing through 2015	Overview of pilot actions are: Ensure reception staff ask for religion and race and input into PAS. POAC record on paper and to ensure always update to PAS. Clarity System – action to explore the possibility of including marital status and religion in the booking in system. E&D group to agree and develop clear purpose for collecting data, to use as communications with patients. Consider the inclusion of a paragraph within the patient information leaflet relating to “Equality Monitoring” – what we are doing and why.

		Consider including the monitoring form with the new patient appointment letter asking patients to complete and bring with them. Agree with the Chief Information Officer to include the requirement to record patient protected characteristics within the specifications for the development of the replacement PAS system to be implemented by July 2016. Confirm possibility of including additional fields and questions within Clarity.

10.0 Appendix 1

The goals and outcomes of Equality Delivery System 2 (EDS2)

Goal 1 - Better health outcomes

1.1 Services are commissioned, procured, designed and delivered to meet the health needs of local communities.
1.2 Individual people's health needs are assessed and met in appropriate and effective ways.
1.3 Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed.
1.4 When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse.
1.5 Screening, vaccination and other health promotion services reach and benefit all local communities.

Goal 2 - Improved patient access and experience

2.1 People, Carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.
2.2 People are informed and supported to be as involved as they wish to be in decisions about their care.
2.3 People report positive experiences of the NHS.
2.4 People's complaints about services are handled respectfully and efficiently.

Goal 3 - A representative and supported workforce

3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all Levels.
3.2 The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations.
3.3 Training and development opportunities are taken up and positively evaluated by all staff.
3.4 When at work staff are free from abuse, harassment, bullying and violence from any source.
3.5 Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives.
3.6 Staff report positive experiences of their membership of the workforce.

Goal 4 - Inclusive leadership

4.1 Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.
4.2 Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed.
4.3 Middle Managers and other Line Managers support their staff to work in culturally competent ways within a work environment free from discrimination.

11.0 Appendix 2

Workforce Race Equality Standard November 2014 for implementation from April 2015

Workforce metrics

For each of these three workforce indicators, the standard compares the metrics for white and BME staff.

1. Percentage of BME staff in Band 8-9 and VSM compared with the percentage of BME staff in the overall workforce.

2. Relative likelihood of BME staff being recruited from shortlisting compared to that of white staff being recruited from shortlisting across all posts.

3. Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

Note. This indicator will be based on data from a two year rolling average of the current year and the previous year.

National NHS Staff Survey findings

For each of these five Staff Survey indicators, the standard compares the metrics for each Survey question response for white and BME staff. For 4. below, the metric is in two parts

4. **Q3.** In the last 12 months, have you had an appraisal, annual review, development review, or knowledge and Skills Framework (KSF) development review? If so

   e) Were any training, learning or development needs identified?

   f) Did your Manager support you to receive this training learning and development?

5. **KF 18.** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the pubic in the last 12 months.

6. **KF 19.** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

7. **KF 27.** Percentage believing that Trust provides equal opportunities for career progression or promotion.

8. **Q 23** In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.

Boards

Does the Board meet the requirement of Board membership as defined in the standard?

9. Boards are expected to be broadly representative of the population they serve.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Scheme of Reservation & Delegation

VERSION NUMBER	5
REVIEW DATE	February 2017
DATE PUBLISHED ON INTRANET	

Document Control Information

AUTHOR (POLICY FACILITATOR)	Paul Athey, Director of Finance
DIRECTOR / POLICY SPONSOR	Paul Athey, Director of Finance
RATIFIED BY (Committee/ Group)	Trust Board
DATE OF RATIFICATION	
NAME OF LOCAL GROUP / FORUM APPROVING THE POLICY **DATE OF LOCAL GROUP APPROVAL**	

VERSION TRACKING

Version	Date	Author Name and Designation	Summary of Main Changes
5	July 2014	Paul Athey, Director of Finance	• Clarification regarding powers for policy approval delegated to CGC and the CEO • Clarification on capital business cases • Clearer definition of clinical audit • Addition of HoFA to operational responsibility for charitable funds tasks • Greater clarity on ability for CEO to approve special payments through NHSLA. • Quotations & Tenders section re-written • Clarification that £100k Trust Board approval limit for tenders and contracts is a per annum figure

			• Differential approval limits between stock and non-stock removed for Directorate Managers • Approval of virements brought in line with expenditure approval limits • New section added on prepayments • Litigation claims over £100,000 covered or recommendation by the NHS Litigation Authority should be reported to the Trust Board
4	Nov 2009	Director of Finance	

PROCEDURAL CHECKLIST

CONSULTATION COMPLETED	Y
CONSULTATION TRACKING SHEET COMPLETED	Y
VERSION CONTROL INFORMATION COMPLETED	Y
EXECUTIVE GOVERNANCE COMMITTEE CHECKLIST COMPLETED (APPENDIX M1)	Y
IMPLICATIONS FOR IMPLEMENTATION COMPLETED (APPENDIX M2)	Y
EQUALITY IMPACT ASSESSMENT COMPLETED AND DECLARATION FORM (APPENDIX M3)	Y
IMPLEMENTATION PLAN COMPLETED (APPENDIX M4)	Y
DATE SUBMITTED TO POLICY COORDINATOR	28/1/15
APPROVED BY POLICY COORDINATOR	January 2015
DATE APPROVED TO RATIFICATION COMMITTEE	

CONSULTATION TRACKING SHEET

This document must be completed and accompany the policy procedure or guideline through the final ratification and authorisation process. A copy of this sheet should be included at the front of the final published policy.

Name of Policy, Procedure or Guideline: Policy on Procedural Documents

Name of person / team / committee asked to provide feedback	**Date request for feedback sent**	**Feedback received Y/N**	**Feedback incorporated into policy Y/N**
Audit Committee	11/11/14	Y	Y
Chief Executive	19/1/15	Y	Y
Company Secretary	15/7/14	Y	Y
Deputy Director of Finance	15/7/14	Y	Y
Charitable Funds sub committee	15/9/14	N	
Chair of Charitable Funds sub committee	15/9/14		
Head of Procurement	15/7/14	Y	Y
Executive Directors	15/7/14	Y (from some)	Y
Head of Financial Accounting	15/7/14	Y	Y
Senior Finance Manager	15/7/14	Y	Y

Key Performance (compliance / success) Indicators (KPI's)

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Breaches of delegated limits (excluding procurement)	0	Reported on Exception Basis to Audit Committee	Audit Committee	Half-Yearly	Director of Finance
Breaches of delegated limits (Procurement)	<1% of total spend	Reported on Exception Basis to Audit Committee	Audit Committee	Half-Yearly	Director of Finance

PERFORMANCE MANAGEMENT OF THE POLICY

Responsible for Producing Action Plans if KPIs are Not Met	Committee to Monitor These Action Plans	Frequency of Review (To be agreed by Committee)
Director of Finance	Audit Committee	Half-Yearly

Contents

1. Executive Summary

Policy Aim

1.1 The Scheme of Reservation and Delegations sets our the powers and decision making responsibility that sits with the Board of Directors and where, if appropriate, these powers are delegated to other members of the Trust.

Policy Description

1.2 The policy describes the powers reserved by the Board of Directors around regulations and control, policy determination, strategic direction, audit & annual accounts and monitoring.

1.3 Table A outlines the delegated authority to members of the Trust, whilst Table B outlines the financial limits linked to this delegated authority.

Key References

1.4 The Scheme of Reservations and Delegation should be read and considered in conjunction with the Trust's Standing Orders and Standing Financial Instructions.

2. Introduction

2.1 Section 1 (Para 1.3) of the Trust's Standing Orders for the Board of Directors states that " 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.". The Code of Accountability also requires that there should be a formal schedule of matters specifically reserved to the Board of Directors of the Foundation Trust.

The purpose of this document is to detail how the powers are reserved to the Council of Governors, Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. However, the Board of Directors remain accountable for all of its functions, even those delegated to Committees, sub-committees, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

3. Policy Objectives

3.1 The Scheme of Reservation and Delegation sets out a framework for internal governance, providing clarity of the responsibilities and powers of every employee within the Trust.

4. Definitions

5. Scope

5.1 Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Director of Finance and other directors. These responsibilities are summarised in Table A and Table B.

Delegated matters in respect of decisions that may have a far-reaching effect must be reported to the Chief Executive. The delegation shown in Table A and Table B is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation consult with other Senior Managers as appropriate.

6. Duties / Responsibilities

6.1 Role of the Chief Executive

All powers of the Foundation Trust, which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he/she will perform personally and which functions have been delegated to other directors or officers for operational responsibility.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

6.2 Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

6.3 Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a director or officer to whom powers have been delegated those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent, powers delegated to him/her may be exercised by the nominated officer acting in his/her absence after taking appropriate advice from the Director of Finance or in his/her absence the Chairman.

6.4 Delegation of Powers to Committee

The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with SO 4.5 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors.

7. General Principles

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

7.1 Accountability

The Code of Accountability, which has been adopted by the Foundation Trust, requires the Board of Directors to determine those matters on which decisions are reserved unto itself. These reserved matters are set out in paragraphs 7.2 to 7.9 below:

The Trust Board remains accountable for all of its functions, even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

7.2 General Enabling Provision

The Board of Directors may determine any matter (for which it has authority) it wishes in full session within its statutory powers.

7.3 Regulations and Control

- Approval of Standing Orders (SOs), a Schedule of Matters Reserved to the Board of Directors and Standing Financial Instructions for the regulation of its proceedings and business.
- Suspend Standing Orders.
- Vary or amend the Standing Orders.

- Ratification of any urgent decisions taken by the Chairman and Chief Executive.
- Approval of a scheme of delegation of powers from the Board.
- Requiring and receiving the declaration of Directors' interests which may conflict with those of the Foundation Trust and determining the extent to which that Director may remain involved with the matter under consideration.
- Requiring and receiving the declaration of officers' interests which may conflict with those of the Foundation Trust.
- To receive reports from committees including those within the Foundation Trust as required by the Constitution to establish and to take appropriate action thereon.
- To confirm the recommendations of the Foundation Trust's committees where the committees do not have executive powers.
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a corporate trustee for funds held on trust.
- To establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors.
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailer for patients' property.
- Authorise the use of the seal.
- Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention.
- Disciplining Board members or employees that report to the Chief Executive, who are in breach of Statutory Requirements or Standing Orders.

7.4 **Appointments/Dismissal**

- Appointment of a Senior Independent Director.
- The appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors.
- Confirm the appointment of members of any committee of the Foundation Trust as representatives on outside bodies.

7.5 **Policy Determination**

The approval of Foundation Trust policies relating to specific powers reserved by the Board of Directors. Powers to approve all Foundation Trust clinical policies is delegated to the Clinical Governance Committee (CGC), and all operational and managerial policies not relating to specific powers reserved by the Board of Directors is delegated to the Chief Executive.

7.6 **Strategy and Business Plans and Budgets**

- Definition of the strategic aims and objectives of the Foundation Trust.
- Approve proposals for ensuring quality and developing clinical governance in services provided by the Foundation Trust, having regard to any

guidance issued by the Secretary of State or the Independent Regulator.

- Approval and monitoring of the Foundation Trust's policies and procedures for the management of risk.
- Approve Outline and Final Business Cases for Capital Investment over £100,000.
- Approve Income,Expenditure and Capital Budgets.
- Approve annually the Foundation Trust's proposed business plan and strategy.
- Ratify proposals for acquisition, disposal or change of use of land and/or buildings.
- Approve PFI proposals.
- Approve proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £100,000 per annum
- Approve proposals in individual cases for the write-off of losses or making of special payments to organisations above the limits delegated to the Chief Executive and Director of Finance.
- Approve proposals for action on litigation against or on behalf of the Foundation Trust where the likely financial impact is expected to exceed £10,000 or contentious or novel or likely to lead to extreme adverse publicity, excluding claims covered or recommended by the NHS Litigation Authority. All claims over £100,000 covered or recommended by the NHS Litigation Authority should be reported to the Trust Board.
- Review use of NHS risk pooling schemes (CNST/RPST).

7.7 Audit Arrangements

To receive recommendations regarding the appointment (and where necessary dismissal) of the internal and external auditors. The appointment or removal of the external auditors must be approved by the Council of Governors.

7.8 Annual Reports and Accounts

- Receipt and approval of the Foundation Trust's Annual Report and Annual Accounts prior to presentation to the Council of Governors at a Members meeting.
- Receipt and approval of the Annual Report and Accounts for funds held on trust.

7.9 Monitoring

- Receipt of such reports as the Board of Directors sees fit from committees in respect of their exercise of powers delegated.
- Continuous appraisal of the affairs of the Foundation Trust by means of the provision to the Board of Directors as the Board of Directors may require from directors, committees, and officers of the Foundation Trust as set out in management policy statements.
- Receive reports from the Director of Finance on financial performance against the budget, business plan and treasury management.

8. Dissemination Process – all policies

Communication of the revised Scheme of Reservation & Delegation will take place via the Trust Brief, with a copy of the policy posted on the intranet.

All staff with delegated responsibility will receive a personal copy and will be asked to sign to say they have read and understood the policy.

9. Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity both within our workforce and in service delivery. This policy will be implemented with due regard to this commitment.

An Equality Impact Screening Assessment will be completed and the outcome noted on Appendix M3 of all policies.

10. Supporting References

11. Training

Finance training is provided to all new starters with budgetary responsibilities via their Directorate Accountant. Responsibilities in line with the Scheme of Reservation & Delegation will be included within this training.

12. Appendices to this policy

TABLE A - DELEGATED AUTHORITY

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
1. Standing Orders/Standing Financial Instructions		
a) Final authority in interpretation of Standing Orders	Chairman	Chairman
b) Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions, and ensuring that they understand the responsibilities	Chief Executive	All line managers
c) Responsibility for security of the Foundation Trust's property , avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Financial Instructions and financial procedures	Chief Executive	All Directors and Employees
d) Suspension of Standing Orders	Board of Directors	Board of Directors
e) Review suspension of Standing Orders	Audit Committee	Audit Committee
f) Variation or amendment to Standing Orders	Board of Directors	Board of Directors
g) Emergency powers relating to the authorities retained by the Board of Directors	Chair and Chief Executive with two non-executives	Chair and Chief Executive with two non-executives
h) Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Finance and Performance Task and Finish Group	All	All
i) Disclosure of non-compliance with SFIs to the Director of Finance (report to the Finance and Performance Task and Finish Group)	All	All
j) Advice on interpretation or application of SFIs and this Scheme of Delegation	Director of Finance	Director of Finance
2. Audit Arrangements		
a) Ensure adequate internal and external audit services, for which they are accountable, are provided (and prepare recommendations to the board for the replacement of either internal or external	Audit Committee	Director of Finance

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
audit. NB. Whilst the board can unilaterally replace the internal auditor, the Council of Governors has to approve the replacement or removal of the external auditor. See Section 2.)		
b) Review, appraise and report in accordance with Public Sector Internal Audit Standards and best practice.	Audit Committee	Head of Internal Audit
c) Provide an independent and objective view on internal control and probity.	Audit Committee	Internal Audit / External Audit
d) Ensure cost-effective audit service	Audit Committee	Director of Finance
e) Implement recommendations	Chief Executive	Relevant Officers
f) Track Progress of recommendation implementation	Director of Finance	Director of Finance
3. Authorisation of Clinical Trials & Research Projects	Chief Executive / Medical Director	Research & Development Committee
4. Authorisation of New Drugs	Medical Director	Medicines Management Committee Drugs and Therapeutics Committee
5. Bank/GBS Accounts/Cash (Excluding Charitable Fund (Funds Held on Trust) Accounts)		
a) Operation:		
• Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Director of Finance	Deputy Director of Finance
• Opening bank accounts	Director of Finance	Director of Finance
• Authorisation of transfers between Foundation Trust bank accounts	Director of Finance	To be completed in accordance with bank mandate/internal procedures
• Approve and apply arrangements for the electronic transfer of funds	Director of Finance	Deputy Director of Finance
• Authorisation of : - GBS schedules - BACS schedules - automated cheque schedules - Manual Cheques	Director of Finance	To be completed in accordance with bank mandate/internal procedures
b) Investment of surplus funds in accordance with the Foundation Trusts	Director of Finance	Deputy Director of Finance

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
investment policy		
c) Petty Cash	Director of Finance	**Refer to Table B Delegated Limits**
6. Capital Investment		
a) Programme:		
• Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans	Chief Executive	Director of Finance
• Preparation of Capital Investment Programme	Chief Executive	Director of Finance Director of Operations
• Preparation of a full business case	Chief Executive	Relevant Directorate Manager/ relevant Executive Director/with financial support
• Financial monitoring and reporting on all capital scheme expenditure including variations to contract.	Director of Finance	Director of Operations/ Deputy Director of Finance
• Authorisation of capital requisitions	Chief Executive	**Refer to Table B Delegated Limits**
• Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost - Non-IT - IT	Chief Executive Director of Finance	Director of Operations Chief Information Officer
• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences	Chief Executive	Director of Finance/Director of Operations
• Issue procedures to support: - Capital investment - Staged payments	Chief Executive	Director of Finance
• Issuing the capital scheme project manager with specific authority to commit capital, proceed/accept tenders in accordance with the SOs and SFIs.	Director of Finance	**Refer to Table B Delegated Limits**
b) Private Finance:		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Board of Directors	Chief Executive	Director of Finance
c) Leases (including property, equipment, finance leases and operating leases)		
• Granting and termination of leases with Annual rent < £100k	Chief Executive	Director of Finance
• Granting and termination of leases of > £100k should be reported to the Board of Directors	Board of Directors	Chief Executive/ Director of Finance
7. Clinical Audit & Governance		
Ensure that a robust process for clinical audit is in place that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change	Chief Executive	Medical Director/Clinical Directors/Directorate Managers/ Department Heads/Director of Nursing and Governance
Approval of clinical policies, protocols & guidance	Clinical Governance Committee	Director of Nursing & Governance
8. Commercial Sponsorship		
• Agreement to proposal		
- Up to £4,999	Chief Executive	Executive Director
- Over £5,000	Chief Executive	Chief Executive
9. Complaints (Patients & Relatives)		
a) Overall responsibility for ensuring that all complaints are dealt with effectively	Director of Nursing and Governance	Complaints and Litigation Manager
b) Responsibility for ensuring complaints relating to directorate/department are investigated thoroughly	Director of Nursing and Governance	Senior Nurses/Directorate Managers/Heads of Department
c) Medico - Legal Complaints Coordination of their management	Director of Nursing and Governance	Complaints and Litigation Manager
10. Confidential Information		
Review of the Foundation Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Medical Director	Chief Information Officer

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Freedom of Information Act compliance code	Chief Executive	Company Secretary
11. Data Protection Act		
Review of Foundation Trust's compliance	Chief Executive	Chief Information Officer
12. Declaration of Interest		
• Maintaining a register • Declaring relevant and material interest	Chief Executive All Directors	**Refer to Table B Delegated Limits** All Staff
13. Disposal and Condemnations		
• Items obsolete, redundant, irreparable or cannot be repaired cost effectively • Develop arrangements for the sale of assets	Director of Finance Director of Finance	**Refer to Table B Delegated Limits**
14. Environmental Regulations		
Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Head of Estates and Facilities
15. External Borrowing		
a) Advise Trust Board of the requirements to pay/draw down Public Dividend Capital	Director of Finance	Deputy Director of Finance
b) Application for draw down of Public Dividend Capital and other forms of NHS Bank funding	Director of Finance	Deputy Director of Finance
c) Application for draw down of overdrafts and other forms of external borrowing	Director of Finance	As per the Treasury Management Policy
d) Preparation of procedural instructions	Director of Finance	Deputy Director of Finance
16. Financial Planning / Budgetary Responsibility		
a) Setting: • Submit business plan to the Trust Board • Submit capital and revenue budgets to the Trust Board	Chief Executive Chief Executive	Director of Finance Director of Finance

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Submit to Board financial estimates and forecasts	Chief Executive	Director of Finance
b) Monitoring:		
• Monitor performance against budget	Director of Finance	Director of Finance/ Deputy Director of Finance/ Senior Finance Manager
• Delegate budgets to budget holders	Chief Executive	Director of Finance/ Deputy Director of Finance
• Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget	Director of Finance	Deputy Director of Finance
• Submit in accordance with Monitor's requirements financial monitoring returns	Chief Executive	Deputy Director of Finance
• Meet reporting requirements of banking terms and conditions	Chief Executive	Director of Finance
• Identify and implement cost improvements and income generation activities in line with the Business Plan	Chief Executive	All budget holders
Preparation of:		
• Annual Accounts	Director of Finance	Deputy Director of Finance/ Head of Financial Accounting
• Annual Plan	Chief Executive	Chief Executive
• Annual Report	Chief Executive	Company Secretary
c) Authorisation of Virement: It is not possible for any officer to vire from non-recurring headings to recurring budgets or from capital to revenue/revenue to capital. Virement between different budget holders requires the agreement of both parties.	Chief Executive	**Refer to Table B Delegated Limits**
17. Financial Procedures and Systems		
a) Maintenance and update on Foundation Trust Financial Procedures	Director of Finance	Deputy Director of Finance
b) Responsibilities:	Director of Finance	
• Implement Foundation Trust's financial policies and co-ordinate corrective action.		Deputy Director of Finance

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Ensure that adequate records are maintained to explain Foundation Trust's transactions and financial position. • Providing financial advice to members of the Board of Directors and staff • Ensure that appropriate statutory records are maintained • Designing and maintaining compliance with all financial systems		Senior Finance Manager/ Head of Financial Accounting Deputy Director of Finance/ Senior Finance Manager Deputy Director of Finance/ Head of Financial Accounting Deputy Director of Finance
18. Fire Precautions • Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact	Chief Executive	Head of Estates and Facilities
19. Fixed Assets		
a) Maintenance of asset register including asset identification and monitoring	Director of Finance	Deputy Director of Finance
b) Ensuring arrangement for financial control and financial audit of building and engineering contracts and property transactions comply with CONCODE and ESTATECODE	Director of Operations	Head of Estates and Facilities
c) Calculate and pay capital charges in accordance with the requirements of the Independent Regulator	Director of Finance	Deputy Director of Finance
d) Responsibility for security of Foundation Trust's assets including notifying discrepancies to the Director of Finance and reporting losses in accordance with Foundation Trust's procedures.	Chief Executive	All Staff
20. Funds Held on Trust (Charitable and Non-Charitable Funds) (SFI 17)		
a) Management • Funds held on trust are managed appropriately	Director of Finance (supported by the Charitable Trustees)	Deputy Director of Finance
b) Maintenance of authorised signatory list of nominated fund holders	Director of Finance	Deputy Director of Finance/ Head of Financial Accounting

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
c) Expenditure Limits	Director of Finance	**Refer to Table B Delegated Limits**
d) Developing systems for receiving donations	Director of Finance	Deputy Director of Finance/Head of Financial Accounting
e) Dealing with legacies	Director of Finance	Deputy Director of Finance/Head of Financial Accounting
f) Fundraising Appeals	Charitable Funds Committee	Fundraising Manager
• Preparation and monitoring of budget	Director of Finance	Fundraising Manager with advice from Head of Financial Accounting
• Reporting progress and performance against budget	Director of Finance	Fundraising Manager advice from Head of Financial Accounting
g) Operation of Bank Accounts		
• Managing banking arrangements and operation of bank accounts	Director of Finance	Deputy Director of Finance/Head of Financial Accounting
• Opening bank accounts	Director of Finance	Director of Finance
h) Investments		
• Nominating deposit taker	Charitable Funds sub-committee	Director of Finance
• Placing transactions in accordance with the Charitable Funds Investment Policy	Director of Finance	Deputy Director of Finance/Head of Financial Accounting
21. Health and Safety		
Review all statutory compliance with legislation requirements including control of Substances Hazardous to Health Regulations	Chief Executive	Head of Estates and Facilities
Health and Safety	Chief Executive	Health and Safety Advisor
22. Hospitality/Gifts		
a) Keeping of hospitality register	Chief Executive	Company Secretary
b) Applies to both individual and collective hospitality receipt items		All staff declaration required in Foundation Trust's Hospitality Register

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
		Refer to Table B Delegated Limits
23. Infectious Diseases and Notifiable Outbreaks	Chief Executive	Director of Nursing and Governance
24. Information Management and Technology		
Financial Systems • Developing financial systems in accordance with the Foundation Trust's IM&T Strategy • Implementing new systems ensure they are developed in a controlled manner and thoroughly tested • Seeking third party assurances regarding financial systems operated externally Ensure that contracts for computer services for financial applications define responsibility re security, privacy, accuracy, completeness and timeliness of data during processing and storage	Director of Finance/ Chief Information Officer	Deputy Director of Finance in conjunction with IT advisors
25. Legal Proceedings		
a) Engagement of Foundation Trust's solicitors	Chief Executive	Chief Executive/Director of Finance
b) Approve and sign all documents which will be necessary in legal proceedings	Chief Executive	Chief Executive/Director of Finance
c) Sign on behalf of the Foundation Trust any agreement or document not requested to be executed as a deed	Chief Executive	Chief Executive/Director of Finance
26. Losses and Special Payments		
a) Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing Counter Fraud Management Services of frauds b) <u>Losses</u> Losses of cash and cash equivalents due to theft, fraud, overpayment and others Fruitless payments (including abandoned Capital Schemes)	Chief Executive	Director of Finance **Refer to Table B Delegated Limits**

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Bad debts and claims abandoned (e.g. private patients, overseas visitors, road traffic act claims) Damage to buildings, fittings, furniture and equipment in use due to culpable causes (e.g. fraud, theft, arson, neglect) General losses (e.g. linen and bedding, equipment, stores items) Unvouched payments Overpayment of salaries, fees and allowances <u>Special Payments</u> i) Clinical negligence after legal advice • Medical negligence ii) Non-clinical negligence • Personal injury iii) Other (Ex-gratia payments) • Compensation payments by Court Order • To patients/staff for loss of personal effects • Extra contractual payments to contractors		**Refer to Table B Delegated Limits**
c) A register of all of the payments should be maintained by the Finance Department and made available for inspection	Director of Finance	Deputy Director of Finance
d) A report of all of the above payments should be presented to the Finance and Performance Task and Finish Group on a quarterly basis.	Director of Finance	Deputy Director of Finance
27. Meetings		
a) Calling meetings of the Foundation Trust Board	Chairman	Company Secretary
b) Chair all Foundation Trust Board meetings and associated responsibilities	Chairman	Chairman

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
c) Calling meeting of Council of Governors	Chairman	Company Secretary
28. Medical		
• Clinical Governance arrangements	Medical Director/ Director of Nursing & Governance	Medical Director, Clinical Directors, Directorate Managers, Senior Nurses
• Medical Leadership	Medical Director	Clinical Directors
• Programmes of medical education	Medical Director	Director of Research & Development
• Medical staffing rotas	Medical Director	Director of Workforce & OD
• Medical Research	Medical Director	Research and Development Committee
29. Non Pay Expenditure		
a) Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B	Chief Executive	Deputy Director of Finance/ Head of Financial Accounting
b) Obtain the best value for money when requisitioning goods/services	Director of Finance	Head of Procurement/ Directorate Managers/ Heads of Department/ Senior Nurses
c) Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a))	Chief Executive	Director of Finance
d) Develop systems for the payment of accounts	Director of Finance	Deputy Director of Finance
e) Prompt payment of accounts	Director of Finance	Deputy Director of Finance
f) Financial Limits for ordering/ requisitioning goods and services	Director of Finance	**Refer to Table B Delegated Limits**
30. Nursing		
• Compliance with statutory and regulatory arrangements relating to professional nursing practice	Director of Nursing & Governance	Senior Nurses/ Nurse Managers
• Matters involving individual professional competence of nursing staff	Director of Nursing & Governance	Senior Nurses/ Nurse Managers
• Compliance with professional training and development of	Director of Nursing & Governance	Senior Nurses/ Nurse Managers

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
nursing staff • Quality assurance of nursing procedures	 Director of Nursing & Governance	
31. Patient Services Agreements		
a) Negotiation of Foundation Trust Contracts and Non Commercial Contracts	Chief Executive	Director of Finance/ Head of Commissioning
b) Monitoring of Healthcare Contracts	Director of Finance	Head of Commissioning
c) Reporting actual and forecast income	Director of Finance	Head of Income
d) Costing Foundation Trust Contracts and Non Commercial Contracts	Director of Finance	Senior Finance Manager
e) Reference costing/ Payment by Results	Director of Finance	Deputy Director of Finance/ Senior Finance Manager
f) Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Director of Finance	Deputy Director of Finance/ Senior Finance Manager
g) Approval of Foundation Trust Contracts and Non Commercial Contracts	Chief Executive	Chief Executive/ Director of Finance
32. Patients' Property (in conjunction with financial advice from the Deputy Director of Finance - SFI 16)		
a) Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Director of Nursing and Governance/Directorate Managers/ Head of Departments/ Ward Managers
b) Prepare detailed written instructions for the administration of patients' property	Director of Finance	Director of Nursing and Governance/ Deputy Director of Finance
c) Informing staff of their duties in respect of patients' property	Director of Finance	Director of Nursing and Governance/Directorate Managers/ Head of Departments/ Ward Managers
d) Issuing property of deceased patients (See SFI 16)		**Refer to Table B Delegated Limits**
• £5,000 in accordance with agreed Foundation Trust policies	Director of Finance	Deputy Director of Finance
• £5,000 only on production of a probate letter of administration	Director of Finance	Head of Financial Accounting
• Repayment of cash held for safe keeping	Director of Finance	Head of Financial Accounting
33. Personnel & Pay		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a) Nomination of officers to enter into contracts of employment regarding staff, agency staff or consultancy service contracts	Chief Executive	Director of Workforce & OD with Director of Finance
b) Develop Human Resource policies and strategies for approval by the Board including employee relations	Chief Executive	Director of Workforce & OD
c) Authority to fill funded post on the establishment with permanent staff	Director of Workforce & OD/ Director of Finance	Executive Director with budgetary responsibility
d) The granting of additional increments to staff within budget	Director of Workforce & OD	Director of Workforce & OD
e) Develop training policies	Director of Workforce & OD/ Director of Nursing & Governance	Training Education and Development Managers
f) All requests for re-grading shall be dealt with in accordance with Foundation Trust procedure	Director of Workforce & OD	Director of Workforce & OD
g) Establishments		
• Additional staff to the agreed establishment with specifically allocated finance	Director of Finance	Deputy Director of Finance/ Senior Finance Manager
• Additional staff to the agreed establishment without specifically allocated finance	Chief Executive	Director of Finance
• Self financing changes to an establishment	Director of Finance	Directorate Manager (within virement limits)
h) Pay		
• Presentation of proposals to the Foundation Trust Board for the setting of remuneration and conditions of service for those staff not covered by the Remuneration and Nominations Committee or national terms and conditions	Chief Executive	Director of Workforce & OD
• Authority to complete standing data forms effecting pay, new starters, variations and leavers	Director of Workforce & OD	Budget Holders
• Authority to commit variable pay	Director of	Budget Holders

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
expenditure	Workforce & OD / Director of Finance	
• Approval of completed variable pay claims forms	Director of Finance	Budget Holders
• Approval of travel and subsistence expenses	Director of Finance	Budget Holders
i) Leave		
<u>Annual Leave</u>		
• Approval of annual leave	Chief Executive	Line/Departmental Manager
• Annual leave - approval of carry forward (up to maximum of 5 days as defined in initial conditions of service)	Chief Executive	Relevant Executive Director/ Directorate Managers/ Heads of Departments
• Annual leave - approval of carry forward over 5 days (to occur in exceptional circumstances only)	Chief Executive	Chief Executive/ Relevant Executive Directors
<u>Special Leave</u>		
• Compassionate leave	Director of Workforce & OD	Relevant Executive Directors/ Directorate Managers/ Heads of Departments
• Special leave arrangements for domestic/personal/family reasons - Paternity leave - Carers leave - Adoption Leave (To be applied in accordance with Foundation Trust Policy)		Relevant Executive Directors/ Directorate Managers/ Heads of Departments
Special Leave - this includes Jury Service, Armed Services, School Governor (to be applied in accordance with Foundation Trust Policy)		Relevant Executive Directors/ Directorate Managers/ Heads of Departments
• Leave without pay		Relevant Executive Director
• Medical Staff Leave of Absence - paid and unpaid		Medical Director/ Clinical Directors/ Directorate Managers
• Time off in lieu		Line/Departmental Manager
• Maternity Leave - paid and unpaid		Automatic approval with guidance

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
Sick Leave		
• Extension of sick leave on pay	Director of Workforce & OD	Relevant Executive Director/ Directorate Managers
• Return to work part-time on full pay to assist recovery		Relevant Executive Director/ Directorate Managers
Study Leave		
• Non-medical leave	Director of Workforce & OD	Relevant Executive Director/ Directorate Managers
• Medical Staff study leave	Medical Director	Medical Director/ Clinical Director
- Consultant / Career grade		Post Graduate Tutor/ Clinical Director
- Doctors in training		
j) Removal expenses, in accordance with Trust policy	Chief Executive/ Director of Finance	Director of Finance
Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		
k) Grievance Procedure		
All grievance cases must be dealt with strictly in accordance with the Grievance Procedures and the advice of the Director of Workforce & OD must be sought when the grievance reaches the level of Directorate Managers/ Heads of Department	Director of Workforce & OD	Executive Director/ Directorate Managers/ Heads of Department
l) Authorised - Car Users		
• Leased car	Chief Executive	Director of Finance
• Regular/standard car user arrangements	Director of Finance	Relevant Executive Director/ Directorate Managers
m) Mobile Phone Users	Chief Executive	Relevant Executive Director/ Directorate Managers/ Heads of Department
n) Renewal of Fixed Term Contract with funded establishment	Director of Workforce & OD	Relevant Executive Director/ Directorate Managers
o) Operation of Staff Retirement Policy	Chief Executive	Relevant Executive Director/ Director of Workforce & OD/ Clinical Services Manager

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
p) Redundancy	Chief Executive	Director of Finance/ Director of Workforce & OD
q) Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department	Director of Workforce & OD	Relevant Executive Director/ Clinical Services Manager
r) Disciplinary Procedure (excluding Executive Directors)	Director of Workforce & OD	To be applied in accordance with the Foundation Trust's Disciplinary Procedure
s) Waiting List Payments		
• Approval of rates of pay - other staff	Chief Executive	Director of Finance/ Director of Workforce & OD
• Approval of rates of pay - medical staff	Chief Executive	Medical Director/Local Negotiating Committee
t) Ensure that all employees are issued with a Contract of Employment which complies with employment legislation	Director of Workforce & OD	Director of Workforce & OD
u) Engagement of staff not on the establishment		
• Management Consultants		**Refer to Table B Delegated Limits**
• Management for use and booking of bank staff		
a. Nursing	Director of Nursing and Governance	Senior Nurses/ Ward Managers
b. Other	Relevant Executive Directors /Directorate Managers	Relevant Executive Directors/ Directorate Managers
• Management for use and booking of agency staff		
a. Nursing	Director of Nursing and Governance	Senior Nurses
b. Other	Relevant Executive Directors /Directorate Managers	Relevant Executive Directors/ Directorate Managers
34. Quotation, Tendering & Contract Procedures		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
a) Services:		
• Best value for money is demonstrated for all services provided under contract or in-house	Director of Finance	Head of Procurement/ Relevant Executive Director/ Clinical Services Managers
• Nominate officers to oversee and manage the contract on behalf of the Foundation Trust	Director of Finance	Relevant Executive Director/ Clinical Services Managers
b) Competitive Tenders:		
• Authorisation Limits	Chief Executive	**Refer to Table B Delegated Limits**
• Receipt and custody of tenders prior to opening	Chief Executive	Chief Executive
• Opening tenders	Chief Executive	Two Directors in accordance with SFI 7.6.3
• Decide if late tenders should be considered	Chief Executive	Director of Finance
c) Quotations	Chief Executive	**Refer to Table B Delegated Limits**
d) Waiving the requirement to request		
• Tenders - subject to SOs	Chief Executive/ Director of Finance	Chief Executive/ Director of Finance in accordance with SFI 7.5.3
• Quotes - subject to SOs	Director of Finance	Director of Finance in accordance with SFI 7.7
35. Records		
a) Review Foundation Trust's compliance with the Retention of Records Act and HSC (99)053 and Department of Health - Records Management NHS Code of Practice 2006	Chief Information Officer	Executive Directors/ Directorate Managers/ Heads of Departments
b) Ensuring the form and adequacy of the financial records of all departments	Director of Finance	Deputy Director of Finance
36. Reporting of Incidents to the Police		
a) Where a criminal offence is suspected	Chief Executive	Executive Directors/ Directorate Managers/ Senior Nurse on-call/ Head of Department/ Caldicott Guardian
• Criminal offence of a violent nature		
• Arson or theft		

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
• Other		
b) Where a fraud is involved (reporting to the Directorate of Counter Fraud Services	Director of Finance	Director of Finance/ Local Counter Fraud Officer
37. Risk Management		
• Ensuring the Foundation Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Director of Nursing and Governance
• Developing systems for the management of risk	Director of Nursing and Governance/ Director of Finance	Director of Finance/ Director of Nursing and Governance/ Company Secretary/ Health & Safety Manager
• Developing incident and accident reporting systems	Director of Nursing and Governance	Health & Safety Manager/ Clinical Risk Manager
• Compliance with the reporting of incidents and accidents	Director of Nursing and Governance	All staff
• Compliance with statutory safeguarding children and young people requirements	Director of Nursing and Governance	Named Nurse/ Named Doctor for Safeguarding Children
38. Seal		
a) The keeping of a register of sealing	Chief Executive	Company Secretary
b) Safekeeping of the seal	Chief Executive	Director of Finance
c) Attestation of seal in accordance with Standing orders (Section 8)	Chairman/ Chief Executive	Chairman/ Company Secretary
d) Report to the Board of Directors at least quarterly	Chief Executive	Company Secretary
e) Property transactions and any other legal requirement for the use of the seal	Chairman/ Chief Executive	Chairman/ Company Secretary
39. Setting of Fees and Charges (Income)		
a) Private patients, Overseas Visitors, income generation and other patient related services	Director of Finance	Deputy Director of Finance
b) Non patient care income	Director of Finance	Deputy Director of Finance
c) Informing the Director of Finance of	Director of Finance	All staff

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
monies due to the Foundation Trust		
d) Recovery of debt	Director of Finance	Deputy Director of Finance
e) Security of cash and other negotiable instruments	Director of Finance	Deputy Director of Finance
40. Stores and Receipt of Goods		
a) Responsibility for systems of control over stores and receipt of goods, issues and returns	Director of Finance/ Director of Operations	Head of Procurement/ Head of Pharmacy
b) Stocktaking arrangements	Director of Finance	Deputy Director of Finance

TABLE B - DELEGATED AUTHORITY

All thresholds are exclusive of VAT irrespective of recovery arrangements.

	Financial Limits (Subject to specific funding earmarked in budget)		**Includes:**
1.	**CHARITABLE FUNDS**		
1.1	**General Funds**		
	Charitable Funds Committee	Over £5,000	
	Chief Executive or Director of Finance and relevant Fund holder	From £501 to £5,000	All named officers to approve
	Named Fund Managers	Up to £500	
1.2	**Specific Funds**		
	Charitable Funds Committee	Over £5,000	
	Chief Executive or Director of Finance and relevant Fund holder	From £501 to £5,000	Ratification of all approvals
	Named Fund Managers	Up to £500	BOTH named officers to approve
2.	**LOSSES AND SPECIAL PAYMENTS - PER INCIDENT**		
2.1	**Losses**		
	Trust Board	Over £50,000	
	Chief Executive/ Director of Finance reported to the Audit Committee	Up to £50,000	
2.2	**Special Payments - Clinical Negligence**		
	Chief Executive / Director of Finance	Unlimited	All Clinical Negligence litigation payments made by the NHSLA, through CNST. No excesses apply.
2.3	**Special Payments - Non-Clinical Negligence**		
	Chief Executive/ Director of Finance	Unlimited	All Non-Clinical Negligence payments by the NHSLA, through the RPST, subject to scheme excesses
2.4	**Special Payments - Others (Ex-gratia payments)**		
	Trust Board	Over £25,000	
	Chief Executive/ Director of Finance reported to the Audit Committee	Up to £25,000	
2.5	**Legal Fees - not related to negligence claims**		
	Chief Executive	Over £10,000	
	Chief Executive/ Director of Finance	Up to £10,000	
3.	**HOSPITALITY/GIFTS**		
	Company Secretary	over £25	Personal gifts or hospitality

	Financial Limits (Subject to specific funding earmarked in budget)		**Includes:**
4.	**PETTY CASH DISBURSEMENTS (authority to pay)**		
4.1	**Sundry Exchequer Items**		
	Executive Director or Deputy Director of Finance	Over £50	
	Petty Cash Imprest Holder	Up to £50	On receipt of signed claim form from an authorised Budget Holder
4.2	**Petty Cash Float Reimbursement**		
	Director of Finance / Deputy Director of Finance / Senior Finance Manager		
5.	**PATIENTS' PROPERTY (INCLUDING CASH)**		
5.1	**Inpatients and Discharged Patients**		
	Head of Financial Accounting	Over £250	On receipt of the appropriate Reclaim Form
	Petty Cash Imprest Holder	Up to £250	On receipt of a signed claim form from an authorised Budget Holder and the patient
5.2	**Deceased Patients**		
	<u>Testate</u>		
	Head of Financial Accounting	Any amount	Copy of Probate required. To the executor to the Will on receipt of indemnity
	<u>Intestate</u>		
	Head of Financial Accounting	Any amount	Letter of Administration required
6.	**QUOTATIONS AND TENDERS (SFI SECTION 7)**		
6.1	**Obtaining Quotations**		
	Head of Estates and Facilities/ Directorate Managers/ Relevant Executive Directors (via Procurement Department)	Below £5,000	No quotations required. Managers should be confident price offers value for money.
		£5,000 to £49,999	Obtain minimum of 3 informal quotations for goods/services/disposals
6.2	**Approval of Quotations**		
	Head of Estates and Facilities / Directorate Managers	£5,000 to £20,000	
	Relevant Executive Director	£20,001 to £49,999	
6.3	**Obtaining Tenders**		
	Head of Estates and Facilities/ Directorate	Over £50,000 (in	Competitive Tenders:

	Financial Limits (Subject to specific funding earmarked in budget)		**Includes:**
	Managers/ Relevant Executive Directors (via Procurement Department)	compliance with EC Directives as appropriate)	Obtaining a minimum of 4 written competitive tenders for goods, services, materials, manufactured articles, rendering of services (including Management Consultancy) construction and disposals
		Supplies and services over £111,676 or Works over £4,322,012	Competitive Tenders: Obtain tenders in accordance with European Legislation (Office Journal of the European Union – OJEU)
	#		
6.4	**Approval of Tenders**		
	Chief Executive / Director of Finance	£50,000 to £100,000 (per annum)	
	Trust Board	Over £100,000 (per annum)	
7.	**NON-PAY REVENUE EXPENDITURE/REQUISITIONING/ORDERING/PAYMENT OF GOODS AND SERVICES (Subject to specific funding earmarked in budget) - Subject to 6**		
7.1	**Chief Executive or Director of Finance**		
	Stock and Non-Stock	Unlimited	
7.2	**Relevant Executive Directors**		
	Stock and Non-Stock	Up to £50,000	
7.3	**Directorate Managers or Head of Estates and Facilities**		
	Stock and Non Stock	Up to £20,000	
7.4	**Budget Holders**		
	Stock	Up to £5,000	
	Non-Stock	Up to £2,500	
7.5	**Chief Executive or Director of Finance**	Orders exceeding 12 month period	

	Financial Limits (Subject to specific funding earmarked in budget)		**Includes:**
7.6	**Capital Expenditure (subject to annual programme being approved by Trust Board)**		
	Trust Board	Over £100,000	Any one-off items of equipment including medical equipment
	Chief Executive, Director of Finance or Director of Operations	Up to £100,000	
7.7	**Management Consultants (Including Professional Services)**		
	Trust Board	Over £100,000	
	Chief Executive / Director of Finance / Audit Committee	£50,000 up to £100,000	
	Chief Executive / Director of Finance	Up to £50,000	
8.	**ASSET DISPOSALS (SFI Section 7.14)**		
8.1	**Asset Register Items (Net Book Value)**		
	Trust Board	Any value	Land and buildings
	Director of Finance	Over £25,000	All other assets
	Deputy Director of Finance	Up to £25,000	All other assets
8.2	**Non-Asset Register Items (Replacement Cost)**		
	Director of Finance	Over £25,000	
	Deputy Director of Finance	Up to £25,000	
9.	**VIREMENTS**		
	Chief Executive or Director of Finance	Over £50,000	Total Directorate/ Departmental budget remains in balance
	Relevant Executive Director	Up to £50,000	Total Directorate/ Departmental budget remains in balance
	Directorate Manager / Head of Estates & Facilities	Up to £20,000	Total Directorate / Departmental budget remains in balance
10	**PREPAYMENTS**		
	Director of Finance	Over £50,000	
	Relevant Executive Director and Deputy Director of Finance	Up to £50,000	
	Relevant Directorate Manager and Deputy Director of Finance	Up to £20,000	

	Financial Limits (Subject to specific funding earmarked in budget) **Includes:**

13. Mandatory Appendices Bundle

APPENDIX M1

Executive governance committee checklist for new or renewed policies

Name of Policy: Scheme of Reservation & Delegation
Date Form Completed: December 2014

Name of Policy Facilitator / Policy Sponsor: Director of Finance

Question	Response Y/N
Does the policy have the appropriate approved front cover layout including the ROH NHS Foundation Trust Logo	**Y**
Is the policy written in 12 point arial font	**Y**
Is the Document Control Information Bundle complete o Author/ Sponsor/ Committee information o Version Tracking o Procedural checklist o Consultation tracking sheet o Compliance monitoring o Performance management o Contents page	**Y**
Has the policy had an EqIA done?	**Y**
Have Mandatory Appendices M1-M4 been completed and provided to the group?	
Has a review date that is a maximum of 2 years from the date of ratification / approval been included in the document control information?	**Y**
Are the pages in the policy numbered?	**Y**
Is the policy name included in the footer?	**Y**
If this policy replaces a previous document, have the results of a previous audit of compliance (undertaken in the previous 2 years) been provided to the group	**Y (provided as part of regular Audit Committees)**
Does the policy include references	**Y**
Has the EMT submission sheet been completed (See Policy on procedural documents **Appendix 2**)	**Y**
Has the Memo to Managers been completed (See Policy on procedural documents **Appendix 3**)	**Y**

Additional comments from the group approving the policy	
Name of group approving the policy	
Chair of the group approving the policy	
Signature on behalf of the group	

APPENDIX M2

Implications For Implementation Of This Policy

This document must be completed and accompany the policy, procedure or guideline through the final ratification and approval process.

Date: December 2014

Name of Policy, Procedure or Guideline: Standing Financial Instructions

Name of Policy Facilitator: Director of Finance

Name of Policy Sponsor: Director of Finance

The following points include those aspects that need to be considered prior to the authorisation of this policy:

Staffing issues arising from implementation of this policy:
The Scheme of Reservation & Delegation provide a framework for all staff with decision making responsibilities to work within

Training issues arising from implementation of this policy:
All staff will be reminded of their responsibilities and powers under the Scheme of Reservation & Delegation, and ad-hoc training will be provided as required

Funding / Cost Issues arising from implementation of this policy:
No additional funding / costs

Barriers to implementation of this policy:
None

Implications on other services or processes from implementation of this policy:
The Scheme of Reservation & Delegation has implications for all services, and should be fully embedded into each service area

APPENDIX M3

Equality Impact Assessment Form

Stage one – *(all policies, procedures, protocols and functions)*

Name of project, policy or activity: Scheme of Reservation and Delegation

Staff member(s) completing screening assessment:

Paul Athey.....

Telephone:

Date: 28/01/15

Screening decision:

Please delete as applicable*:

We have decided it is not necessary to undertake EIA screening after all.

Statement explaining this decision:

The Scheme of Reservation and Delegation applies equally to all members of staff regardless of their protected characteristics

Signature: **Date:**

Checked by Equality, Diversity and Human Rights advisory group:

Recommendation: requires Screening

Statement explaining this recommendation:

All policies should be impact assessed for equality and diversity.

Signature: ..... **Date:** ……
If you have decided that you do need to go ahead, proceed to section one (screening).

APPENDIX M4

Implementation Plan – [Policy Name]

No	Objective	Responsible	Deadline	Status
1	Full review with Audit Committee	Director of Finance	November 2014	
2	Final checks with key stakeholders	Director of Finance	January 2015	
3	Formal Board sign-off	Director of Finance	February 2015	
4	Written circulation to all relevant parties	Director of Finance	February 2015	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 **ENCLOSURE NUMBER: 15**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Paul Athey**
AUTHOR(S)	**Paul Athey**

TITLE	**Approval of revised Standing Financial Instructions and Scheme of Reservation and Delegation**

SUMMARY

The Trust's Standing Financial Instructions regulate the conduct of all members of staff and officers in relation to financial matters, and ensure compliance with relevant legislation and guidance. They outline the duties and responsibilities of individuals and groups with regards to a variety of financial duties, including the procurement of goods and services, contracting, budgetary control, receipt of income and cash, investment and personnel.

The Scheme of Reservation and Delegations sets out the powers and decision making responsibility that sits with the Board of Directors and where, if appropriate, these powers are delegated to other members of the Trust.

The policies were last formally ratified by the Trust Board in April 2008 and November 2009 respectively. A review of the policies took place in 2011, however it does not appear that any changes were made or that this was formally reported.

The Director of Finance has reviewed these policies, and has consulted with Board members and other senior managers across the Trust. They were formally reviewed by Audit Committee in November 2014, with minor changes made as a result of this feedback. The proposed changes, including those proposed by audit Committee are outline below:

Standing Financial Instructions & Scheme of Reservation & Delegation

- Full review of SFIs and Scheme of Delegation required as previous version was updated in 2008
- Policy redesigned into new format with clearer objectives, scope and responsibilities
- Policies updated in line with revised Standing Orders

Standing Financial Instructions

- References to external stakeholders updated (NHS Protect, Government Banking Service etc.
- Clarification of authorisation rules around prepayments
- Removal of rules around Protected Property. These no longer apply under the new regulatory framework, and have been simplified under rules for Commissioner Requested Service Assets
- Funds Held on Trust section updated to provide greater clarity and to specify the role of the charitable funds sub-committee.

Scheme of Reservation & Delegation

- Previous policy only required capital business cases where total cost was below OJEU limit and did not specify how to treat cases where cost would exceed OJEU limit. Distinction between below and above OJEU removed with regards to business cases as OJEU is not relevant from an internal decision making point of view.
- Clearer definition of clinical audit
- Clarification regarding the authority of Clinical Governance Committee and the Chief Executive to approve certain trust policies.
- Clarification of Directorate Manager autonomy to make self-financing establishment changes within virement framework
- Addition of Head of Financial Accounting to operational responsibility for a number of charitable funds tasks
- Greater clarity on ability for Chief Executive to approve special payments through NHSLA, with payments over £100,000 reported to the Trust Board
- Quotations & Tenders section completely re-written to provide greater clarity and to ensure limits match (i.e. previous limits allowed Directorate Managers to approve expenditure up to £20k, but quotations only up to £10k)
- Clarification that £100,000 Trust Board approval limit for tenders and contracts relates to the per annum value.
- Approval of virements brought in line with expenditure approval limits
- New section added on prepayments

RISK & IMPLICATIONS

There is a clear risk that outdated SFIs and powers of delegation could lead to inadequate financial controls and a decision making framework that is not fit for purpose.

RECOMMENDATIONS

Trust Board are asked to approve the Standing Financial Instructions and Scheme of Reservation & Delegation as attached.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Standing Financial Instructions

VERSION NUMBER	5
REVIEW DATE	February 2017
DATE PUBLISHED ON INTRANET	

Document Control Information

AUTHOR (POLICY FACILITATOR)	Paul Athey, Director of Finance
DIRECTOR / POLICY SPONSOR	Paul Athey, Director of Finance
RATIFIED BY (Committee/ Group)	Trust Board
DATE OF RATIFICATION	
NAME OF LOCAL GROUP / FORUM APPROVING THE POLICY **DATE OF LOCAL GROUP APPROVAL**	

VERSION TRACKING

Version	Date	Author Name and Designation	Summary of Main Changes
5	December 2014	Paul Athey, Director of Finance	• References to external stakeholders updated • Clarification of authorisation rules around prepayments • Removal of rules around Protected Property (replaced by Commissioner Requested Service Assets) • Funds Held on Trust section updated to provide greater clarity and to specify the role of the charitable funds sub-committee
4	Apr 2008	Director of Finance	

PROCEDURAL CHECKLIST

CONSULTATION COMPLETED	Y
CONSULTATION TRACKING SHEET COMPLETED	Y
VERSION CONTROL INFORMATION COMPLETED	Y
EXECUTIVE GOVERNANCE COMMITTEE CHECKLIST COMPLETED (APPENDIX M1)	Y
IMPLICATIONS FOR IMPLEMENTATION COMPLETED (APPENDIX M2)	Y
EQUALITY IMPACT ASSESSMENT COMPLETED AND DECLARATION FORM (APPENDIX M3)	Y
IMPLEMENTATION PLAN COMPLETED (APPENDIX M4)	Y
DATE SUBMITTED TO POLICY COORDINATOR	28/1/15
APPROVED BY POLICY COORDINATOR	January 2015
DATE APPROVED TO RATIFICATION COMMITTEE	

CONSULTATION TRACKING SHEET

This document must be completed and accompany the policy procedure or guideline through the final ratification and authorisation process. A copy of this sheet should be included at the front of the final published policy.

Name of Policy, Procedure or Guideline: Policy on Procedural Documents

Name of person / team / committee asked to provide feedback	**Date request for feedback sent**	**Feedback received Y/N**	**Feedback incorporated into policy Y/N**
Audit Committee	11/11/14	Y	Y
Chief Executive	19/1/15	Y	Y
Company Secretary	15/7/14	Y	Y
Deputy Director of Finance	15/7/14	Y	Y
Charitable Funds sub committee	15/9/14	N	
Chair of Charitable Funds sub committee	15/9/14	Y	Y
Head of Procurement	15/7/14	Y	Y
Executive Directors	15/7/14	Y (from some)	Y
Head of Financial Accounting	15/7/14	Y	Y
Senior Finance Manager	15/7/14	Y	Y

Key Performance (compliance / success) Indicators (KPI's)

Describe Key Performance Indicators (KPIs)	Target	How will the KPI be Monitored?	Which Committee will Monitor this KPI?	Frequency of Review	Lead
Breaches of SFIs (excluding procurement)	0	Reported on Exception Basis to Audit Committee	Audit Committee	Half-Yearly	Director of Finance
Breaches of SFIs (Procurement)	<1% of total spend	Reported on Exception Basis to Audit Committee	Audit Committee	Half-Yearly	Director of Finance

PERFORMANCE MANAGEMENT OF THE POLICY

Responsible for Producing Action Plans if KPIs are Not Met	Committee to Monitor These Action Plans	Frequency of Review (To be agreed by Committee)
Director of Finance	Audit Committee	Half-Yearly

Contents

1. Executive Summary

Policy Aim

1.1 Standing Financial Instructions regulate the conduct of all members of staff and officers in relation to financial matters, and ensure compliance with relevant legislation and guidance.

Policy Description

1.2 They outline the duties and responsibilities of individuals and groups with regards to a variety of financial duties, including the procurement of goods and services, contracting, budgetary control, receipt of income and cash, investment and personnel.

Key References

1.3 Standing Financial Instructions should be read in conjunction with the Trust's Standing Orders and Scheme of Reservation and Delegation.

References are included to the Health and Social Care Act 2012, Monitor's Risk Assessment Framework issued in October 2013 and the NHS Foundation Trust Code of Governance issued in December 2013 and the Audit Code for NHS Foundation Trusts issued in March 2011 by Monitor.

2. Introduction

2.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They are also intended to ensure that the Trust's members, directors and officers act within the Health and Social Care Act 2012, Monitor's Risk Assessment Framework issued in October 2013 and the NHS Foundation Trust Code of Governance issued in December 2013 and the Audit Code for NHS Foundation Trusts issued in March 2011 by Monitor and that the Foundation Trust remains compliant with its Authorisation. They shall have effect as if incorporated in the Standing Orders (SOs).

3. Policy Objectives

3.1 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law

and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Reservation and Delegation adopted by the Trust.

3.2 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

3.3 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

3.4 Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions 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 formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

4. Definitions

5. Scope

5.1 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. **All financial procedures must be approved by the Director of Finance.**

6. Duties / Responsibilities

6.1 **The Foundation Trust shall at all times remain a going concern as defined by the relevant accounting standards in force.**

6.2 **The Trust Board**

The Board exercises financial supervision and control by:

6.2.1 formulating the financial strategy;

6.2.2 requiring the submission and approval of budgets within approved allocations/overall income;

6.2.3 defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

6.2.4 defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Reservation and Delegation.

6.2.5 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Scheme of Reservation and Delegation. All other powers have been delegated to such other committees as the Trust has established.

6.3 The Chief Executive

6.3.1 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

6.3.2 Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

6.3.3 It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

6.4 The Director of Finance

The Director of Finance is responsible for:

6.4.1 implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

6.4.2 maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

6.4.3 ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

6.4.4 the provision of financial advice to other members of the Board and employees;

6.4.5 the design, implementation and supervision of systems of internal financial control;

6.4.6 the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

6.5 Board Members and Employees

All members of the Board and employees, severally and collectively, are responsible for:

6.5.1 the security of the property of the Trust;

6.5.2 avoiding unplanned loss;

6.5.3 exercising economy and efficiency in the use of resources;

6.5.4 conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Reservation and Delegation.

6.6 Contractors and their Employees

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

7. General Principles

7.1 AUDIT

7.1.1 Audit Committee

7.1.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and

following guidance from Monitor's NHS Foundation Trust Audit Code published March 2011, which will provide an independent and objective view of internal control by:

(a) appointing and overseeing the Internal Audit service;

(b) overseeing the External Audit service and recommending the appointment of the External Auditor to the Council of Governors;

(c) reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(d) reviewing 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;

(e) monitoring compliance with Standing Orders and Standing Financial Instructions;

(f) overseeing the implementation of the Trust's Whistle Blowing Policy;

(g) reviewing the effective implementation of corporate governance measures to enable the Foundation Trust to implement Trust practice as set out in appropriate guidance. This will include the Risk Assurance Framework and control related disclosure statements, for example the Annual Governance Statement and supporting assurance processes, together with any accompanying audit statement, prior to endorsement by the board.

7.1.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to Monitor.

7.1.1.3 It is the responsibility of the Director of Finance to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when/if an Internal Audit service provider is changed.

7.1.1.4 The Board shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

7.1.2 Director of Finance

7.1.2.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

7.1.2.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

7.1.3 Role of Internal Audit

7.1.3.1 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

(e) Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Monitor.

7.1.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

7.1.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

7.1.3.4 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years.

7.1.3.5 Managers in receipt of audit reports referred to them, have a duty to take appropriate remedial action within the agreed timescales specified within the report. The Director of Finance shall identify a formal review process to monitor the extent of compliance with audit recommendations.

7.1.4 External Audit

7.1.4.1 The External Auditor is appointed and dismissed by the Trust's Council of Governors following a recommendation from the Audit Committee. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor, Council of Governors and Board of Directors.

7.1.5 Counter Fraud and Counter Corruption

7.1.5.1 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.

7.1.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Monitor Fraud and Corruption Manual and guidance.

7.1.5.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff at NHS Protect in accordance with the NHS Fraud and Corruption Manual.

7.1.5.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

7.1.6 Security Management

7.1.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

7.1.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

7.1.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management.

7.1.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

7.2 ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

7.2.1 Preparation and Approval of Business Plans and Budgets

7.2.1.1 The Chief Executive will compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Annual Plan will be in accordance with Monitor's requirements and will include:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

7.2.1.2 Prior to the start of the financial year the Director of Finance will, on Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Annual Business Plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

7.2.1.3 The Director of Finance shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

7.2.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

7.2.1.5 All budget holders will sign up to their allocated budgets at the commencement of each financial year.

7.2.1.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

7.2.2 Budgetary Delegation

7.2.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

7.2.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

7.2.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

7.2.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, or the Director of Finance.

7.2.3 Budgetary Control and Reporting

7.2.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) regular financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) balance sheet, including movements in working capital;

(iii) cash flow statement;

(iv) capital project spend and projected outturn against plan;

(v) explanations of any material variances from plan;

(vi) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

(f) advising the Chief Executive and Foundation Trust Board of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects.

7.2.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Chief Executive or Board of Directors in accordance with the Scheme of Delegation;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive via the business case process other than those provided for within the available resources and manpower establishment as approved by the Board.

(d) Any new proposals/schemes to increase revenue spending other than those approved within the budget setting process will require a business case to be submitted for approval by the Executive Management Team.

7.2.3.3 The Chief Executive is responsible for ensuring that cost improvements and income generation initiatives are identified and implemented by Trust Officers in accordance with the assumptions in the Annual Business Plan and a balanced budget.

7.2.4 Capital Expenditure

7.2.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 7.11).

7.2.5 Monitoring Returns

7.2.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to Monitor within the specified timescales.

7.3 ANNUAL ACCOUNTS AND REPORTS

7.3.1 Accounts

7.3.1.1 The Trust is to keep accounts in such form as Monitor may with the approval of the Treasury direct.

7.3.1.2 The accounts are to be audited by the Trust's External auditor.

7.3.1.3 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

(a) the accounts;
(b) any records relating to them; and
(c) any report of the financial auditor on them.

7.3.1.4 In preparing its annual accounts, the Trust is to comply with any directions given by Monitor with the approval of the Treasury as to:

(a) the methods and principles according to which the accounts are to be prepared;

(b) the information to be given in the accounts;

7.3.1.5 The annual accounts, any report of the External auditor on them, and the annual report are to be presented to the Members' Council at a General Meeting.

7.3.1.6 The Trust shall:

(a) lay a copy of the unaudited accounts to Monitor;

(b) lay a copy of the annual accounts, and any report of the financial auditor on them, before Parliament; and

(c) once it has done so, send copies of those documents to Monitor.

7.3.1.7 Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the accounting officer.

7.3.2 **Annual Reports**

7.3.2.1 The Trust is to prepare annual reports and send them to Monitor. The reports are to give:

(a) information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership; and

(b) any other information Monitor requires.

7.3.2.2 The Trust is to comply with any decision Monitor makes as to:

(a) the form of the reports;

(b) when the reports are to be sent to it;

(c) the periods to which the reports are to relate.

7.3.3 **Plans**

7.3.3.1 The Trust is to give information as to its forward planning in respect of each financial year to Monitor. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors.

7.4 BANK AND GBS ACCOUNTS

7.4.1 General

7.4.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts.

7.4.1.2 The Board shall approve the banking and treasury management arrangements for the Trust.

7.4.2 Bank and GBS Accounts

7.4.2.1 The Director of Finance is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

(e) preparing the Trust's Treasury Management Policy;

(f) adhering to and providing monitoring information to the Board in accordance with the Trust's Treasury Management policy.

7.4.3 Banking Procedures

7.4.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

7.4.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

7.5 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

7.5.1 Income Systems

7.5.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

7.5.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

7.5.2 Fees and Charges

7.5.2.1 The Trust shall follow the Department of Health and Monitor's advice in accordance with Payment by Results Guidelines and the introduction of patient costing in setting prices for NHS contracts.

7.5.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by Monitor/Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

7.5.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

7.5.3 Debt Recovery

7.5.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

7.5.3.2 Income not received should be dealt with in accordance with losses procedures.

7.5.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

7.5.4 Security of Cash, Cheques and other Negotiable Instruments

7.5.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

7.5.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

7.5.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

7.5.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7.6 TENDERING AND CONTRACTING PROCEDURE

7.6.1 Duty to comply with Standing Orders and Standing Financial Instructions

7.6.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

7.6.2 EU Directives Governing Public Procurement

7.6.2.1 Directives by the Council of the European Union promulgated by the Department of Health prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

7.6.3 Capital Investment Manual and other Department of Health Guidance

7.6.3.1 The Trust shall comply as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" and “Estate code and Monitor's guidance on PFI” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS".

7.6.4 Formal Competitive Tendering

7.6.4.1 **General Applicability**

7.6.4.1.1 The Trust shall ensure that competitive tenders are invited for:

(a) the supply of goods, materials and manufactured articles;

(b) the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

(c) For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

7.6.4.2 **Health Care Services**

7.6.4.2.1 Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 8.

7.6.4.3 **Exceptions and instances where formal tendering need not be applied**

7.6.4.3.1 Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000;

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 7.13;

(d) where the requirement is covered by an existing contract;

Formal tendering procedures **may be waived** in the following circumstances:

(e) where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(f) Where NHS Supply Chain, Office of Government Commerce or other NHS agreements can be utilised;

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

7.6.4.3.2 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

7.6.4.3.3 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record. Volumes and values, along with material waivers, should be reported to the Audit Committee as per the agreed work plan

7.6.4.4 **Fair and Adequate Competition**

7.6.4.4.1 Where the exceptions set out in SFI Nos. 7.6.1 and 7.6.4.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.6.4.5 **Building and Engineering Construction Works**

7.6.4.5.1 Competitive Tendering cannot be waived for building and engineering construction works and maintenance without Trust Board approval.

7.6.4.6 **Items Which Subsequently Breach Thresholds After Original Approval**

7.6.4.6.1 Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

7.6.5 **Contracting/Tendering Procedure**

7.6.5.1 **Invitation to tender**

7.6.5.1.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

7.6.5.1.2 Invitations to tender shall state that no tender will be accepted unless:

(a) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated manager;

(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

7.6.5.1.3 Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable;.

7.6.5.1.4 Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode. When the content of the works is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects

7.6.5.2 **Receipt and safe custody of tenders**

7.6.5.2.1 The Chief Executive or their nominated representative (not from the originating department) will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

7.6.5.2.2 The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

7.6.5.3 **Opening tenders and Register of tenders**

7.6.5.3.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two Directors of the Trust. The Trust's Company Secretary will count as a Director for the purposes of opening tenders.

7.6.5.3.2 A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £50,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Reservation and Delegation.

7.6.5.3.3 A register shall be maintained by the Chief Executive, or his/her nominated officer, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;

- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

7.6.5.3.4 Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (Standing Order No. 7.6.6.5 below).

7.6.5.4 **Admissibility**

7.6.5.4.1 If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

7.6.5.4.2 Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.5.5 **Late tenders**

7.6.5.5.1 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his/her nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

7.6.5.5.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his/her nominated officer or if the process of evaluation and adjudication has not started.

7.6.5.5.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his/her nominated officer.

7.6.5.6 **Acceptance of formal tenders (See overlap with SFI No. 7.6.6)**

7.6.5.6.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

7.6.5.6.2 The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

7.6.5.6.3 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive or his/her nominated officer.

7.6.5.6.4 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or his/her nominated officer.

7.6.5.6.5 The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

7.6.5.6.6 All tenders should be treated as confidential and should be retained for inspection.

7.6.5.7 **Tender reports to the Trust Board**

7.6.5.7.1 Reports to the Trust Board will be made on an exceptional circumstance basis only.

7.6.5.8 **List of approved firms (see SFI No. 7.5.5)**

7.6.5.8.1 Firms invited to tender shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion, gender or sexual orientation, and will comply with the provisions of the Equality Act (2010), the Human Rights Act (1998), the Equal Pay Act (1970), the Bribery Act (2010) and any amending and/or related legislation.;

7.6.5.8.2 Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

7.6.5.8.3 **Financial Standing and Technical Competence of Contractors**

The Director of Finance may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

7.6.5.8.4 In the case of the provision of healthcare services to the Trust by a private sector provider, the Director of Finance is satisfied as to their financial standing and the Medical Director is satisfied as to their technical/medical competence.

7.6.6 **Quotations: Competitive and non-competitive**

7.6.6.1 General Position on quotations

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £5,000 but not exceed £49,999.

7.6.6.2 **Competitive Quotations**

7.6.6.2.1 Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

7.6.6.2.2 Quotations should be in writing unless the Chief Executive or his/her nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone

quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

7.6.6.2.3 All quotations should be treated as confidential and should be retained for inspection.

7.6.6.2.4 The Chief Executive or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

7.6.6.3 **Non-Competitive Quotations**

7.6.6.3.1 Non-competitive quotations in writing may be obtained in the following circumstances:

(a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) miscellaneous services, supplies and disposals;

(d) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

7.6.6.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

7.6.7 Authorisation of Tenders and Competitive Quotations

7.6.7.1 Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

Head of Estates and Facilities / Clinical Services Managers	up to £20,000
Trust Board Directors	up to £50,000

Chief Executive/Director of Finance	up to	£250,000
Trust Board	over	£250,000

7.6.7.2 These levels of authorisation may be varied or changed and need to be read in conjunction with the Scheme of Reservation and Delegation.

7.6.7.3 Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

7.6.8 Instances where formal competitive tendering or competitive quotation is not required

7.6.8.1 Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use the local procurement service for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use the local procurement service - where tenders or quotations are not required, because expenditure is below £5,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

7.6.9 Significant and Material Transactions

7.6.9.1 All significant and material transactions, must comply with the requirements of the Risk Assessment Framework, other Monitor guidance relating to transations, and the Trust Constitution.

7.6.9.2 All major transactions whether or not they comply with the definitions of "Significant or Material transactions" will be risk assessed in line with best practice and in line with the Risk Evaluation for Investment Decisions by NHS Foundation Trusts (REID) manual.

7.6.9.3 All major transactions must be explicitly approved by the Board.

7.6.10 Compliance requirements for all contracts

7.6.10.1 The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions;

(c) any relevant directions including the Capital Investment Manual, Estatecode and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.6.11 Personnel and Agency or Temporary Staff Contracts

7.6.11.1 The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.6.12 Healthcare Services Contracts (see overlap with SFI No. 7.7)

7.6.12.1 Contracts with NHS providers for the supply of healthcare services shall be drawn up in accordance with guidance issued by theindependent regulator, or subsequent responsible NHS body

7.6.12.2 The Chief Executive shall nominate officers to commission contracts with providers of healthcare in line with a commissioning plan approved by the Board.

7.6.13 Disposals (See overlap with SFI No. 7.13)

7.6.13.1 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his/her nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £5,000 this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

7.6.14 In-house Services

7.6.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.6.14.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £250,000, a Non-Executive member of the Trust Board should be a member of the evaluation team.

7.6.14.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.6.14.4 The evaluation team shall make recommendations to the Board.

7.6.14.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.6.15 **Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 7.16)**

7.6.15.1 These Instructions shall not only apply to expenditure from exchequer funds but also to works, services and goods purchased from the Trust's charitable funds and private resources.

7.7 NHS CONTRACTS FOR PROVISION OF SERVICES (see overlap with SFI No. 7.13)

7.7.1 NHS Contracts

7.7.1.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services.

All contracts should aim to implement the agreed priorities contained within the Operating Framework and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that contracts build where appropriate on existing Joint Investment Plans;
- that contracts are based on integrated care pathways.

7.7.2 Involving Partners and jointly managing risk

A good contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

7.7.3 Reports to Board on NHS Contracts

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the contracts. This will include information on costing arrangements, which increasingly should be based upon Healthcare Resource Groups (HRGs) and Patient Level Costing. Where HRGs are

unavailable for specific services, all parties should agree a common currency for application across the range of contracts.

7.8. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

7.8.1 Remuneration and Nominations Committee (see overlap with Standing Orders for the Practice and Procedure of the Board of Directors No. 4)

7.8.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee and a Nominations Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

7.8.1.2 The Committees will:

Nominations

(a) Advise the Board of the skills available and needed at Board level.

(b) Review periodically, and at least once every three years, the structure, size and composition of the Board

(c) Oversee Board succession planning

(d) Oversee eligibility checks for Board Members

(e) Advise the Board of an appropriate recruitment process for the Chief Executive and Executive Board members.

(f) For appointment of Non Executive Directors, ensure that a majority of Governors have been involved in the process.

Remuneration

(a) Advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors (and other senior employees on Trust salaries and performance related pay), 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.

(b) Consider, commission and evaluate any independent consultants employed to advise on terms and conditions other than those staff covered under Agenda for Change;

(c) Make such recommendations to the Board on the remuneration and terms of service of the Chief Executive and Executive Directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's affordability and to the provisions of any national arrangements for such staff where appropriate.

(d) Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national and Treasury guidance as is appropriate.

(e) Review and advise of the development of any PRP system and non-pay benefits system for all staff.

7.8.1.3 The Committees shall report in writing to the Non-Executive Directors of the Board the bases for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

7.8.1.4 The Remuneration Committee and Nominations Committee will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committees.

7.8.1.5 The Council of Governors will determine the pay and allowances of the Chairman and non-executive members of the Board.

7.8.2 **Funded Establishment**

7.8.2.1 The manpower plans incorporated within the annual budget will form the funded establishment. The establishment of the Trust will be monitored by the Director of Workforce & OD under delegation from the Chief Executive.

7.8.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Reservation and Delegation.

7.8.3 Staff Appointments

7.8.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary

nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Director of Workforce & OD and Director of Finance;

(b) within the limit of their approved budget and funded establishment.

7.8.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

7.8.4 Processing Payroll

7.8.4.1 The Director of Workforce & OD in conjunction with the Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

7.8.4.2 The Director of Workforce & OD in conjunction with the Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

7.8.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Workforce & OD instructions and in the form prescribed by the Director of Workforce & OD;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Workforce & OD must be informed immediately.

7.8.4.4 Regardless of the arrangements for providing the payroll service, the Director of Workforce & OD shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

7.8.5 Contracts of Employment

7.8.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

7.9. NON-PAY EXPENDITURE

7.9.1 Delegation of Authority

7.9.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

7.9.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

7.9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

7.9.2 Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 7)

7.9.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

7.9.2.2 **System of Payment and Payment Verification**

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms.

7.9.2.3 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Reservation and Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Trust employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 7.9.2.4 below.

7.9.2.4 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply and where the financial advantages outweight the disadvantages. In such instances:

(a) Where prepayments are requested, these should be approved in line with Section 10 of the Scheme of Reservation & Delegation.

(b) The appropriate officer must provide a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

7.9.2.5 **Official orders**

Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

7.9.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (except as otherwise provided for in the Scheme of Reservation and Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(d) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(e) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract, purchases from petty cash or purchasing card, utility bills, NHS recharges, for rental of property and where the value of the goods is less than £250 and from an approved supplier.

(f) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(h) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(i) changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

(j) purchases from petty cash or purchasing card are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance;

(k) petty cash and purchasing card records are maintained in a form as determined by the Director of Finance.

7.9.2.7 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

7.9.3 **Joint Finance Arrangements with Local Authorities and Voluntary Bodies**

7.9.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

7.10 EXTERNAL BORROWING

7.10.1 Public Dividend Capital

7.10.1.1 On authorisation as a Trust the Public Dividend Capital held immediately prior to authorisation continues to be held on the same conditions.

7.10.1.2 Additional Public Dividend Capital may be made available on such terms the Secretary of State (with the consent of the Treasury) decides.

7.10.1.3 Draw down of Public Dividend Capital should be authorised in accordance with the mandate held by the Department of Health Cash Funding Team, and is subject to approval by the Secretary of State.

7.10.1.4 The Trust shall be required to pay annually to the Department of Health a dividend on its Public Dividend Capital at a rate to be determined from time to time, by the Secretary of State.

7.10.2 Working Capital Facility

7.10.2.1 The Director of Finance shall ensure that consideration is given to the requirement for a working capital facility, taking into account the cost of the facility and the requirement for working capital flexibility. The Director of Finance will advise the board as to whether the purchase of such a facility will represent good value for money.

7.10.2.2 The Trust must only draw down against this facility in respect of true working capital needs, and in accordance with the terms and conditions of the facility.

7.10.3 Commercial Borrowing and Investment

7.10.3.1 The Trust may borrow money from any commercial source for the purposes of or in connection with its functions.

7.10.3.2 The Trust may invest money (other than money held by it as Charitable Trustee) for the purposes of or in connection with its functions. Such investment may include forming, or participating in forming, or otherwise acquiring membership of bodies corporate.

7.10.4 Investment of Temporary Cash Surpluses

7.10.4.1 Temporary cash surpluses must be held only in such public and private sector investments as authorised by the Board in the Trust's Treasury Management Policy.

7.10.4.2 The Trust Board is responsible for establishing and monitoring an appropriate Treasury Management Policy.

7.10.4.3 The Director of Finance is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held.

7.10.4.4 The Director of Finance will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Trust's Treasury Management policy will incorporate guidance from Monitor as appropriate.

7.11 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

7.11.1 Capital Investment

7.11.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of the availability of resources to finance all revenue consequences, including capital charges.

7.11.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

7.11.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of “Estatecode”.

7.11.1.4 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

7.11.1.5 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

7.11.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 7.6.6);

(c) approval to accept a successful tender (see overlap with SFI No. 7.6.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estatecode" guidance and the Trust’s Standing Orders.

7.11.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the requirements of Monitor in respect of approval of Capital Scheme.

7.11.2 Private Finance (see overlap with SFI No. 7.6.10)

7.11.2.1 The Trust should appraise the use of PFI when considering capital procurement. When the Trust proposes to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to Monitor or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

7.11.2.2 All schemes considering PFI should follow the guidance laid down by Monitor document issued October 2007 "Roles and Responsibilities in the Approval of NHS Foundation Trust PFI Schemes".

7.11.3 Asset Registers

7.11.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

7.11.3.2 Each Trust shall maintain an asset register recording fixed assets.

7.11.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

7.11.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

7.11.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

7.11.3.6 The value of each asset shall be depreciated using methods and rates determined by the Trust.

7.11.3.7 The Director of Finance of the Trust shall calculate and pay capital charges as required by Monitor.

7.11.4 Security of Assets

7.11.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

7.11.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

7.11.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

7.11.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

7.11.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

7.11.4.6 Where practical, assets should be marked as Trust property.

7.11.5 **Commissioner Requested Service Assets**

7.11.5.1 A register of Commissioner Requested Service Assets is required to be maintained in accordance with requirements issued by Monitor.

7.12. STOCKS, STORES AND RECEIPT OF GOODS

7.12.1 General position

7.12.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

7.12.2 Control of Stocks, Stores, Stocktaking, condemnations and disposal

7.12.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

7.12.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

7.12.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

7.12.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

7.12.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

7.12.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 7.13 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

7.12.3 Goods supplied by NHS Logistics

7.12.3.1 For goods supplied via the NHS Logistics or successor organisation central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge

7.12.4 Consignment Stock

7.12.4.1 For goods supplied on a consignment basis a schedule of goods supplied should be provided by the supplying organisation which should be countersigned by the delegated manager and updated on every change and made available at the request of the Director of Finance.

7.13 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

7.13.1 Disposals and Condemnations

7.13.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

7.13.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

7.13.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance;

(b) recorded by the condemning officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

7.13.1.4 The condemning officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

7.13.2 Losses and Special Payments

7.13.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

7.13.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS and CFSMS regional team in accordance with Secretary of State for Health's Directions.

The Director of Finance must notify the Counter Fraud and Security Management Services (CFSMS) and the External Auditor of all frauds.

7.13.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Audit Committee,

(b) the External Auditor.

7.13.2.4 The Board shall delegate the approval to write off all losses to the Audit Committee.

7.13.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

7.13.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

7.13.2.7 The Director of Finance shall maintain a Losses and Special Payments Register in which write-off action is recorded.

7.13.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Board.

7.13.2.9 All losses and special payments must be regularly reported to the Audit Committee.

7.14. INFORMATION TECHNOLOGY

7.14.1 Responsibilities and duties of the Director of Finance

7.14.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

7.14.1.2 The Director of Finance shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

7.14.1.3 The Company Secretary shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

7.14.2 **Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application**

7.14.2.1 In the case of computer systems which are proposed General Applications (i.e. Connecting for Health initiatives) all responsible directors and employees will send to the Chief Information Officer:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

7.14.3 **Contracts for Computer Services with other health bodies or outside agencies**

7.14.3.1 The Director of Finance in conjunction with the Chief Information Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

7.14.4 **Risk Assessment**

7.14.4.1 The Director of Finance in conjunction with the Chief Information Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

7.14.5 **Requirements for Computer Systems which have an impact on corporate financial systems**

7.14.5.1 Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as the Information Management and Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Director of Finance staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

7.15. PATIENTS' PROPERTY

7.15.1 The Trust has a responsibility to provide safe custody for money and property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

7.15.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets;
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

7.15.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

7.15.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

7.15.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

7.15.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

7.15.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

7.16. FUNDS HELD ON TRUST

7.16.1 **General**

7.16.1.1 The Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. The management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to its dual accountabilities to the Charity Commission.

7.16.1.2 The reserved powers of the Board and the Scheme of Reservation and Delegation make clear where decisions are to be taken and by whom.

7.16.1.3 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

7.16.1.4 The over-riding principle is that the integrity of each charitable fund must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from exchequer activities and funds.

7.16.1.5 Charitable funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Trust Board acting as Trustees.

7.16.1.6 The Director of Finance shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trust as trustees of non-exchequer funds, including an investment register.

7.16.2 **Existing Charitable Funds**

7.16.2.1 The Director of Finance shall arrange for the administration of all existing funds. A "deed of establishment" must exist for every fund and detailed codes of procedure shall be produced covering every aspect of the financial management of charitable funds, for the guidance of fund stewards. The deed of establishment shall identify the restricted nature of certain funds, and it is the responsibility of fund stewards, within their delegated authority, and the Charitable Funds sub committee, to ensure that funds are utilised in accordance with the terms of the deed.

7.16.2.2 The Director of Finance shall periodically review the funds in existence and shall make recommendations to the Charitable Funds sub committee regarding the potential for rationalisation of such funds within statutory guidelines.

7.16.2.3 The Director of Finance shall ensure that all funds are currently registered with the Charity Commission in accordance with the Charities Act 2011 or subsequent legislation.

7.16.3 **New Charitable Funds**

7.16.3.1 The Director of Finance shall recommend the creation of a new fund where funds and/or other assets, received for charitable purposes, cannot adequately be managed as part of an existing fund. All new funds must be covered by a deed of establishment and must be formally approved by the Charitable Funds sub committee.

7.16.3.2 The deed of establishment for any new fund shall clearly identify, inter alia, the objects of the new fund, the nominated fund steward, the

estimated annual income and, where applicable, the Charitable Funds sub committee's power to assign the residue of the fund to another fund contingent upon certain conditions e.g. discharge of original objects.

7.16.4 **Sources of New Funds**

7.16.4.1 All gifts accepted shall be received and held in the name of the charity and administered in accordance with the charity's policy, subject to the terms of specific funds. As the charity can accept gifts only for all or any purposes relating to the NHS, officers shall, in cases of doubt, consult the Director of Finance before accepting any gift.

7.16.4.2 All gifts, donations and proceeds of fund-raising activities, which are intended for the charity's use, must be handed immediately to the Director of Finance via the Cashiers Office to be banked directly to the charitable funds bank account.

7.16.4.3 In respect of donations, the Director of Finance shall:-

(a) provide guidelines to officers of the Trust as to how to proceed when offered funds. These will include:-

(i) the identification of the donor's intentions;

(ii) Information regarding the requirement to create a deed of establishment;

(ii) where possible, the avoidance of creating excessive numbers of funds;

(iii) the avoidance of impossible, undesirable or administrate difficult objects;

(iv) sources of immediate further advice; and

(v) treatment of offers for personal gifts.

(b) provide secure and appropriate receipting arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted.

7.16.4.4 In respect of Legacies and Bequests, the Director of Finance shall be kept informed of and record all enquiries regarding legacies and bequests. Where required, the Director of Finance shall:-

(a) provide advice covering any approach regarding:-

(i) the wording of wills;

(ii) the receipt of funds/other assets from executors;

(b) after the death of a testator all correspondence concerning a legacy shall be dealt with on behalf of the charity by the Director of Finance who alone shall be empowered to give an executor a good discharge.

(c) where necessary, obtain grant of probate, or make application for grant of letters of administration;

(d) be empowered to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

(e) be directly responsible, in conjunction with the Charitable Funds sub committee, for the appropriate treatment of all legacies and bequests.

7.16.4.5 In respect of fund-raising, approval for all appeals will be given by the Trust Board. The Director of Finance shall:-

(a) advise on the financial implications of any proposal for fund-raising activities;

(b) deal with all arrangements for fund-raising by and/or on behalf of the charity and ensure compliance with all statutes and regulations;

(c) be empowered to liaise with other organisations/persons raising funds for the charity and provide them with an adequate discharge;

(d) be responsible for alerting the Charitable Funds sub committee and the Board to any irregularities regarding the use of the charity's name or its registration numbers; and

(e) be responsible for the appropriate treatment of all funds received through fundraising appeals.

7.16.4.6 In respect of investment income, the Director of Finance shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

7.16.5 **Investment Management**

7.16.5.1 The Charitable Funds sub committee shall make recommendations to the Trust Board with regards to the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Director of Finance shall be required to provide advice shall include:-

(a) the formulation of investment policy which meets statutory requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers and, where appropriate, investment fund managers. The Director of Finance shall recommend the term of these appointments, and any written agreements shall be signed by the Chief Executive..

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme.

(d) the participation by the charity in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

7.16.5.2 The Director of Finance shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for charitable funds.

7.16.6 **Expenditure from Charitable Funds**

7.16.6.1 Expenditure from charitable funds shall be monitored by the Charitable Funds sub committee on behalf of the Board. In so doing the sub committee shall be aware of the following:-

(a) the objects of various funds and the designated objectives;

(b) the availability of liquid funds;

(c) the powers of delegation available to commit resources;

(d) the avoidance of the use of exchequer funds to discharge endowment fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the exchequer shall be discharged by charitable funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust; and

(f) the definitions of "charitable purposes" as agreed by the Department of Health with the Charity Commission.

7.16.6.2 Delegated authority to incur expenditure which meets the purpose of the funds are set out in the Scheme of Reservation and Delegation; exceptions are as follows:-

(a) Any staff salaries/wages costs require Charitable Funds sub committee approval;

(b) Any items of expenditure over £5,000 require the approval of the Charitable Funds sub committee;

(c) No funds are to be "overdrawn" except in the exceptional circumstance that Charitable Funds sub committee approval is granted.

7.16.7 **Banking Services**

7.16.7.1 The Director of Finance shall advise the Charitable Funds sub committee and, with its approval, shall ensure that appropriate banking services are available in respect of administering the charitable funds. These bank account should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

7.16.8 **Reporting**

7.16.8.1 The Director of Finance shall ensure that regular reports are made to the Charitable Funds sub committee with regard to, inter alia, the fund balances, investments and expenditure.

7.16.8.2 The Director of Finance shall prepare annual accounts in the required manner, which shall be submitted, to the Board within agreed timescales.

7.16.8.3 The Director of Finance shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Charitable Funds sub committee.

7.16.9 **Accounting and Audit**

7.16.9.1 The Director of Finance shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

7.16.9.2 Distribution of investment income to the charitable funds and the recovery of administration costs shall be performed on a basis determined by the Director of Finance.

7.16.9.3 The Director of Finance shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He will liaise with external audit and provide them with all necessary information.

7.16.9.4 The Charitable Funds sub committee shall be advised by the Director of Finance on the outcome of the annual audit or inspection.

7.17 ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with Standing Orders for the Practice and Procedure of the Board of Directors No. 7 and SFI No. 7.9.2.6 (d))

7.17.1 The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy is deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with Standing Orders for the Practice and Procedure of the Board of Directors No. 7).

7.18 RETENTION OF RECORDS

7.18.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidance.

7.18.2 The records held in archives shall be capable of retrieval by authorised persons.

7.18.3 Records held in accordance with latest guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

7.19 RISK MANAGEMENT AND INSURANCE

7.19.1 Programme of Risk Management

7.19.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Monitor Risk Assessment Framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of

internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement on the effectiveness of Internal Control (SIC) within the Annual Report and Accounts.

7.19.2 **Insurance: Risk Pooling Schemes administered by NHSLA**

7.19.2.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

7.19.3 Insurance arrangements with commercial insurers

7.19.3.1 The board will decide which risks should be insured by arrangements with commercial insurers. These will include:

(a) Insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

(b) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into;

(c) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority;

(d) Directors' & Trustees indemnity insurance

(e) Business Continuity

7.19.4 Arrangements to be followed by the Board in agreeing Insurance cover

7.19.4.1 Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority, the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

7.19.4.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

7.19.4.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

8. Dissemination Process – all policies

Communication of the revised Standing Financial Instructions will take place via the Trust Brief, with a copy of the policy posted on the intranet.

All staff with delegated responsibility will receive a personal copy and will be asked to sign to say they have read and understood the policy.

9. Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity both within our workforce and in service delivery. This policy will be implemented with due regard to this commitment.

An Equality Impact Screening Assessment will be completed and the outcome noted on Appendix M3 of all policies.

10. Supporting References

11. Training

Finance training is provided to all new starters with budgetary responsibilities via their Directorate Accountant. Responsibilities in line with the Trust's Standing Financial Instructions will be included within this training.

12. Appendices to this policy

None

13. Mandatory Appendices Bundle

APPENDIX M1

Executive governance committee checklist for new or renewed policies

Name of Policy: Standing Financial Instructions
Date Form Completed: December 2014

Name of Policy Facilitator / Policy Sponsor: Director of Finance

Question	Response Y/N
Does the policy have the appropriate approved front cover layout including the ROH NHS Foundation Trust Logo	**Y**
Is the policy written in 12 point arial font	**Y**
Is the Document Control Information Bundle complete o Author/ Sponsor/ Committee information o Version Tracking o Procedural checklist o Consultation tracking sheet o Compliance monitoring o Performance management o Contents page	**Y**
Has the policy had an EqIA done?	**Y**
Have Mandatory Appendices M1-M4 been completed and provided to the group?	
Has a review date that is a maximum of 2 years from the date of ratification / approval been included in the document control information?	**Y**
Are the pages in the policy numbered?	**Y**
Is the policy name included in the footer?	**Y**
If this policy replaces a previous document, have the results of a previous audit of compliance (undertaken in the previous 2 years) been provided to the group	**Y (provided as part of regular Audit Committees)**
Does the policy include references	**Y**
Has the EMT submission sheet been completed (See Policy on procedural documents **Appendix 2**)	**Y**
Has the Memo to Managers been completed (See Policy on procedural documents **Appendix 3**)	**Y**

Additional comments from the group approving the policy	
Name of group approving the policy	
Chair of the group approving the policy	
Signature on behalf of the group	

APPENDIX M2

Implications For Implementation Of This Policy

This document must be completed and accompany the policy, procedure or guideline through the final ratification and approval process.

Date: December 2014

Name of Policy, Procedure or Guideline: Standing Financial Instructions

Name of Policy Facilitator: Director of Finance

Name of Policy Sponsor: Director of Finance

The following points include those aspects that need to be considered prior to the authorisation of this policy:

Staffing issues arising from implementation of this policy:
The Standing Financial Instructions provide a framework for all staff with decision making responsibilities to work within

Training issues arising from implementation of this policy:
All staff will be reminded of their responsibilities under the SFIs, and ad-hoc training will be provided as required

Funding / Cost Issues arising from implementation of this policy:
No additional funding / costs

Barriers to implementation of this policy:
None

Implications on other services or processes from implementation of this policy:
The Standing Financial Instructions have implications for all services, and should be fully embedded into each service area

APPENDIX M3

Equality Impact Assessment Form

Stage one – *(all policies, procedures, protocols and functions)*

Name of project, policy or activity: Standing Financial Instructions

Staff member(s) completing screening assessment:

Paul Athey.....

Telephone:

Date: 28/1/15

Screening decision:

Please delete as applicable*:

We have decided it is not necessary to undertake EIA screening after all.

Statement explaining this decision:

The SFIs provide an overarching framework for all staff regardless of their protected characteristics

Signature: **Date:**

Checked by Equality, Diversity and Human Rights advisory group:

Recommendation: requires Screening

Statement explaining this recommendation:

All policies should be impact assessed for equality and diversity.

Signature: ..... **Date:** …….
If you have decided that you do need to go ahead, proceed to section one (screening).

APPENDIX M4

Implementation Plan – [Policy Name]

No	Objective	Responsible	Deadline	Status
1	Full review with Audit Committee	Director of Finance	November 2014	
2	Final checks with key stakeholders	Director of Finance	January 2015	
3	Formal Board sign-off	Director of Finance	February 2015	
4	Written circulation to all relevant parties	Director of Finance	February 2015	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 **ENCLOSURE NUMBER: 16**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Interim Company Secretary**
SUBJECT:	**Nominations Committee (Executive Directors) TOR revision**

This paper proposes an update to the Nominations Committee (Executive Directors) Terms of Reference

IMPLICATIONS

This rationale for this proposal is to improve the clarity of the terms of reference of the Committee in accordance with its remit as described in the Constitution.

RECOMMENDATIONS

The Board is asked to:

1. Approve the revised terms of reference of the Nominations Committee (Executive Directors) as detailed in Appendix 1

Appendix 1

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Nominations Committee (Executive Directors)
Terms of Reference
Draft Revision February 2015

1 Constitution

Relevant extracts from the Trust's Constitution and Standing orders are as follows (in addition to the more general requirement for the establishment of a Nominations Committee with terms of reference agreed by the Board):

Main Constitution

- The non-executive directors shall appoint or remove the Chief Executive.
- The appointment of the Chief Executive shall require the approval of the Council of Governors.
- A committee consisting of the Chairman, the Chief Executive and the other non-executive directors shall appoint or remove the other executive directors.

Standing Orders

- 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.
- The Nominations Committee of the Board of Directors shall appoint or remove the other Executive Directors

The duties section of these terms of reference reflect the above roles

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;

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 appoint or remove the executive directors other than the Chief Executive
6.5 To appoint or remove the Chief Executive. When the Committee is carrying out this role the CEO will be required to withdraw.
6.6 To be responsible for seeking the approval from the Council of Governors of any candidate to be appointed to fill the position of Chief Executive.
6.7 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.

.

7 Permanency

The Committee is permanent

8 Membership

Chair

A non-executive Director – the Chairman or Senior Independent Director. Members of the committee have the power to elect one of their members as

Vice Chairman to act as the Chairman in the absence of the substantive Chairman

Other members
All Non-Executive Directors
CEO (except in the case of matters relating to the CEO themselves)

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 – unless the business of the Committee relates to the CEO role in which case the Chairman of the Committee shall seek an alternative executive lead

13 Frequency of meetings
Not less than once a year.

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
Revised February 4th 2015

16 Date of review
February 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 **ENCLOSURE NUMBER: 17**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Interim Company Secretary**
SUBJECT:	**Clinical Governance Committee TOR revision**

This paper proposes an update to the Clinical Governance Committee Terms of Reference

IMPLICATIONS

This rationale for this proposal is to make clear the delegated authority of the Committee to approve clinical policies as set out in the Scheme of Delegation.

RECOMMENDATIONS

The Board is asked to:

1. Approve the revised terms of reference of the Clinical Governance Committee as detailed in Appendix 1

Appendix 1

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust Clinical Governance Committee Terms of reference Draft Revision February 2015

1 Constitution

The Constitution of the Trust provides that 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

The Constitution states that “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.

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; this includes the authority to approve any Trust policy relating to a clinical matter;
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 establish Advisory Groups including forums. The Committee shall determine the membership and terms of reference of those Advisory Groups including forums.

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, clinical policies 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

6.2.3 The committee will review and approve the Trusts' clinical policies on a basis agreed with the Trust Board

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 and Governance
.

9 Quorum

At least 2 NEDs and one from Medical Director or Director of Nursing and Governance

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 **February 4th 2015**
Date of review **February 2016**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 4 February 2015 **ENCLOSURE NUMBER: 18**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Professor Phil Begg Director of Strategy and Transformation**
SUBJECT:	**Update on Transformation Progress**

TITLE: Update and Progress report on Transformation and Strategic Planning for 2015/16

SUMMARY:

This report provides an update to Board members of key issues and activities of the Transformation Team and the Progress against the 7 Trust Strategic Work streams.

IMPLICATIONS:

To ensure Board members are aware of the work of the Transformation Team and the progress against the work plan.

RECOMMENDATIONS

- The Board is asked to accept the report and acknowledge the progress to date.
- The Board is asked to note the contents of the report and discuss items as appropriate.

Report To:	Trust Board
Report of:	Director of Strategy and Transformation
Purpose of the Report:	To update the Board on the progress of the Transformation work. To update the Board on the timelines for the development of the Monitor 1 year Operational Planning requirements for 2015/16.
Recommendation:	The Board is respectfully asked to note the contents of the report and discuss items as appropriate.

This report provides Board members with an overview of key developments in relation to the Transformation agenda and the Strategic Development of the Trust.

1 Transformation

1.1 Stocktake and Review

A comprehensive review of all projects being undertaken across the Trust has been partially completed, stage on has been completed and this identified all the high level projects that have been started as a result of the 5 year Strategic plan or were underway prior to this. These will now be mapped against a criterion for completion or deletion, using the following criteria:

1. The project, is a project developed out of the new 5 year strategic plan and fits into a current work stream and will contribute to the success of one of the Strategic Initiatives and should be completed;

2. The project was started in advance of the strategic plan, but fits into a strategic initiative and will contribute to the Trust strategic plan and so should continue;

3. The project, is not necessary and so should be deleted, if appropriate;

4. The project was never a formal project and should be considered business as usual and therefore no longer on the project management spreadsheet.

The remaining piece of work in this area is to determine what other smaller projects are underway that do not sit within the strategic portfolio and determine their validity and purpose; this will be completed by the end of February 2015.

1.2 Model of change and communication

Since the last Trust Board meeting there have been two development sessions to take forward the transformation agenda and in particular develop the tools that will be used across the organisation in the development and progression of the 7 strategic work streams within the Trusts' 5 year Strategy.

The workshops focus was on determining the change model and the structure of the Transformation Committee; the following things were agreed through the workshops:

- The stage gate system of project management was agreed;
- The tools for teams across the Trust to use in implementing the various promises, have now been developed and will be centrally stored on the Trust intranet, for simple access for staff.
- There will be a series of events linked to the "*NHS Change Day"* on 11th of March 2015, to share with staff across the Trust progress to date on the various promises, and how to access and use the transformation tools in designing future work streams. This will be heavily supported by Head of Communications and the Transformation Team.

Finally, the reporting mechanism has also been agreed with specific templates for the project (Promises) leads to feed progress in detail to the Executive lead who in turn will present a collated report to the Transformation Committee meeting each month, the summary report following scrutiny by the Transformation Committee will be encompassed within the Director of Strategy and Transformations report to the Trust Board.

2 Project updates

2.1 Context

As the Transformation Committee meeting schedule falls slightly out of sync with the February Board meeting, there is a more detailed reporting of some of the key projects within this report.

There has been significant progress in the past 3 months in the tempo of change within the organisation, with key projects gathering some degree of traction and some becoming Business As Usual (BAU). Detailed below are some of the ley projects that the Board should be updated on, as they contribute heavily to the transformation agenda situated within the 5 year strategic plan. Whilst this is an update on some of the projects, it is not a complete picture, as some are moving at a slightly slower phase and some are subject to procurement procedures, such as the ePMA, which is currently out to a restricted OJEU procurement. However, this project in particular will be under closer scrutiny at the first Transformation Committee on 17th February 2015.

2.2 Project updates

2.2.1 Digital Dictation/Voice Recognition

Background

- Project group decided to go for a full roll out rather than a pilot covering half of the organisation
- Roll out will be split into phases within Specialties

    1) Switch analogue devices to digital (keep transcribing methods the same)
    - Microphones will be used in the Clinic Rooms for clinic letters
    - We will standardise the other devices
    2) Current outsource transcription to be switched to voice recognition - this will require a change to dictation methods with the introduction of standard voice commands
    3) Move in house transcription to voice recognition

Timescales

- Business case to EMT 11th February 2015 for approval to proceed with rollout with selected vendor
- Roll out of phase 1 to start at the beginning of March pending any procurement process and all three phases will be completed by the end of July

Next Steps

- Complete cost benefit analysis and vendor appraisal for business case
- Create detailed roll out plans by Specialty taking into consideration current methods of working

2.2.2 ESR Self Service

The Project has met its December 14 Go live dead line and delivered the following:

- Implemented Self Service across the whole of ROH organisation.
- Tested functionality and processes through piloting and live trials.
- Quantified and base lined benefits from use of Self Service in conjunction with the ESR footprint already established.
- Supported employees through training.

2.2.3 West Heath Rehabilitation Project

The Project has identified and delivered an agreed Criterion for rehabilitation patients that are sent to West Heath, this is being used to drive a trial Multi-Disciplinary Team (MDT) ward meeting. First indications suggest a reduction in patients being sent to West Heath rehabilitation facilities due to existing ROH

ROCS team being able to access the patients in the MDT and refer them to ROCS to support the patient in the home environment.

After data analysis an alternative rehabilitation provider to complement existing rehabilitation provision is being sought in the Dudley area for ROH patients.

Next steps to complete analysis of the multi-disciplinary team meeting efficiencies and review SLA requirement with existing rehabilitation provider.

2.2.4 R&D Innovation Pathway.

R&D staff are mapping their innovation pathway from idea generation to licensed product. The Transformation team is supporting the process- mapping activity and collaborating to define capturing and governance of ideas that bring change.

2.2.5 Ideas from frontline.

Alan & Roger (Porters Facilities)

To improve the flow of patients between Ward and X-ray by means of 'Visual Control Board' scheduling and letting patients know the timing so they can be ready by means of an appointment card.

A weeks Trial has started on Ward 1 with team including ward sister, ward clerk, porters and x-ray dept. refining the process.

2.2.6 Referral Management System

- Project group currently defining the scope and objectives
- 6PM demo put on hold until they can provide a clear description of what they are trying to demo
- We have a visit planned to UHB later this week to view their system

Timescales

- Project/Promise specification to be finalised by 30th January 2015
- Delivery plans to be completed by 6th February 2015

Next Steps:

- Clearly define the problem we are trying to solve

Understand UHB systems and take lessons learnt for implementation of similar systems/solutions

2.2.7 Enhanced Recovery

The TIARA audit is underway which records the time to first mobilisation and adherence to the Protocol, this data feeds into the newly created dashboard. The agreement of the protocol by the surgeons and anaesthetists is taking longer than anticipated – a meeting is scheduled for this week with the Medical Director to progress this urgently. A monitoring phase has been planned and will conclude in May, the project will move to Business as Usual.

Next Phases are yet to be planned, however initial ideas are:

- Phase 2 - refinement and addition to our protocols
- Phase 3 - innovation work stream that seeks to trial new initiatives for ER in a clinically safe environment with all of the relevant safeguards in place

2.2.8 7 Day Working

Three core standards have been agreed at EMT to take forward to 2015/16 contract negotiation with the commissioners, however, following very recent feedback, the Commissioners nationally may require five core standards. The original analysis will be revisited to identify a further two Core Standards over the next 2-3 weeks.

Phase 2 – Implementation. This requires planning and the identification of leads for each Core Standard. An initial meeting to discuss this next phase is scheduled for 10/2/15.

2.2.9 Nursing Acuity

The requirements documents for the web browser has been completed – this will stream line the reporting process and allow the wards to enter acuity and staffing level data and eliminate manual calculations for the Unify Safe Staffing upload. Mobile working - an assessment of mobile devices has taken place on two wards, as there is a potential requirement for mobile working with ePMA. Liaison is taking place to ensure that we have one device that will meet the needs of both projects.

2.2.10 Patient Access Development Programme

Creation and implementation of the SOP's remains a priority. The workstream objectives are being reviewed at the next Project Board meeting 29/1/14. The Patient Access Development strategy is being created to support and compliment the Transformation Strategy.

2.2.11 EDT (Electronic Document Transfer)

Phase 1 of the project is moving to BAU, handover of system and hub administration will be completed by 1/4/15 to the IT team.
Phase 2 – rollout to three further CCG's has been delayed, we are awaiting information from the Commissioning Support Unit to allow us update our firewall with the GP IP addresses. This has been escalated to the CSU Programme Manager 20/1/15.

2.2.12 Patient Pathway

An initial lunch and listen event occurred in October, the output of this session was collated in a single spreadsheet and was shared with the group in

December. As a result of the feedback in the December follow-up event, further engagement work has been undertaken to ensure that other stakeholders are familiar with progress to date and the next steps. Three cluster sessions are being held in the first week of February to discuss and agree the 'ideal' pathway and identify the priorities of each department.

3 Strategic Planning Development

3.1 Monitor expectation and time frame

This year there is an expectation from Monitor that there will be a single focus on the 2015/16 financial year, as opposed to detailed 5 year, strategic plans. The focus is on two determining factors, those being; sustainability and resilience. The timeframe for the development of the one year plan and the expected content is set out below.

The plan should reflect a high level overview which displays:

- Proof that the Trust has a robust strategy for 'survival' in the next financial year;
- One year operational plan only;
- High level draft plan by 27th Feb 2015;
- Final detailed plan by 10th April 2015;

Whilst Monitor do not require a 5 year plan at this stage, it is very likely that a detailed 5 Year strategic plan will be required later in the year, with 2016/17 being year one of the plan.

3.2 Format of Operational Plans 2015/16

Whilst Monitor is not looking to set a template for plans, they have been clear that they expect to see the following detail:

3.2.1 Section 1. Strategic Context (max. 3 pages)

- Significant Variations
- Changes in overall performance
    - Financial (Performance against plan 2014/15, driver of significant variance)
    - Quality (Performance against plan 2014/15, driver of significant variance)
    - Significant missed access targets
- Changes in External Environment
- Local commissioning assumptions and affordability restraints

- Significant changes in government or regulatory policy

3.2.2 Section 2. The outcome (how the Trust Board has or intends to):

- Recommit
- Refresh
- Recreate

3.2.3 Section 3. Progress against delivery of the Strategy (max. 5 pages)

- Summary of how ROH and Local Health Ecconomy partners intend to respond to 'Five Year Forward View' (particularly in the context of the joint planning guidance set out in 'The Forward View into action: partnership and planning for 2015/16)
- Strategic Initiatives
    - Goals
    - Targets
    - KPI's by year
- Action against poor performance
- Summary (key themes and differentiation of tactical or transformational)
    - Productivity;
    - Efficiency;
    - CIP programmes

  (This section should include plans to improve efficiency and productivity through more effective use of IT)
- Capital Programme
- Resources (reallocation following reflection of strategic priorities)

3.2.4 Section 4. Plan for short-term resilience

3.2.5 Section 5. Quality priorities (max. 2 pages)

- National and local commissioning
- Quality goals
- Existing quality concerns
- Key risks

3.2.6 Section 6. Operational requirements (max. 3 pages)

- Inputs needs (such as physical capacity, workforce, WF development, IT and beds)

- Key risks

3.2.7 Section 7. Financial forecasts (max. 7 pages)

- Financial pressures
- Activity
- Key movements (investments in quality/non-recurring income or expenditure)
- Strategic initiatives

3.2.8 Section 8. Board declaration for sustainability and resilience

- Sustainability
- Resilience

Progress of the plan will be fed by the development of the overall operational plans currently being developed within the Trust and will feed up into the 1 year plan required by Monitor, the timeline have been set and are well underway, with all operational plans submitted by 29th January 2015, following a set of facilitated workshops with operational managers leading up to the deadlines.

The 1 year plan will now be completed and submitted by the 27th February 2015 as a first submission and will be finalised, following feedback from Monitor.

4 Recommendation

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

REPORT TO TRUST BOARD: Clinical Governance Committee: 14/01/15

AUTHOR	**Tauny Southwood: NED, Chair of CGC**
TITLE	**Feedback from the Clinical Governance Committee (CGC) meeting of 14th Jan 2015**

1. Controlled Drugs Review: The CEO introduced this item and reminded the Committee that the CQC had identified lack of compliance during its inspection in 2014 and the Trust was currently working to improve in order to satisfy the Compliance Action placed on the Trust by the CQC. Some non-compliance has been identified in theatres and this has been addressed through a number of actions including reinforcement of Trust policies, education, new controlled drugs registers and spot checks. The Trust has commissioned KPMG to undertake a review of clinical practice and compliance, and to review governance and make recommendations as required. The senior KPMG clinical manager (Sue Cordon), attended to provide an interim verbal update. Early analysis has confirmed there is evidence of poor record keeping and the intervention by executives had returned the department to compliance, with spot checks confirming improvements. Further work is continuing on the review including governance arrangements and the flow of information through committees to the Board. The Chief Executive has informed the CQC of this additional work in support of achieving compliance. The Committee was assured by the actions taken and the involvement of KPMG who had a wealth of experience and knowledge of other organisations. When considering the risks overseen by the CGC, members recommended that the risk rating for medicines management compliance be increased in the light of the current review; this will be reflected in the Board Assurance Framework report to the Board.

2. Review of Trust policies: It was reported to the Committee in September that a review of Trust policies was complete, however, the CEO had identified that a large number of policies appeared to be time-expired, including a number of clinical policies. Urgent action was being taken to bring policies back into date and ensure all were consistent with current requirements. Priority had been given to policies directly supporting patient safety; of 44 clinical policies, 11 had been identified as priorities. It was agreed that going forward there needed to be a more robust system for maintaining policies.

3. Clinical Audit: A complete list of projects on the Trust's 2014-5 Clinical Audit database was presented. There appeared to be an inconsistent approach to assessing studies against the criteria for clinical audit, compared to service improvements or research projects. The Medical Director has been asked to clarify this as part of taking forward the transformation workstream, ROH: The Knowledge Leader. It was unclear how many audits had been completed where these had been supported by junior doctors on rotation. Further assurance was sought to ensure that there was a feasible clinical audit strategy, that high quality minutes of clinical audit meetings were kept and presented to CGC, and that a mechanism was in place to ensure that projects met acceptable standards for priority, design, methodology, completion, dissemination of results and re-audit to demonstrate improvement. It was noted that additional senior staff support for the clinical audit processes was now in place.

4. Quality Improvement and Quality Report: Areas of concern included NJR standards of consent and reporting (often less than the required 95%), compliance with the WHO checklist (below contractual compliance target of 99%) and prolonged starvation times before elective surgery. There had been a decrease in incident reporting and it was of concern to the Committee that it was not assured there was a healthy culture of raising

concerns and reporting ‘near misses’. There has been progress with VTE and patient experience. A patient death and never event were reported and were the subject of on-going investigations.

RECOMMENDATIONS

The Trust Board is asked to;

- **Note** the assurances provided by the CGC meeting and areas of concern.
- **Note** the recommended increase in the risk rating for medicines management compliance
- **Recommend** changes to future reports
- **Identify** any further areas for CGC scrutiny

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital

Charitable funds sub-committee meeting 26 January 2015

1. Few trustees attended the charitable funds sub-committee meeting on 26 January 2015.
2. As at 31 December 2014 the total held by the various charitable funds was £832k of which £339,000 represents unrestricted and £470,000 restricted funds; two endowment funds stood at £23,000. There are 31 restricted funds. These figures include a recent legacy (restricted to expenditure related to MRI) but exclude the substantial recent Dubrowsky bequest (see below.) In the quarter ended 31 December 2014, expenditure on charitable funds was modest.

Requests for money

3. Two requests were discussed in detail:
    a. Knowledge hub: Matt Revell explained the request for funding for a collaborative project between ROH and UHB to collect and analyse data to facilitate study of risk and outcomes in relation to joint replacement. The project should help strengthen ROH's approach to governance in relation to analysis of risks and outcomes. The proposal is consistent with ROH's strategy. The sub-committee agreed to recommend use of charitable funds to share, on a 50:50 basis with UHB, the cost of a statistician for a three-year pilot study.
    b. On-site research lab: Martin Snow explained the request made by him and Lee Jeys for funding to create an on-site lab for the study of tissue. It is hoped that this, in the long term, will form the foundation for an internationally recognised centre for excellence in regenerative medicine. EMT has examined the business case and approved the use of space and support for this activity. It is hoped that there will be an income stream. It was stressed that the facility must be badged in such a way that its relationship to ROH is clear. The best location for the lab will not be available until 2016. In the meantime, work can begin on trying to set up income streams from the proposed facility. The current estimate is that building work will cost £160k; in addition, funding is requested for staff costs for the first three years of the project. The proposal is consistent with ROH's strategy. The sub-committee agreed to recommend support for this scheme.

Learning and development for bands 1-4

4. Pauline Jones gave an excellent report on the use made of the grant of £75,000 for learning and development of staff in bands 1-4. Pauline and Anne Cholmondeley have made imaginative use of the funds, with many members of staff benefitting from programmes for eg personal development,

technical skills, apprenticeships, NVQs. Pauline has persuaded providers to be flexible so that staff can undertake courses in their free time; some providers now come to ROH to deliver training. It was agreed that a celebration be held later this year.

Dubrowsky bequest

5. The ROH is sole beneficiary under Mr Dubrowsky's will. His will requires that the money be used for research relating to dedifferentiated chondrosarcoma. The value of the gift is currently put at about £1.3m. The solicitor executors are likely to release funds in about June 2015.

Fund raising

6. There is enthusiasm for fund raising, but calls for use of charitable funds remain slow. It was agreed that discussion about the most appropriate way to approach funding should take place when ideas for projects had been identified.

Protocol for receipt of funds and fund raising

7. Paul and Hannah will develop a draft protocol/policy for discussion at the next meeting or during the summer.

Risks

8. The sub-committee will agree at its next meeting a risk register for charitable funds.

Next meeting

9. The next meeting will be held in April 2015. All trustees are, of course, encouraged to attend.

Frances Kirkham 26 January 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Council of Governors meeting held in on Wednesday 26 November 2014 in the Board Room

Present:
Yve Buckland, (Chairman)
Alan Last, Public Governor
Stella Noon, Public Governor
Jean Rookes, Public Governor
Marion Betteridge, Public Governor
Sue Loccoco, Staff Governor
Yvonne Scott, Public Governor
Rob Talboys, Public Governor
Dia Martin, Public Governor
Karen Hughes, Staff Governor
Marion Thompson, Appointed Governor
Ronan Treacy, Staff Governor
Sue Arnott, Public Governor
Anthony Thomas, Public Governor
Alison Braham, Staff Governor

In attendance:
Jo Chambers, Chief Executive
Rod Anthony, Non-Executive Director
Julian Denney, Interim Company Secretary
Ed Davis, Director of Research

Apologies:
Andy Clark, Appointed Governor
Richard Burden, Appointed Governor
Paul Sabapathy, Appointed Governor

Agenda No.	Agenda Item	ACTION
1	**Apologies** There were apologies from Andy Clark, Richard Burden, and Paul Sabapathy.	
2	**Welcome and Introductions and Declarations of interest** The Chairman welcomed all to the meeting and congratulated the four newly elected members of the Council: Alan Last, Sue Arnott,	

	Anthony Thomas, and Alison Braham. There were no new declarations of interest	
3	**<u>Minutes of the meeting held on Wednesday 29 October 2014 and Matters arising</u>** **Resolved:** That the minutes of the above meeting be and are hereby approved as a true record	
	<u>Governor feedback and issues to raise with the Board (Standing Item)</u> **The Chairman invited feedback from members of the Council. Two staff governors raised a series of issues as follows:** • *Theatre facilities* – particularly the unsatisfactory changing room infrastructure and untidy conditions, and lack of facilities for eating and drinking – this is particularly problematic for theatre staff because of the time needed to change clothing to go to the canteen and back. Staff are happy to pay for their drinks and lunch. • *ADCU pre-operative area* - is under considerable pressure and can be a bottle neck in the patient journey • *ROH case mix* - There are also questions about a possible reduction in complexity and a perception that fewer of the most complex revisions or most ill patients are being seen • *Medical/ non-medical staff mx* – there were questions regarding a possible substitution of medical staff by non-medical staff. • *Job Plans* - Medical staff had questions about the approach to developing consultant job plans • *Recent expenditure on interim staff and HQ refurbishment* -Staff questioned the priority of this spend. • *Possible excessive workload*- Staff were concerned that additional activity pre-Christmas – in particular from other Trusts- may create excessive pressure and could impact on standards of care. Also there are increasing numbers of frail and elderly patients who have additional needs. The CEO responded as follows: • The Director of Operations is already looking at the changing rooms in theatres and noted that all staff bear some responsibility for keeping their working environment tidy. She will ask him to explore options for in situ catering. Theatre recruitment is also being looked at – this is a national issue, and plans are being developed for international recruitment. • The Board has discussed in the issue of patient flow at its meeting earlier today and it is a priority for the Transformation	

	Programme. • The ROH strategy is to build on its position as a leader in high complexity cases. There is certainly no intention to reduce the amount of complex work. A letter has been sent to other Trusts by the Medical Director, setting out the protocol for other Trusts to use when referring complex cases to ROH. The Trust's strategy is to continue to do complex work. • The question of substitution would be considered off line. • Work is being done on Consultant job plans to establish a baseline and ensure compliance with and contractual guidelines, and this is considered critical for the strategy of the Trust • It has been necessary to fill some key gaps with temporary arrangements prior to a permanent appointment, An example is communications where we have had to use an agency for 2 days a week prior to the permanent appointment of Sally Xerri-Brooks. • While building work on HQ may not appear urgent, it is a listed building and the Trust is required to refurbish it every seven years. There is also work that must be carried out for safety reasons – e.g. electrical repairs. This is explained in ROH Life • While it is accepted that staff may be very busy it should not be assumed that this creates patient safety risks. The recent Safe Staffing report showed the ROH to be highly compliant and with very favourable statistics in comparison to its pears and local DGHs. The Safe Staffing model allows for high need patients. The CEO is encouraged by evidence that flow issues are starting to improve with enhanced weekend working and that LOS is reducing. • The CEO accepts that internal communications need improving, hence the investment in a Head of Communications. It is also important that members of the Council are fully appraised of external pressures which can influence key decisions internally. She is very happy for informal approaches to be made to her regarding matters which concern staff. The Chairman said that it was important to make a distinction between those matters which were clearly within the remit of the Council and those which were more appropriately progressed via staff negotiation groups. She suggested that the Council could be given a detailed briefing about the wider operational and financial pressures affecting the West Midlands health economy and within that the implications for the ROH. The CEO said that she would have welcomed advance notice of the issues being raised in order to give time for answers to be prepared or relevant executives to be asked to attend the meeting. To help with this the Governors' pre meeting would be held at least	YB/JC ALL/JD

<table>
<tr><td></td><td>two weeks before the actual Council meeting and any questions would be passed to the Chairman and Company Secretary at least 10 clear days before the actual Council meeting so that agendas could be amended and any staff required to attend could be advised.

E.G.<table><tr><td>Activity</td><td>Date</td></tr><tr><td>Council Meeting</td><td>Wednesday, February 04 2015</td></tr><tr><td>Questions passed to the Chairman and CoSec</td><td>By Friday January 23rd 2015</td></tr><tr><td>Governors pre meeting</td><td>By Wednesday January 21st 2015</td></tr></table></td><td></td></tr>
<tr><td>5</td><td><u>Research Briefing – Ed Davis</u>

Ed Davis gave a presentation (attached)

Points made in discussion

• The ROH collaborates with many centres in addition to those mentioned in the presentation e.g. it is working on stem cells research with Keele and Russell Hall but have to recognise that in some cases collaborators may also be competitors.
• There are two main income streams for ROH R&D – NIHR and industry
• The ROH Charity has provided very helpful pump priming support for research
• The key enablers to enhance the work of R and D include:
o Embed research as an expectation across the organisation rather than the preserve of a few enthusiasts
o Improve facilities – the nurse’s home is not ideal
o Celebrate success more
The CEO commented that the strategy envisages an integrated capability for research and evaluation and this would provide clarity regarding the role of R&D, the R&T Centre and the Charitable Fund.

It was agreed that part of each Council Agenda should look to the longer term

The Council of Governors passed on its thanks to Ed Davis</td><td>YB/JD</td></tr>
<tr><td>6</td><td><u>Update by CEO</u>

Strategy Update

• National context- this is a turbulent time of the NHS with immense pressure in the system. This can also create opportunities e.g. for cross referrals from other providers.</td><td></td></tr>
</table>

	• **New care delivery models** – seven will be prioritised and promoted by NHS England of which two seem particularly relevant to the ROH: o Viable smaller hospitals o Specialised care – stronger concentration of a particular care service. • **Tariff changes** - the Board has made representations to Monitor along with colleague organisations in the Specialist Orthopaedic Alliance (SoA) which has resulted in changes to the original proposals; nonetheless it is expected that there will be eventually a net loss of revenue to the ROH. This underpins the need to continue to make efficiency gains and seek other income generation opportunities • **Monitor review of Strategic Plan –** an initial review meeting has taken place with Monitor and no major concerns were identified. The plan has been rated "amber" in common with most FTs. Monitor have requested that the ROH review the financial assumptions in the plan and model the effect of the proposed tariff changes for 2015/16. • **Transformation Programme-** Professor Phil Begg took up post on 01 November 2014 and has been meeting with Tim Pile regarding the mobilisation of the programme. Early work will focus on improving flow, for example in outpatients. ***CQC Inspection report and Quality summit*** • The CQC Inspection report was published on 17th October 2014. The CQC standard action plan template was submitted to the CQC on time. To date progress has been made against all urgent actions • CQC will be returning to perform a inspection in March focusing those areas where they raised concerns during their first visit. ***RTT – action to reduce waiting lists*** • £1.4M additional funding has been received to support backlog clearance. The funding has been used to support patients across the pathway – this a reason why despite increased activity the Trust complies with Safe Staffing requirements. • Of the ROH backlog of 210 patients 200 have now been removed. • The Trust continues to support Walsall with 37 of its patients – this underpins its strategy as the "go to place for orthopaedic care".	
7	**<u>Governor Elections</u>** ***Progress– update by Julian Denney on behalf of Lisa Kealey***	

	There were four elected Governor vacancies and the following have been elected: • Sue Arnott • Alan Last • Anthony Thomas • Alison Braham will be the new Non-Clinical staff representative. ***Induction pack – revised version following comments – to be launched following elections*** More detail was requested for the pack regarding the following • A map of the hospital • Explanation of nursing staff roles e,g how do you recognise what someone does from their uniform ***Role profile for governors revised version following comments*** • No further comments ***Monthly drop in clinic for governors especially staff governors*** • There was some support for this idea but it was noted that in the past this had been tried with limited interest. There would need to be clarity what the purposes of the clinics were and good publicity for them.	**LK**
8	**Election of Lead Governor** Alan Last was elected by all present to serve for his entire term of office. It was agreed that this would be reviewed annually. Alan thanked the other members of the Council for their confidence in him.	
9	**Chairman's Items** ***Key areas of interest for Governors and opportunities to influence- progress update*** It was noted that discussion had begun with the chairs of Trust working groups in which Governors had expressed an interest. However it was considered that these observer roles should not be finalised until new governors had had a chance to express an interest in particular groups. A draft role profile had been prepared and is attached. Karen Hughes noted that there was a potential for conflict of interest for staff governors serving on working on groups and the Chairman	

	stated that in her view this should not be an impediment provided that any conflicts were declared if they arose. It was also noted that it was intended to have a trial joint meeting of the Patient and Carer's Council and Governors' Patient Experience Committee. Another source of information for Governors was ROH Life; the CEO agreed to ensure that Governors continue to receive this. ***West Midlands Chair and NEDs Forum*** Alan Last and Stella Noon had attended the last meeting of this group. The focus had been planning for 2015; it was agreed that there should be 3 meetings of 2.5 hours length each. The ROH might host one of the meetings. ***Recruitment of a new NED with a clinical and improvement background – including relationship with the Nominations and Remuneration Committee*** The Chairman explained that the legislation says that : *"It is for the Council of governors at a general meeting to appoint or remove the…non-executive directors".* Therefore, it is for the Council of governors as a whole (rather than, say, a committee or a working group) to appoint or remove the non-executive directors. In accordance with the legislation appointment is by a majority of the governors attending the relevant meeting. The Nominations and Remuneration Committee role includes the requirement to : "*Agree with the Council of Governors a clear process for the nomination of a non-executive director. This process should ensure that any regulatory requirements or FT Code of Governance recommendations (such as the "Fit and Proper" test and the need to confirm the status of any non-executive required to be independent) are complied with . "* The enclosure describes the proposed process. **Resolved :** That the Council of Governors hereby agrees the proposed process for the recruitment of an additional Non-Executive Director	

	Communications – website progress (PA) **Comments from Governors:** It was noted that Jean Rookes has confirmed that she would be interested in helping to update the Governor area of the Trust's website. Arrangements will be made for Jean to meet with Vickie Pring, website manager. ***Governors' Award – update*** It was noted that a review of all staff awards was being undertaken and that the Governors interest in contributing to one of the awards was welcomed and would be incorporated into the review.	
10	**NED attendance at Council meeting** The Chairman introduced Rod Anthony Chairman of the Audit Committee. Rod referred to his work making the following key points relating to the Audit Committee : • The Committee reviews a number of key external reports such as the Annual Report & Accounts • It oversees the work of internal audit whose work is relied upon by external audit in forming a view of the Trust's internal controls and who provide an annual statement of assurance for the CEO • It ensures that the risk management process works effectively • It receives assurance from individuals executives regarding their area of work • It relies on the work of the Clinical Governance Committee for assurance regarding clinical matters • It ensures that audit recommendations are followed up • Areas of concern include: o Financial risk particularly related to tariff changes o Progress on clinical audit o Commissioning and contracting o Staff pressures and the use of high levels of usage of agency staff	
11	**Proposed timetable of Meetings for 2015** The proposed timetable of meetings was agreed by the Council.	
12	**Any Other Business** • It was noted that Julian Denney was continuing to serve as interim company secretary pending a review of the role going forward • Ronan Treacy declared an interest in a medical devices company which made a "smart Elastoplast" which he then	

	described to the meeting.	
	Date and Time of Next Meeting 04 February 2015 at 9.00 a,m in the Board room.	

Role of Governors on Trust Working Groups: Draft

Rather than trying to create their own Committees we will ask the Governors to attend and listen to some key working groups within the Trust which have an impact on patient experience. We are piloting this approach to see if it would better fulfil the requirement to ensure that Governors are properly engaged in Trust activities and can reflect and feedback to the Board any of their issues and concerns.

We are basing this approach on the successful model whereby governors attend some public Board meetings which they have found useful in helping to inform them about Trust activities and key issues.

We would expect the Governors to bring back any issues from the working group to the Council and also to report back generally to the Council on the business of the group, including any decisions and actions by the group.

The role of the Governors is to assure themselves and the public about what is going on in the Trust; as a result they cannot be in any way executive members of any working group i.e. taking part in decision making or giving actions to the groups.

We would expect the Chairman of the working group to draw the Governors into the process and enable them to ask questions (just as happens at Board meetings).

Governors are not expected to attend every meeting but we will ask the working group chair to provide the Agenda (when available) and the dates when meetings are planned.

To be circulated with the Council minutes (2)

Clinical Governance Committee

Dates for 2015

14th January	**Board room, 9-12noon**
11th February	**Board room, 9-12noon**
11th March	**Board room, 9-12noon**
15th April	**Board room, 9-12noon**
13th May	**Board room, 9-12noon**
10th June	**Board room, 9-12noon**
8th July	**Board room, 9-12noon**
No meeting August	**NO MEETING**
11th September	**Board room, 10-12.30noon**
14th October	**Board room, 9-12noon**
13th November	**Board room, 9-12noon**
9th December	**Board room, 9-12noon**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Enclosure 1

Minutes of the Trust Board Meeting
held in public on February 04th 2015 at Beeches Conference Centre

Present:
Trust Board
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
Mr Andrew Pearson, Medical Director
Professor Tauny Southwood, Non-Executive Director
Ms Elizabeth Chignell, Non-Executive Director
HH Frances Kirkham, Non-Executive Director

In attendance:
Mr Julian Denney, Interim Company Secretary
Ms Sally Xerri-Brooks Communications Manager
Professor Phil Begg Director of Strategy and Transformation
Ms Anne Cholmondeley, Director of Workforce & Organisational Development
Ms Lisa Newton (Senior Nurse) - to present the Patient Case

Apologies:
Dame Yve Buckland, Chairman

Agenda No.	Agenda Item	ACTION
02/15/01	**Apologies and welcomes** Apologies were received from Dame Yve Buckland, Chairman It was noted that Tim Pile, Vice Chairman, would take on the Chairman's duties in this meeting owing to the Chairman's absence. The Vice Chairman noted that Roger Tillman had served between May 2013 until December 2014 as Deputy Medical Director in early December and thanked him for his work on the Board's behalf.	
02/15/02	**Declarations of Interest** It was noted that the register of interests was being updated following the annual re declaration of interests as previously agreed. Jonathan Lofthouse declared an interest as follows:	

	"Previously my partner, Serena Stirling worked through my company, for KPMG. My company supplied services to KPMG's health audit team. Prior to Christmas Serena took a substantive full time role with Health Audit at KPMG and consequently no longer works through my company. For clarity KPMG's engagement rules dictate that Serena may not undertake any work, onsite or remotely for ROH"	
02/15/03	**Patient Case – an illustration of the work we do** Lisa Newton (Senior Nurse) presented a case about a complaint following a patient's death. The patient's daughter wanted her mother's story to be shared, and this has been done and it has been hugely helpful in motivating change. There were many valuable learning points around a wide range of issues including improving communications, specific nursing procedures, escalating staffing concerns, pain control, and dementia screening and staffing levels. An action plan was prepared and since then there has been much improvement It was agreed that further work including clinical audit should be done to ensure there were no wider systems issues that should be addressed. The Board thought the story was very helpful and the CEO congratulated Lisa Newton and her team and asked for the Board's appreciation of the lessons learnt to be communicated to the patient's family.	**AP**
02/15/04	**Minutes of the Trust Board meeting held on 26th November 2014** The following amendments were agreed: (a) On Page 13 the sentence : •Spinal deformity still remains an area of risk; negotiations are in progress with the Middlesex for access to theatre slots. Should read: •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. (a) The spelling of Jonathan Lofthouse's name should be	

<table>
<tr><td></td><td>checked

Resolved:
The Trust Board hereby:

1. Approves the minutes of the above meeting subject to the above amendments as a true record.</td><td></td></tr>
<tr><td>02/15/05</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>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</td><td>Complete – covered in CPR</td></tr>
<tr><td>11/14/147

It was noted that there was a</td><td>In progress:</td></tr>
</table></td><td></td></tr>
</table>

	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.	Declarations of interest and hospitality being coordinated by Company Secretary and Director of Finance Fit and Proper – covered later on the agenda		
	11/14/151 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.	Largely complete – suggest close		
	11/14/153 Possibility of 'near' patient testing for INR –it was agreed that this should be looked at as part of a wider issue which	Report has been requested and it has been received very recently- to be closed at the next meeting		

had multiple consequences for patient quality and length of stay.	
11/14/154 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	Will be adjusted for next financial year – suggest close
11/14/158 Regarding the CQC Action Plan 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.	Close and replace by: interim Director of Nursing and Governance to review the action plan and suggest any changes.
11/14/159 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.	In progress. YB has sent letters out to potential partners Phil Begg will be making contact with Emory Health Care as a possible partner.

		RA is arranging a video conference with a leading orthopaedic surgeon in the US inviting PB and JL	
	11/14/162 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.	Still unresolved: a lead for clinical audit is being sought. Keep on the agenda. Some additional part time support is being sought to help with medical engagement which is relevant to this issue	
02/15/06	**Chairman and NEDs' update** Tim Pile, Vice Chairman updated the Board as follows: ***Director of Nursing and Governance*** The Vice Chairman noted that the Director of Nursing and Governance had resigned. He said that the Chief Executive and the Chairman had consulted Rod Anthony, Tauny Southwood and himself and they had all agreed that the vacant position needed to be filled by an interim post holder pending appointment of a permanent post holder, The CEO, with support from the Director of Operations then appointed Garry Marsh as interim Director of Nursing and Governance. The Board hereby notes the exercise of the CEO and Chairman's "urgent decisions" powers with regard to the agreement that the position of Director of Nursing and Governance needs to be filled by an interim post holder. ***Recruitment of additional NED*** • It was noted that Gatenby Sanderson , search and selection consultants had been appointed following a competitive procurement process to assist the Council of Governors Nominations and Remuneration Committee in their role in supporting the Council of Governors in this process • There has been a substantial interest in the role from senior clinicians	

	Attendance at Council meetings by NEDs • Tim Pile has attended the Council this afternoon to talk about the work of the Transformation Committee and Tauny Southwood is being invited to attend the May 2015 meeting of the Council to talk about the work of the Clinical Governance Committee. A list of Council meeting dates with the suggested programme of NED attendees would be circulated • Governors are currently considering how their observer role on Trust working groups and Committees can work most effectively; one idea is for there to be a NEDS/ Governors informal meeting	**JD**
02/15/07	**<u>Chief Executive's Report</u>** Jo Chambers introduced her report inviting a discussion. A number of points were highlighted as follows: ***Dalton Review*** • This was provided for information. The CEO's paper has highlighted the key recommendations for the Board to focus on ***Strategic Development of Organisational Capability*** • The Kings Fund undertook their planned interviews in November and December 2014. Unfortunately not all consultant medical staff invited to interviews were able to attend and as a result it was agreed to extend the timeline for the project until the end of January to allow sufficient doctors to contribute their views via a survey which closed on Monday evening. Early indications are that the work is influencing engagement positively. Verbal feedback on the Kings Fund's findings is expected during February. The Trust Board will be appraised of the findings at the Board workshop in March. ***Trust Business and Learning Day (TBALD) – Update*** • The original objectives of TBALD were to ensure there was protected time for directorate discussions, clinical audit and a Q & A session with the CEO. The opportunity has been taken to review the effectiveness of TBALD in its current form with a view to improving how its objectives can be delivered with minimum disruption to patient services.	

	• Feedback has been sought and there are a variety of views. Based on this feedback and a continuing commitment to engagement and development, it has been decided to try an alternative approach to make it easier for doctors to attend and this has been well received • The Board supported this approach and suggested that it would be helpful for there to be some further analysis of the impact of changing TBALD days and also some analysis of website usage to assess which features of TBALD were most useful. TS offered to work with SXB to share his experiences re e-learning • Signing in and signing out to and from TBALD sessions will be strengthened ***Executive Management Team*** • In addition to the actions reported in the paper , the CEO stated that there has been a meeting with Aston University regarding a possible strategic alliance • PB recently attended a Monitor event around new models of care including surgery. The ROH has accepted an invitation to collaborate with Monitor to support this. **Resolved:** The Trust Board hereby: 1. Notes the CEO's report	
02/15/08	**<u>Medical Director's Update</u>** Andy Pearson introduced his report which focused mainly on concerns raised by the Junior Doctor Forum and the Trust's response **Resolved:** The Trust Board hereby: 1. Notes the Medical Director's report.	

02/15/09	**<u>Fit and Proper Test</u>** Anne Cholmondeley introduced the Policy on the Fit and Proper Persons Test inviting a discussion. A number of points were highlighted as follows: • The paper seeks to distil how the Trust will comply with the Test • It will be implemented in relation to appointment of the Director of Nursing and Governance. **Resolved:** The Trust Board hereby: 1. Approves the Policy on the Fit and Proper Persons Test	
02/15/10	**<u>Quarter 3 Declaration – October to December 2014</u>** The CEO stated that the Q3 Declaration to Monitor had been submitted at the end of January by a Committee of her and the Chairman on the Board's behalf and this was acknowledged by the Board. The Board confirmed its intention to continue to delegate the authority to submit future draft quarterly reports to Monitor on its behalf to a Committee of the Chairman and CEO. The CEO highlighted the following points in relation to the report : ***Learning Disabilities Indicator*** • Since the submission there has been a challenge from Monitor in relation to a learning disabilities metric which in the past was believed to be not applicable • The Trust is undertaking the relevant audits to underpin this metric and believes that it is compliant ; this indicator will form part of future reporting • The report will be resubmitted with the indicator populated ***Medicines management*** • The report refers to a review of medicines management in the Trust which has identified a number of areas for improvement which are being addressed. Board members have been kept up to date through briefings and key contacts at CQC and Monitor have been informed. Monitor have confirmed that an exception report is not required in respect of these activities.	

	Board Briefing for future reports It was agreed that to have a Board briefing in relation to issues to be included in draft quarterly reports in the month before they were due to be submitted. **Resolved:** The Trust Board hereby: 1. Notes the submission of the Q3 report to Monitor made on its behalf by a Committee of the Chairman and CEO and the proposed amendment re the learning difficulties metric as described above	
02/15/11	**<u>Corporate Performance report</u>** Paul Athey introduced his report. A number of points were highlighted as follows: ***RTT*** • There has been a 52 week breach in December, with a further 2 confirmed breaches in January with potentially a further two in February. The cases are spinal deformity patients who were due to be operated on at BCH within 52 weeks. A principal cause was BCH cancelling theatre availability for seven consecutive weeks which offset capacity headroom bought at the Cromwell Hospital. • The longest waiting patients are currently at 65, 54 and 51weeks (2 patients). We are working with BCH and North Midlands University Hospitals Trust but they have little capacity and the Cromwell Hospital is not a simple option. The Trust's own spinal surgeons have been very helpful regarding on site working but we are restricted by the need for PICU facilities. The longest waiting patient is not fit for surgery for reasons unconnected with the delay. • The CEO stated that a dialogue would begin with commissioners and a case identifiable escalation to NHS England will now be considered. ***Cancellations*** • There has been an increase in cancellations which will be analysed – often this is due to unfitness on the day and associated POAC related issues. The Board requested an analysis of the impact of improvements on the number of cancellations on the day of the procedure.	**JL** **JL**

Finance

Paul Athey gave a presentation – **attached**
The following points were highlighted in relation to YTD performance and the possible range of forecast outturns:

- The Trust is currently £292,000 behind plan at the end of December 2014
- This equates to a c£100,000 deterioration per month since the end of Quarter 2, when the Trust was at broadly break-even against plan
- The reasons for the shortfall include:
    - Significant increase in case-mix complexity, with knock-on impact to pay & non pay pressures
    - Continued growth in agency & locum usage (£0.7m in Q1, £1.0m in Q2, £1.5m in Q3)
    - Non Pay overspend largely linked to use of Cromwell hospital
- Additional short-term controls have been introduced to mitigate this trend during Q4. If these controls hold the position as it currently stands, the Trust would outturn at a surplus of around £200k
- A continuation of the trend seen in Q3 would leave uthe Trust with a deficit of around £100k
- Additional non-recurrent costs of circa £280,000 during Q4 would see the outturn position reduce to a deficit of between £80,000 and £400,000 depending upon the scenarios that have been modelled.
- The Trust is maintaining a Continuity of Services rating of 4

The Trust Board were asked to make a judgement regarding the forecast outturn and to consider the following options:
- A breakeven position
- A deficit position of circa £200k

The Board discussion included the following points:
- In the best case scenario there might be a small surplus if cost control was very successful and additional work was undertaken to support other trusts at 125% of tariff ; and 52 week fines were avoided
- However a deficit of £200k deficit was most likely and in the worst case scenario the deficit could be greater.
- The ROH has never been in deficit before although

	many Trusts are in deficit nationally • The ROH has had to incur exceptional costs • The Board challenged the understanding of the cost volume relationships which PA agreed to analyse to ensure that additional activity was profitable and it was noted that the Medical Director was investigating if there was any relationship between infection rates and activity • The Board agreed that, based on current understanding, the forecast outturn should be on the basis of a deficit of £200k. In the submission to Monitor a clear explanatory narrative will be very important so that the exceptional circumstances affecting the Trust are made apparent. **Resolved:** The Trust Board hereby: 1. Notes the Corporate Performance report.	**PA**
02/15/12	**<u>The Patient Quality Report</u>** Jonathan Lofthouse introduced his report highlighting the following: • Following the conclusion of an investigation into a surgical error incident (originally reported in September 2014) this has now been escalated to, and confirmed as, a Never Event in December 2014. • The Deputy Director of Nursing and Governance has scheduled an urgent meeting with the Matron for POAC to understand the reasons why all patients do not appear to have been given access to NJR consent process. Accurate filing of forms also requires improvement as on occasions NJR consent forms are completed but cannot be easily sourced in medical notes Following the Board discussion it was noted that regarding the matters raised under page 13(suboptimal care) JL would discuss further with FK outside of the meeting **Resolved:** The Trust Board hereby:	

	1. Notes the Patient Quality report.	
02/15/13	**<u>The Safe Staffing Report</u>** Jonathan Lofthouse introduced his report and noted that monthly information shared with the Board will be broadened to include data indicating the overall percentage of bank and agency usage for ward areas. A 6 month review of nursing establishments will also be included in next month's papers. In addition: • The Trust will roll out a standardised template for safe staffing on ward display boards • The ROH is still one of the best performing in the West Midlands • The CGC still needs to do the detailed scrutiny of the Safe Staffing information; aggregated information should go to the Board including any external reports. • The interim Director of Nursing and Governance will be asked to talk to TS re the structure of the report based on his experience **Resolved:** The Trust Board hereby: 1. Notes the Safe Staffing report.	
02/15/14	**<u>Board Assurance framework (BAF)</u>** The CEO presented the BAF and highlighted the following: ***BAF Themes*** • There was a new risk reflecting recent medicines management issues • Both the CQC registration and 'Monitor Licence' themes have been escalated in December 2014 owing to concerns relating to compliance with the CQC safety domain 'management of medicines' and non-compliance with safe controlled drugs practice. ***Strategic Risks*** • Some work has been undertaken by the Company Secretary and Director of Nursing and Governance on new corporate risks associated with implementing the Trust's strategy following a Board workshop in November 2014. These are currently being reviewed by executives.	

	Resolved: The Trust Board hereby: 1. Notes the Board Assurance Framework.	
02/15/15	**<u>CQC Action Plan</u>** CEO presented the CQC Action Plan highlighting the following : • This report provides Board members with an update on progress to implement the action plan arising from the Care Quality Commission inspection in June 2014 and report received on 17 October 2014. • Attachment 1 sets out the agreed actions and timescales for achievement as agreed by the Board in November 2014- this was used at the meeting with the CQC • Internal checks have identified additional risks in relation to medicines management and these have been incorporated in the action plan • The Care Quality Commission have been informed of the latest position and further actions and the CEO is in dialogue regarding the date for a potential re inspection • Signed letters have been received from c 50% of consultants regarding the security of patient sensitive data and the remainder will be followed up. ***Wider issues*** • There is a general issue about a security of Trust data e.g. if there is any patient sensitive data being sent outside of NHS Mail The Board raised concerns about the loss of patient notes and widely circulated emails referring to these • The security of Board papers was also discussed and it was noted that TP had identified a new system which had the potential for improving security. **Resolved:** The Trust Board hereby: 1. Notes the CQC Action Plan report, and in particular the additional actions associated with the additional risks identified	**AP** **PA/AP** **PA/JD**
02/15/16	**<u>Childrens' and Adults' Safeguarding Report</u>** Jonathan Lofthouse presented the Childrens' and Adults' Safeguarding Report. Board comments were as follows: • The Board sought assurance that there were sufficient	

	resources to support this area and that staff were giving it sufficient priority • The Board also sought assurance that vulnerable staff being treated fairly given they may complain less **Resolved:** The Trust Board hereby: 1. Notes the Children's' and Adults' Safeguarding Report	
02/15/17	**<u>Infection Prevention Annual Report</u>** Andy Pearson presented the Infection Prevention Annual Report explaining that at the next Board meeting he would give a presentation of an infection control audit. Discussions with directorate managers will embed actions within job plans **Resolved:** The Trust Board hereby: 1. Notes the Infection Prevention Annual Report	
02/15/18	**<u>Equality and Diversity Report</u>** Anne Cholmondeley presented the Equality and Diversity Report explaining that • Positive progress on Contact Officer recruitment and training occurred during May 2014. • Ther was some perception of less favourable treatment of staff with a BME background; we are in dialogue to understand this better • There is expected to greater scrutiny of Equality and Diversity outcome measures **Resolved:** The Trust Board hereby: 1. Notes the Equality and Diversity Report.	
02/15/19	**<u>Revision to the Scheme of Delegation</u>** Paul Athey introduced his report highlighting the following changes (which had been to audit committee) from the more detailed list covered in the report : <u>Standing Financial Instructions & Scheme of Reservation & Delegation</u> • Full review of SFIs and Scheme of Delegation was	

	carried out as the previous version was updated in 2008 <u>Scheme of Reservation & Delegation – key changes</u> • Clarification regarding the authority of Clinical Governance Committee and the Chief Executive to approve certain trust policies. • Greater clarity on ability for Chief Executive to approve special payments through NHSLA, with payments over £100,000 reported to the Trust Board • Quotations & Tenders section completely re-written to provide greater clarity and to ensure limits match (i.e. previous limits allowed Directorate Managers to approve expenditure up to £20k, but quotations only up to £10k) **Resolved:** The Trust Board hereby: Approves the Standing Financial Instructions and Scheme of Reservation & Delegation as detailed in the Board papers	
02/15/20	**<u>Nominations Committee (Executive Directors) TOR revision</u>** Julian Denney introduced his report highlighting the following: • The rationale for the proposal was to improve the clarity of the terms of reference of the Committee in accordance with its remit as described in the Constitution. **Resolved:** The Trust Board hereby: 1. Approves the revised Nominations Committee (Executive Directors) Terms of Reference as detailed in the Appendix to the Board paper	
02/15/21	**<u>Clinical Governance Committee TOR revision</u>** Julian Denney introduced his report highlighting the following: The main purpose of proposing revised CGC TOR is to allow the CGC to approve clinical policies. Since the paper was drafted it has become clear that in addition a mechanism is needed for approving clinical policies in urgent situations when it is not practicable to use the CGC. It was also noted that Frances Kirkham had suggested an	

	amendment and the Board agreed with both of these further changes. **Resolved:** The Trust Board hereby: 1. Approves the revised Clinical Governance Committee Terms of Reference as detailed in the appendix to the Board paper subject to: a. the Terms of Reference of the Clinical Governance Committee being amended to exclude the approval of policies which the Chief Executive considered, acting on appropriate clinical advice, needed to be approved more quickly than the Clinical Governance Committee could accommodate; b. and paragraph 6.3.1 i. "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" being replaced with ii. "The committee will oversee, by appropriate monitoring of actions taken by responsible officers, compliance with standards set by the Care Quality Commission and, insofar as they relate to clinical matters, those set by Monitor" 2. Delegates the approval of such policies to the Chief Executive acting on appropriate clinical advice, including at least one clinically qualified Executive Director with the expectation that the Clinical Governance Committee would receive and note these policies as soon as practicable and 3. Makes the necessary consequential changes to the Trust's Scheme of Reservation and Delegation to reflect (1) and (2) above	
02/15/22	**<u>Update on Five Year Strategic Plan</u>** Phil Begg presented his report highlighting the following points: • There will a "soft launch" of the Transformation Programme on the NHS Change Day • The appointment of the rest of the team is in progress • A template including a three page narrative will need to be sent to Monitor regarding the strategic plan. This will need to be completed by the 27th of February with a 20	

	page summary submitted on the 10th of April. • The Board will need to provide any comments in advance of the February summary submission – this would be done by email circulation • Regarding specific projects , in general staff are positive about the ESR system **Resolved:** The Trust Board hereby: 1. Notes the Update and Progress report on Transformation and Strategic Planning for 2015/16	
02/15/23	**Report of the Chair of the Audit Committee** Rod Anthony, Chair of the Audit Committee gave an update and noted that Patrick Green has replaced Glen Palethorpe from Baker Tilly, **Resolved:** The Trust Board hereby**:** 1. Notes the update of the Chair of the Audit Committee	
02/15/24	**Report of the Chair of the Clinical Governance Committee** Tauny Southwood, Chair of the Clinical Governance Committee noted that several reports considered by CGC had already been discussed such as the CQC report The CEO noted that there are 11 time expired clinical polices and they should be approved by this Friday **Resolved:** The Trust Board hereby**:** 1. Notes the report of the Chair of the Clinical Governance Committee	
02/15/25	**Report of the Chair of the Charitable Funds committee** Frances Kirkham reported on the Charitable funds committee meeting of 26 January 2015 as follows : • The Board was asked to approve two requests for funding which was agreed • The CFC was working to ensure greater communication about the availability of funds • Greater clarity was required as to why some requests for funding were declined – e.g. because the Trust wishes to mainstream a solution. It may be better to allow more requests through to the CFC.	**PA**

	Resolved: The Trust Board hereby**:** 1. Notes the report of the Chair of the Charitable Funds Committee 2. Approves the two requests for funding detailed in the paper	
02/15/26	**<u>Report of the Chair of the Transformation Committee</u>** Tim Pile commented that Phil Begg's report had covered much of Transformation Committee business. He asked the Board to agree a minor change to the Transformation Committee TOR as follows In the Membership Section , under "Other Members" *Trust Chairman* *3 additional non-executive Directors* Be replaced by *Trust Chairman* *At least 1 and up to 3 additional non-executive Directors* **Resolved:** The Trust Board hereby**:** 1. Notes the report of the Chair of the Transformation Committee 2. Approves the change to the TOR of the Transformation Committee as described above	
02/15/27	**<u>Report of the Chair of the Remuneration committee</u>** Elizabeth Chignell stated that there had been no meeting of the Committee since the last Board meeting but a meeting was planned later today .	
02/15/28	**<u>Report of the Chair of the Council of Governors</u>** Some Board members had attended the Council meeting. There had been interest from Council members in greater involvement with NEDs outside of formal meetings.	

02/15/29	**<u>Any Other Business</u>** TP reiterated the Board's thanks to Lisa Newton for her presentation of a particularly helpful patient case.	
<u>Date and Time of Next Trust Board Meeting</u> Date of Next Meeting: Wednesday 01 April 2015 at a time to be advised. There is also a private Board development event planned for Wednesday 4 March 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 4 FEBRUARY 2015,
1.00PM AT THE BEECHES CONFERNCE CENTRE

AGENDA

ITEM	TITLE	NOTES	BOARD ACTION	PAPER
02/15/01	**Apologies & Welcomes**		To Note	
02/15/02	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
02/15/03	**Patient Case – an illustration of the work we do** Director of Nursing & Governance			
02/15/04	**Minutes of Public Board Meeting held on the 29th November 2014** Chairman		For Approval	Enc. 1
02/15/05	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
02/15/06	**Chairman & NED update** **Including:** • Recruitment of additional NED • Attendance at Council meetings by NEDS Chairman & NEDs		For Information	
02/15/07	**Chief Executive's Report** **Including:** • Dalton Review • TBALD update • King's Fund diagnostic debrief Chief Executive		For Information and Assurance	Enc. 3
02/15/08	**Medical Director's Update** Medical Director		For Information and Assurance	Enc. 4

02/15/09	**Fit and Proper Test** Director of Workforce& Organisational Development		For Information and Assurance	Enc. 5
	Performance Management / Assurance Reports			
02/15/10	**Quarter 3 Declaration – October to December 2014** Chief Executive		For Information	Enc. 6
02/15/11	**Corporate Performance Report** Director of Finance		For Assurance	Enc. 7
02/15/12	**Patient Quality Report** Director of Nursing & Governance		For Assurance	Enc. 8
02/15/13	**Safe Staffing Report** Director of Nursing & Governance		For Assurance	Enc. 9
02/15/14	**Board Assurance Framework** Director of Nursing & Governance		For Assurance	Enc. 10
02/15/15	**CQC Action Plan** Director of Nursing & Governance		For Assurance	Enc. 11
02/15/16	**Children's' and Adults' Safeguarding Report** Director of Nursing & Governance		For Assurance	Enc. 12
02/15/17	**Infection Prevention Annual Report** Medical Director		For Assurance	Enc. 13

02/15/18	**Equality and Diversity Report** Director of Workforce& Organisational Development		For Assurance	Enc. 14
02/15/19	**Revision to the Scheme of Delegation** Director of Finance		For Approval	Enc. 15
02/15/20	**Nominations Committee (Executive Directors) TOR revision** Company Secretary		For Approval	Enc. 16
02/15/21	**Clinical Governance Committee TOR revision** Company Secretary		For Approval	Enc. 17
	Strategy			
02/15/22	**Update on Five Year Strategic Plan** Director of Strategy and Transformation		For Information	Enc. 18
	Board Committees			
02/15/23	**Report of the Chair of the Audit Committee**		For Assurance	Verbal
02/15/24	**Report of the Chair of the Clinical Governance Committee**		For Assurance	Enc. 19
02/15/25	**Report of the Chair of the Charitable Funds Committee**		For Assurance	Enc. 20
02/15/26	**Report of the Chair of the Transformation Committee**		For Assurance	Verbal
02/15/27	**Report of the Chair of the Remuneration Committee**		For Assurance	Verbal

02/15/28	**Council of Governors – including Minutes of the meeting of November 26 2014** Chairman		For Information	Enc. 21
02/15/29	**Any Other Business**			
	Date of Next Meeting: Wednesday 1 April 2015 at a time to be advised. **There is also a private Board development event planned for Wednesday 4 March 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.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Council of Governors Meeting

Wednesday 4th February 2015 at 10.00 a.m.
At the Beeches Conference Centre

A G E N D A

1.	Apologies	
2.	Welcome and introductions and declarations of interest	
3.	Minutes of the meeting held on Wednesday 26th November 2014 and Matters arising	Enc. 1
4.	Action Log	Enc. 2
5.	Governor feedback and issues to raise with the Board (Standing Item): • Website and Governor member communication	
6.	Update by CEO/Dir of Ops/Dir of Finance • Strategy Update • Wider operational and financial pressures affecting the West Midlands health economy and implications for the ROH • CQC Action Plan and proposed return visit • Theatre refurbishment and related matters (JL) • Financial position – update (PA)	
7.	Patient and Carer's Council – Feedback and other updates	
8.	Chair's Items: • Key areas of interest for Governors and opportunities to influence- progress update • Recruitment of a new NED with a clinical and improvement background –update • Fit and Proper Test (AC)	Enc. 3
10.	NED attendance at Council meeting • Tim Pile – Transformation Programme	
11.	Any Other Business	

12. Date and Time of Next Meeting

Wednesday 6 May 2015 – 9am

Note: there may need to be an additional meeting before then to appoint the new NED

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Enc. 1a

Minutes of the Council of Governors meeting
held in on Wednesday 04 February 2015 at the Beeches Conference Centre

Present:
Yve Buckland, (Chairman)
Alan Last, Public Governor
Stella Noon, Public Governor
Jean Rookes, Public Governor
Marion Betteridge, Public Governor
Sue Loccoco, Staff Governor
Yvonne Scott, Public Governor
Rob Talboys, Public Governor
Dia Martin, Public Governor
Karen Hughes, Staff Governor
Marion Thompson, Appointed Governor
Ronan Treacy, Staff Governor
Sue Arnott, Public Governor
Alison Braham, Staff Governor
Paul Sabapathy, Appointed Governor

In attendance:
Jo Chambers, Chief Executive
Julian Denney, Interim Company Secretary
Jonathan Lofthouse, Director of Operations
Paul Athey, Director of Finance
Tim Pile Non-Executive Director
Elizabeth Chignell, Non-Executive Director
Frances Kirkham, Non-Executive Director

Apologies:
Andy Clark, Appointed Governor
Richard Burden, Appointed Governor
Anthony Thomas, Public Governor

Agenda No.	Agenda Item	ACTION
1	**Apologies** There were apologies from Richard Burden, Andy Clark and Anthony Thomas	
2	**Welcome and Introductions and Declarations of interest** The Chairman welcomed all to the meeting. She noted that the	

	Bournville Village Trust had nominated Paul Sabapathy to serve as an Appointed Governor for a second term and the Trust was delighted to confirm his appointment for three years from 1st February 2015 There were no new declarations of interest	
3	**Minutes of the meetings held on Wednesday 26 November 2014 and Wednesday October 29th 2014 and Matters arising** ***Wednesday October 29th 2014*** It was noted that the minutes of the meeting of Wednesday October 29th stated that: "It was agreed that Stella Noon, Karen Hughes, Yvonne Scott Marion Betteridge and Alan Last (if elected) would comprise the Nominations and Remuneration Committee …" . It was agreed that the minutes should have said: "It was agreed that Stella Noon, Karen Hughes, Yvonne Scott Marion Thompson and Alan Last (if elected) would comprise the Nominations and Remuneration Committee…" . ***Wednesday 26 November 2014*** It was noted that : (1) Yvonne Scott gave apologies. (2) Regarding item 4 the governors cannot recall references to the pre meeting dates or timetable. It was agreed that going forward Alison would email all governors asking them to let Alan Last have details of any issues they wanted to raise two weeks prior to the Council meeting. (3) It was also agreed that draft minutes would be circulated two weeks from the date of the meeting to Council members. **Resolved:** 1. That the minutes of the meeting of Wednesday October 29th should be corrected as detailed above 2. That the minutes of the meeting of Wednesday 26 November 2014 be and are hereby approved as a true record subject to the amendment above Matters arising :	ALL

JL reported as follows:

Building work

Trust HQ refurbishment was necessary partly as result of safety issues and listed building requirements. The work is still in progress (including work to improve the Board room).The rewiring and decoration is complete on first part of the upper floor. Work has started on the HQ ground floor and rest of upper floor refurbishment will follow.

Refurbishment is in progress elsewhere including work to improve educational facilities; Ward 7 is being taken down and the process to level the building will be completed in June.

Staff Accommodation in theatre suite

- JL has met with David Marks and others creating costed options for improvements
- The male and female changing rooms are overcrowded. A scheme to extend these rooms by 25% and 30% respectively is envisaged. This will give all staff an allocated storage environment
- A high use drinks machine has been purchased to reduce the need for washing mugs etc. The Trust is considering the use of volunteers or the housekeeping service to supply staff lunches. It is also considering whether the conservatory extension could be used to create a lounge environment for staff. This work should start in 3-4 weeks. The drinks machine won't be free but there will be a system for pre paying to enable this to be simple for staff

Flow Issues

- These are improving – amendments have been made to the patient pathway including additional weekend working. There has been no increase in falls
- There has been some increase in cancellations but this is thought to be seasonal
- NHS England have asked if we can do additional theatre work in March at 125% tariff and we believe this is feasible. This should be confirmed soon.

Further Questions

- Charitable funds may be considered if internal funding is insufficient – in general the preference is to use charitable funds for patient areas but it is accepted that a good environment for staff helps patients
- Regarding the flow of patients into theatres external consultancy input should help improve inadequacies in

	ADCU and POAC. More consideration needs to be given to patients in wheel chairs and the need for some a patients to go to a bed immediately	
4	**Action Log** It was agreed that the Action Log was a useful tool. The action log was updated (see separate sheet):	
5	**Governor feedback and issues to raise with the Board (Standing Item)** The Chairman invited feedback from members of the Council: **Comments from Governors:** • The governors wanted a higher degree of interaction with the NEDs – this was not always easy to do in the middle of a formal meeting with only a limited number of NEDs present. Governors wished to meet the NEDs on their own. The Chair stated that are every meeting at least NED would report on their area of interest; in addition Governors would feed into NED formal appraisal. She agreed that we should explore NED / Governor joint meetings – perhaps twice a year. • A list of each NEDs area of responsibility was requested and it was agreed that this would be circulated. • The 15 step walkabout potentially could be done by NEDs and Governors jointly ***Website and Governor member communication (SXB)*** • Communications for Governors will include a better section on the website, a governor profile in the newsletter and a communication to members. • Jean Rookes has met with Vicki Pring regarding the website; it envisage that pictures and a profile will be included on a separate governors web page	YB/JD JD
6	**Update by CEO/Dir of Ops/Dir of Finance** ***Strategy Update including wider operational and financial pressures affecting the West Midlands health economy and implications for the ROH*** • Phil Begg may come to a future meeting as the executive lead for the new five year strategic plan. • There is much discussion by all political parties about the NHS; and a common thread concerns increased pressures and demands, especially in A and E with a knock on effect for elective care.	

	• This has created opportunities for the ROH to support other providers with elective RTT pressures; the Trusts expects to able to resource this through additional shifts or agency work but if this becomes sustainable we will consider recruitment. There is a national shortage of theatre staff but we have been more successful in recruitment in recent weeks. We may still need to recruit from overseas for c6-7 vacancies. • Some areas – such as the paediatric ward have additional capacity • There is a great deal of financial pressure in the system; the national tariff has been suspended and commissioners are finding it difficult to plan • This creates a very uncertain planning environment for the ROH • This year Monitor are asking for a 1 year plan; we are being asked to focus on sustainability and resilience in this plan. There will be a high level submission on Feb 27. April 10 is the deadline for final submission. • We have to make assumptions in absence of clear commissioning guidance • Regarding the long term in the local unit of planning group 2030 modelling is being carried out. ***CQC Action Plan and proposed return visit*** • Regarding the compliance action for controlled drugs additional issues have been identified which are being addressed beyond the original CQC requirements ***Theatre refurbishment and related matters (JL)*** • Covered under matters arising ***Financial position – update (PA)*** • There has been a significant deterioration in the last quarter and we are c£300k behind plan. Much of the changes relates to agency staff expenditure: for Q1 this was £700k, for Q2 this was £1m and for Q3 this was £1.5m. The underlying reasons include the impact of safe staffing, junior doctor lack of availability and difficulties in filling vacancies; whilst a small element of these additional costs are related to additional activity performed in Q3, the main drivers for the staffing cost increase are the provision of compliant junior doctor rotas, increased acuity on the wards affecting safe staffing ratios and increased vacancies in theatres. • In Q4 there have been some exceptional costs associated with safety and compliance issues • Additional activity attracts funds to cover the additional costs • We are unlikely to be able to recover the position and it may	

	be difficult to break even this year • In the next financial year there are likely to be further pressures from commissioners. • We continue to have to get more and more efficient • This is similar to the position in most FTs	
7	**Patient and Carer's Council – Feedback and other updates** • The Chair explained that we are trialling new ways of working to determine whether it is necessary to run both the Forum and the Council Patient Experience Committee	
8	**Chairman's Items** ***Key areas of interest for Governors and opportunities to influence- progress update*** It was noted that there had been some technical issues with sending the emails linking Governors to groups they were interested in but this has now been done. An update would be provided at the next full meeting of the Council. ***Recruitment of a new NED with a clinical and improvement background – update*** The Chairman explained that the Nominations and Remuneration Committee of the Council had met in November and agreed a brief to Search Consultants. Gatenby Sanderson had been appointed following a competitive procurement process and were attending a meeting of the Nominations and Remuneration Committee of the Council to update on progress and discuss next steps. The new NED will have a clinical background and will be able to support TS. There has been considerable interest including some high quality applicants It was likely the Committee would be in a position to make a recommendation to the Council of Governors as a whole prior to the May meeting and it would therefore be desirable to convene an additional Council meeting to make the appointment which would be by a majority of the governors attending the relevant meeting. ***Fit and Proper Test (AC)*** The Chairman and AC explained that the process for the nomination of a non-executive director to the Council should ensure that any regulatory requirements or FT Code of Governance recommendations (such as the "Fit and Proper" test) are complied with. Anne Cholmondeley explained the Fit and Proper test this was intended to prevent those responsible for failure being appointed and	**JD/AN**

	described how the compliance with the test would be ensured: The process could cause an extension to the appointment timescales– in some cases by as much as six weeks. Recruitment consultants may be able to do some of the checking. The procedure was presented to the Council for approval There are two corrections: • On page 10/11 reference should be to " a panel to be convened by the Chairman" • On page 16/17 – it should say e.g. not i.e. **Resolved:** The Council of Governors with the above amendments hereby approves the Policy on the Fit and Proper Persons Test	
10	**NED attendance at Council meeting** The Chairman introduced Tim Pile, Chairman of the Transformation Committee, Vice Chairman of the Board and of the Council and Senior Independent Director Tim referred to his work making the following key points relating to the Transformation Committee : • The purpose of the Transformation Committee is to ensure the successful delivery of the ROH strategy • This will require disciplines such as project management budget oversight etc • Prioritisation will be key given all of the other pressures on the Trust • Measurement of milestones will be critical • Understanding interdependencies so things are done in the right order is essential • Communication is vital – especially around early success • So far there have been 1.5 meetings. The early focus is to get some additional people in place and processes and reporting right • A lot has been achieved as much was already work in progress but has been subsumed under the oversight of the Transformation Committee • A stocktake and review of all initiatives/ projects to prioritise them and eliminate unnecessary work is being undertaken • We are focusing on communications with help from Sally XB – the NHS Change day will be a focal point; this needs to be a two way process taking into account concerns of staff • Specific projects include ESR and digital dictation • Staff are making valuable suggestions which are being	

	considered • OD and culture change is one of the strands of activity • In the future there may be more focus on process reengineering to improve efficiency and exploration of new ways of working • Growth should offset reductions in resource associated with improved process thus underpinning job security for staff • Phil Begg may come to a future meeting of the Council as he is the executive lead • Council members wanted to be copied in on the relevant Board report	**JD/AN**
11	**<u>Any Other Business</u>** • Members requested a written version of the CEO's brief	**JC**
	Date and Time of Next Meeting Wednesday 6 May 2015 – 9am Note: there may need to be an additional meeting before then to appoint the new NED probably in the last week in March; this will also allow the Director of Finance to share the latest view of the 1 year plan with the Council.	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Council of Governors Meeting

Tuesday 24 March 2015 at 11.00 a.m.
In the Board Room

A G E N D A

1.	Apologies	
2.	Welcome and introductions and declarations of interest	
3.	Minutes of the meeting held on Wednesday 4th February 2015 and Matters arising	Enc. 1
4.	Action Log	Enc. 2
5.	Governor feedback and issues to raise with the Board (Standing Item)	
6.	Appointment of Non-Executive Director	
7.	Quality Account: governor selected indicator for 2014/15.	
8.	1 year operational plan (PA)	Presentation
9	Year End Progress Report including briefing on year end declarations	Enc. 3
10	Election for NHS Providers Governor Policy Board 2015	Enc. 4
11	Guidance to help governors represent the interests of NHS foundation trusts members and the public.	Enc. 5
12.	Any Other Business	
13	Date and Time of Next Meeting To be confirmed	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 April 2015 **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 The National Context

1.1 The performance of the NHS as a whole has been the subject of much scrutiny and commentary as 2014/15 comes to an end. Of particular concern is the deteriorating financial position with many organisations now forecasting a deficit, resulting in current estimates that the provider sector will overspend by more than £800m. There is some acknowledgement of competing pressures such as professional bodies setting out safer staffing requirements but the national tariff is driving increased productivity (same activity with less staff) through price reductions.

1.2 There are also significant challenges in performance, in particular access targets such as A & E and ambulance waiting times. Other access targets are also under pressure as demand continues to rise.

1.3 The 2015/16 tariff continues to give providers significant challenge and there remains a group of hospitals that are challenging the principle of the enhanced tariff. Providers are encouraged to sign up to contracts with realistic assumptions built in and robust commissioning plans. The marginal rate for specialised services continues to be a big concern for the most complex services provided by tertiary and specialist centres.

1.4 There are many competing pressures for resources such as reducing current deficits, increasing the national transformation fund, pump priming new schemes, recruiting extra staff (to reduce locum and agency costs) or investing in infrastructure.

1.5 Work is going on nationally to support the development of new models of care, following the Five Year Forward View (5YFV) and the Dalton Review. 29 vanguards have been selected to try new models within health systems and Greater Manchester has agreed to a whole system devolution of health and social care funding in partnership with the local authorities.

1.6 A number of reports have been published over the last period, which will be reviewed by management and any actions arising or recommendations will be brought back to a future meeting. Of particular note are:

- **Freedom to Speak Up** – an independent review into creating an open and honest reporting culture in the NHS.
- **Lessons Learnt** – Jimmy Savile investigations

- **Report of the Morecombe Bay investigation**

2 Strategic Development of Organisational Capability

The King's Fund report into medical leadership is expected to be received towards the end of April. This will enable us to have a better understanding of attitudes at the ROH towards medical leadership, barriers and enablers. It is our intention to use this diagnostic report to support and develop our leadership model with particular focus on medical staff. We are keen to develop a shared approach to leadership of the organisation with clinicians and managers working together to develop and lead the organisation going forward.

Natural turnover has provided some flexibility to re-shape the current directorate structure and management roles. The preparatory work is in the final stage of completion and discussions will commence more formally during April. A number of other senior vacant posts are in the recruitment process which will hopefully see a transition away from the use of interims to a stabilisation of the management team. There remain a number of budgetary pressures which are still being worked through and will form part of the Board's budget setting discussions.

3 Pre-election period 2015

Guidance has been published for public sector organisations to observe during the pre-election period. 30 March is the dissolution of Parliament and the start of the pre-election period. Guidance will be issued for 2015 on the Cabinet Office website and the Department of Health may also issue guidance to the NHS. As a key election subject area it is essential that NHS organisations avoid campaigning to influence voters. Some key principles are:

- No activity should be undertaken which could be considered politically controversial or influential.
- Providers must be able to demonstrate taking the same approach for every political party or candidate in order to avoid allegations of bias and ensure the ability to form a constructive relationship with whoever wins the seat.
- It is recommended that organisations have a plan in place for the risk of being singled out in the media, locally or nationally.

Normal business and regulation needs to continue during the pre-election period. Board meetings should continue as normal and ensure the agenda is confined to those matters that need a board decision or require board oversight. Matters of future strategy or the future deployment of resources may be construed as favouring one party over another and should be avoided.

4 Executive Management Team – February and March 2015

4.1 February 2015

- The governance arrangements were clarified and EMT is confirmed as an advisory group which enables full engagement with all leadership groups in support of directors of the board exercising their delegated responsibilities. EMT is not a sub-committee of the Board.
- The 2015/16 annual plan, tariff and budget setting principles were discussed.
- CQC action plan review was noted.

- EMT risks were reviewed.
- The digital dictation business case noted.
- Routine performance reports were reviewed:
  - Patient Quality
  - Safe Staffing
  - Corporate Performance Report
- The Quality Account timetable and content was noted
- The following policies were recommended and approved:
  - PALS and Complaints Policy (to be noted at next Clinical Governance Committee)
  - Clinical Coding Policy
  - Coroners Policy
  - Maternity, Paternity, Adoption and Shared Parental Leave Policy
  - Honorary Contract and Research Passport Policy
  - Network Security Policy
  - Patient Information Policy

4.2 March 2015

Due to my involvement in the interviews for a non-executive director, the meeting was chaired by Paul Athey, who will provide a verbal update of key points.

The following policies were recommended for approval by the CEO, which has been given since the meeting:

- Copying Correspondence for Patients Policy
- Records Management Policy
- IT Access Policy
- Overseas Visitors Policy
- Media Policy
-

5 Stakeholder and Partnership Engagement

Key stakeholder and partnership engagement activities over the period include:

- Chaired Academic Health Science Network Central Spoke meeting
- Attended the West Midlands Academic Health Science Network Board meeting
- West Midlands Provider Chief Executive Forum
- Smith Review on Improvement and Leadership Development Capability – participation in national roundtable discussion
- Professor Asif Ahmed and Dr Ahmed, Aston University
- NHS Providers Chairs and CEO Network meeting
- NHS Providers Annual Quality Conference
- Birmingham, Sandwell and Solihull Strategic Urgent Care Network
- Birmingham, Sandwell and Solihull Unit of Planning meeting
- Birmingham Safeguarding Children Board

In addition to usual on-site visits to clinical areas I have also visited our laboratory at the University of Birmingham/ Queen Elizabeth Hospital campus. Our laboratory undertakes specialist work and handles over 3,500 cases per year; we have unique expertise in processing and diagnosing preoperative biopsies as well as major surgical resections of such tumours. The laboratory is one of only two centres in the UK dealing with rare and complex bone tumours and has

developed a number of unique diagnostic tests which attract an increasing number of second opinion referrals.

On 12 March 2015 I was pleased to welcome examiners for the Hand Diploma Examination, a prestigious national award which is run by the British Society of the Hand (BSSH) in conjunction with Manchester University. It is a tertiary subspecialty qualification after FRCS Orth or FRCS Plast and is aimed at first Consultant appointment candidates in the specialty of Hand surgery.

Mr Mike Waldram, one of our senior hand surgeons and Clinical Director for small joints, is Chairman of examiners and has overseen growth in the programme since its inception in 2007 to a record 17 candidates this year. This was a great opportunity for the whole hospital to excel using a variety of facilities including our outpatient pods.

6 Business Updates

6.1 Regulation – Monitor

A routine monitoring teleconference was held with Monitor following the Q3 submission. Based on this and the analytical review Monitor have confirmed the following rating (Attachment 1) which will be published on Monitor's website:

- Continuity of Services risk rating - 4 (best rating)
- Governance risk rating - Green

6.2 Inspection - Care Quality Commission

Further to the inspection in June 2014 and publication of the Trust's report in October 2014, we are in discussion with the Care Quality Commission regarding the opportunity for re-inspection and this will be discussed with the Board. The action plan is on the agenda separately for review by the Board.

6.3 Staff Engagement Activities

April will see the start of over 20 staff engagement events that will run until the middle of June. These important events will be led by Executives and are designed to develop engagement in the Trust's strategic intentions and how all members of staff can contribute to our success. The sessions will include time for our values to be considered and for staff to understand more about the behaviours that support our values. Additionally, we will spend some time on our staff survey results and prioritisation of actions arising.

The initial sessions will be aimed at managers who will then be invited to help lead the remaining sessions so that we are developing our leading capability through the process.

7 Recommendation

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

Monitor
Making the health sector work for patients

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: enquiries@monitor.gov.uk
W: www.monitor.gov.uk

5 March 2015

Ms Jo Chambers
Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham
B31 2AP

Dear Jo

Q3 2014/15 monitoring of NHS foundation trusts

Our analysis of your Q3 submissions is now complete. Based on this work, the Trust's current ratings are:

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

These ratings will be published on Monitor's website later in March. The Trust has been assigned a Green governance risk rating.

A report on the FT sector aggregate performance from Q3 2014/15 is now available on our website[1] which I hope you will find of interest.

We have also issued a press release[2] setting out a summary of the key findings across the FT sector from the Q3 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 020 3747 0617 or by email (Rebecca.Farmer@Monitor.gov.uk).

Yours sincerely

Rebecca Farmer
Senior Regional Manager

[1] https://www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-3-201415
[2] https://www.gov.uk/government/news/nhs-foundation-trusts-tackle-rising-patient-demand

cc: Dame Yve Buckland DBE, Chair
Mr Paul Athey, Finance Director

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1st April 2015 **ENCLOSURE NUMBER: 4**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Andrew Pearson**
SUBJECT:	**Medical Director's Report**

SUMMARY

This report provides an update to Board members of key issues and activities involving the medical director 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

This report is intended to provide Board members with an overview of matters and issues that have occupied the time of the Medical Director

Issues resolved since last report

1. Exclusions

Both consultants who have been formally excluded have now either undergone their interviews or are in the process of being interviewed. The opinion of the GMC and NCAS was that one of the exclusions could be investigated and managed internally and that one required an external investigation, this is the one understandably taking longer to complete.

2. Near Patient Testing

A report has been received from the Head of Pathology Services, Mr Maurice Adkins. His report on Point of Care Testing (POCT) does not support expansion of what is presently performed (blood gas monitoring and blood sugar monitoring). He feels the controls and quality assurance processes necessary to ensure patient safety with expansion of POCT to blood haemoglobin level and INR are not in place and therefore to do so would be, in his opinion, unsafe at present.

Meetings attended

1. NHS Providers Clinical Leaders Network

An interesting day of presentations from NHS Providers on their *Strategic Policy Update* and NHS England on the *Five Year Forward View* in the morning and then in the afternoon a presentation from Prof. Sir Mike Richards on CQC visits and how they have evolved over the last year. Finally a presentation from Peter Lees, CEO and MD of the Faculty of Medical Leadership & Management on *Excellence in Clinical Leadership*

2. WM Academic Health Science Network - Adoption and Innovation

The purpose of the meeting was to discuss a Framework for implementation of complex clinical guidance and a Preventable Mortality initiative.

a) The Effective Practice study - designed to work with local NHS acute Trusts to apply an evidence-based framework for the implementation of complex NICE guidelines for chronic conditions.

b) Preventable mortality case-note review in the West Midland NHS Trusts, which aims to implement a credible, standardized, externally reviewed (unbiased) case

notes methodology, in order to establish a West Midland's Preventable Mortality Index, in order to give meaning to Hospital Standard Mortality Ratios.

3. WM Clinical Research Network Partners

An afternoon hearing about the likely division of funding allocation across the partner hospitals and the LCRN Annual Plan.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 April 2015 **ENCLOSURE NUMBER:5**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Interim Company Secretary/ Dame Yve Buckland Chairman**
SUBJECT:	**Board work plan 2015/2016**

This paper proposes a work plan for 2015 / 2016 for the Board.

IMPLICATIONS

The attached work plan is intended to provide the Board with a basis for planning 2015/2016 having regard to recent decisions and external recommendations from the Good Governance Institute that the BAF should " drive the Board cycle"

RECOMMENDATIONS

The Board is asked to:

1. Approve the attached Board work plan as detailed in Appendix 1

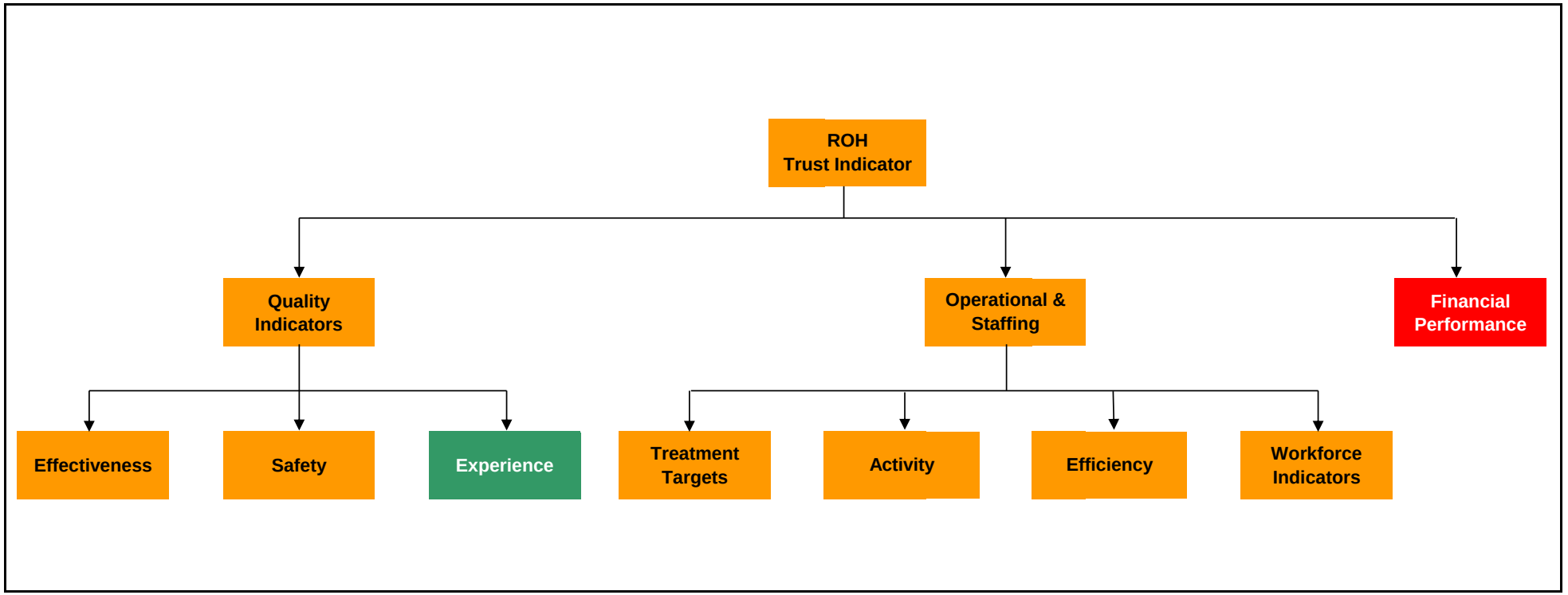
Board Work Plan 2015/2016 (Draft March 16 2015) v2

	All Full length Public Boards	April Public Board	May Public Board	May 26 Special Board (telecon) after AC	June Work shop	July Public Board	Sept Public Board	Oct Board work shop	Nov Public Board	Dec Public Board	Jan Work shop	Feb Public Board	March Work shop
Strategic Risks workshop								√					
Monitor quarterly declaration			√				√		√			√	
Monitor annual declaration			√	√									
Patient story	√												
Audit Committee Report	√												
Clinical Governance report	√												
Charitable Funds Committee report	√												
Remuneration Committee Report	√												
Transformation Committee Report	√												

	All Full length Public Boards	April Public Board	May Public Board	May 26 Special Board (telecon) after AC	June Work shop	July Public Board	Sept Public Board	Oct Board work shop	Nov Public Board	Dec Public Board	Jan Work shop	Feb Public Board	March Work shop
Strategic Plan update	√												
1 year Operational Plan		√											
Annual report and accounts Draft/Final			√	√									
Budget sign off Draft/Final		√											
CPR	√												
Patient quality report	√												
Staff survey												√	
Patient survey			√										
BAF (now quarterly)			√				√		√			√	
Safe Staffing	√												
CQC Action Plan		√	√			√							
Quarterly workforce													
Equality and diversity												√	

	All Full length Public Boards	**April Public Board**	**May Public Board**	**May 26 Special Board (telecon) after AC**	**June Work shop**	**July Public Board**	**Sept Public Board**	**Oct Board work shop**	**Nov Public Board**	**Dec Public Board**	**Jan Work shop**	**Feb Public Board**	**March Work shop**
Children's safeguarding annual report												√	
Adult safeguarding annual report												√	
Infection prevention annual report												√	
Audit Committee Annual Report						√							
Revalidation Annual Report						√							
Policy on policies		√							√				

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending February 2015



Quarterly Detailed Report
Executive Summary as at February 2015

Headlines

- Despite an over-performance on activity, the 18 week backlog has increased in month, and this has largely been driven by an increase in the admitted backlog, which has become red rated.
- All 3 RTT targets were met in month
- For the year to date the Trust made a deficit before impairments of £285k compared to a planned surplus of £208k.

Monitor Compliance Framework Targets	February 2015 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	95.11%	95.34%	0	6
Referral to treatment time - Admitted %	90%	91.61%	91.89%	0	6
Referral to treatment time - Incomplete Pathways %	92%	93.94%	94.11%	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
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		February 2015 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	5		3
	Complaints	<=12	6		4
	CQUINS	100%	90%	-	11
	Total Unexpected Hospital Deaths	0	1		5
Efficiency & Workforce	Total Backlog Patients	<400	433		6
	Incomplete 14 - 18 Week Waiters	<450	540		6
	Total Admitted Patient Care Patients vs Plan	100%	104.2%		7
	Unused Theatre Sessions	<44	24		8
	Sickness	3.7%	4.8%		9
Financial	Surplus	£335k	(£285k)		10
	CIP	£1,680k	£1,284k		10
	Agency Expenditure	£91k	£284k		11
	Locum Doctor Expenditure	£46k	£153k		11

Trust Summary

The backlog has increased in month, and this has largely been driven by an increase in the admitted backlog, which has become red rated.

All 3 RTT targets were met in month.

For the year to date the Trust made a deficit before impairments of £285k compared to a planned surplus of £208k.

Both elective and day case performance was above plan, with non-elective behind plan.

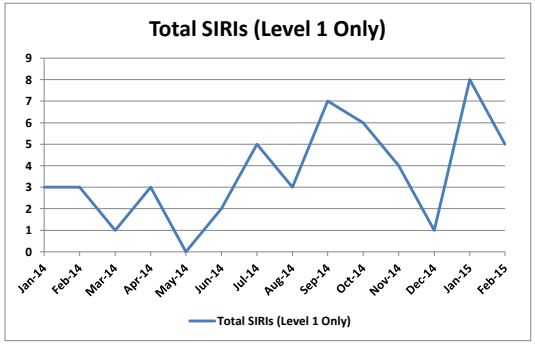
Sickness absence has improved in line with seasonal trends (the range has been 4.7-5.3% in the last 5 years in February) but is still higher than target. Long term absence has decreased since January, partly as a result of better housekeeping in ESR manger self-service.

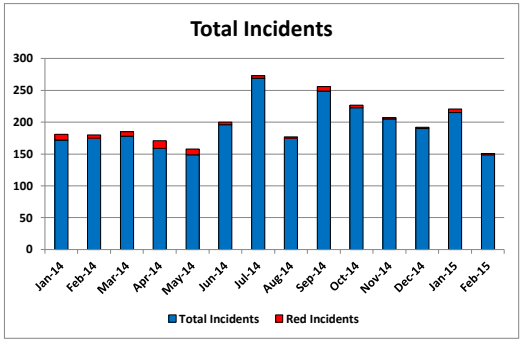
Quarterly Detailed Report
Safety Indicators as at February 2015

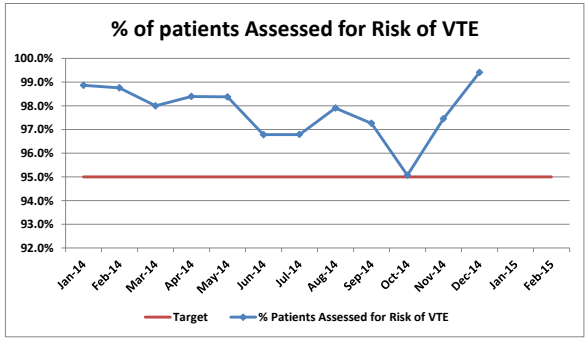
Headlines

- Patient falls have increased and have returned to red rating from green last month.
- The percentage of harm free care has improved for the second month.
- The level of SIRIs this month remains high, although it has improved on prior month.

	Monitor	National	CQC Standard		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	14/15 Full Year Position
Safety		N	4,16	Never Events	0	0	0	0	0	0	0	0	0	0	0	1	1	0	2
			4,16	Total SIRIs (Level 1 Only)	3	3	1	3	0	2	5	3	7	6	4	1	8	5	4
			4,16	SIRI per 1000 bed days	0.90	0.85	0.27	0.89	0.00	0.56	1.30	0.86	1.90	1.58	1.07	0.31	2.35	1.42	1.11
			4,16	Total Incidents	172	175	178	159	149	196	269	175	249	223	205	190	215	149	198
			4,16	Incidents per 1000 bed days	51.71	49.30	47.94	47.04	41.98	54.87	69.74	50.23	67.52	58.73	54.71	59.69	63.05	42.26	55.44
			4,16	Red Incidents	9	5	7	12	9	4	4	2	7	4	2	2	6	2	5
			9,16	Total Medicine Incidents Reported	11	18	18	19	17	12	22	17	12	16	16	20	15	18	17
			9,16	Medicine Incidents Reported per 1000 bed days	3.31	5.07	4.85	5.62	4.79	3.36	5.70	4.88	3.25	4.21	4.27	6.28	4.40	5.10	4.72
				Medicine Incidents with Harm	1	3	3	3	2	4	7	6	4	0	5	5	2	2	4
		N	1	Mixed Sex Occurrences	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			9	% Patients Assessed for Risk of VTE	98.87%	98.76%	98.00%	98.40%	98.38%	96.78%	96.80%	97.91%	97.27%	95.07%	97.46%	99.41%	98.51%		97.56%
			9	Incidence of Hospital Related VTE	1	1	1	1	0	1	2	2	3	2	1	1	5	1	19
			4	Patient Falls - Inpatients	3	6	12	6	7	5	6	5	13	12	7	5	3	4	7
			4	Patient Falls per 1000 bed days	0.90	1.69	3.23	1.78	1.97	1.40	1.56	1.44	3.52	3.16	1.87	1.57	0.88	1.13	1.84
				Avoidable Patient Falls with Harm				0	0		2	2	2	0	0	0	0	1	1
			4,16	% Harm Free Care	97.41%	100.00%	97.71%	89.90%	99.02%	96.91%	95.88%	98.25%	98.04%	97.96%	94.50%	91.95%	97.89%	98.94%	96.34%







Safety Commentary

VTE Risk Assessment - Reported one month in arrears

There were 5 SIRIs this month, an improvement on last month, but still red rated.

The percentage of harm free care improved for the second month and remains green.

Total incidents have reduced from 215 to 149, a red rating.

Medicine incidents have increased, and remain red rated.

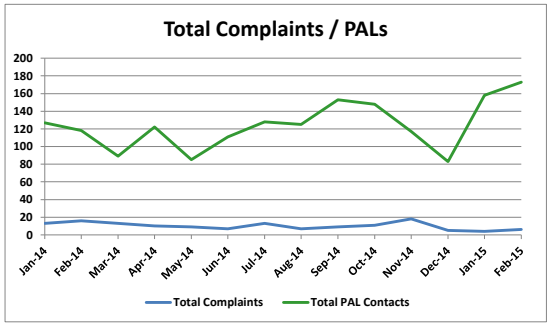
Patient falls have increased and have become red rated again.

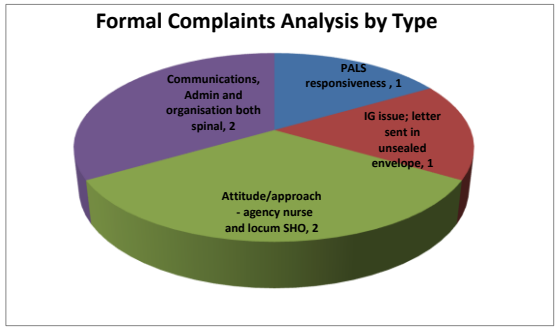
Quarterly Detailed Report
Experience Indicators as at February 2015

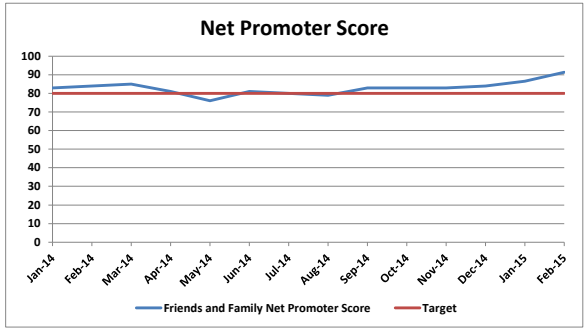
Headlines

- Complaints are up from 4 to 6, but this remains a green rating.
- PALs contacts increased from 158 to 173, with the percentage of concerns increasing from 50% to 55%.
- Total compliments increased from 433 to 449.

	Monitor	National	CQC Standard		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	14/15 Full Year Position
Experience			17	Complaints to Compliments Ratio	1:37	1:27	1:42	1:46	1:48	1:60	1:31	1:73	1:31	1:42	1:29	1:107	1:108	1:75	**1:50**
			17	Total Complaints	13	16	13	10	9	7	13	7	9	11	18	5	4	6	**9**
			17	Complaints reverted to informal <48 hrs	0	0	0	0	0	0	0	0	1	1	0	0	0	0	**0.2**
			17	Formal	13	16	13	10	9	7	13	7	8	10	18	5	4	6	**9**
			17	Complaints per 1000 bed days	3.91	4.51	3.50	2.96	2.54	1.96	3.37	2.01	2.44	2.90	4.80	1.57	1.17	1.70	**0.23**
				Complaints Response Time (Average No of Days)	45	53	25		46	59	41	24		109	67	69	24	27	51.78
			17	Total PAL Contacts	127	118	89	122	85	111	128	125	153	148	117	83	158	173	**128**
			17	PALS Contacts per 1000 bed days	38.18	33.24	23.97	36.09	23.95	31.08	33.19	35.88	41.49	38.98	31.22	26.08	46.33	49.06	**35.76**
				Total PALS Concerns	65	65	56	80	59	49	88	73	84	68	67	52	79	96	72
			17	Total Compliments	481	439	552	455	436	423	409	511	276	465	522	534	433	449	**447**
			17	Compliments per 1000 bed days	144.62	123.66	148.67	134.62	122.85	118.42	106.04	146.67	74.84	122.47	139.31	167.77	126.98	127.33	**126.12**
				Food - Real Time Patient Survey	95.0%	93.0%	98.2%	97.2%	90.6%	97.7%	94.2%	95.0%	95.5%	98.3%	96.8%	96.5%	96.4%	98.8%	**96.1%**
			17	Friends and Family Net Promoter Score	83	84	85	81	76	81	80	79	83	83	83	84	87	91	**83**
				Friends and Family Response Rate	40.0%	43.0%	46.0%	53.0%	39.0%	40.0%	53.0%	52.0%	46.5%	51.7%	58.0%	50.3%	61.0%	59.6%	**51.3%**







PALS
PALs contacts increased from 158 to 173, with the percentage of concerns increasing from 50% to 55%.

COMPLAINTS
Complaints are up from 4 to 6, but this remains a green rating.

COMPLIMENTS
Total compliments increased from 433 to 449.

Quarterly Detailed Report
Effectiveness Indicators as at February 2015

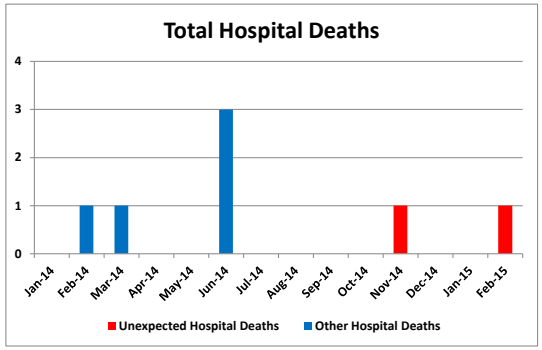
Headlines

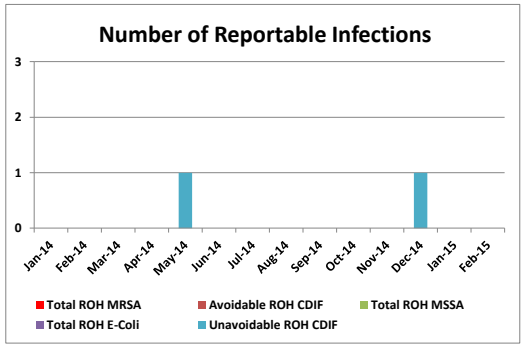
There was 1 unexpected death in month.

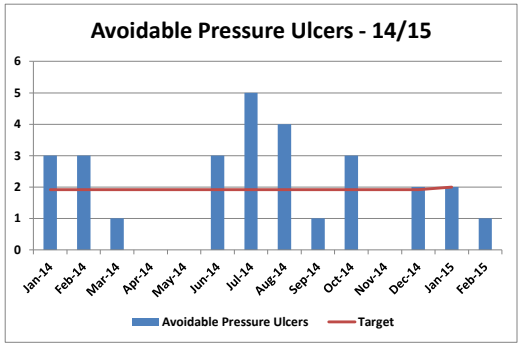
There were no cases of *C. diff* in month.

There were no grade 3/4 pressure ulcers and grade 1/2 dropped from 2 to 1.

	Monitor	National	CQC Standard		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	14/15 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	1	1	0	0	3	0	0	0	0	1	0	0	1	0.5
			4,18	Hospital Deaths per 1000 bed days	0.00	0.28	0.27	0.00	0.00	0.84	0.00	0.00	0.00	0.00	0.27	0.00	0.00	0.39	0.14
			4,18	Unexpected Hospital Deaths	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0.2
				Other Hospital Deaths	0	1	1	0	0	3	0	0	0	0	0	0	0	0	3
			8	MRSA % Screened	135.40%	102.00%	109.00%	115.00%	118.00%	126.00%	122.20%	107.00%	103.00%	124.90%	125.30%	1.11%	118.40%	121.80%	118%
	M	N	8	Total ROH MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
				Avoidable ROH CDIF					0	0	0	0	0	0	0	0	0	0	0
				Unavoidable ROH CDIF					1	0	0	0	0	0	0	1	0	0	2
			8	Total ROH MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			8	Total ROH E-Coli	0	0	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	1	0	0	0	0	0	1
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	0	0	0	0	0	0	1	0	0	2	0	0	0	0	3
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	3	3	1	0	0	3	4	4	1	1	0	2	2	1	18
			4	Avoidable Pressure Ulcers per 1000 bed days	0.90	0.85	0.27	0.00	0.00	0.84	1.30	1.15	0.27	0.79	0.00	0.63	0.59	0.39	0.54
				% Completion of WHO Checklist	100.00%	100.00%	100.00%	98.69%	96.88%	97.88%	96.23%	97.69%	95.92%	97.96%	98.23%	97.81%	98.90%	98.90%	97.74%







Effectiveness Commentary

There was 1 unexpected death in month, which is discussed in further detail in the Quality Report.

Most of the other indicators are green in month.

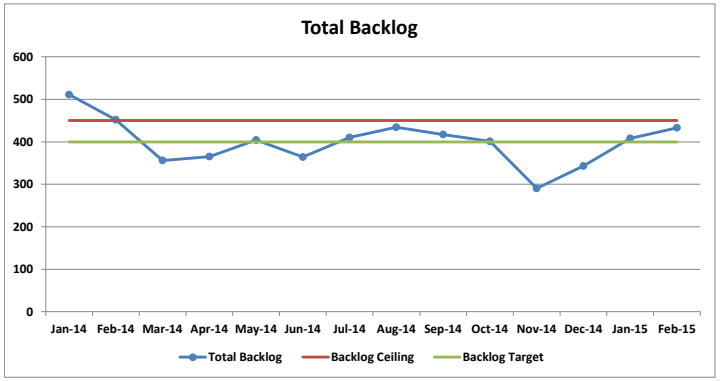
Further information on effectiveness is included in the Quality Report.

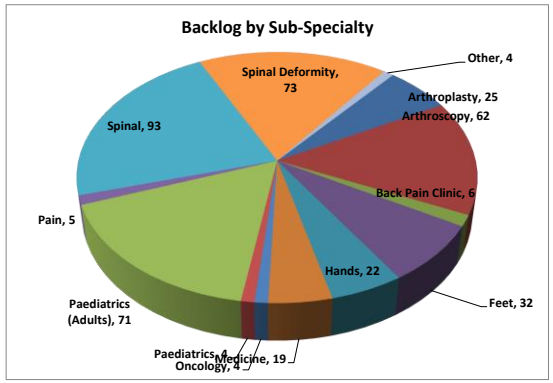
Quarterly Detailed Report
Treatment Targets as at February 2015

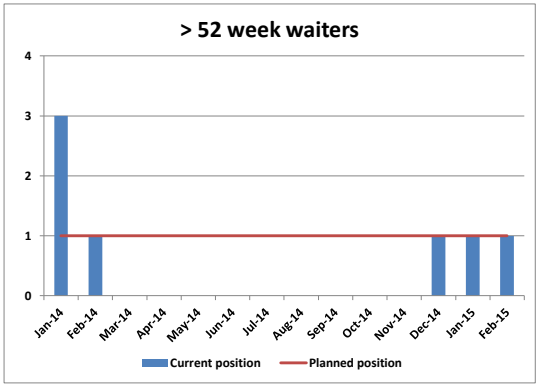
Headlines

- The backlog has increased in month, and this has largely been driven by an increase in the admitted backlog, which has become red rated.
- All 3 RTT targets were met in month.
- There were 2 28 day breaches, both being outside of the Trust's control.

	Monitor	National	CQC Standard		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	14/15 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	3	1	0	0	0	0	0					1	1	1	1
				Referral to treatment waits over 45 weeks	6	5	7	5	4	5	4	4	8	11	6	12	13	11	11
	M	N	4	Referral to treatment time - Non Admitted %	95.13%	95.00%	95.01%	95.32%	95.48%	95.15%	95.75%	95.24%	95.05%	92.68%	92.65%	95.52%	95.58%	95.11%	94.78%
	M	N	4	Referral to treatment time - Admitted %	83.65%	88.76%	88.37%	91.12%	92.51%	91.74%	93.21%	91.57%	91.96%	91.63%	86.32%	93.05%	92.17%	91.61%	91.44%
	M	N	4	Referral to treatment time - Incomplete Pathways %	92.71%	93.21%	94.63%	94.75%	94.43%	95.10%	94.52%	94.09%	94.26%	94.67%	95.96%	95.20%	94.27%	93.94%	94.72%
			4	Non admitted Backlog - Pathways waiting >18 wks	260	199	152	156	211	174	173	168	168	137	110	119	149	153	153
			4	Admitted Backlog - Pathways waiting >18 wks	251	253	204	209	193	190	237	266	249	264	180	224	259	280	280
			4	Total Backlog - 18 week pathways waiting >18 wks	511	452	356	365	404	364	410	434	417	401	290	343	408	433	433
			4	Incomplete 14 -18 Week Waiters	721	520	475	379	574	547	536	471	594	531	438	520	581	540	540
				Non Admitted Median Wait (Weeks)	8.54	8.53	7.91	7.80	8.46	8.90	8.39	8.46	9.00	8.92	8.10	8.45	9.21	9.07	8.61
				Admitted Median Wait (Weeks)	11.23	10.67	9.95	9.20	9.29	9.49	9.54	9.69	10.64	10.06	10.79	10.61	11.12	11.59	10.18
				Incomplete Median Wait (Weeks)	7.10	6.02	5.62	5.90	6.65	5.71	5.81	6.24	6.30	5.63	5.44	6.40	6.66	5.53	6.02
	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%	94.90%	100.00%	100%*	99.71%
	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%	100.00%	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%	94.10%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	99.19%
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	81.80%	100.00%	100.00%	100.00%	100.00%	90.90%	93.10%	85.70%	90.90%	83.30%	100.00%	83.30%	100.00%	100%*	90.67%
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	98.90%	99.82%	99.57%	99.15%	99.58%	99.15%	99.09%	99.58%	99.06%	99.33%	99.25%	99.79%	99.49%	99.87%	99.38%
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	0	0	0	0	0	0	0	1	0	0	0	2	1
			1,21	Data Quality on Ethnic Group - Inpatients	96.19%	96.16%	96%	95.58%	95.50%	96.00%	95.75%	97.23%	96.74%	95.67%	94.11%	94.24%	97.56%	93.01%	95.55%







Treatment Targets Commentary

There were two 28 day breaches, both being outside of the Trust's control. One related to the sickness of a consultant on the day of surgery, and the patient then chose to move the day of their operation as a result. The second was a combined procedure between one of our consultants and a vascular consultant from UHB. The vascular consultant was called away to perform an emergency procedure, and as a result the operation had to be cancelled and has been rescheduled.

Quarterly Detailed Report
Activity Targets as at February 2015

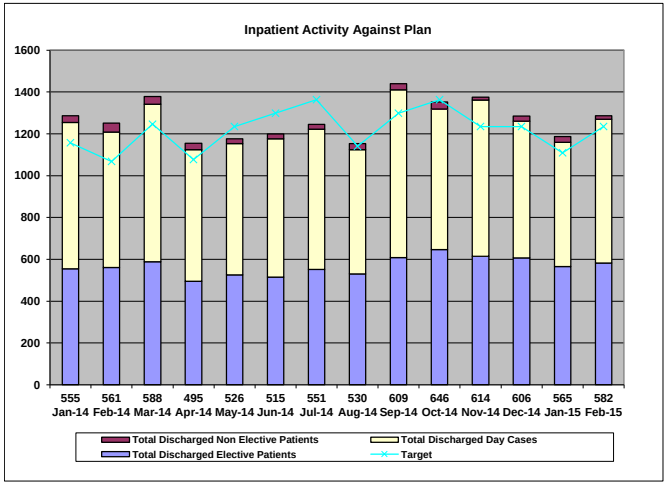
Headlines

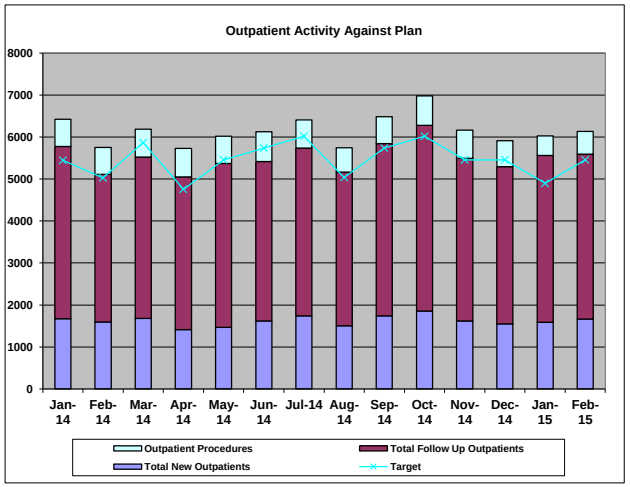
Day Case and elective activity were above plan this month.

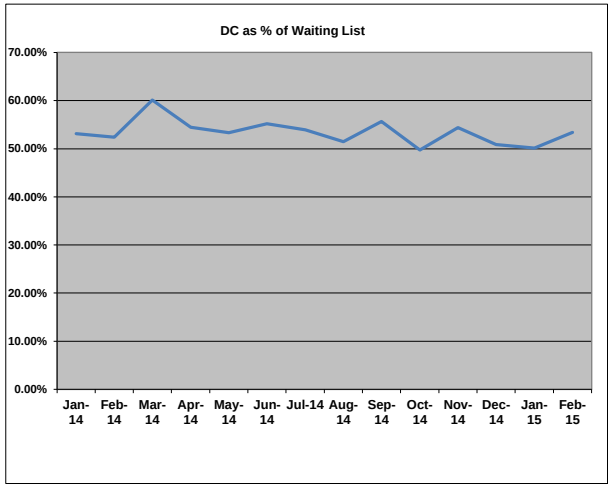
Outpatient activity remains strong, although outpatient proecures remain red rated

Non elective activity was significantly below plan.

	TargetID	Data Lead	Monitor	National	CQC Standard		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	14/15 Full Year Position
Activity	381	HI			4	Total Discharged Elective Patients	555	561	588	495	526	515	551	530	609	646	614	606	565	582	6239
	382	HI			4	Total Discharged Non Elective Patients	32	43	38	31	23	22	23	30	30	34	14	25	27	18	277
	383	HI			4	Total Discharged Day Cases	700	647	753	629	628	662	672	594	801	673	748	654	595	687	7343
	384	HI			4	Total New Outpatients	1672	1593	1682	1415	1467	1618	1742	1506	1740	1857	1617	1552	1591	1667	17772
	385	HI			4	Total Follow Up Outpatients	4101	3519	3840	3636	3902	3802	3993	3656	4107	4424	3876	3739	3968	3923	43026
	386	HI			4	Outpatient Procedures	652	643	663	675	646	707	671	585	634	697	671	621	471	543	6921
	460	HI				DC as a % of WL	53.15%	52.39%	60.10%	54.46%	53.36%	55.21%	53.93%	51.47%	55.63%	49.74%	54.36%	50.89%	50.13%	53.38%	52.98%
		HI			4	Elective as % Against Plan	94.2%	103.1%	92.6%	98.4%	91.2%	84.8%	86.5%	99.4%	100.3%	101.4%	106.4%	105.0%	109.1%	100.9%	98.3%
		HI			4	Non Elective as % Against Plan	85.5%	124.5%	94.3%	110.7%	71.9%	64.7%	63.9%	100.0%	88.2%	94.4%	43.8%	78.1%	93.1%	56.3%	78.0%
		HI			4	Day Cases as % Against Plan	132.0%	132.2%	131.9%	115.2%	100.3%	100.6%	97.4%	102.8%	121.7%	97.5%	119.5%	104.5%	105.9%	109.7%	106.6%
		HI			4	% New Outpatients Against Plan	121.1%	125.0%	113.1%	107.9%	97.5%	102.3%	105.0%	108.4%	110.0%	111.9%	107.4%	103.1%	117.8%	110.8%	107.4%
		HI			4	% Follow Up Outpatients Against Plan	119.7%	111.3%	104.1%	124.8%	116.8%	108.2%	108.4%	118.5%	116.9%	120.1%	116.0%	111.9%	132.3%	117.4%	117.1%
		HI			4	% Outpatient Procedures Against Plan	102.0%	109.0%	96.3%	127.0%	106.0%	110.3%	99.9%	104.0%	99.0%	103.7%	110.1%	101.9%	86.1%	89.1%	103.2%







Activity Commentary

Quarterly Detailed Report
Efficiency Indicators as at February 2015

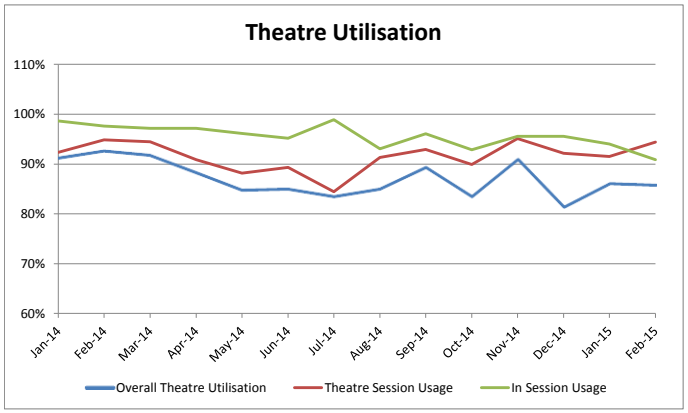
Headlines

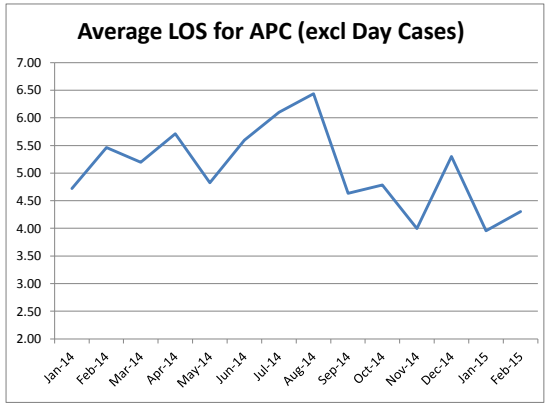
The theatre metrics have been largely positive this month.

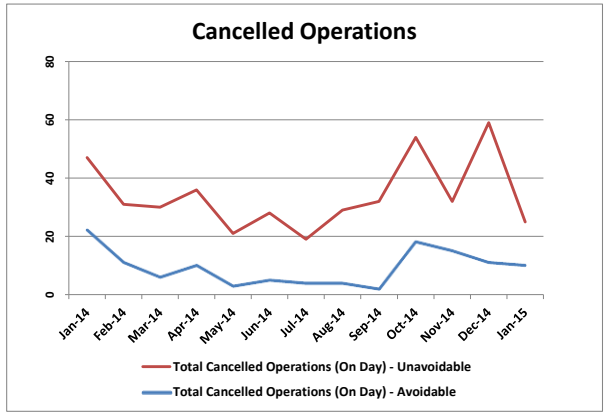
Cancellations data was not available at the time the report was finalised

AVLOS has declined and has become amber rated.

	Monitor	National	CQC Standard		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	14/15 Full Year Position
Efficiency			4	Overall Theatre Utilisation	91.13%	92.59%	91.74%	88.30%	84.76%	84.98%	83.48%	84.97%	89.30%	83.47%	90.91%	81.38%	86.08%	85.77%	**85.76%**
			4	Theatre Session Usage	92.37%	94.88%	94.44%	90.88%	88.17%	89.30%	84.42%	91.29%	92.94%	89.88%	95.12%	92.14%	91.54%	94.41%	**90.92%**
			4	In Session Usage	98.66%	97.59%	97.14%	97.16%	96.14%	95.16%	98.88%	93.07%	96.09%	92.87%	95.58%	95.58%	94.04%	90.85%	**95.04%**
			4	Unused Theatre Sessions	36	21	25	33	51	46	74	33	32	50	21	21	38	24	**38**
			4	Number of Cases per Theatre Session	2.83	3.10	3.11	3.31	2.98	2.98	2.97	3.15	3.27	2.88	3.20	2.97	2.72	2.99	**3.03**
			4	Total Cancelled Operations (On Day or Day Before)	78	71	58	67	53	61	54	56	39	54	74	88	53	60	**60**
			4	Total Cancelled Operations (On Day) - Avoidable	22	11	6	10	3	5	4	4	2	18	15	11	10	10	**8**
			4	Total Cancelled Operations (On Day) - Unavoidable	25	20	24	26	18	23	15	25	30	36	17	48	15	23	**25**
			4	Total Cancelled Operations by Hospital (On Day)	9	3	5	5	8	6	8	8	11	15	11	7	3	3	**8**
			4	% Cancelled Operations by Hospital	0.73%	0.25%	0.38%	0.46%	0.71%	0.52%	0.67%	0.73%	0.80%	1.17%	0.84%	0.58%	0.27%	0.25%	**0.06%**
			4	Total T&O Review-To-New Ratio (including Spinal)	2.58	2.44	2.50	2.76	2.78	2.49	2.43	2.54	2.41	2.48	2.38	2.43	2.67	2.41	**2.53**
			4	Pain Review-To-New Ratio	3.72	3.85	3.64	4.74	4.26	4.07	2.63	4.33	3.55	3.34	2.85	3.69	2.71	2.69	**3.53**
			4	Outpatient DNAs	9.59%	8.18%	8.65%	8.42%	8.40%	8.48%	8.78%	9.21%	8.13%	8.23%	8.13%	9.21%	8.41%	7.93%	**8.49%**
			4	Bed Occupancy - Adults	83.60%	88.61%	80.72%	80.32%	81.21%	86.15%	86.40%	80.63%	84.25%	83.17%	79.45%	69.20%	76.02%	79.93%	**80.54%**
			4	Bed Occupancy - Paediatrics	63.80%	65.87%	82.80%	69.26%	50.87%	54.44%	89.96%	88.17%	50.00%	44.44%	60.74%	55.36%	55.36%	65.08%	**62.14%**
			4	Bed Occupancy - HDU	87.45%	86.89%	91.40%	69.88%	75.10%	77.05%	69.85%	63.64%	73.39%	68.15%	70.46%	55.70%	67.42%	68.22%	**69.10%**
			4	Bed Occupancy - Private Patients	80.28%	68.88%	78.80%	65.52%	81.57%	83.25%	84.33%	76.04%	82.86%	80.65%	84.33%	83.67%	84.29%	83.33%	**80.74%**
			4	Admissions on the Day of Surgery	421	415	445	358	383	396	392	393	477	503	478	464	421	438	**4703**
			4	AVLOS for APC (excl day cases)	4.72	5.47	5.20	5.71	4.83	5.60	6.10	6.43	4.64	4.79	4.00	5.30	3.96	4.31	**5.06**







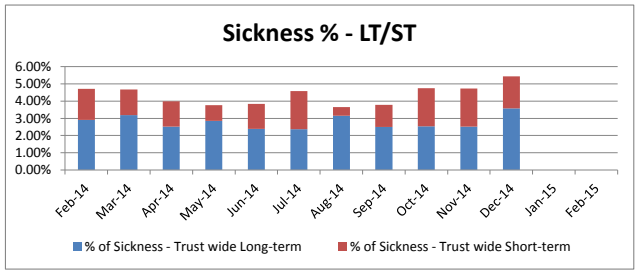
Efficiency Commentary

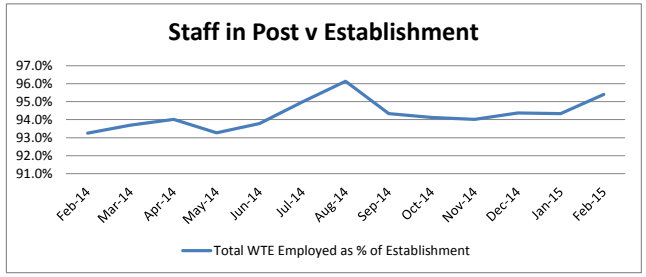
Monthly Report
Workforce Indicators as at January 15

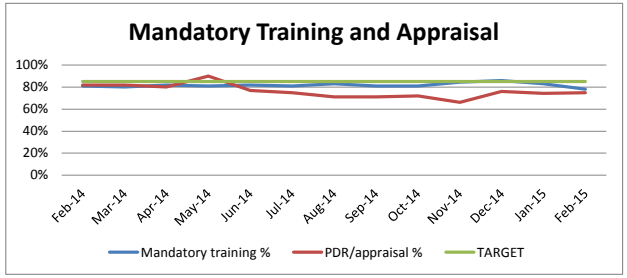
Headlines

- Mandatory training has dropped down to 78%, and become red rated.
- Vacancy position still green
- Sickness absence still above Trust target

	Monitor	Contract	CQC Standard		Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	14/15 Full Year Position
Workforce				Total WTE Employed as % of Establishment	93.3%	93.7%	94.0%	93.3%	93.8%	95.0%	96.1%	94.3%	94.1%	94.0%	94.4%	94.3%	95.4%	94.4%
				Staff Turnover (%) - Unadjusted	11.8%	11.3%	11.6%	11.3%	11.9%	12.7%	12.8%	10.8%	11.4%	11.8%	10.6%	10.3%	10.6%	11.4%
				Staff Turnover (%) - Adjusted	7.4%	7.1%	7.7%	7.7%	9.5%	8.4%	8.4%	7.1%	8.9%	9.5%	9.3%	9.0%	8.9%	8.6%
				% of Sickness - Trust wide	4.7%	4.7%	4.0%	3.8%	3.8%	4.6%	3.7%	3.8%	4.8%	4.7%	5.4%	5.5%	4.8%	4.4%
				% Staff received mandatory training last 12 months	81%	80%	82%	81%	82%	81%	83%	81%	81%	84%	86%	83%	78%	82%
				% Staff received formal PDR/appraisal last 12 months	82%	82%	80%	90%	77%	75%	71%	71%	72%	66%	76%	74%	75%	75%







Workforce Commentary

Sickness absence has improved in line with seasonal trends (the range has been 4.7-5.3% in the last 5 years in February) but is still higher than target. Long term absence has decreased since January, partly as a result of better housekeeping in ESR manger self-service.

The vacancy position taken from the ledger shows a position of less than 5%. This indicator has now been green for some 18 months.

The turnover figure remained green for the month and the adjusted ("true leavers") figure was boradly consistent with the previous 5 months at around 9.%. This is not currently a concern.

The mandatory training position has decreased to 78%, and has therefore become red rated.

The appraisal position remains a cause for concern at 75% (although it is holding steady) and will be discussed with directorates in their respective performance reviews.

Monthly Report

Finance Dashboard as at 28th February 15

	Surplus £	Cash £	Capital spend £
Plan	208k	15,517k	6,289k
Actual	(285k)	15,850k	3,468k
Forecast for next month (YTD)	(200k)	14,844k	4,474k

	Year to date		
	Actual	Plan	Risk Rating
Capital Servicing Capacity	2.2	2.3	3
Liquidity Ratio	56.8	47.5	4
Overall Continuity of services ratio			4

The capital balance is behind plan largely due to the delay in spend for EPMA and data warehouse, and due to the phasing of spend across the year.

A capital reforecast was submitted to Monitor at the end of Q3 to confirm that the spend is likely to fall into 2015/16.

Cash is higher than plan as a result of capital spend being lower than expected (offset by debtors being higher than expected).

Although the Trust's Capital Servicing Capacity is a 3, the Trust's liquidity rating results in an overall COSRR of 4.

The pay expenditure is significantly higher than Monitor plan, with the gap increasing.

Theatres agency use and Junior Doctors continue to drive the majority of this figure, although spinal and large joints also have large overspends.

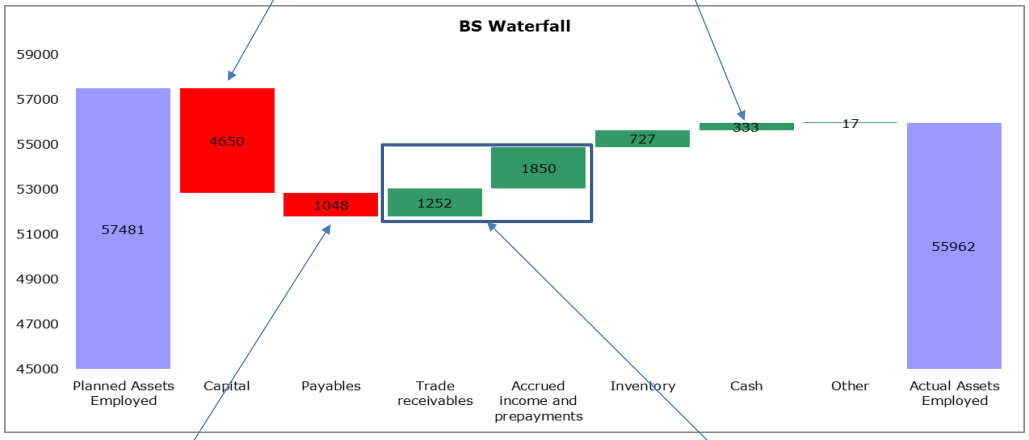
When reviewed against prior month, locum payments have increased slightly, agency spend continues to be significantly higher than planned, with spend in month of £284k (a reduction in prior month's spend of £324k).

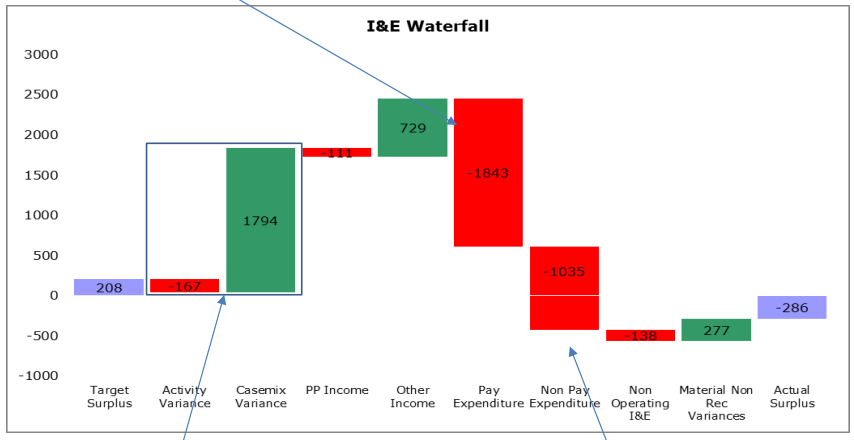
The predicted impact of impairments in the year was calculated for the Monitor plan, and spread throughout the year.

The planned and actual results include the first 3 quarter's elements of the expected impairment (£641k).

The underlying plan was therefore a surplus of £208k, compared to an actual deficit of £285k.

	Plan	Actual
Surplus/(deficit) before imp.	208k	(285k)
Impairments	(641k)	(641k)
Surplus/(deficit) after imp.	(433k)	(926k)





Creditors are higher than plan as a result of expenditure being much higher than expected as explained in the I&E waterfall.

Agency invoices are a particular challenge as it is usual to receive an invoice for every timesheet submission, rather than once a month or for the period of the engagement. These invoices are then required to be sent around the organisation for approval by the relevant manager before payment.

Debtors and accrued income are higher than plan as a result of a number of different factors;

- £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.
- Differences in timing of the expected payment of debtors in comparison to plan.
- Higher than expected overperformance accruals due to the additional activity performed over the past few months.

The Trust overperformed against the elective and day case activity plans for January, narrowing the negative activity variance.

Overall case mix continues to be richer than expected, and as a result income is above plan.

There has been a significant 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 have been costs incurred in relation to medicines management which have been included in this month's position.

Monthly Report

CIP Dashboard as at 28th February 15

Plan for YTD	£1679k
Actual for YTD	£1284k
Difference	-£395k

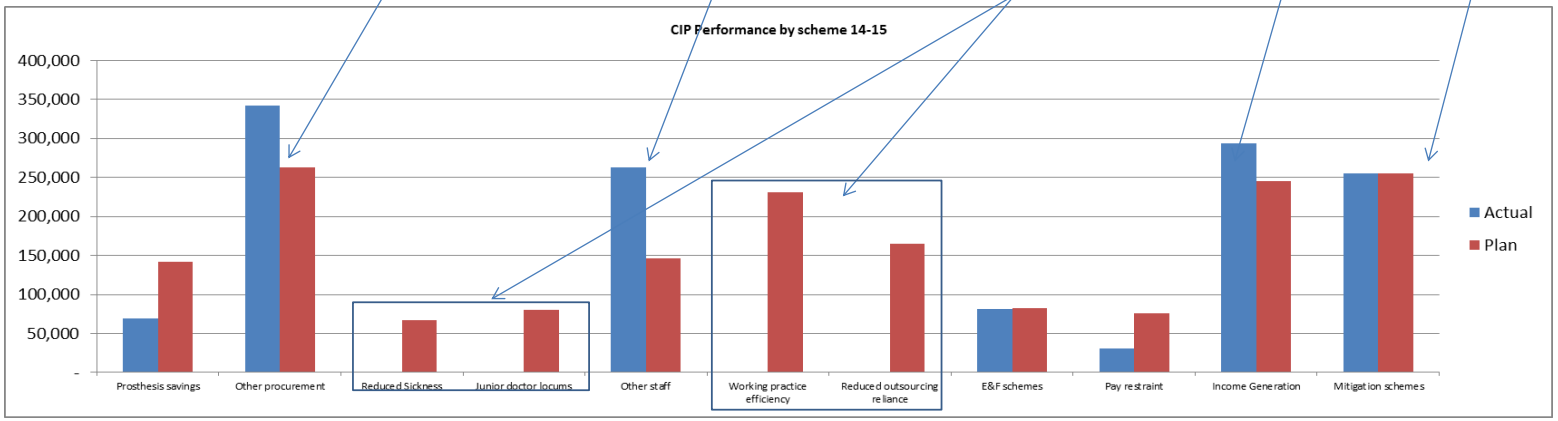
Negotiation of better rates on SLAs accounts for the majority of this performance, with £58k relating to agreeing a lower PACs service contract, and £47k relating to the Orthotics contract. In addition there are theatres savings for power tools of £48k.

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.

Increased use of locums and agency, in addition to outsourcing work to Cromwell have meant that it is not possible to recognise CIP savings in these schemes. However, this underperformance has been partly offset by some overperformance on other schemes.

A significant proportion of this area is from paediatrics physio and botulinum clinics, in addition to the increase in car parking and catering charges in the Trust.

The CIP recognised relates to improvements in cancellations, and pay restraint savings.

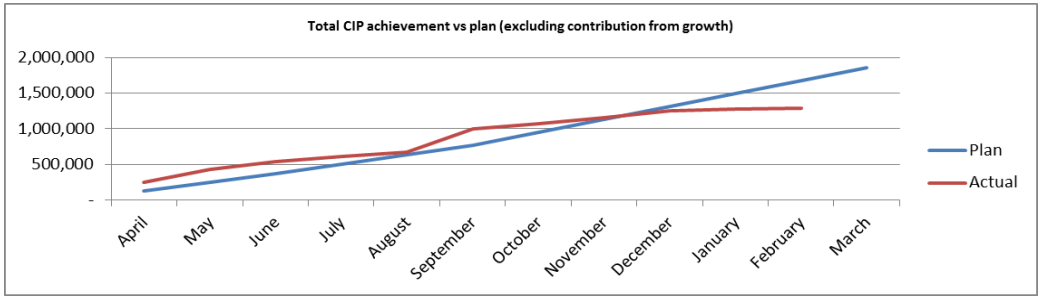


Overall performance against plan has continued below plan for the third month.

The strongest performance to date has been in 'other procurement', 'income generation', 'other staff' and the 'mitigation schemes'.

As part of the Annual Planning process, plans for 2015-16 CIPs have been reviewed. These will need to be further refined, added to and owned by the relevant directorates.

The Director of Finance and Director of Operations have continued to meet with individual directorates to review budgets on a line by line basis to challenge the possibility of further savings in 2015-16.

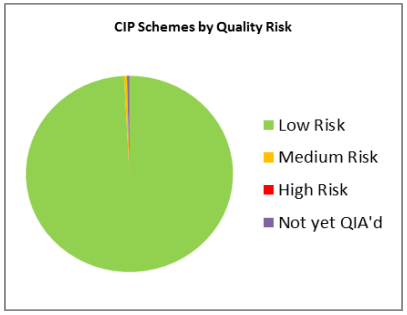


Overall performance by category

	£'000
Completed recurrent	665
Completed non-recurrent	364
Completed mitigation scheme	255
Planning/Implementation	221
Scheme Ideas	67
Mitigating Schemes	79
Unidentified	368
Total CIP target	**2019**

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.

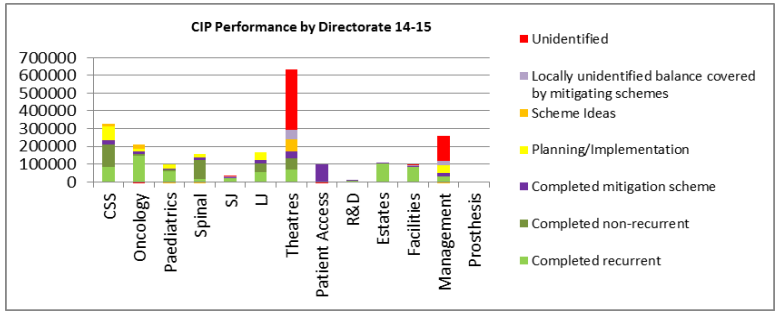
It is important to note that the income targets for the year to date have been met, despite activity targets being missed, and so the income CIP target for the year to date has been recognised.



99% of schemes have been QIA assessed.

The Directorates with outstanding schemes which have yet to be QIA'd are Oncology and R&D.

QIAs will begin shortly for the 2015-16 schemes identified.



CSS continues to have the strongest performance to date in terms of completed schemes, although a significant proportion is non-recurrent performance. Oncology has the highest recurrent achieved balance.

Theatres continue to have the largest unidentified balance.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board : 1 April 2015 **ENCLOSURE NUMBER: 7**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	Garry Marsh Director of Nursing and Governance
NAME OF AUTHOR:	Lisa Pim, Deputy Director of Nursing and Governance Alison Braham, Governance Manager
SUBJECT:	Patient Quality Report

SUMMARY

This paper provides an update on patient quality, safety and experience activity during February 2015 and sets out the 2014/15 national, 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 EMT in bringing together key quality issues for debate, assurance and information.

Key areas of note this month:-

- There has been a 31% decrease in incident reporting this month in comparison to January figures. Areas of particularily low reporting include: Paediatric ward, Wards 7, Ward 10, High Dependency Unit (HDU) and Pre-Op Assessment Clinic (POAC). The Governance Department will be liaising with leads for these areas to discuss reasons for low reporting and what can be done to improve this.

- 100% compliance was achieved in the completion of falls risk assessments and high risk care planning across in-patient areas.

- Patient death referred to the Coroners Court, also being investigated as a Serious Incident. Further detail will be included within the patient quality report when the incident investigation has been completed.

- 1 avoidable Grade 2 Pressure Ulcer occurred this month on Ward 1. The avoidable status was concluded following an RCA in which gaps in documentation were identified.

- Uptake of flu vaccinations for staff is 39.7% against a 75% target. The paper outlines the Trusts performance against other Trusts regionally.

- The 90% PROMs target compliance rate for completed questionnaires for knee replacement surgery was not achieved (88%). Work is being undertaken to fully understand why there has been a decrease in compliance including how the consent forms are filed and made available for Consultant/Theatre Team review.

RECOMMENDATIONS

Trust Board are asked to:

- note and discuss the Patient Quality Report
- 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 – February 2015

REPORTING REQUIREMENT: National Incident Reporting Requirement & Quality KPI Contractual Requirement

There were 5 Serious Incidents reported during February 2015. Appendix 1 outlines details of all ongoing Serious Incident investigations.

1.2 All other incidents requiring an investigation

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

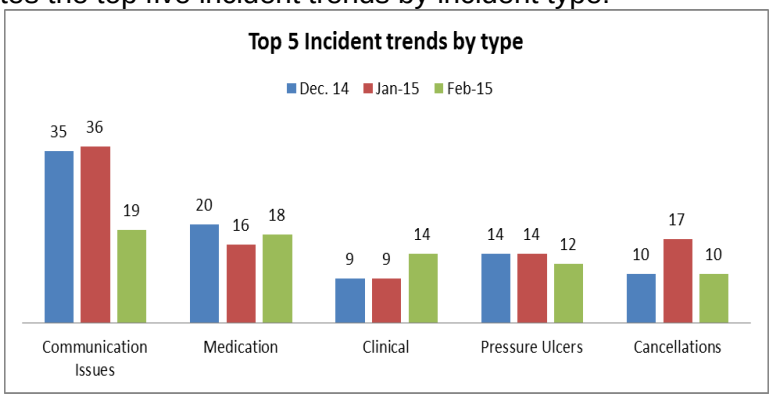
A total of 149 incidents were reported during February, compared to 215 incidents reported during January. This represents a 31% decrease in incident reporting when compared to the previous month. This continues to be monitored and the importance of incident reporting remains a priority for the Trust.

There has been a 31% decrease in incident reporting this month in comparison to January figures. Low incident reporting also correlates with early feedback from the latest Trust-wide Patient Safety Culture Survey where 27% of respondents stated they had not reported an incident in the last 12 months.

Areas of particularily low reporting are: Paediatric ward, Wards 7, Ward 10, High Dependency Unit (HDU) and Pre-Op Assessment Clinic (POAC). The Governance Department will be liaising with leads for these areas to discuss reasons for low reporting and what can be done to improve this.

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:



'Clinical' and 'Pressure Ulcer' incidents replaced 'Access, Admission, Transfer and Discharge'' and 'Staffing' in the Top 5 Incident categories reported in February.

Incidents categorised as 'Clinical' include instances of deterioration in clinical condition, inadequate nursing or medical care, failure to act on test results and radiation safety.

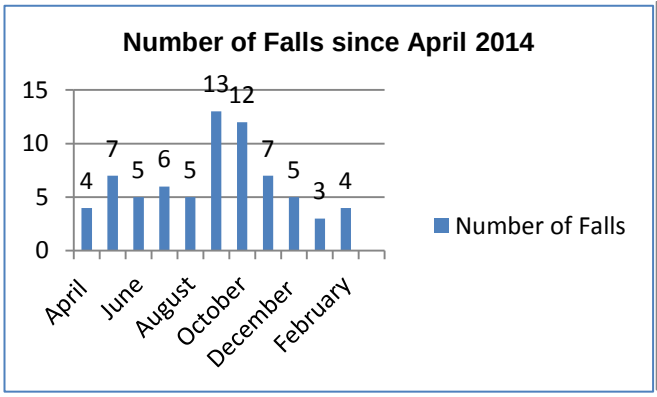
1.3 Deaths

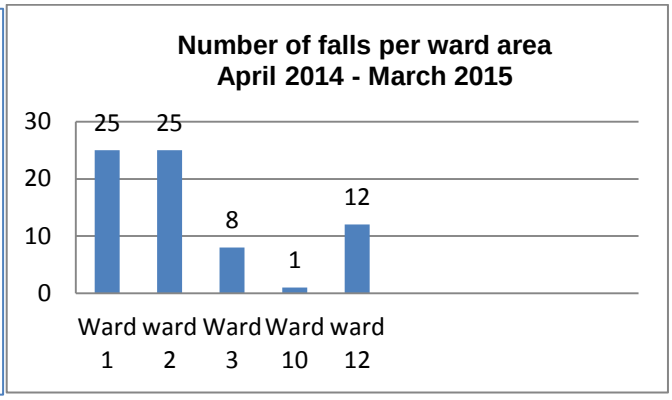
In February 2015 there was one patient death reported of a spinal patient who came into the Trust from another hospital on the 5th February 2015. The patient received treatment here before their condition deteriorated and the patient then died on the 8th February 2015. This case has been referred to the Coroners and this is being investigated as a Serious Incident.

1.4 Falls

REPORTING REQUIREMENT: National Incident Reporting Requirement & Quality KPI Contractual Requirement

There have been 4 (adult) inpatient falls for the month of February 2015





- All 4 falls were unwitnessed by staff.
- Three falls occurred during working hours and 1 fall occurred overnight.
- Two falls were deemed unavoidable, 1 fall was avoidable and the remaining fall incident is currently undergoing investigation.

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 4 falls reported during February, 3 resulted in either no harm or minor physical harm.

The 4th patient fall incident was occurred within the patient identified in the section above. This patient subsequently died and all contributory factors will be outlined in the RCA investigation.

Falls Risk Assessments & Care Planning - Quality indicator requirements

Qu1.	Has the falls assessment been completed within 6 hours of admission? Yes/No N/A	February 2015	100%
Qu2.	If the patient is identified as high risk is a care plan in place? Yes/ N/A	February 2015	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

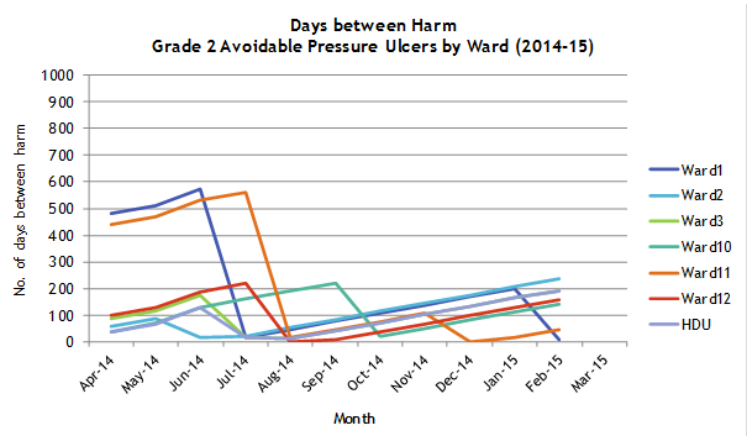
1.5.1 Infection Prevention and Control

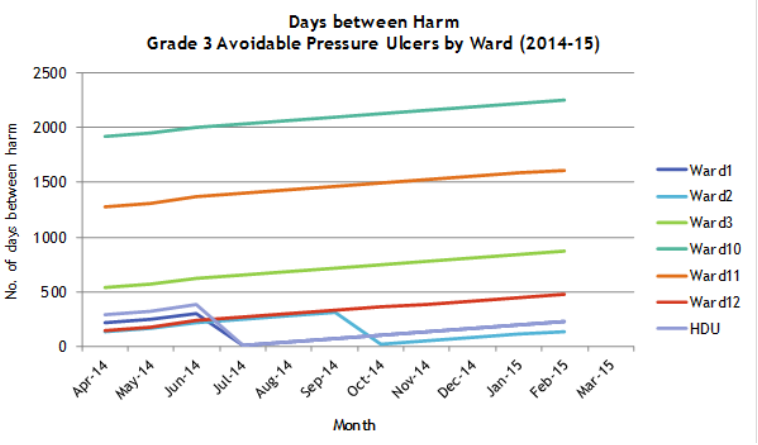
There have been no MRSA or MSSA bacteraemias this month, and there are zero cases of *Clostridium Difficile* to report.

1.5.2 CQUIN Scheme: Safety Thermometer

The safety thermometer is a snapshot audit and because the figures at ROH are so small the Trust was asked to monitor continuously and report the days between harm. Therefore an upward trend is what the viewer is looking to see.

The contractual target for avoidable grade 2 pressure ulcers is no more than 20 by year end; there have currently been 17 avoidable grade 2 pressure ulcers at ROH since April 2014. Approximately 80% of these were potentially unavoidable had the documentation been accurately completed. A business case has been submitted to obtain funding for a pressure care booklet than reduces the amount of time nursing staff spend recording all that is necessary to prove that appropriate precautions and care were put in place. This booklet is well liked by the nursing staff and completion rates are much improved – it therefore reduces the risk of unavoidable pressure ulcers being classified as avoidable.





Hygiene code compliance:
The Hygiene Code sets out the standards expected for Infection Control and Cleanliness and are the standards the Care Quality Commission (CQC) measures all Trusts by, these standards are required by law to be maintained. At present a draft of the updated Health Act 2008 (Regulated Activities) Regulation 2014 is out for public consultation. This updated version makes some significant changes that may apply to the Trust if they are agreed, in brief these include:

- A much greater emphasis on cleanliness, with language changing from 'Infection Prevention and Control' to 'Infection Prevention and Cleanliness'.
- Specific requirements around antimicrobial prescribing and the reporting of resistance information and 'Drug-bug' combinations and a multidisciplinary antimicrobial stewardship committee being in place.
- Some specific changes in the expectations of Trust information provision to visitors and patients.

In light of the new 2014 regulations IPC are undertaking a full review of the Trust's position with regards to compliance. There are some areas which require specific input and the theatre environment continues to remain a concern. One of the principal issues is the inconsistent reporting to IPC of audit information undertaken at a departmental level. A joint approach to audit involving Facilities / Estates, Matrons, IPC and Ward Managers will be implemented from April 2015 in order to strengthen assurance both internally and externally.

1.5.3 Tissue Viability

There were 4 pressure ulcers (grade 2) during February, 1 was deemed avoidable and the other 3 unavoidable. Each case is investigated and the status (avoidable or unavoidable) is determined following the route cause analysis.

The avoidable case occurred on ward 1 and was investigated, there were gaps in the documentation which meant that there was no evidence that appropriate care was in place at the correct time. The other 3 cases were also investigated and documentation is all cases was complete. All appropriate interventions were in place and these cases are therefore deemed unavoidable. A year-end report will offer full analysis

of all pressure ulcers that have occurred at ROH and their avoidable or unavoidable classification, this will form part of the IPC Annual report.

The tables below show the number of pressure ulcers by ward. Please note that there are incidences where there are apportioned cases across more than one clinical area and so these are highlighted in yellow. Theatres are not specifically identified in these tables but are included in the overall data. The figures below are not to be used for total incidence reporting as these are provided elsewhere separately. The tables 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		Nov'14		Dec'14		Jan'14		Feb'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	A S	U S	A S	U S	A S	U S	A S	U S
Ward1							1	1													1	1
Ward2					3		1			2		1										1
Ward3		1					2	1	1													
Ward10												2		1								
Ward11									1							1	1		1			1
Ward12								1	1		1					1		1				
HDU								2		1	2		1									

Table 2: Grade 3 Hospital Acquired Pressure Ulcers by Ward

Grade 3	Apr'14		May'14		Jun'14		Jul'14		Aug'14		Sep'14		Oct'14		Nov'14		Dec'14		Jan'14		Feb'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	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									1						

Key:

Avoidable

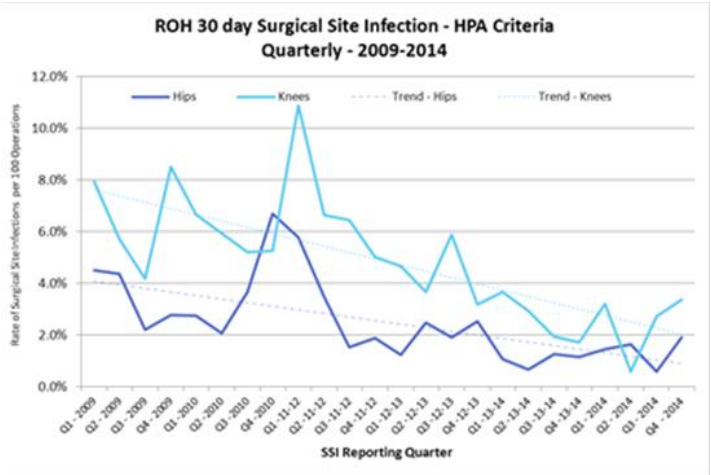
Unavoidable

Shared

1.5.4 Surgical Site Infection

In February 2 spinal patients were readmitted with infection, and are currently receiving treatment. SSI rates are closely monitored within arthroplasty with all patients being kept under surveillance for 1 year post operatively. All readmissions for infection, no matter which specialty are also investigated and closely monitored.

The graph below details the SSI rates at 30 days post op for all arthroplasty patients:



1.5.5 Bone Infection Unit

Activity within the unit remains fairly static with 52 patients under the care of the team, 8 of whom are inpatients.

1.5.6 Flu vaccination

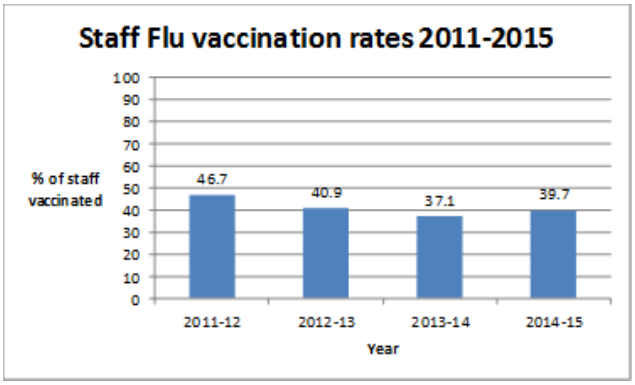
The flu vaccinations have been undertaken by Occupational Health this year, supported by HR and IPC. Uptake is 39.7% of frontline staff at the end of this year's programme. The national target was to vaccinate 75% of all frontline staff. There are also a significant number of staff who have been vaccinated elsewhere and we are awaiting clarification as to how these are reported as this will increase the uptake if we can include them as part of the Trust's data.

The detail of those vaccinated at ROHFT is in the table below (it is reported cumulatively):

	Total	Oct	Nov	Dec	% uptake
Doctors	108	17	20	22	20.30%
Qualified Nurses	226	63	75	79	34.90%
Professionally Qualified - clinical	242	34	57	61	25.20%
Support to clinical staff	181	115	136	139	76.70%
Overall uptake end December 2014 = 39.7%					

There have been no cases of flu in patients this month.

National press has recently been reporting that the efficacy of this year's vaccine is very low (around 3% in some reports). This will clearly have an impact next year as well as now; and makes reaching the vaccination targets even harder. The graph below details the level of success we have seen over the past 4 years:



When compared with other Trusts we fall short of the expected uptake rates:

Trust	2013/14	2014/15	⇧/⇩	Comments
BCH	86.2	89.2	⇧	Top Trust
HEFT	37.9	75.6	⇧	Most improved Trust
BWH	56	38.6	⇩	
B'Ham Community	39.8	37.6	⇩	
Sandwell & West Bham	77	81.2	⇧	
QEHB	35.2	50.2	⇧	
Walsall	69.8	70.8	⇧	
Wolverhampton	71.2	82.8	⇧	
Dudley Grp Hospitals	45	39.1	⇩	
Warwick	51.4	49.4	⇩	
ROH	37.1	39.8	⇧	
RJAH	52.1	55.7	⇧	
RNOH	32.4	30.4	⇩	

1.5.7 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 in October 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.

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 for February 2015

Adult Safeguarding Training

- Adults Level 1 (Basic Awareness) – 93%
- Mental Capacity (MCA)- 87.68%
- Deprivation of Liberty Safeguards (DoLs) – 89.11%
- Level 2 – Enhanced (External provider) – 90.29%
- Level 3/4 – For Leads = 100%

Concerns possible alerts reported to team -5
Incidents reported - 0
Deprivation of Liberties application submitted – 0
Mental Capacity Assessments-0

Key learning:
Clear written documentation and agreed actions, to protect patient and staff in patient handovers. To ensure alerts are shared with all professionals as required with regard to potential concerns. Community patient incident demonstrated information as required not appropriately shared, table top discussion to be held early March to review case and share learning and actions required.

Children Safeguarding Training

- Children's Level 1 (Basic Awareness) – 93%
- Level 2- Enhanced Child Protection – 86.32%
- Level 3/4 – For Lead and Named Nurse/Doctor – 100%

Concerns reported and possible alerts to team: 8 plus one follow- up call.

Key learning:
Working together in partnership with all professionals /agencies is essential to ensure good planning for family, child and vulnerable adult. Ensuring follow up on cases undertaken to update on progress also to record patient/users feedback.

Section 47 (safeguarding referral)	0
Section 18 (children in need)	1 prior to admission
Section 20 (looked after children-voluntary with parental consent)	2
Common Assessment Framework	0
Concerns Reported	8
Section 31looked after children (care proceedings court)	0
Telephone	3 +Video call
Email	2
Incident form	o
Face-face	2

1.7 Patient Safety Alerts
REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement

A total of 8 Patient Safety alerts were closed during February 2015, 5 of which required no further action by the Trust.

Alert(s) open beyond deadline

Reference	Alert title	Issue Date	Status	Deadline
NHS/PSA/D/2014/006	* Improving medical device incident reporting and learning	20-Mar-14	Action Required: Ongoing 11.3.15 - The Medical Director is producing Terms of Reference for a Device Advisory Group. Advice is also being sought from Robert Jones & Agnes Hunt NHS Hospital Trust in terms of how they have implemented the requirements of this alert. It is advised that this alert is likely to remain open until May whilst an appropriate committee and monitoring structure is implemented and embedded.	19-Sep-14

1.8 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 compliance figure for February was 98.90% compliance against a revised and agreed target of 98%. This indicates we have met the agreed and revised target as part of the remedial action plan with Commissioners.

1.9 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). Raising awareness of blood safety in general across the organisation remains a focus to maintain the improvements seen this year.

There was 100% traceability for February, with no traceability incidents reported for 11 months to date.

1.10 CQUIN Schemes

REPORTING REQUIREMENT: National and Local CQUIN Requirement

All evidence for for Quarter 3 has been submitted – we have received confirmation that we have achieved all CQUIN milestones for this financial year with the exception of Dementia where we have failed to meet the agreed contractual targets which will result in a quarterly loss of CQUIN payment.

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 173 up from 158 last month, an increase of 15 or 9%.

Of the 173 contacts, the split between general enquiries and concerns was 96 (55%) concerns and 77 (45%) enquiries which is 5% difference to the split of last month which was even 50/50.

Greatest area of concern continue to be:

- what's happening with care and treatment plans; lack of info/clarity; chasing update and progress; no follow up booked post-surgery etc.
- poor administrative systems
- appointments changed and not always informed
- Consultant wording of letter caused more concern; request to change surgeons
- Orthotics issues
- injection waiting times

Highest volumes of general enquiries were:

- Work Experience and clinical placement requests
- Copy medical records
- PP enquiries
- Parking enquiries
- How to contact colleagues enquiries

2.1.2 Complaints

Number of complaints received this month is 6, up from 4 last month
Areas of concern:

- PALS responsiveness
- IG issue; letter sent in unsealed envelope
- Attitude/approach - agency nurse x 1 and locum SHO x 1
- Communications, Admin and organisation x 2 both spinal

% of complaints resolved within timeline was 100% (3/3) against KPI of 80% . Average length of time to close complaints in February was 27 days, up from 24 in January was 24 days.

2.1.3 Compliments

Number of compliments received this month is 449 up by 16 or 4% on 433 last month.

2.1.4 Friends and Family Test

The Friends and Family Test for February is 91.5 with a 59.6% return rate which meets the CQUIN requirements for the month. The detractor rate for the month is 1.1% which remains low. The Q4 CQUIN asks that we maintain an average response rate of 40% across the quarter and as January and February average is 60%, we are well placed to meet this.

2.1.5 Child Patient Experience

The January FFT Score for Ward 11 (under 16) is 86, which is below the Trust average . As previously indicated, this scoring system is significantly affected by smaller numbers and the likely response being counted as passive. There was only 1 detractor in the sample of 24 patients and 4 people stating likely.

The Fabio Surveys conducted for Under 13's in February show that in the main, patients were very happy with the care and treatment provided. Controlling Pain and Communication scores were high and the scores for food have greatly improved (75% saying they can get food they like, 25% saying the can get food they like most of the time)

The Fabio Surveys for Over 13's include the Teenage Cancer Trust feedback questions. Patients over 13 showed greatest concern about family accommodation and whether other people can hear if they are having treatment. Controlling Pain and Communication Scores were also high.

2.2 Litigation

REPORTING REQUIREMENT: ROH NHSFT Good Practice

New Cases

Four new potential clinical negligence cases were received in February 2015.

Ref	Description	Directorate
T482	failure to treat scaphoid fracture - patient referred to QE - joint claim against 4 Trusts	Small joints
T481	patient had a fall while inpatient	Large joints
T480	patient reviewed by surgeon, consented for surgery - surgery didn't seem to take place	Small joints
T479	management of post op infection	Large joints

Closed Cases

The following ongoing claims were closed in February 2015:

Ref	Date of notification	Details	Settlement	Directorate
T368	Nov 2012	Failure to catheterise pre/post op (discectomy)	liability admitted damages c.£76k claimant's costs: £65k defence £12k	Spinal & Large joints
T315	Nov 2011	Paediatric diathermy burn	liability admitted damages £14k claimant's costs £21.5k defence costs £675	Theatres

The following cases were closed in February 2015 – these did not proceed beyond disclosure of the patient's notes to solicitors

Ref	Date of notification	Details	Directorate
T311	Nov 2011	hip replacement - patient post op advice leaflet	large joints
T289	Feb 2011	spinal procedure resulting in further 3 procedures	spinal
T353	July 2012	loss of sensation and foot drop	large joints
T395	March 2013	potential product liability	large joints

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 February.

3. EFFECTIVENESS OF CARE

3.1 National Joint Registry (NJR) Update

REPORTING REQUIREMENT: National Requirement & ROH NHSFT Good Practice

Monthly NJR Compliance:

	Jan 15	Feb-15
% Compliance	92%	94%

Current 2015 overall compliance: 93% average, against the target of 90%.

Monthly NJR Consent Compliance:

	Jan-15	Feb-15
% NJR Consent compliance	81%	89%

Current 2014 Consent compliance: 85% average, against the advised target of 95% (and Best Practice Tariff target of 75%).

Action: The NJR process is being scrutinised by the Knowledge Management Team with a view to ensuring a higher overall compliance and consent compliance figure.

3.2 Patient Reported Outcome Measures (PROMs)

REPORTING REQUIREMENT: National Requirement & ROH NHSFT Good Practice

PROMS compliance stats for Feb 2015

	Indicator	December 2014
4A N13ii	PROMs: Hip replacement - % patients completing questionnaires.	90%
4A N13iv	PROMs: Knee Replacement- % patients completing questionnaires.	88%

Breakdown – Feb 2015

No patients meeting PROMS criteria	No patients refusing to complete	Q's completed	% eligible patients completing Q's
193	0	172	89.1%

PROMs compliance is a contractual requirement and the target compliance rate is 90% for both hip and knee replacement surgery.

3.3 Safety Thermometer
REPORTING REQUIREMENT: National Reporting Requirement

2014-15		Feb -15
Pressure Ulcers	All	0%
	New	0%
Falls with harm		1.06%
CAUTI		0%
New VTE		0%
Total Harm Free		98.94%

3.4 Matron KPI
REPORTING REQUIREMENT: ROH NHSFT Good Practice

Please also see Appendix 5 for overview of Ward KPI's.

Matron feedback

WARD 3
February 2015 - Matron JR Feedback- Overall Amber - but increased result from January with 3 Green, 2 Amber and 1 Red.
Workforce: PDRs 100%- and Sickness has decreased to less than 1%- well done.
Training: Noted we have x2 new starters so training dipped whilst they complete their competencies.
Patient Experience: FFT results are excellent. No formal complaints received.
Safety: 1 patient fall- no harm and deemed unavoidable. No red or amber incidents reported.
Efficiency: Staffing Budget over but running on safe staffing levels so this cannot be avoided- supported by Directorate and Acuity Tool concurs to staffing booked to utilised (which is over base-line budget).

OPD
Feb: Overall Amber
Workforce: PDRs 92% and Sickness 2.9%
Training: All green except E-learning modules x2 = 80% (1 person to complete)
Patient Experience: All good indicators but failure to submit patient story/observation of care brought KPI down (sickness issue as detailed below).
Safety: excellent results in all safety aspects but due to sickness (and only 5 trained nurses in whole establishment) where no one could safety be released there were non- attendance at 2 meetings bringing the Green rating down to Amber.
Efficiency: Amber- due to cost on non-pay for essential post CQC equipment and staffing to fulfil OPD requirements (business case submitted).

HDU
Workforce- increase in sickness. 1 member of staff off following bereavement
Safety- sharp decrease in incident reporting. Monitor this closely.
Training- PDN has plan in place to increase compliance with achievement of competencies

Efficiency- remain in the red but decrease in bank and agency spend is encouraging to see
Outcomes- some missing IPC audits. PDN to discuss link nurse as to reasons why.
Plan- monitor and encourage incident reporting. Ensure IPC audits completed.

OUTREACH
Feb 2015- No concerns raised re. KPIs.

ADCU
Workforce-sickness down to 8%, great to see. All staff on phased return or operational. I memebr to return next week.
VTE and insulin-numbers increasing, well done.
1 complaint but increased number of compliments.
1 missed CD check still checked in the 24 hour period. I am aware of this.

LARGE JOINTS – Wards 10, 12 and 2
All areas within the directorate are indicating sustained improvement and progress. No areas of concern noted this weekend.

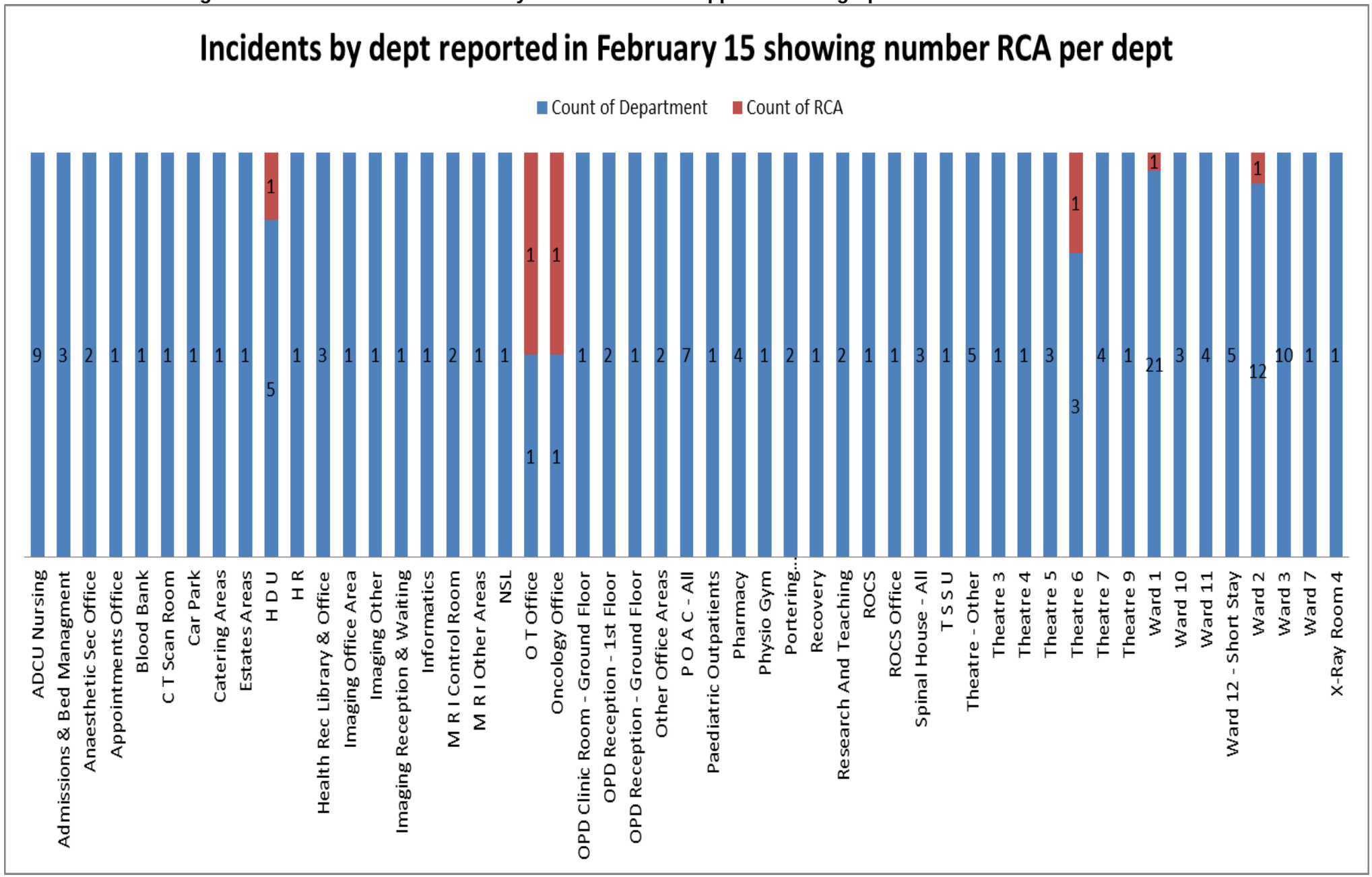
APPENDIX 1a – Ongoing Serious Incidents Requiring Investigation (SI) – February 2015

Ref	Incident date	Date reported to CCG	Type of incident	Level of harm (Prior to completion of RCA investigation)	Directorate	Status	Final RCA due
14800 STEIS 2015/7073	19/2/15	23/2/15	VTE	Low	Oncology	Investigation underway	29/3/15
14780/2 STEIS 2015/6276	16/2/15	17/2/15	VAC bleed	Moderate	Spinal	Investigation underway	23/4/15
14743/14732 STEIS 2015/5872	5/2/15	13/2/15	Fall/death	Death	Spinal	Investigation underway	21/4/15
14750 STEIS 2015/5992	9/2/15	13/2/15	Wrong sided implant	No harm	Large Joints/ Theatres	Investigation underway	21/4/15
14712 STEIS 2015/4428	3/2/15	3/2/15	Grade 3 pressure ulcer	Low	OPD/ Oncology	Investigation underway	9/4/15

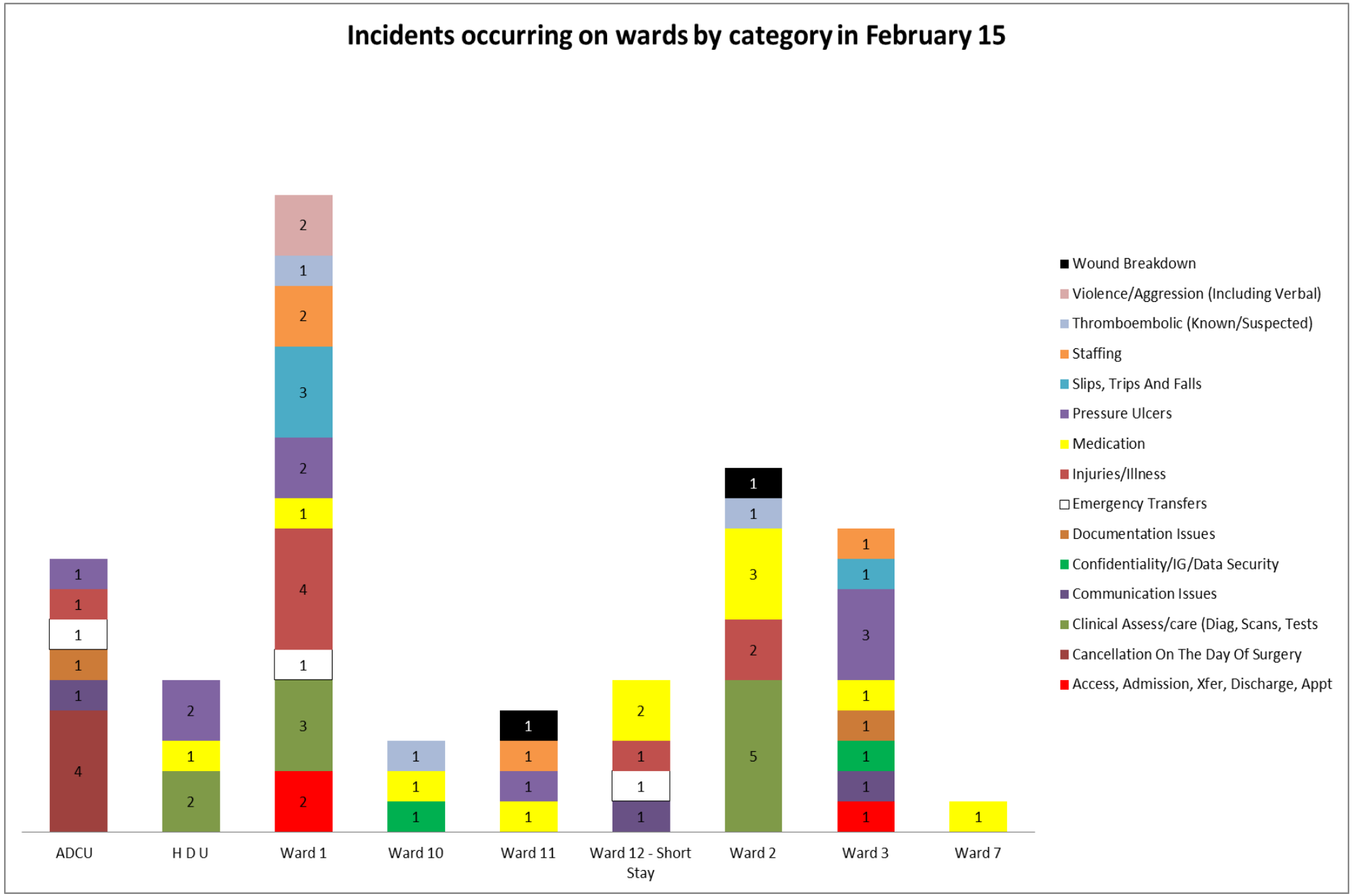
APPENDIX 1b - Closed Serious Incident investigations
None closed in February 2015.

Appendix 1c Monthly summary of findings from Serious Incident RCA investigations:
None this month.

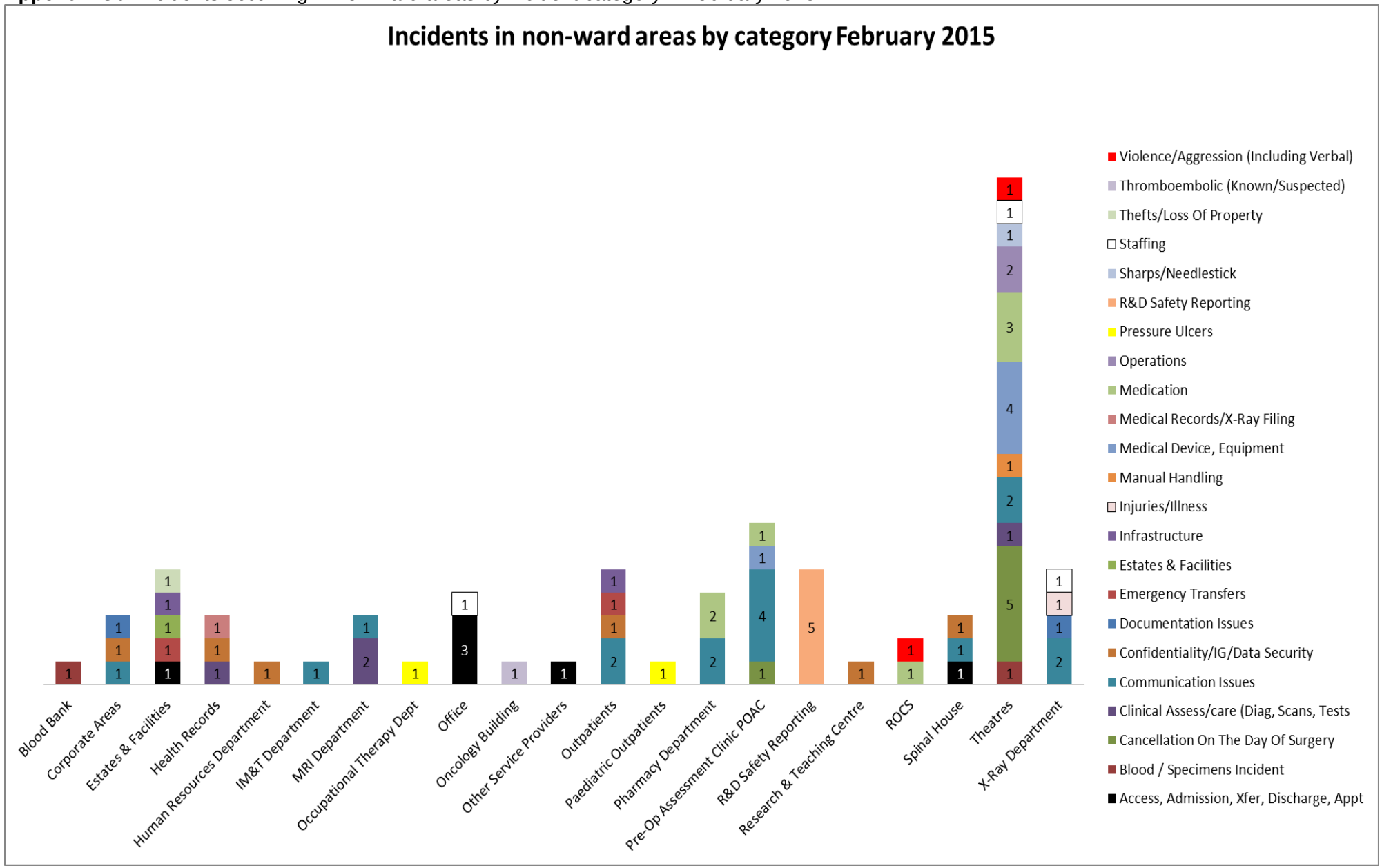
Appendix 2: No. of Incidents requiring an RCA investigation by department – February 2015
NB: One RCA investigation was commenced in January 2014 and will not appear on this graph.



Appendix 3a: Incidents occurring in ward areas by incident category – February 2015



Appendix 3b: Incidents occurring in non-ward areas by incident category – February 2015



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	25	9	16	93	162	0	12	14	285
Corporate	46	37	9	224	71	2	9	16	243
Large Joint	21	6	15	100	151	1	32	206	1638
Oncology	11	6	5	34	57	1	6	35	359
Paediatrics	9	5	4	14	53	0	3	68	510
Small Joint	10	4	6	29	48	0	6	5	39
Spinal	47	9	38	56	246	2	23	6	843
Theatres	4	1	3	18	41	0	6	99	1147
TOTAL	173	77	96	568	829	6	97	449	5064

Appendix 5 – Matron KPI

February 2015							Large joints Gareth Hyland			Directorate of Theatres and Anaesthetics												Spinal	Paediatric	Oncology	OPD and Support services	OPD and Support services
							Stacey Keegan			Talitha Carding/Rachel Bradley												Evelyn O'Kane	Evelyn O'Kane	Julie Romano	Shelley Price	Julie Romano
							Ward 2	Ward 12	P. Suite	TH 1	TH 2	TH 3	TH 4	TH 5	TH 6	TH 7	TH 8	TH 9	TH 10	HDU	Theatre	Recovery	CCO	ADCU	Ward 1	Ward 11	Ward 3	POAC	OPD
1	Workforce: Overall RAG score	Matron scoring				Monthly																							
2	Training: Overall RAG score	Matron scoring				Monthly																							
3	Patient Experience /Feedback: Overall RAG score	Matron scoring				Monthly																							
4	Safety: Overall RAG score	Matron scoring				Monthly																							
5	Efficiency: Overall RAG score	Matron scoring				Monthly													Incomplete										
6	Outcomes: Overall RAG score	Matron scoring				Monthly													Incomplete						Incomplete				
	Matron and Managers overall score																		Incomplete						Incomplete				

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 April 2015 **ENCLOSURE NUMBER: 8**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	Garry Marsh Director of Nursing & Governance
SUBJECT:	Safer Nurse Staffing Report

SUMMARY

This paper is presented to the Trust Board to give the mandatory six monthly update on the position of Nurse Staffing within ROH wards.

It will give a position statement on compliance against national guidance, evidence that the number of nurses on duty within ROH wards is sufficient to meet our patient's needs, give detail of the external data that has been reported and intentions for the required periodic nurse establishment review.

IMPLICATIONS

Failure to achieve safe nurse staffing levels within our clinical areas and fulfil the requirements of national guidance will not only see shortfalls in the quality of care delivered to the patients that we serve but also see enhanced scrutiny and potential non-compliance with our Regulators.

RECOMMENDATIONS

That Trust Board is asked note the contents of this paper and support the actions and intended works within it.

That Trust Board is asked to note that actions are in place to achieve full compliance with National guidance, that the number of nurses on duty within our wards is sufficient to meet our patients nursing needs as evidenced by the use of a nationally recognised acuity tool, that an establishment review is scheduled.

Contents

This paper is presented to the Trust Board to give a six monthly update on the position of Nurse Staffing within ROH wards. The paper is in addition to the monthly paper received by Executive Management Team meeting and Clinical Governance Committee each month.

It will give a position statement on compliance against national guidance, detail of externally reported nurse staffing levels, results of internal acuity studies, plans to review nurse establishments and the number of Safe Nurse Staffing incidents reported within ROH.

1.ROH Compliance against National Requirements

Safer Nurse Staffing has received heightened attention since the publication of the Francis Report in 2013. ROH is required to fulfil the requirements described within nationally published documents from the National Quality Board and NICE. ROH progress against these documents is described below.

1.1 Progress against National Quality Board Expectations

In November 2013 national guidance 'How to ensure the right people, with the right skills are in the right place at the right time: A guide to nursing, midwifery and care staff capability and capacity.' was published by the National Quality Board (NQB) to support both providers and commissioners to make the right decisions about nursing, midwifery and care staffing capacity and capability.

In February 2015 the Interim Director of Nursing & Governance met with the Deputy Director of Nursing & Governance and engaged Matrons to review the continued progress against the NQB Expectations.

The table shows our current compliance with the 10 expectations of the NQB guidance and actions that are required to achieve any partial compliance.

Any areas of partial compliance result from undocumented processes or shortfalls in engagement of all required stakeholders with no immediate patient safety risks identified.

NQB Expectations	Compliance	Progress to date:	Action required to achieve compliance
Expectation 1 Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staff capacity and capability	Compliant	The Board and Executive Team have received update papers detailing Nurse Staffing levels and compliance with the required standards within clinical environments. The Executive team has supported the usage of additional resource to deliver Nurse Staffing levels whilst detailed work is undertaken.	

Expectation 2 Process are in place to enable staffing establishments to be met on a shift-to-shift basis	Partially Compliant	ROH has a system that documents the both number of staff and the skill of staff on duty within ward areas which is kept live throughout the day by the Duty Manager or Site Coordinators. Each area has described minimum safe levels. Clearly documented log sheets are available to demonstrate any measures taken to address maintain safer nurse staffing levels throughout the 24hour period. Duty rotas are stored at ward level for inspection. A monthly safe staffing hour is held with attendance by Senior nurses and Senior Sisters to review all aspects of nurse staffing including incidents. Biweekly safety debriefs are held with the Deputy Director of Nursing and Matrons to look at any staffing issues both historical and prospective. Any incidents impacting on quality are also discussed. These debriefs are documented and stored centrally by the Trust.	ROH does not have policies that formally describe the delivery and maintenance of Safe Nurse Staffing and is reliant on a "way of working". Policies are therefore required. ROH does not have a policy that describes risk assessment and the delivery of enhanced nursing care to patients known locally as "specialing". Again there is a "way of working". Policies are therefore required.

Expectation 3 Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability	Partially Compliant	ROH utilises the Safer Nurse Staffing Tool to assess the required vs actual number of staff on duty to meet the needs of our patients. The tool has been utilised daily since September 2014 and following training, consistency in application across clinical areas is now achieved. Scrutiny of the results occurs in a variety of forums but not at a forum with attendance by a representative cross section of nurses. There is no methodology to share the results with ward nursing teams	Forum to allow scrutiny of results by key stakeholders to be designed and implemented. Methodology of sharing with wider ward teams to be designed.
Expectation 4 Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.	Compliant	ROH has a whistleblowing policy and is a member of the Speaking Out Safely Campaign. Reporting mechanisms are available to raise incidents and evidence of this system being utilised is evident.	
Expectation 5	Partially	The Director of	Process to be

A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments	Compliant	Nursing leads the process and engagement with the wider team is achieved by Safe Nurse Staffing papers being discussed and challenged at SMT, EMT, CGC and Trust Board. The nursing management teams work closely with finance when agreeing the funded establishments. However there is variance in demonstrable engagement of Senior Sisters in agreeing establishments.	clearly described within policy to include formal engagement of all stakeholders described within the NQB guidance.
<u>Expectation 6</u> Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	Compliant	Establishments contain funding (ringing) to allow leave and study. ROH invested in establishment to allow Senior Sisters weekly supervisory time and allow coverage for site management rota commitments.	
<u>Expectation 7</u> Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.	Partially compliant	Safe Nurse Staffing papers are submitted to a cross section of forums including Trust Board. These papers do not contain detail of externally reported information around Safe Nurse Staffing, acuity study data or wider workforce information. The reports do not always include clear	Absent content to be included within Safer Staffing paper.

		actions being undertaken to address challenges. .	
Expectation 8 NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.	Partially Compliant	Board to display staffing information are in place outside each clinical area. Evidence this is "live" for example presence of date not always evident.	Senior Nursing team to monitor accuracy and maintenance of "live" information.
Expectation 9 Providers of NHS services take an active role in securing staff in line with their workforce requirements	Compliant	Evidence of workforce planning processes and sharing of plans with local LETB, CCG and NHS England exist at ROH.	
Expectation 10 Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers whom they contract.	Compliant	CCG receive copy of Trust Board Paper every 6 months	

1.2 Progress against NICE Safe Staffing Guideline

In July 2014 NICE published guidance that described Safe Nurse Staffing levels in adult inpatient wards in acute hospitals. The guideline identifies a series of organisational and managerial factors that are required to support safe staffing for nursing, and indictors that should be used to provide information on whether safe nursing care is being provided in adult inpatient wards in acute hospitals.

Work across ROH has been undertaken to fulfil the recommendations of the guideline demonstrated by enhanced nursing numbers on duty within clinical areas, acuity studies and the evidence of reporting of staffing incidents and their assessment against Safe Nurse Staffing levels.

1.2.1 Assessing if nursing staff available on the day meet patients' nursing needs

As described in the NQB section "ways of working" need to be formally documented within ROH policies around Safe Nurse Staffing.

It is evident that assessment of the number of staff on duty vs patients nursing needs is being met by the utilisation of the Safer Nurse Staffing acuity tools.

It is also clear that the described minimum Registered Nurse staffing of a 1:8 ratio is being met within clinical areas with incident reporting occurring when this is not happening and reporting within the monthly staffing reports. This standard is met within the day.

However, overnight our ward areas are predominantly 1:12 Registered Nurse ratio.
It should be noted that for 2 hours of the night shift this will increase to 1:24 due to break coverage with support provided by a supernumerary night site manager. Whilst this may not be considered best practice it does not contravene NICE guidance.

1.2.2 Red Flag System

NICE clearly describes that hospitals need to have a system in place for nursing red flag events which can be reported by any member of the nursing team, patients, relatives and carers to the Registered Nurse in charge of the ward or shift.

Whilst ROH again has a "way of working" to meet most of the red flag events there is an absence of a documented system. ROH requires a system and policy that clearly describes our response to red flag events both at the time and to inform future planning for nurse staffing levels within wards.

NICE Red Flag events are defined as:

- Unplanned omission in providing patient medications
- Delay of more than 30 minutes in providing pain relief
- Patient vital signs not assessed or recorded as outlined in the care plan
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan
- Shortfall of more than 8 hours or 25% (whichever is reached first) of registered Nurse time.
- Less than 2 Registered nurses present on a ward during any shift.

Other red flag events can be agreed locally.

1.3 Safer Staffing Performance Indicator Development

In February 2015 NHS England published an intention to extend the information to be externally published within NHS Choices to include the following information:

- Staff sickness rate taken from ESR
- The proportion of mandatory training completed, taken from the National Staff Survey
- Completion of a Performance development review in the last 12 months, taken from the national staff survey measure
- Staff views on staffing, taken from the national staff survey measure
- Patient views on staffing, taken from the National patient survey measure

At this point the mechanisms are being developed by NHS England and further information is to be presented in Spring 2015.

On initial scoping it is not predicted the utilisation of these measurements would have a detrimental impact on ROH.

2. Publication of Monthly data

From June 2014 it became mandatory for all hospitals to publish information pertaining to the number of nursing staff working on each ward, together with the percentage of shifts meeting safe staffing guidelines.

DRAFT not for use - final version to be made available via the UNIFY system

Fill rate indicator return

Staffing: Nursing, midwifery and care staff

Reporting Period: 1/5/2014 to 31/05/2014

Please provide the URL to the page on your trust website where your staffing information is available

Hospital Site Details		Ward name	Main two specialties on each ward		Day				Night				Day		Night	
					Registered nurses/ midwives		Care Staff		Registered nurses/ midwives		Care Staff					
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		S1	S2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Select from from drop down list		Select from from drop down list	Select from from drop down list									Automatic calculation	Automatic calculation	Automatic calculation	Automatic calculation

The national template above is uploaded onto UNIFY by the 10th of every month and will be linked to NHS choices.

Since reporting has commenced ROH has been Green with no identified shortfalls. ROH submissions can be seen within Appendix 1.

3. Safer Nurse Staffing Tool

The Safer Nursing Care Tool (SNCT) is a nationally developed and validated acuity/dependency tool to measure nursing workload and estimate staffing requirements. The tool is widely used across the NHS. It has been used to assess the dependency and/or acuity of patients across the in-patient wards at ROH since September 2014.

The acuity and/or dependency is measured by assessing each patients care needs. These needs are then interpreted against nationally defined 'Levels of Care' ,resulting in each patient being given a level of care allowing a multiplier for the number of whole time equivalents registered nurses required to nurse this type of patient to be calculated. .

At ROH the Safe Staffing tool continues to be completed by Senior Sisters, checked by Matrons, and submitted to the Director of Nursing & Governance on a weekly basis.

The tool has been further enhanced to recognise the use of 'specialing' shifts for high dependency patients, such as those at high risk/actual falls. The tool has consistent application of methodology across all clinical areas. Five months of data is now available.

This data is demonstrating that the number of nursing staff on duty within ROH is at a number that meets the requirements of our patients. This is demonstrated in the table below detailing recommended numbers of Whole Time Equivalent (WTE) on duty versus actual numbers of WTE on duty.

Sept 2014 – January 2015				
		Staffing		
Ward	Ward Name	Recommended Establishment	Actual Establishment	Budgeted Establishment
Ward 1	Spinal	26.06	26.63	22.89
Ward 2	Orthopaedics	26.27	27.66	23.15
Ward 3	Oncology	28.51	27.71	24.35
Ward 10	Private Suite	6.92	10.43	12.06
Ward 11	Paeds	8.01	15.23	17.13
Ward 12	Short Stay	23.96	25.97	25.36
HDU	-	23.14	21.43	26.03

It is notable that there are gaps between the budgeted vs the required WTE. The implication of this is that the clinical areas cannot permanently appoint to the required WTE.

However wards are permitted to utilise bank and agency to ensure the required numbers of nurses are on duty within clinical areas. The table below shows the utilisation of bank and agency staff within our clinical areas.

Bank & Agency Utilisation Sept 2014 – January 2015			
	Permanent	Bank	Agency
Ward 1	80.0%	17.2%	2.8%
Ward 2	73.7%	21.2%	5.1%
Ward 3	77.0%	17.2%	5.8%
Ward 11	87.8%	12.2%	0.0%
Ward 12 & 10	74.9%	19.5%	5.6%
HDU	80.2%	9.1%	10.7%
TOTAL ALL WARDS	**78.0%**	**16.8%**	**5.2%**

This level of usage of bank and agency nurses is frequently raised by our nursing staff as a concern, namely around continuity for our patients and variance in the skill set of some staff provided in particular from agencies.

4. Establishment Review

In order to amend this utilisation of bank and agency detailed financial work is currently being undertaken to understand how movement of budgetary components known as "ringing" that are used to support bank and agency costs can be amended to permanent budget to allow permanent recruitment and an understanding thereafter of any further investment that may be required in nursing establishments that will reduce the utilisation of bank and agency within our clinical areas therefore enhancing the quality of our patients experience.

This work will involve the Director of Finance, Director of Nursing, Matron and Senior Sister to ensure a full establishment review has been undertaken for each clinical area. This work will be completed within the next 12 weeks.

5.Reported Staffing Incidents

In addition to the Safer Nurse Staffing tool being used and interpreted, clinical areas are encouraged to report all Safe Staffing incidents.

An analysis and review of safe staffing incidents reported during the period September 2014 to February 2015 has been undertaken and is represented in the graph below.

Safe staffing reported incidents
September 2014 to February 2015

The review highlighted that 87 safe staffing incidents were reported but only 5 incidents involved a breach of minimum safe staffing as defined by NICE.

Where safe staffing breaches occurred, these all related to either 'Short notice sickness absence' or 'Failure of agency staff to attend shifts booked'. Actions have been taken to strengthen the agency non-attendance.

The key contributory factors and themes arising from safe staffing incidents have included:

- Short notice sickness absence
- Failure of agency staff to attend shifts booked
- Clinical Site Co-ordinator/Bleep-holder covering shifts and therefore no longer supernumerary
- Unplanned HDU admissions

For all safe staffing incidents reported, patient safety was maintained in all instances with appropriate escalation taking place and no patinet harm reported.

6. Conclusion

This paper has given an update ROH compliance against National Requirements and identifed actions to remedy shortfalls in compliance. It is noted that any partial complianance does not pose any immediate patient saftey risk. Complianace will be delivered over the next three months.

This paper gives summary of ROH externally reported information demonstrating achievement nursing hours required by our patients are being met.

This paper demonstrates that the number of nurses on duty within our wards is correct to meet the needs of our patients by utilising the Safer Nurse Staffing tool.

This paper demonstrates that action to reduce the number of bank and agency nurses used within ROH is planned involving the Director of Finance, Director of Nursing , Matron and Senior Sister when undertaking full nurse staffing reviews.

Appendix 1 - UNIFY Returns for September 2014 – February 2014

September 2014

Only complete sites your organisation is accountable for			Day				Night				Day		Night	
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Ward 1	110 - TRAUMA & ORTHOPAEDICS		1416	1416	817	817	660	660	649	649	100.0%	100.0%	100.0%	100.0%
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1341	1341	1004	1004	726	726	704	704	100.0%	100.0%	100.0%	100.0%
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPA	1605	1605	900	900	620	620	550	550	100.0%	100.0%	100.0%	100.0%
Ward 10 - Private Suite	110 - TRAUMA & ORTHOPAEDICS		849	849	201	201	671	671	0	0	100.0%	100.0%	100.0%	-
Ward 11	171 - PAEDIATRIC SURGERY		1119	1119	278	278	594	594	11	11	100.0%	100.0%	100.0%	100.0%
Ward 12 - Short Stay	110 - TRAUMA & ORTHOPAEDICS		1364	1364	819	819	671	671	777	777	100.0%	100.0%	100.0%	100.0%
HDU	110 - TRAUMA & ORTHOPAEDICS		1382	1382	224	224	1243	1243	99	99	100.0%	100.0%	100.0%	100.0%

October 2014

Only complete sites your organisation is accountable for			Day				Night				Day		Night	
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Ward 1	110 - TRAUMA & ORTHOPAEDICS		1464.3	1461.3	873.3	873.3	682	682	703.5	703.45	99.8%	100.0%	100.0%	100.0%
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1,443.10	1,428.10	825.6	1050.6	682	682	682	803	99.0%	127.3%	100.0%	117.7%
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPA	1,567.50	1,552.50	900	892.5	620	620	600	600	99.0%	99.2%	100.0%	100.0%
Ward 10 - Private Suite	110 - TRAUMA & ORTHOPAEDICS		839.6	839.6	135.8	135.8	671	671	11	11	100.0%	100.0%	100.0%	100.0%
Ward 11	171 - PAEDIATRIC SURGERY		1,165.50	1,165.50	193.5	193.5	627	627	22	22	100.0%	100.0%	100.0%	100.0%
Ward 12 - Short Stay	110 - TRAUMA & ORTHOPAEDICS		1,381.40	1,381.40	737.2	737.2	682	682	627.4	627.4	100.0%	100.0%	100.0%	100.0%
HDU	110 - TRAUMA & ORTHOPAEDICS		1,462.10	1,462.10	229.5	229.5	1287	1,287.00	55	55	100.0%	100.0%	100.0%	100.0%

November 2014

Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Ward 1	110 - TRAUMA & ORTHOPAEDICS		1471.5	1471.5	831.7	828.7	660	660	650	660	100.0%	99.6%	100.0%	101.5%
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1,502.10	1,462.10	921.6	1103.6	682	682	561	715	97.3%	119.7%	100.0%	127.5%
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPA	1,628.50	1,605.00	1110	1110	600	600	590	590	98.6%	100.0%	100.0%	100.0%
Ward 10 - Private Suite	110 - TRAUMA & ORTHOPAEDICS		811.2	811.2	119.6	119.6	660	654.5	0	0	100.0%	100.0%	99.2%	-
Ward 11	171 - PAEDIATRIC SURGERY		1,170.00	1,170.00	240	240	682	682	55	55	100.0%	100.0%	100.0%	100.0%
Ward 12 - Short Stay	110 - TRAUMA & ORTHOPAEDICS		1,387.20	1,387.20	785.2	785.2	649	649	646.5	646.5	100.0%	100.0%	100.0%	100.0%
HDU	110 - TRAUMA & ORTHOPAEDICS		1,341.60	1,341.60	250.5	250.5	1144	1144	44	44	100.0%	100.0%	100.0%	100.0%

December 2014

Only complete sites your organisation is accountable for			Day				Night				Day		Night	
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Ward 1	110 - TRAUMA & ORTHOPAEDICS		1443	1,440.50	775.8	775.8	704	704	550	550	99.8%	100.0%	100.0%	100.0%
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1,332.90	1,325.40	706.6	888.6	660	660	407	583	99.4%	125.8%	100.0%	143.2%
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPA	1,567.50	1,552.50	960	952.5	640	640	490	490	99.0%	99.2%	100.0%	100.0%
Ward 10 - Private Suite	110 - TRAUMA & ORTHOPAEDICS		617.1	617.1	101.9	101.9	462	462	0	0	100.0%	100.0%	100.0%	-
Ward 11	171 - PAEDIATRIC SURGERY		1054.5	1054.5	265.5	265.5	616	616	110	110	100.0%	100.0%	100.0%	100.0%
Ward 12 - Short Stay	110 - TRAUMA & ORTHOPAEDICS		1368.8	1368.8	798.6	798.6	682	682	536.1	536.1	100.0%	100.0%	100.0%	100.0%
HDU	110 - TRAUMA & ORTHOPAEDICS		1346.7	1346.7	182.6	182.6	1078	1078	22	22	100.0%	100.0%	100.0%	100.0%

January 2015

Only complete sites your organisation is accountable for			Day				Night				Day		Night	
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Ward 1	110 - TRAUMA & ORTHOPAEDICS		1434	1,434.00	941.4	941.4	682	682	625.4	625.4	100.0%	100.0%	100.0%	100.0%
Ward 2	110 - TRAUMA &		1,397.70	1,397.70	755.2	846.2	671	671	495	649	100.0%	112.0%	100.0%	131.1%
Ward 3	800 - CLINICAL	110 - TRAUMA &	1,627.50	1,620.00	1,050.00	1,042.50	660	660	560	560	99.5%	99.3%	100.0%	100.0%
Ward 10 - Private Suite	110 - TRAUMA &		546.6	546.6	79.9	79.9	374	374	0	0	100.0%	100.0%	100.0%	-
Ward 11	171 - PAEDIATRIC		1137	1,137.00	300	300	638	638	33	33	100.0%	100.0%	100.0%	100.0%
Ward 12 - Short Stay	110 - TRAUMA &		1597.2	1,597.20	749.7	749.7	693	693	630.6	630.6	100.0%	100.0%	100.0%	100.0%
HDU	110 - TRAUMA &		1578	1,578.00	240	240	1287	1,287.00	22	22	100.0%	100.0%	100.0%	100.0%

February 2015

Only complete sites your organisation is accountable for			Day				Night				Day		Night	
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Ward 1	110 - TRAUMA & ORTHOPAEDICS		1,324.10	1,324.10	889.5	909	605	605	605	605	100.0%	102.2%	100.0%	100.0%
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1,270.20	1,270.20	804	804	660	660	539	539	100.0%	100.0%	100.0%	100.0%
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1,605.00	1,582.50	960	945	560	560	520	520	98.6%	98.4%	100.0%	100.0%
Ward 10 - Private Suite	110 - TRAUMA & ORTHOPAEDICS		749.2	749.2	88.5	88.5	616	616	0	0	100.0%	100.0%	100.0%	-
Ward 11	171 - PAEDIATRIC SURGERY		1,086.00	1,086.00	237	237	616	616	11	11	100.0%	100.0%	100.0%	100.0%
Ward 12 - Short Stay	110 - TRAUMA & ORTHOPAEDICS		1,278.80	1,278.80	779.9	779.9	627	627	591.4	591.4	100.0%	100.0%	100.0%	100.0%
HDU	110 - TRAUMA & ORTHOPAEDICS		1,537.50	1,537.50	178.5	217.5	1,262.00	1,262.00	11	11	100.0%	121.8%	100.0%	100.0%

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 April 2015 **ENCLOSURE NUMBER: 9**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	Garry Marsh, Director of Nursing & Governance
NAME OF AUTHOR:	Alison Braham, Governance Manager
SUBJECT:	CQC action plan update

SUMMARY

This paper provides a progress update against the CQC action plan produced in response to the findings of the Trust's CQC Inspection in June 2014. The CQC report (published on 16th October 2014) specified a number of actions the Trust must take with regard to both regulated and non-regulated activities.

This paper comprises:

1. CQC inspection rating
2. Status of regulated activities requiring compliance action
3. Status of non-regulated activity actions
4. Appendix 1 - Composite CQC action plan with details of actions taken to date

IMPLICATIONS

Risks associated with not complying with the requirements of the CQC action plan include patient experience, safety and the quality of care being compromised, further compliance actions being served at the next inspection and a deterioration of the CQC rating for the Trust.

RECOMMENDATIONS

The Trust Board are asked to:

- Note the progress to date against the CQC action plan
- Recognise that cultural change and clinical engagement is key to delivery in conjunction with IT and policy solutions described within this paper.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CQC action plan update - March 2015

1. CQC inspection rating

The CQC report was published on 16th October 2014 and 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

The Trust was allocated an overall rating of 'Requires Improvement' and individual ratings for each of the CQC inspection domains are as follows:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Requires improvement	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Children & young people	Good	Outstanding	Good	Good	Good	Good
Outpatients	Requires improvement	Inspected but not rated[1]	Good	Inadequate	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

2. Status of regulated activities requiring compliance action

The table below provides an overview of progress to date against regulated activities requiring action following the CQC inspection of June 2014.

For actions not yet achieved (eg. those graded as 'Amber'), details of outstanding future actions are outlined.

Compliance action (Regulated activities)	RAG status	Outstanding future actions
Medicines are managed at all times in line with legal requirements.		None
A chaperone policy is developed and chaperones made available to support patients' privacy and dignity		New Chaperone policy drafted and is currently out for consultation until 31st March 2015.
Equipment is properly checked and maintained in accordance with electrical safety requirements		This is a rolling compliance action. Estates are current working through a refresh of the electrical Asset Register to maintain a clear schedule of circa 7000 electrical items.
Confidential patient information and records are not left unsupervised in unrestricted public areas of the outpatient department		None
Appointments are organised for all clinics to reduce waiting times for patients and improve their experience in the outpatient department		Automated monitoring continues to be a challenge and is largely still paper based. This situation will continue until the In-touch with Health solution is operationalised during latter spring. During the intervening period the Interim Head of Outpatients continues to work with individual clinical colleagues and with the GooRoo planning tool to more evenly balance patient volumes.

3. Status of non-regulated activity actions

A number of specified actions which the Trust should take, and which are non-regulated activities, were also highlighted during the CQC inspection. The table below provides an overview of progress to date against these actions.

Non regulated activity action	RAG status	Outstanding future actions
Letters to GPs and other referring bodies are sent out within set timescales to ensure effective communication		The current process of turnaround monitoring to the Activity Review Group continues on a weekly basis with any concerns being highlighted and actioned. The accelerated timeline for the operationalisation of Digital Dictation and voice recognition software installation suggests a go live from Mid-April 2015. Regular project updates are being received. Once installed this will allow for real time monitoring of all turnaround times via the ICT platform. There is ongoing review of turnaround times, and resources are reallocated to keep turnaround times short. Following the implementation of Digital Dictation there will be reductions in turnaround times and greater transparency will be provided by the system
Resuscitation equipment is routinely checked in accordance with the Trusts' procedures and records of checks are kept in outpatients		None
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		The interim Head of Outpatient Improvement started with the Trust on 1st November 2014. This individual is working to an extensive GANTT Improvement timeline. The substantive post was originally going to national advert during February 2015 however this is held pending the organisational structure. There is local management of the outpatients service, which is overseen by Clinical Support Directorate. There is currently no manager with overall responsibility for all outpatients so this is currently managed by liaising with directorate teams . A clinic coordinator role is being introduced to oversee patient flow and identify and address

		potential problems which could impact on patient flow or patient experience.
Non regulated activity action	**RAG status**	**Outstanding future actions**
Discharge arrangements to facilitate early identification and availability of beds for patients admitted on the day of surgery are improved.		None
The implementation of Enhanced Recovery Programmes to reduce patient length of stay in hospital and promote greater patient involvement in their care		Partially achieved. All actions have been taken but some engagement is still ongoing with regards to anaesthetist protocols.
When the reception desk is closed there is clear, visible signage to direct patients and visitors form the main entrance to other departments.		None

This paper has provided an overview of actions taken to date against the CQC action plan. An overarching CQC action plan comprising detailed updates with regard to both regulated and non-regulated activities is included as Appendix 1.

The Royal Orthopaedic Hospital - Status of compliance with CQC Action Plans Last updated: 25th March 2015

Key (RAG Status column)

- Completed
- Delayed completion
- Activity not yet commenced

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
Treatment of disease disorder and injury; surgical procedures	The registered person must, so far as reasonably practicable, make suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17(1)(a) HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving service users.	The Inspection team were not made aware that the Privacy and Dignity policy has a section referring to chaperone support. A specific chaperone policy is to be developed and chaperones made available to support patients' privacy and dignity. Paragraph 1, Page 76 ''The directorate manager told us there was not a chaperone policy but the lead nurse in outpatients was able to accommodate patients that might be in need of a	Clinical Directors, Senior Nurses and Matrons informed of the chaperone section of the existing policy. Develop a specific chaperone policy, ratify and launch across the Trust to all staff groups, as relevant, using existing forums Develop posters for display in Outpatients and around the hospital informing patients, carers and visitors of the option for a chaperone. Outpatient staff to note within the patient medical records when a chaperone has	Matron for Outpatients	Director of Nursing & Governance		January 2015	Communication complete with OPD staff via team meeting. Cd informed ESP/Physio. Patient and Public Services Manager advised Volunteers. ANPs made aware from Senior Nurse Meetings and Clinicians during conversation in OPD but NEEDS Corporate Communication (not seen at Present) as OPD touches all workforces outside of	New Chaperone policy drafted and is currently out for consultation until 31st March 2015.

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
		chaperone. We asked eight patients who attended appointments alone whether they had ever been asked. Half told us they had been asked if they wanted a chaperone although none had taken up this offer.''	been provided The outpatient senior sister to monitor the request and use of chaperones to ensure patient and service needs can be met. The Matron and senior nurse will undertake random spot checks, seeking the views of patients within the outpatient department Should an incident or complaint arise in relation to privacy and dignity this will be fully investigated					Matrons remit. New Policy drafted and out for consultation until 31st March 2015. Awaiting Corporate steer on expectations- ie Chaperone by Default or by Request of chaperones as a Trust. NB this option will influence if further workforce review/Business case required in OPD if by default. Posters displayed throughout OPD and baseline audit of chaperone awareness compiled through Listening Event in Nov 2014. New documentation approved by Documentation Committee and	

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
								DDON in December 2014 and being rolled out 20/1/15. This will be audited in due course. Clarity due an upgrade and Chaperone question will be incorporated at this point too. Spot checks being competed in OPD by Triumvirate on awareness of Chaperones and auditing once paperwork in full use. Incidents/Complaints sent to TC and referred to JR- to date non since Action Plan.	

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
Treatment of disease disorder and injury; surgical procedures	People who use services were not protected from the risks associated with the unsafe management of medicines because controlled drugs were not checked in accordance with legislation. Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines	The Controlled Drug cupboard was left open and unattended within the High Dependency Unit.	HDU Nursing Team have been briefed on the professional responsibilities for safe management of controlled drugs through meeting with, and a letter from, the Executive Director of Nursing and Governance. All HDU staff have been re issued with Medicine Management policy for personal reference. Unit based medicine management training is being delivered by the Practice Development Nurse and Clinical Tutor Sharing of the learning experience with all nursing teams at the Nurse Forum has taken place. Sharing of the learning experience with all clinical teams across the organisation through established	Matron for HDU	Director of Nursing & Governance		December 2014	Unit based medicine management training has been given informally. Director of Nursing met with all staff to brief them on their professional and legal responsibility with regards to the management of controlled drugs, this conversation was minuted. Pharmacy delivering training programme currently on the new CD book Letter sent to all staff from Director of Operations, Director of Nursing and Medical Director CD spot check audits in	

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
			forums is happening. Random spot checks of CD management within the unit are being undertaken by Matron, Professional Development Nurse, Clinical Nurse Tutor, Pharmacy team and Deputy Director of Nursing, reporting their findings to the Executive Director of Nursing and Governance. Incident reporting and investigation of all non compliance associated with controlled drug management and storage is in place. Timely and appropriate performance management, with reference to the capability and conduct policy, for staff found to be non concordant with the regulations will take place where relevant.					progress, evidence kept by DDON PA. Performance management process actioned appropriately following CD drug error.	

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
Treatment of disease disorder and injury; surgical procedures	The registered person must ensure that patient records which may be in paper or electronic form are kept securely. Regulation 20 (2)(a) HSCA 2008 (Regulated Activities) Regulations 2010.	Within the Outpatients Department Confidential patient information and records were found unsupervised in unrestricted public areas of the outpatients department.	Brief all permanent staff who work within or use the Outpatient Department of the requirement to appropriately secure confidential patient information. Ensure all Bank or agency staff, within local inductions, are informed of the requirement to appropriately secure confidential patient information. Provide appropriate, closed and lockable medical notes storage within public areas. Senior Sister, Matron, Clinical Director undertake random, documented spot checks and to feed back to staff their findings. Dependant on the outcome of the spot checks local actions are to	Matron for Outpatients Department	Medical Director (Caldicott Guardian)		December 2014	All actions in place and new notes trolley x2 arrived and in action December 2014. There are lockable trolleys in use in outpatients to secure notes. Computer screens are away from patient areas Corporate Communication required for all staff groups awareness as not all accessible to Matron of OPD	

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
			be taken, as appropriate. Consideration of the appropriate use of the disciplinary policy will be taken should individual staff members persist in inappropriate management of confidential patient information. Brief all staff across the Trust of the importance of appropriate management of confidential patient information, using existing forums and communication methods.						

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
Treatment of disease disorder and injury; surgical procedures	People who use services were not protected from the use of unsafe equipment as electrical safety checks were not routinely undertaken. Regulation 16 (1)(a) HSCA 2008 (Regulated Activities) Regulations.	Equipment was found that there was no visible evidence of having been properly checked and maintained in accordance with electrical safety requirements.	The Estates department will utilise the existing communication strategy across the ROH to highlight that non mobile electrical equipment where it is supported by documented risk assessment requires 'PAT' testing on a 3 yearly cycle and mobile equipment requires assessment yearly. The outcome of which is that staff will have greater awareness, and be supportive of, 'PAT' testing within their own working environments. The existing database of electrical device safety checks will be maintained and reviewed at regular intervals, to include an overview at the performance review of the Estates and Facilities Service.	Head of Estates and Facilities	Director of Operations		Rolling compliance action	The process of rolling review continues to be the primary assurance tool.	Estates are working through a refresh of the electrical Asset Register to maintain a clear schedule of our circa 7000 electrical items. Education regarding the risk assessment of non-moveable items continues.

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
			The assessment of compliant equipment will be enhanced, and from an additional action of patient safety walk-arounds.						
Treatment of disease disorder and injury; surgical procedures	The provider did not have systems in place to monitor the quality of services in OPD. Regulation 10(1)(a)(b) HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision	The Inspection team found that appointments were not always organised for clinics and led to lengthy waiting times for patients, this had a detrimental effect on the experience of the patient/carer in the outpatients department. The Inspection team found an inconsistent view of the oversight and management of the quality of the services within Outpatients	Recruit to a new position of Head of Outpatients. Provide oversight through progress reports formally received by the weekly Activity Review Group. The Trust has invested in an IT performance tool, Gooroo, which will map outpatient activity and demand thereby helping proactive planning of services and an enhanced patient experience. A specific improvement action plan and score card of performance is currently being developed, as this progresses a richer weekly score card	Head of Outpatients	Director of Operations		July 2015	We have recruited to a new position of Head of Outpatients and the quality of day to day service provision will form the key operational management component of the post-holder. Oversight is provided through progress reports formally received by the weekly Activity Review Group, chaired by the Directorate Manager to the Executive Director of Operations. These reports utilise a range of information sources allowing the operational performance and patient experience of outpatients to be monitored and the	Automated monitoring continues to be a challenge and is largely still paper based. This situation will continue until the In-touch with Health solution is operationalised during latter spring. During the intervening period the Interim Head of Outpatients continues to work with GooRoo planning tool to more evenly balance patient volumes.

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
			will be produced covering service and patient experience review. A patient stakeholder listening into action event has been held during November 2014 and will again be held during March 2015 to embrace suggestions from service users. A OPD patient and carer group was proposed to be established in January 2015 however it has been agreed to affiliate to the existing Patient and Carers Council. Technology is being explored to ensure the outpatients department and visitors are able to give real time patient and carer feedback. The use of the visual display screens within the department will be adapted to include					appropriate remedial actions taken in a timely manner. Support is provided through this group for the actions to be taken to address concerns or strengthen the delivery of the plans. A patient Listening into Action event was held over 5 days during November 2014. Circa 400 patients contributed to this event, broadly 20% of the week's OPD attenders. Work is ongoing to review and amend clinic templates to reduce waiting times. Patients are informed of waiting times and delays by staff. The clinic coordinator roles will assist in identifying and resolving issues. Closer	

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
			relevant patient information about the running of the day's clinics, this is linked to the PAS upgrade scheduled to take place in April 2015 and will become active after this point in time. The Trust is in the final stage of procurement and anticipates working with a preferred partner from April 2015. A 'you said we did' patient information display will be developed to pictorially evidence our service improvement. The Outpatient team are exploring examples of best practice in other organisations' Outpatient Departments, this will be supported through site visits and contacts.					liaison with the Patient Forum The introduction of the clinic coordinator role will assist in avoiding late running and rebooking due to overruns. An electronic patient flow system will be purchased and rolled out to provide information about clinic flow to identify and address areas for action with directorates and clinical teams. Work is ongoing to collate information relating to cancellations so that this can be shared for action with directorate and clinical teams. Start and finish times are now being collated manually until an electronic system is installed. In common with many trusts, outpatients activity is delivered in one area, but	

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
								responsibility for it sits within directorates. Local review is already in place within directorates. A dashboard which collates data for review is being developed . The Access Review Group will undertake review of outpatients activity and efficiency, and it will also become part of directorate performance reviews	
None specified	No regulation identified 'Action Trust must take' section of inspection report.	Letters to GPs and other referring bodies are sent out within set timescales to ensure effective communication.	Typing turnaround is monitored at consultant level and reported on a weekly basis at the Activity Review Group and onward to the Director of Operations. Approval has been secured to roll-out	Divisional Manager for Patient access	Director of Operations		July 2015	The current process of turnaround monitoring to the Activity Review Group continues on a weekly basis with any concerns being highlighted and actioned.	The accelerated timeline for the operationalisation of Digital Dictation and voice recognition software installation suggests a go live from Mid- April 2015. Regular project updates are being received. Once installed this

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
			the provision of digital dictation to surgical consultants by July 2015 – 9 month project plan. This timescale takes account of procurement timeline. A project manager has been secured to lead the procurement implementation and roll out. This project formally reports monthly via the Clinical Programme Board.						will allow for real time monitoring of all turnaround times via the ICT platform. There is ongoing review of turnaround times, and resources are reallocated to keep turnaround times short. Following the implementation of Digital Dictation there will be reductions in turnaround times and greater transparency will be provided by the system

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
None specified	No regulation identified 'Action Trust must take' section of the inspection report.	There is managerial oversight of all outpatient services to ensure the efficient and effective operation of the department and to ensure patients' experiences of care are improved.	The Trust will introduce the managerial post of Head of Outpatient Services. This post will sit above the current nursing management and provide organisational wide daily oversight for both the pre planning and daily provision of service. From point of introduction until 31st March 2015 this post will report directly to Executive Director of Operations. From 1st April 2015 the post will drop to sit with one of the core service divisions The Trust will recruit a temporary Head of Outpatient improvement from 1st November 2014 .	Director of Operations	Director of Operations			The interim Head of Outpatient Improvement started with the Trust on 1st November 2014. This individual is working to an extensive GANTT Improvement timeline. The substantive post will go to national advert during February 2015.	There is local management of the outpatients service , which is overseen by Clinical Support Directorate. There is currently no manager with overall responsibility for all outpatients so this is currently managed by liaising with directorate teams . A clinic coordinator role is being introduced to oversee patient flow and identify and address potential problems which could impact on patient flow or patient experience. A Listening Event was held during which over 400 patients shared their views and these have been incorporated into the action plan

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
None specified	No regulation identified 'Action Trust must take' section of the inspection report.	When the reception desk is closed, there is clear, visible signage to direct patients and visitors from the main entrance to other departments.	Enhanced site maps and signage will be introduced across all core areas of the Trust to aid patient and visitor navigation.	Director of Operations	Director of Operations		December 2014	The Trusts Mini Reception desk is now open Monday to Friday 0800 to 1700 with a business case to extend to 0700 to 1900. Enhanced signage has been installed to aid way finding out of hours. Further new hospital site maps are currently being produced for installation during February. Enhanced information will then be added to patient's appointment letters. Additional patient car parking has been secured adjacent to ADCU following patient feedback.	

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
None specified	No regulation identified 'Action Trust must take' section of the inspection report.	Resuscitation equipment is routinely checked in accordance with the trust's procedures and records of the checks are kept in outpatients	Confirm with Outpatient staff the requirement to check resuscitation equipment every day the department is open, at the start of the working day. Staff to be aware of what actions to take should a piece of equipment or drug not be available within the resuscitation trolley. The daily checks to be recorded legibly on the standard checking form and in the same location within the folder located on the resuscitation trolleys on both floors of the department. The Senior Sister and Matron to undertake random spot checks of the resuscitation trolleys, these checks are to be recorded within the folder on each trolley. Outpatient staff are	Matron for Outpatients Department	Director of Nursing and Governance		December 2014	All actions in place and new notes trolley x2 arrived and in action December 2014. Corporate Communication required for all staff groups awareness as not all accessible to Matron of OPD Resuscitation trollies are standardised across the Trust and a checklist is available in the resuscitation policy. The trollies are checked daily by a practitioner in their area. Outreach conduct audits of the trollies in a rolling programme. Checks are in place daily and records kept in the department.	

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
			to be kept informed of results of the spot checks All new starters, or staff returning to work after a period of prolonged absence, are to be given an induction by the Senior Sister and shown the correct manner in which to check the resuscitation trolleys. Staff are to maintain their mandatory resuscitation training, with the responsibility for managing this and supporting staff held by the Senior Sister. Patient incidents requiring the use of the resuscitation trolley are to be investigated by the Senior Sister, to ensure the correct equipment was available and no patient harm resulted from a lack of core stock items, drugs or medical devices. Feedback to staff					The directorate management team conduct spot checks and the records of these are kept in the directorate office for review. This record can be found via the pdrive-critical care-resus trolley audits/2014 archived info if you need to review. The grab bags kept with the porters are audited weekly by Outreach (records of this are kept in the bag).	

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
			following any incident to be undertaken at the next available staff meeting Appropriate and proportional use of the capability and conduct policy if staff are found to be non-compliant with equipment checks.						

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
None specified	No regulation identified 'Action Trust must take' section of the inspection report.	Discharge arrangements to facilitate early identification and availability of beds for patients admitted on the day of surgery are improved.	Enhanced elective patient scheduling to be developed and designed to reduce bottle necks, smooth variation and clarity of the anticipated patient throughput. The actions being taken within the enhanced recovery programme and with the ROCS team will support this action.	Directorate Manager for Patient Access	Director of Operations		April 2015	This action sits with Director of operations and Chris Wood as DM for capacity. However the issues regarding capacity and flow became apparent to myself within the first few weeks of my appointment. We met as a directorate to discuss a way to address some of these issues. We collaborated with all matrons, scheduled care coordinators and DOM's to agree a plan. We developed an escalation plan used within HDU and recovery to provide guidance on escalation when there is pressure on the system. Following this the discharge	

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
								lounge has been utilised more effectively. Richard Banks as previous DM for capacity conducted weekly capacity look forward meetings which engaged with all matrons to ensure we were expediting discharges from the ward effectively.	
None specified	No regulation identified 'Action Trust must take' section of the inspection report.	The implementation of Enhanced Recovery Programmes to reduce patient length of stay in hospital and promote greater patient involvement	Enhanced Recovery Group, reporting to Transformation Board, has been established and Executive lead, terms of reference, membership and action plan are in	Directorate Manager for Patient Access	Medical Director		June 2015	Partially met.	All actions have been taken but some engagement is still ongoing with regards to anaesthetist protocols. Red on transformation plan as behind schedule

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
		in their care	place. Initially this will be delivered within primary hip and knee clinical services, with a view to implementing across the organisation as clinically relevant to improve the patient experience Engagement with surgical and anaesthetic staff to ensure rapid implementation of the programme Engagement with other NHS bodies and a third party private sector partner to ensure that best practice is utilised in developing the ROH programme The action plan specifies the details of delivery, timescales and responsible individuals. A set of relevant key performance indicators has been						on that plan but not on the CQC timeline of June 2015.

Regulated activity	Regulation	How the regulation was not being met:	Actions to be taken to meet the regulation	Responsibility of	Lead Director	RAG status	Planned Completion date	Actions taken to date	Outstanding future actions
			agreed, such as time to mobilisation, length of stay, pain management and patient satisfaction. These will be monitored by the Enhanced Recovery Group. A review of the groups work is planned for June 2015, recognising that enhanced recovery programmes develop over time						

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 April 2015 **ENCLOSURE NUMBER: 10**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	Garry Marsh, Director of Nursing & Governance
SUBJECT:	Kate Lampard's Report Re: Savile ROH position Statement

SUMMARY

This paper gives a position statement at ROH in response to the recommendations from the recently published "lessons learnt" report by Kate Lampard associated with Jimmy Savile.

In this paper is Kate Lampard's Report regarding Savile ROH Position Statement and Report Regarding Savile ROH Detailed Action Plan

IMPLICATIONS

The implications around non-compliance to these recommendations are associated with our duty to safeguard the patients that we serve from such occurrences as described within the report and the associated media coverage that would ensue.

Non adherence will result in challenge of ROH by Monitor and our regulatory bodies.

RECOMMENDATIONS

The Trust Board are asked to note the position of ROH at this time and review the completed recommendations at a future date.

Kate Lampard's Report Re: Savile ROH position Statement

Following the death of Jimmy Savile and the subsequent allegations of his wrong doing at NHS organisations, the Department of Health launched an inquiry into his activities across the NHS. This resulted in the publication of a total of 44 reports being published following investigations triggered by this exercise.

The Savile case covers the time periods from 1954 to 2011 and has involved allegations and proven incidences of abuse by Savile at 41 acute hospitals, five mental health trusts, two children's hospitals, and other care settings.

In October 2012, the Secretary of State for Health asked former barrister Kate Lampard to produce an independent report on 'lessons learned', drawing on the findings from all published investigations and emerging themes. This report was published in March 2015 and included 14 recommendations for the NHS, the Department of Health (DH) and wider government.

The Secretary of State for Health has accepted 13 of the recommendations, 10 of which apply to NHS Trust and Foundation Trusts. The Secretary of State did not accept recommendation 6 on Disclosure and Barring checks.

Monitor have written to all Chief Executives of Foundation Trusts and instructed that by Monday 15th June 2015 the recommendations have been reviewed and implemented within their organisations.

This paper gives the Trust Board a first status of ROH compliance against the recommendations. The table below gives a summarised RAG rating against each recommendation with a detailed action plan as required by Monitor cited within Appendix 1, to move ROH to a position of compliance.

Recommendation Number	Status
1	
2	
4	
5	
7	
9	
10	
11	
12	
13	
14	

At this stage the Director of Nursing & Governance identifies no predicted issues in achieving compliance by the requested date.

Appendix 1

Report on actions in response to Kate Lampard's report into Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile				
NAME OF TRUST:				
(add more lines to the table if necessary)				
Recommendation	**Issue identified**	**Planned Action**	**Progress to date**	**Due for completio**
R1 All NHS hospital trusts should develop a policy for agreeing to and managing visits by celebrities, VIPs and other official visitors. The policy should apply to all such visits without exception.	**Existing policy requires some amendments**	**Policy Review Undertaken Submitted for next EMT**	**May CEO/EMT Approval**	**31st May 2015**

R2 All NHS trusts should review their voluntary services arrangements and ensure that: • they are fit for purpose; • volunteers are properly recruited, selected and trained and are subject to appropriate management and supervision; and • all voluntary services managers have development opportunities and are properly supported.	**No issues identified**	**Ongoing review of volunteer policy, placements, handbook and audits** **VSM has annual appraisal and is set objectives including development opportunities and training**	**There are contract standards in place regionally in order for (in particular) medical and nursing staff to have received expected checks from agencies. These are audited regionally as part of the framework.** **It is expected that contractors in estates/ facilities will follow appropriate guidance in providing people who are fit for purpose in terms of professional qualifications and any necessary checks**	**Complete/ ongoing**

R4 All NHS trusts should ensure that their staff and volunteers undergo formal refresher training in safeguarding at the appropriate level at least every three years	**Record of training for volunteer staff to be provided as evidence.** **Trust SG training strategy to be reviewed and updated by end Q1 2015**	**Volunteers to have updated as part of annual update provided by Lead PPE manager LK supported by Named Nurse and Lead if required.** **Lead Patient Public Engagement has completed higher Level training.** **Bespoke training for general porters.**	**Safeguarding training is mandatory for required staff roles** **PDR process to review if staff competency and compliance** **Training is every 3 years, level dependent on role. Leads updated annually.** **Basic awareness is updated annually for all staff via pay slips**	**Ongoing** **June 2015**

R5 All NHS hospital trusts should undertake regular reviews of: • their safeguarding resources, structures and processes (including their training programmes); and • the behaviours and responsiveness of management and staff in relation to safeguarding issues to ensure that their arrangements are robust and operate as effectively as possible.	**Training to be updated in line with Care Act 2014** **Audit required with regard to training outcome** **Spot checks of staff awareness and understanding**	**Annual review and training strategy to be undertaken in Q1 2015/16.** **Questions to be asked at mandatory day update to assess staff understanding from April 2015.** **Include into training lessons from NHS investigations for children and adults.** **Purple edged documentation roll out and workshop** **Incident reporting of concerns, queries encouraged and reviewed by named nurse and lead and governance dept. monthly. Internal reporting of concerns and actions reported.**	**Training was reviewed by external CCG designated Leads in 2013/14.** **Trust have reviewed governance structure for the safeguarding group ,membership and reporting structure** **Spot checks by lead and named nurse in depts.** **Link champions group meeting to review concerns and actions taken to share learning and review if processes in place to protect patient/staff.**	**30th April 2015** **May 2015** **End of May 2015**

R7 All NHS hospital trusts should undertake DBS checks (including, where applicable, enhanced DBS and barring list checks) on their staff and volunteers every three years. The implementation of this recommendation should be supported by NHS Employers.	**Cost, value and legality of such an arrangement, which is not currently supported by NHS Employers in any event.** **The Secretary of State has not accepted this as a recommendation.**	**Most Trusts have long since ceased to apply blanket checks in this way.** **They very, very rarely highlighted occasions where staff had forgotten to bring to a Trust's attention that they had In fact received a caution or conviction, at a cost both of in terms of administration time and direct cost (tens of thousands of pounds, even in smaller Trusts) which was consistently felt to massively outweigh the benefit.** **There is no evidence that this arrangement would have resulted in the earlier detection of Jimmy Savile.** **Professional staff are bound by their codes of conduct (NMC, GMC, HCPC, GPC) to raise criminal cautions/ convictions with their professional bodies.** **It is a criminal offence to request a DBS check on anyone who is not carrying out a controlled or regulated activity**	**Bank staff are checked annually –** **Fit and Proper Persons Test declaration/ checks for new starters cover this adequately at Board level** **DBS policy is active and currently in date**	**Complete – no further action save policy review in 2016.**

R9 All NHS hospital trusts should devise a robust trust-wide policy setting out how access by patients and visitors to the internet, to social networks and other social media activities such as blogs and Twitter is managed and where necessary restricted. Such policy should be widely publicised to staff, patients and visitors and should be regularly reviewed and updated as necessary	**SXB: The newly updated Media Policy includes this.**		**Achieved in Updated Media policy**	**Complete**

R10 All NHS hospital trusts should ensure that arrangements and processes for the recruitment, checking, general employment and training of contract and agency staff are consistent with their own internal HR processes and standards and are subject to monitoring and oversight by their own HR managers.	**Lack of control over contract staff, in particular.** **Risk shifting away from contract managers and service managers makes this unviable.**	**Head of HR Operations to contact Head of Facilities to ensure SLA's with contractors are sufficiently robust to assure against risk.**	**There are contract standards in place regionally in order for (in particular) medical and nursing staff to have received expected checks from agencies. These are audited regionally as part of the framework.** **It is expected that contractors in estates/ facilities will follow appropriate guidance in providing people who are fit for purpose in terms of professional qualifications and any necessary checks**	**31 March 2015**

R11 NHS hospital trusts should review their recruitment, checking, training and general employment processes to ensure they operate in a consistent and robust manner across all departments and functions and that overall responsibility for these matters rests with a single executive director.			**Director of Workforce and OD has this responsibility.** **Equality and diversity annual reporting, together with staff survey analysis, in addition to grievances against the recruitment and selection process, offer assurance in this regard**	**Complete**
R12 NHS hospital trusts and their associated NHS charities should consider the adequacy of their policies and procedures in relation to the assessment and management of the risks to their brand and reputation, including as a result of their associations with celebrities and major donors, and whether their risk registers adequately reflect such risks.	**Partially Achieved by updated media policy** **Risk Register requires review**	**Risk Register to be reviewed in conjunction with Chair of Committee**	**Partially Achieved in Updated Media policy**	**31st May 2105**

R13 Monitor, the Trust Development Authority, the Care Quality Commission and NHS England should exercise their powers to ensure that NHS hospital trusts,(and where applicable, independent hospital and care organisations), comply with recommendations 1, 2, 4, 5, 7, 9, 10 and 11.	**As described in relevant sections**			
R14 Monitor and the Trust Development Authority should exercise their powers to ensure that NHS hospital trusts comply with recommendation 12.	**As described in relevant sections**			
I confirm that this NHS foundation trust Board reviewed the full recommendations in Kate Lampard's lessons learnt report SIGNED: DATE: CE NAME:				

Please return to MonitorJSlearnings@monitor.gov.uk by 5pm Monday 15 June 2015. If you have any questions or queries you may also use this email address to send them to us.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 April 2015 **ENCLOSURE NUMBER: 11**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Professor Phil Begg Director of Strategy and Transformation**
SUBJECT:	**Update on 5 Year Strategic Plan Progress**

TITLE:

SUMMARY

This report provides an update to Board members of key issues and Progress on the development of the Strategic Plan.

IMPLICATIONS

To ensure Board members are appraised of the requirements from Monitor on the 2015/16 cycle of strategic planning.

RECOMMENDATIONS

- The Board is asked to accept the report and acknowledge the progress to date.
- The Board is asked to note the contents of the report and discuss items as appropriate.

Report To:	Trust Board
Report of:	Director of Strategy and Transformation
Purpose of the Report:	To update the Board on the progress of the Strategic Plan 2015/16.
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 developments in the development of the 5 year strategic plan.

1 The 2015/16 Monitor Requirements.

The 2015/16 cycle has been challenging, with a changing timeline and requirements normally expected.

In December 2014 Monitor issued guidance on the 2015/16 planning cycle. In a break with normal cycles of planning, Monitor required Foundation Trusts to submit a 1 year Operational Plan with a specific set of headings and financial details.

It is clear that in this cycle Monitor are looking for assurance around Trust to either, refresh or recommit to their current strategic plan or in extreme cases to recreate their plan. The main focus will be centred on:

1. Strategic context including:

    a. any variation to the plan,
    b. changes in performance in regard to finance, quality or targets,
    c. changes in the external environment
    d. changes in commissioning assumption/affordability;
    e. Significant changes in government/regulatory policy.

2. Progress against delivery of the strategy including:

    a. Response to 5 year Forward View;
    b. Strategic initiatives;
    c. Poor performance;
    d. Key themes;
    e. Capital programme
    f. Resources.

3. Plan for short-term resilience.

4. Quality priorities

5. Operational requirements

6. Financial forecasts

7. Board Declaration.

The deadlines for submission were, the high level 3 page summary by 27th Feb 2015, and the final 20 page plan by 10th April 2015. The first drafts of these were sent around the board in late January and again, following the Board meeting in early February for comment; this draft is attached in appendix 1 of this report for information only. The completed document required the financial aspects to be attached and was due to be submitted on time.

We were advised shortly before the deadline that a new revised timetable would be released and that the original timescales had been altered, no draft was required by the 27th February, although some activity data was still required to be submitted. This was submitted on time.

The new deadlines have now been advised and are as follows:

- Submission of draft plans (3 pages) - 7th April 2015
- Plans to be approved by Trust Boards – Early May 2015
- Final plans (20 pages) – 14th May 2015
- Feedback to Trusts – July 2015

Although, at this point, there is no formal requirement to revise the full 5 year strategic plan, it is likely that in the late summer, early autumn of this year that an updated 5 year strategy will be required with year 1 of the new plan being 2016/17.

2. Our Internal Timeline

The attached draft, has been through two cycles of Board oversight for review and comments, it will go through one further cycle during the first week of April 2015. Following this review it will be submitted to Monitor on 7th April 2015.

The more extensive 20 page document will be developed during mid-April and circulated for comment and additions, and will have final oversight by the Trust Board prior to submission on 14th May 2015.

Work will begin on the review of the more detailed 5 year strategic plan in June 2015, with a target of refreshing and preparing for a potential Monitor submission in the autumn of 2015.

5 Recommendation

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

Appendix 1.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Draft One Year Operational Plan (Summary Document)

2015-16

The Royal Orthopaedic Hospital NHS Foundation Trust

Our vision is,
"To be the FIRST CHOICE for ORTHOPAEDIC CARE"

1. Introduction

In the first year of the current 5 year Strategic Plan, the Trust has made good progress towards the delivery of the 7 strategic initiatives clearly set out in the narrative last year. The infrastructural work required to deliver the transactional component is well underway with significant changes in processes and material hardware such as IT investment and a clear IM&T strategy developed in support of delivering a modern fit for purpose organisation.

The transformational initiatives have been more challenging, but have still developed well, and the Trust Board has full engagement and oversight of the change agenda and plans. This has largely been achieved with the establishment of a Transformation Committee of the Board being implemented and chaired by a Non-Executive Director. The singular focus of the committee is to hold to account, monitor and challenge strategic developments within the organisation that materially improve the patient experience within the Trust.

Following the Trusts participation as a pilot site for the CQC inspection programme for specialist Trust, we have, in collaboration with our stakeholders, developed a detailed action plan, to further improve the quality of our clinical care and facilities to raise the CQC rating from 'needs improvement' to 'Good' on our journey to 'Outstanding. Work is underway to meet the outcomes agreed in our action plan, although there have been some significant challenges in year.

Although, the context of this summary is set within challenging times, the vision and values, commitment to the delivery of our strategic initiatives and our measurement of outcomes remains consistent. This summary of our Operational Plan will set out our key assumptions for 2015/16 and associated risks in delivery alongside our financial summary and potential pressures and drivers of our forecasted financial performance

2. Key Assumptions 2015/16

- **Financial:** 2015/16 will be a challenging year financially for the Trust. Tariff changes result in a loss of income of c.£1.5m, with unfunded national cost pressures linked to pay award changes, CNST cost pressures and the implications of recommendations linked to the Francis report & 7 day working of £0.6m. The Trust has built into the financial model tariff deflation of 2.18%, employee expense inflation of 1.91% and non-pay inflation of 4.54%.

  The Trust has modelled an overall CIP target of £2.8m (3.5%), in line with the efficiency target included with the national tariff.

  Despite this challenging CIP target, the Trust is expecting to deliver a deficit position before impairments in 2015/16 of £2.0m.

- **Workforce:** The planned growth in the number of patients treated will be cared for through more effective use of existing workforce capacity as well as additional staff employed in some specific roles. Each CIP scheme which involves a reduction in the workforce will be risk assessed to ensure safe patient care can be maintained. It is expected that a small number of non-clinical staff will be redeployed or potentially made redundant during the year. An area of focus during the year will be to increase the efficiency of the medical workforce through implementation of a new workforce

model providing care to inpatients together with further improvements in job planning for consultant medical staff. Our work on improving the organisational culture will continue with a specific focus on improving clinical standards, particularly to address compliance matters arising in 2014 and improving overall medical engagement following work undertaken by the Kings Fund.

- **Commissioners:** A growth rate of around 3% in day case and elective activity commissioned by West Midlands CCGs has been assumed within our planned financial position for 2015/16. This is based on the trend of referrals we have seen within the past year. This has been built in to contract baselines with our local CCGs. Our projections also include the reinvestment of under-performance on specialist services in 2014-15 into additional support for our spinal deformity service. These discussions are ongoing with NHS England, but have been received favourably to date.

- **Transformation:** The 7 main work streams are being led by an executive director and are overseen in the Transformation committee, improvement work is underway with examples being the introduction of digital dictation, out-patient improvements in physical environment and in IT solutions to ensure a smoother patient pathway through the hospital systems, electronic prescribing management systems procurement and roll out, nursing acuity tool, developing new models of care and transforming the workforce. We will be exploring this with partners in orthopaedic care nationally and internationally to investigate gold standards in care for our patients.

3. Key Drivers of Financial Performance

The Trust is committed to a position of diversification and business development this will be done by:

- CCG Growth
- Support for other providers
- Development of sustainable plans to address long-term challenges around specialist services waiting times

Growth in demand / activity projections

- CCG referral growth – The Trust has seen a 6.1% growth in referrals across our CCG contracts in 2014/15, based on a 12-month moving average. Whilst this is due to a range of factors, with differential rates across our various sub-specialties, there is a clear correlation between the timing of the increase in referrals and the escalation of access and RTT issues within neighbouring acute Trusts.

  In discussion with our CCG commissioners, taking into account the limitations of basing forward projections on short-term trends, we have agreed an increase in funding for day case and elective activity of between 3% and 4% for the majority of our CCG contracts.

The Trust has taken active steps in highlighting the unique benefits that we can offer with regards to access, capacity and relative certainty of care regarding elective surgery, and this is clearly having an impact on our referral numbers.

- Demand to support health economy RTT delivery – The Trust has been approached by a number of Trusts in 2014/15 to support them with their ongoing RTT challenges. We have worked particularly closely with Walsall Healthcare NHS Trust, undertaking 179 outpatient attendances and 73 elective procedures for them in the period from October 2014 to January 2015. Agreements are in place to continue this arrangement into 2015/16, with Walsall indicating they wish to commissioner services to provide around 50 elective procedures per month.

  The Trust has also had conversations with a number of other Trusts around providing additional support, and anticipates further opportunities in 2015/16 to support ongoing RTT challenges within the local health economy. Our current financial projections include a prudent 15 day cases and 25 elective procedures per month from Walsall and other NHS providers.

- Spinal Deformity growth – The Trust continues to face major challenges with access to spinal deformity surgery, with a handful of patients breaching 52 weeks in Quarter 4 of 2014/15. Access to capacity with appropriate paediatric intensive care facilities remains the major stumbling block to addressing this backlog of patients, however we are working closely with the University Hospitals of North Midlands NHS Trust with the aim of accessing one theatre list per fortnight on their Stoke site. This would provide capacity to treat 26 major scoliosis cases per annum, and our modelling suggests this could reduce waiting lists back towards 18 weeks over the next 2 years. An element of this growth is being built into contract baselines with NHS England, and discussions are ongoing about the possibility of funding additional activity at 100% of tariff.

Tariff changes

Despite significant concerns with the changes to the tariff in 2015/16, the Trust has reluctantly agreed to sign up to the Enhanced Tariff Offer in order to provide some certainty in income streams moving forward. The financial model is therefore based on this tariff pricing.

The tariff has a major impact on the financing of orthopaedic services, which has created massive financial challenges for single-specialty orthopaedic trusts. Changes the orthopaedic prices are largely driven by a significant reduction in the national quantum of funds within Chapter H of the payments by results tariff structure. This, in conjunction with the tariff deflator, has resulted in expected losses of circa £1.5m for the ROH in 2015/16.

The price changes proposed, in addition to the 70% marginal rate for specialist growth, will have a significant impact on the financial performance the ROH is able to deliver in 2015/16.

Inflationary increases

Our current financial model has utilised the expected inflationary increases assumed within Monitor's draft tariff guidance, with two notable exceptions:

- Pay Award – This has been modelled based on the revised offer to trade unions at the end of January, however funding was not made available within the tariff for the changes agreed in the revised offer.
- CNST – The Trust's CNST premium has increased by £850,000 between 2014/15 and 2015/16. Our modelling suggests that only £600,000 of funding has been made available within the differential CNST increases in tariff chapters, leaving a cost pressure of £250,000 for the trust to fund locally.

CIPs / Transformational efficiencies

The Trust is planning to achieve an overall CIP saving of £2.8m (3.5%), in line with the efficiency target included with the national tariff.

The £2.8m expenditure savings target includes key schemes relating to negotiated savings on prosthetics, the use of digital dictation and reducing agency spend.

In addition, the Trust has been working with Newton Europe to identify process opportunities in theatres, outpatients, radiology and the ward environment that we feel give us significant scope to make major process efficiencies and support the Trust's growth plans.

The Trust recognises that this is a challenging CIP target of 3.5%, however schemes have already been identified to achieve 95% of this target. Work is still ongoing to develop detailed project delivery plans in some of these areas.

4. Alignment with Main Commissioners

The Trust plans to deliver around 3% growth in day case and elective surgery, and these figures have been built into contract baselines. These contracts have not yet been signed, but the finance and activity plans have been agreed in principle.

Discussions are still ongoing with NHS England regarding our specialist services contract, however these have been largely positive to date and the Trust anticipates some growth in spinal deformity surgery being supported within our contract.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 April 2015 **ENCLOSURE NUMBER: 12**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Paul Athey**
AUTHOR(S)	**Paul Athey, Director of Finance & Alex Gilder, Deputy Director of Finance**

TITLE	**1 year operational plan and 2015/16 Budget**

SUMMARY

This paper, and associated appendices, details the 2015/16 Budget and the information to be included in the draft operational plan, which will be submitted to Monitor on 7th April.

In addition to the overall financial position, the paper outlines the Trust's Cost Improvement Programme and Capital Plan for 2015/16, and includes details on risks and mitigation strategies in place to support delivery of the financial target.

A discussion will take place in the private session of the Trust Board regarding alternative financial models, so this paper should be considered in conjunction with those discussions.

RISK & IMPLICATIONS

The paper includes a detailed review of the risks and implications inherent in the financial plan

RECOMMENDATIONS

The Trust Board are asked to:

- Approve the 2015-16 revenue plan, including a planned deficit of £2m
- Approve the 2015-16 directorate budgets in line with Appendix 1
- Approve the 2015-16 capital plan in Appendix 4
- Note the planned mitigations in place if a downside scenario occurs

Introduction and Strategic Context

2014-15 has been a particularly challenging year for the Trust's finances, with an expected deficit outturn position for the first time.

The planned outturn for the year was a surplus of £500k, which was lower than the previously achieved surplus in 2013-14 of c.£2m due largely to investment in transformation.

The outturn position however, is expected to be a deficit of c.£200k, and has been driven by additional cost pressures particularly linked to locum and agency staffing, in addition to recurrent and non-recurrent costs in relation to medicines management. The agency spend has been driven largely through ensuring junior doctor compliance, ensuring safe staffing levels on the wards in line with the Francis report recommendations and to cover vacancies in areas with recruitment challenges due to national or local staffing shortages.

The 2014-15 position has not been aided by the underachievement of CIP, with an expected gap of c.£600k, c.£430k of which is within theatres.

Many of the pressures felt in 2014-15 are likely to continue within 2015-16, although there are also some additional significant challenges. These include;

- Tariff – Changes in the national Payment by Results tariff have resulted in the Trust losing around £1.5m from our NHS clinical income baseline
- Unfunded national cost pressures – The Trust has a shortfall of £600k in the funds set aside in the tariff to cover national cost pressures. This includes over £200k on CNST premiums, around £200k on that national Agenda for Change pay award and the cost pressures linked to meeting national expectations within the Francis Report and the national contract.
- Local cost pressures – These include the cost of meeting the recommendations from the CQC and medicines management reviews, an increase in the cost of rehab beds in the community and the impact on depreciation and PDC of our capital investment programme.

In addition to the above particular challenges, the Board continues to be clear that transformation of the Trust is required to ensure the Trust is fit for purpose in the coming years. The original budget of £1m set aside to deliver the transformation identified in the Trust's 5 year strategy in retained in this financial plan.

As a result of the above, the Trust is planning a deficit position of £2.0m in 2015-16.

This is unprecedented for the Trust, and relies on the organisation being able to deliver a challenging CIP of £2.8m, in addition to meeting our activity growth targets.

A summary of the expected financial position for 2015-16 is shown below:

	2015-16 Plan (£m)	2014-15 Forecast Outturn (£m)
Clinical Revenue	74.9	72.6
Other Operating Revenue	5.5	6.2
Total Operating Revenue	**80.4**	**78.8**
Pay	(46.2)	(45.4)
Clinical Supplies	(20.8)	(20.5)
Non Clinical Supplies	(4.4)	(4.4)
Other operating expenses	(6.8)	(5.0)
Total Operating Expense	**(78.2)**	**(75.3)**
EBITDA	**2.2**	**3.5**
Non-operating Revenue & Expenses	(4.2)	(3.7)
Deficit before Impairments	**(2.0)**	**(0.2)**

Healthcare Income & Activity

a) Tariff

As previously discussed at Trust Board, the Trust has signed up to the Enhanced Tariff Offering (ETO) for 2015/16. The key features of this tariff, in comparison to 2014/15 are:

- Significant reductions in the funding within Chapter H (Trauma and Orthopaedics), estimated at over £200m nationally.
- Increased funding for outpatients
- Inbuilt efficiency of 3.5%
- Specialist work performed over the 2014-15 plan paid at 70% of tariff
- Marginal rate removed for over-performance on unbundled diagnostic scanning.

The change to tariff will result in a reduction of income in the region of £1.5m.

b) Contract negotiations

Contract negotiations are ongoing with Birmingham Cross City CCG, acting as host commissioner for the West Midlands CCGs and with the NHS England Team with regards to Specialist Commissioning.

Discussions thus far have been largely positive, and at the time of writing, we are close to agreeing finance and activity plans with both commissioners. We have been successful in negotiating activity increases of between 3%-4% (against our recurrent baseline) to be included within our CCG contracts, whilst discussions with NHS England suggest that they are supportive of our plan to reinvest the underperformance in this year's specialist services contract into our spinal deformity service rather than banking the saving. These discussions

are still ongoing, and the Trust is continuing to push for additional spinal deformity activity to be funded over and above our contract baseline. The introduction of the 70% marginal rate for this activity has complicated the negotiations, however we are continuing to argue our case for full funding support.

We have also received support from our host CCG to increase the rate charged for Oncology outpatient attendances and funding for the nurse led clinics we run for metal-on-metal patients. This additional income is largely offset by an agreed reduction in the tariff for heel pain shockwave therapy. The cost of providing this therapy is significantly lower than the income received, and as a result the tariff has been reduced to ensure continue support for this growing service.

In addition to our commissioner negotiations, we have continued to work with other local providers to support their elective activity challenges. The Trust has a verbal agreement in place to take 50 arthroplasty patients a month from Walsall Healthcare NHS Trust, and is also working with George Elliott NHS Trust to take a smaller number of revision joints.

c) <u>Activity plan</u>

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

	2015-16 Activity Plan	**2014-15 Forecast Outturn**	**Growth %**
Day Cases	8,300	8,118	2.2%
Electives	7,143	6,858	4.2%
Non Electives	304	305	(0.3%)
Total	**15,747**	**15,281**	**3.0%**

The additional growth in elective surgery in comparison to day cases is driven by the case-mix of the work agreed with Walsall Healthcare NHS Trust.

Directorate budgets

The Executive Management Team is required to recommend to the Trust Board an operating budget for approval at its April meeting for the following financial year. The operating budget forms the basis of the plan to be submitted to the regulator Monitor in April 2015.

The process for budget setting is split into the following 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 asked to sign off their budgets;
- Income – contractual negotiation with commissioners takes place to determines 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 2015-16. The cost pressures were then collated – bids in excess of £4.9m were received.

The bids were then considered by the Director of Finance, Director of Operations and Deputy Director of Finance, with further queries being raised where appropriate. These bids were then split into 3 categories;

- Funded (£2.6m) – This includes national cost pressures, such as CNST increase, and unavoidable local cost pressures such as the increase cost of rehab beds. It also includes costs link to a growth in actual and planned activity, including increased spend on surgical implants.
- Not funded (£1.2m) – the Directorates are required to mitigate these pressures and/or fund these cost pressures through their existing budget. A number of these costs relate to existing overspends that are being addressed through transformation schemes. In some instances where there is a longer lead time for transformation, the costs have been centrally reserved and will be released non-recurrently during the transformation.
- More information required (£1.2m) – these costs have been reserved and will be released based on further appropriate information being 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, directorates have been asked to draft their individual business plans. As part of this process, the Directorates were asked to identify their aspirations and options for growth, and to develop business cases for funding.

These bids took the form of a 1-2 page pitch document, to ease the initial burden on Directorate of writing full business cases.

In total £1.7m of bids were received for development funding. Where these bids related to opportunities for growth or invest to save schemes, these will be considered by the Cost Improvement Programme Board and full business cases will be requested where appropriate. A number of the bids also related on ongoing transformation workstreams, so will considered through that route. Any bids either not in line with existing transformation priorities, or not likely to generate a financial contribution, have not been taken forward for support at this stage.

c) CIP Plans

The Trust requires a reduction in its cost base of £2.8m or 3.5% in 2015-16. This represents the level of cash that must be released from budgets and reduced from actual spend.

This level of efficiency gain is significant and has only been achieved once before in 2012-13 (with £2.3m of savings from one scheme in that year – repatriation from BMI). A target of this magnitude will need close monitoring, and strong focus by the Director Managers, Clinical Directors and Executives.

Initial plans were submitted by Directorates as part of the Business Planning process. These plans currently total £862k. In addition to these schemes, the Executive Team have highlighted a number of trust-wide improvement and efficiency schemes, the majority of which are linked to existing transformation workstreams. These schemes total an additional £1,640k

The combined total of the Directorate and transformation schemes is £2,502k, leaving a shortfall of £285k. A further £278k of mitigating schemes also need developing in order to provide a 10% contingency for underperformance. These issues have been discussed at Cost Improvement Programme Board, and each Directorate is aware of the additional target that they are required to achieve.

The Trust intends to use the disciplines of the Transformation programme to manage a number of the major CIP schemes, and all scheme leads will be developing project plans and quality impact assessments to ensure efficient and safe delivery of the required savings.

Details of the Cost Improvement Programme Schemes have been included in Appendix 3.

Capital Plan

Over the next year the Trust anticipates spending £8.1m on capital schemes. Appendix 4 shows the detail supporting this expenditure plan, and the audit trail from year two of the five year capital plan approved in 2014/15.

The major items of planned expenditure are as follows:

- £2.0m on the new ePMA system
- £1.4m on other IM&T equipment and developments to support the Trust strategy
- £0.5m on theatre environment improvements
- £1.2m on other estates schemes
- £1.2m on the build costs for a new MRI scanner
- £1.2m on the final stages of the current Radiology equipment replacement programme
- £0.6m on theatre and other clinical equipment replacement

The proposed capital programme for 2015/16 has been reduced by £2.5m in line with the reduction in the planned surplus. This maintains cash balances at a sustainable level.

Appendix 5 shows the existing capital programme for 2016/17 to 2018/19. The Board are asked to consider whether the capital programme for the next 4 years continues to represent the main priorities within the Trust's strategy and whether it continues to address our key risks.

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
Underperformance in activity or deliver of activity plan at additional costs to planned levels	• Activity plans broadly in line with activity levels delivered since September 2014. • Detailed directorate level activity plans are being agreed with each clinical team • Key growth areas are producing operational delivery and resourcing plans • Ongoing performance management through Directorate Performance Reviews
Non achievement of expenditure CIP	• Each Directorate to plan for 10% contingency • Each major scheme to have a lead director and operational lead. • Major schemes to be monitored through the Transformation Committee and to be governed by robust project management principles. • CIP Programme Board to monitor ongoing performance and escalate as appropriate
Contract penalties for non-achievement of CQUIN, waiting times and other KPIs	• CQUINs to be limited to fewer number of major schemes, each to be delivered using robust project management principles. • Ongoing negotiation with NHS England regarding capacity constraints around the delivery of 52 week targets in spinal deformity. • Progress to be monitored via Executive Management Team and Trust Board • Ongoing performance management through Directorate Performance Reviews.
Agency and locum spend remains at the current monthly level	• Medical Workforce Project re-invigorated and moved within the remit of the Transformation Committee • Options for e-rostering and electronic booking of agency and locum staff being considered • Ward staffing model under review by Interim Director of Nursing & Governance • Refresh of theatre recruitment programme • Introduction of new operational structure will allow recruitment to corporate vacancies • Continued agency and locum sign off at Exec Director level
Recurrent and non-recurrent costs of medicines management higher than expected	• Close monitoring of costs at Executive level

The risks are not dissimilar to the challenges faced during 2014-15, but given the current deficit plan, there is substantially reduced flexibility in the overall plan. It is therefore vital that these risks are minimised through strong planning and performance management.

If a downside scenario occurred, the following additional mitigations would be required:-

Further Mitigations	Explanations	Value (£'000)
Increase activity target, generating additional contribution	A further increase in the target could deliver additional contribution if costs could be appropriately controlled	£200k - £500k
Release of contract penalty reserve	£250k has been reserved in the financial plan to mitigate an element of commissioner fines and underperformance on CQUIN targets	£250k
Reduction in transformation funding	Transformation funding would be held back and potentially withdrawn to offset overspends. Approximately £600k of costs have not yet been allocated.	£600k
Reduction in capital expenditure	The capital plan could be scaled back, thereby reducing both the revenue impact of the increase in assets (depreciation & PDC dividends), and also avoiding any revenue costs associated with the delivery of the schemes	£100k-250k
Other mitigations	More challenging measures such as vacancy controls, headcount reduction and reductions in discretionary spending (e.g. training) would be implemented	£100k-£200k
	Total Further mitigations	**£1,250k - £1,800k**

Recommendations

The Trust Board are asked to:

- Approve the 2015-16 revenue plan, including a planned deficit of £2m
- Approve the 2015-16 directorate budgets in line with Appendix 1
- Approved the 2015-16 capital plan in Appendix 4
- Note the planned mitigations in place 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	192	7,360	4,038			(422)	**10,976**
Paediatrics	37	1,691	56			(122)	**1,625**
Oncology	67	3,482	2,339			(200)	**5,621**
Spinal	56	3,086	1,832			(122)	**4,796**
Small Joints	15	1,208	9			(92)	**1,125**
Large Joints	115	5,279	870			(122)	**6,027**
Theatres	221	9,256	11,556			(31)	**20,781**
Estates	17	605	1,825			(289)	**2,141**
Facilities	75	1,605	2,002			(285)	**3,322**
Patient Access	37	875	14			(22)	**867**
R&D	3	130	-			-	**130**
Corporate	122	5,726	8,027			(545)	**13,208**
							-
Total Directorates	**959**	**40,303**	**32,568**	**-**	**-**	**(2,252)**	**70,619**
							-
Trust Wide Income						(75,784)	**(75,784)**
Development Reserves					1,212		**1,212**
Growth Reserves					2,637		**2,637**
Operational Reserves*				(2,786)	6,102		**3,316**
							-
Total Trust Wide	**959**	**40,303**	**32,568**	**(2,786)**	**9,951**	**(78,036)**	**2,000**

*Operational reserves include reserves for areas such as 15-16 pay award, the ongoing cost of agency & locum staffing in clinical areas and local cost pressures where more information has been requested prior to the release of funds.

Growth reserves will be allocated to Directorates upon final agreement of local activity plans, in line with specific growth areas.

Development reserves include the remaining elements of the transformation fund plus funding to support the impact of the CQC and medicines management reviews

Appendix 2 – Cost Pressure Decisions by Directorate

Directorate	Fund	Hold in Reserves	Do Not Fund
	(£'000)	(£'000)	(£'000)
Small Joints	£0	£0	£108
Management	£99	£59	£93
CNST	£864	£0	£0
Spinal	£4	£118	£21
Estates	£19	£0	£42
Facilities	£122	£21	£28
Theatres	£1,265	£238	£701
Oncology	£34	£74	£88
Clinical support	£29	£289	£62
Large Joints	£161	£42	£65
Ward / HDU Nursing		£340	
	£2,597	**£1,181**	**£1,208**

Appendix 3 – Cost Improvement Programme Progress by Directorate

Schemes	**Plan**
Trust-wide schemes - Cash releasing	
Prosthesis Savings - Negotiated prices and associated efficiencies	£300,000
Tighter controls of surgeon ADHs & compliance with 42 week rule	£150,000
Digital Dictation	£200,000
Reduced length of stay, thereby reducing outsourcing	£375,000
Trustwide schemes - Efficiency (Doing more for same resources)	
Improving list utilisation	£225,000
Reducing theatre cancellations	£225,000
Reducing DNAs / Outpatient efficiency	£165,000
Contingency / Planned Slippage	-£164,000
TOTAL TRUSTWIDE SCHEMES	**£1,476,000**
Local Schemes - Cash releasing / income generating	
Small Joints	£27,586
Estates & Facilities	£137,000
Theatres, HDU & ADCU	£220,000
Clinical Support	£193,724
Corporate	£433,000
Contingency / Planned Slippage	-£131,051
Unidentified	*£430,246*
TOTAL LOCAL SCHEMES	**£1,310,506**
TOTAL EXPENDITURE SCHEMES	**£2,786,506**

Appendix 4 – Detailed Capital Plan 2015/16

	2015/16 - Plan approved by the Board in June 2014	Brought forward into 2014/15	Slippage from 2014/15	Slippage to 2016/17	Reduction in spend - Reduced surplus target	Proposed changes	REVISED PLAN v2 - 2015/16	Notes
General Site improvements / rationalisation								
- Fire & DDA	30						**30**	
- Hospital Signage	9						**9**	
- Replacement Windows	43						**43**	
- Enabling Works Gas	65						**65**	
- Enabling Works Electricity	65						**65**	
- Legionella Works	22						**22**	
- Estates Rationalisation	43						**43**	
- Lifts	65						**65**	
- Asbestos Removal	43						**43**	
- Road works	85						**85**	
- Cadbury House Refurbishment						**200**	**200**	
- Demolition of Wards 5 & 7 / Theatre Pad						**350**	**350**	
- Improvement works in theatres						**500**	**500**	**Environmental improvements (£200k), Move Plaster Room**
- Estates contingency						**200**	**200**	
IT Infrastructure								
- Servers / Disaster Recovery / VDIs - Other	21		77				**98**	
- Data Warehouse	0		600		(600)		**0**	**Functionality of Data Warehouse obtained through revenue upgrades in 2014/15. Savings of circa £500k on**
- Ongoing replacement / maintenance	285						**285**	
IT - New Systems								
- Pharmacy / E-Prescribing	1,000		1,500	(500)			**2,000**	
- Portal to support Electronic Patient Records	1,500				(1,000)	**(300)**	**200**	**Current projection suggests original estimate of spend was too high. Some costs in 15/16, with further development in 16/17**
- New clinical systems / Electronic Patient Record	2,000				(900)	**(900)**	**200**	
- Clinical Outcomes	0		50				**50**	
- Referral management system						**100**	**100**	**In line with current transformation schemes**
- Electronic document management						**200**	**200**	**In line with current transformation schemes**
- InTouch Kiosks						**110**	**110**	**In line with current transformation schemes**
- Mobile Devices						**100**	**100**	**In line with current transformation schemes**
- Digital Dictation						**26**	**26**	**In line with current transformation schemes**

Draft Capital Programme - 2015/16 (continued)

New MRI Scanner								
- Equipment	1,500			(1,500)			**0**	
- Build	1,400		100			**(312)**	**1,188**	**Based on QS assessment**
Radiology Equipment - New & Replacement								
Image intensifiers	360						**360**	
DR Plates	1,100					**(300)**	**800**	
Other	60					**(40)**	**20**	
Theatre Equipment - Replacement								
Operating Tables	100		80			(120)	**60**	
Anaesthetic Equipment	56					34	**90**	
Arthroscopy Stacking systems	60					(60)	**0**	**Based on theatre review on revised priorities**
Power Tools	50	(50)					**0**	
Theatre lights	40						**40**	
Other	50					105	**155**	
Stock System						90	**90**	**To address challenges with stock storage and monitoring in**
Other Equipment								
- Rolling Replacement Programme	50						**50**	
- Emergency Equipment replacement	100					**17**	**117**	
	10,202	**(50)**	**2,407**	**(2,000)**	**(2,500)**	**0**	**8,059**	

Appendix 5 – Detailed Capital Plan 2016/17 onwards

	2016/17 - Plan approved by the Board in June 2014	Slippage from 2015/16	Reduction in spend - Reduced surplus target	REVISED PLAN - 2016/17	2017/18 - Plan approved by the Board in June 2014	2018/19 - Plan approved by the Board in June 2014
General Site improvements / rationalisation						
- Fire & DDA	17			17	29	17
- Hospital Signage	5			5	8	5
- Replacement Windows	25			25	41	25
- Enabling Works Gas	37			37	61	37
- Enabling Works Electricity	37			37	61	37
- Legionella Works	12			12	20	12
- Estates Rationalisation	25			25	41	25
- Lifts	37			37	61	37
- Asbestos Removal	25			25	441	25
- Road works	50			50	82	50
IT Infrastructure						
- Ongoing replacement / maintenance	400			400	400	400
IT - New Systems						
- Pharmacy / E-Prescribing	0	500		500		
- New clinical systems / Electronic Patient Record	500			500	1,000	1,000
- Clinical Outcomes	500			500		
- PAS/ORMIS Replacement	3,000		(240)	2,760		
New MRI Scanner						
- Equipment	0	1,500		1,500		
Radiology Equipment - New & Replacement						
MRI Scanner (Renewal of lease)	0			0	0	1,500
Image intensifiers	360		(360)	0	0	0
DR Plates	200			200	200	200
Building work linked to new equipment	400		(400)	0	0	500
Theatre Equipment - Replacement						
Operating Tables	100			100	100	100
Anaesthetic Equipment	56			56	56	56
Arthroscopy Stacking systems	60			60	60	60
Power Tools	50			50		
Theatre lights	20			20		
Other	50			100	100	100
Other Equipment						
- Rolling Replacement Programme	50			50	50	50
- Emergency Equipment replacement	100			100	100	100
	6,116	**2,000**	**(1,000)**	**7,166**	**2,911**	**4,336**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 April 2015 **ENCLOSURE NUMBER: 13**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Interim Company Secretary**
SUBJECT:	**Trust Board Committees : TOR and Membership**

This paper proposes minor changes in relation to the Trust Board's Committees' Terms of Reference and changes to Trust Committee Membership to reflect the appointment of a new Non-Executive Director and previously discussed revisions to existing NED portfolios.

IMPLICATIONS

. In summary it is proposed to:

1. Update the terms of reference of the Clinical Governance Committee (CGC), Transformation Committee and Remuneration Committee to reflect minor changes in wording proposed by the Chairman , the CGC itself and HH Frances Kirkham
2. Update the membership of the Transformation and Audit Committees to reflect the request from Elizabeth Chignell to stand down from them
3. Appoint Mrs Kathryn Sallah who has recently been appointed to the Board as a Non-Executive Director to the Audit, Remuneration, Nominations and Clinical Governance Committees.

RECOMMENDATIONS

The Board is asked to:

1. Approve the revised terms of reference of the Clinical Governance Committee, Transformation Committee and Remuneration Committee as detailed in Appendices 1 and 3
2. Approve or confirm the appointment of Chairmen and Committee members as listed in Appendix 4

Appendix 1

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Clinical Governance Committee
Terms of reference
Revised April 2015

1 Constitution

The Constitution of the Trust provides that 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

The Constitution states that "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.

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; this includes the authority to approve any Trust policy (including any revision to a Trust Policy) relating to a clinical matter except for policies which the Chief Executive considered, acting on appropriate clinical advice, needed to be approved more quickly than the Clinical Governance Committee could accommodate
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 establish Advisory Groups including forums. The Committee shall determine the membership and terms of reference of those Advisory Groups including forums.

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, clinical policies 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 The committee will oversee, by appropriate monitoring of actions taken by responsible officers the provision of evidence of trust performance in line with contractual requirements commissioners.

6.2 **Leadership for quality**
6.2.1 Provide oversight to maintain a focus on quality by the Trust's leadership provide assurance to the Board regarding the adequacy of 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

6.2.3 The committee will review and approve the Trusts' clinical policies subject to the exclusion explained in paragraph 2.1.2

6.3 **Regulatory Assurance** – Monitor and CQC (review of guidance, CQC outcome assurance report, quarterly governance declaration)
6.3.1 The committee will oversee, by appropriate monitoring of actions taken by responsible officers, 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 receive reports on cases which are dealt with by the NHSLA or any successor body and will seek to monitor lessons learnt.

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
At least two other NEDs
Medical Director
Chief Executive
Director of Nursing and Governance

9 Quorum

At least 2 NEDs and one from Medical Director or Director of Nursing and Governance

10 Secretariat
Company Secretary

11 In attendance, by invitation

Deputy Director of Nursing
Others relevant to the agenda of the meeting such as chairs of advisory groups

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 April 1st 2015
Date of review April 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Remuneration Committee Terms of Reference
Revised April 2015

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 oversee the application of any remuneration arrangements that are related to the performance of individual directors such as the application of variable pay schemes

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. Members of the committee have the power to elect one of their members as Vice Chairman to act as the Chairman in the absence of the substantive Chairman

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 and April 01 2015

16 Date of review
April 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Transformation Committee
Terms of Reference – April 2015

1 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 and other groups 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. Members of the committee have the power to elect one of their non-executive members as Vice Chairman to act as the Chairman in the absence of the substantive Chairman. This should ideally be 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
At least 1 and up to 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
01 April 2015

16 Date of review
April 2016

Appendix 4

Committee Chairmen and Membership: Existing

The membership of the Board's Committees as agreed in October 2014 was as follows (C = Chair, M= Member):

	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
KS					
CE			M	M	M
MD				M	M
DN				M	M
DF					M
DO					M

Committee Chairmen and Membership: Proposed

With the appointment of Mrs Kathryn Sallah as the new NED and as a member of the Audit, Remuneration, Nominations and Clinical Governance Committees, and with Elizabeth Chignell stepping down from the Audit and Transformation Committees, the proposed Committee membership is as follows:

	Aud	Rem	Noms	CGC	Trans
YB		M	C		M
TP	M	M	M		C
FK		M	M	M	
EC		C	M	M	
TS		M	M	C	
RA	C	M	M		M
KS	M	M	M	M	
CE			M	M	M
MD				M	M
DN				M	M
DF					M
DO					M

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

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.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 April 2015 **ENCLOSURE NUMBER: 14**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Interim Company Secretary**
SUBJECT:	**Policy on the development and approval of ROH Policies**

This paper proposes a revision to the Policy on the development and approval of ROH Policies. The original policy dates from May 2013; this version has been reviewed by Frances Kirkham, non-Executive Director following discussions at Clinical Governance Committee. It incorporates feedback received after consultation across the Trust.

IMPLICATIONS

This rationale for this proposal is to improve the clarity of the above policy and to align it better with recent changes in the powers delegated by the Board to approve policies.

Related work is being carried out to update Trust policies and to improve policy governance for example in providing better assurance that updated polices have been cascaded to Trust staff and that over time , all "sub-policy" documents such as protocols and guidelines come under the remit of an existing or new policy. For this reason it is expected that a further review of this policy will be undertaken in around six months' time.

RECOMMENDATIONS

The Board is asked to:

1. Approve the revised Policy on the development and approval of ROH Policies as detailed in Appendix 1

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

DRAFT – Version 8
Policy on the development and approval of ROH Policies

This document replaces the 'Policy for development of policy documents' approved in March 2013 insofar as that Policy applied to the contents of this policy

VERSION NUMBER	V8
APPROVAL DATE	
REVIEW DATE	October 2015
NAME OF GROUP/PERSON APPROVING THE POLICY	
DATE PUBLISHED ON INTRANET	

Contents

1. Executive Summary

1.1 Policy Aim

This policy aims to set standards which all Trust policies should adhere to.

All staff must act in accordance with the law. In relation to guidance issued by a relevant professional body and/or national guidance the Trust expectation is that this will be followed. Exceptionally, where it is considered that such guidance should not be followed this must be approved by an appropriate authority and documented.

It is Trust policy that there should be no standalone protocols or guidelines although it is accepted that until work is completed to rectify the existing situation there will be a transitional period when such standalone protocols or guidelines will exist. A standalone protocol or guideline is one that does not fall under the remit of a Trust policy.

1.2 Activity during the transitional period

Standalone protocols or guidelines can be divided into two categories:

1.2.1 Category (a) - Those which could fall within the remit of a specific existing policy

These protocols or guidelines should be brought under the remit of the policy to which they relate and approved with that policy.

1.2.2 Category (b) Those which affect more than one policy or which relate to no existing policy

These should be regarded as potentially giving rise to policies in their own right and therefore the expectation would be that a new policy needs to be created and approved in accordance with the process set out in this policy.

At the end of the transitional period the treatment of any deviation from guidance issued by a relevant professional body and/or national guidance will be specified within the relevant policy as described in this section.

1.3 Policy Description

This policy provides details on the agreed standards for the process of development, approval, implementation, and archiving of all Trust policies.

Guidance on the use of this policy and support to meet its requirements can be sought from the Governance Department or Company Secretary.

1.4 References

None

1.5. Policy Objectives

The objectives of this policy are to provide standardisation across Trust-wide policies, guidelines and protocols including as a minimum:

1.5.1 Required content for all policies:

a) Lead author and Executive sponsor;
b) Rationale for policy;
c) Legislative, professional body or other national guidance;
d) Mandatory external reporting;
e) List of supporting references as appropriate;
f) Arrangements for internal monitoring and reporting mechanisms.

1.5.2 Compliance requirements for all policies:

Mandatory appendices bundle:

a) Checklist for new or renewed policies;
b) Implications for implementation of the policy;
c) Equality Impact Assessment;
d) Implementation plan.

Document Control Information

AUTHOR (POLICY AUTHOR) / OWNER	Company Secretary
DIRECTOR / POLICY SPONSOR	Company Secretary
APPROVED BY	**Trust Board**
DATE OF APPROVAL	

PROCEDURAL CHECKLIST

CONSULTATION COMPLETED	Yes
CONSULTATION TRACKING SHEET COMPLETED	Yes
VERSION CONTROL INFORMATION COMPLETED	Yes
APPROVAL CHECKLIST COMPLETED (APPENDIX M1)	Yes
IMPLICATIONS FOR IMPLEMENTATION COMPLETED (APPENDIX M2)	Yes
EQUALITY IMPACT ASSESSMENT COMPLETED AND DECLARATION FORM (APPENDIX M3)	N/A
IMPLEMENTATION PLAN COMPLETED (APPENDIX M4)	Yes
DATE SUBMITTED TO POLICY COORDINATOR	25/3/2015
CHECKED BY POLICY COORDINATOR	Yes

Key Performance (compliance/success) Indicators (KPI)

Describe Key Performance Indicators (KPI's)	How will the KPI be measured	Target	Who will Monitor this KPI?	Frequency of Review	Responsible Lead
All Trust policies should comply with this policy	Audit	100%	Governance Manager	Bi-Annually	Company Secretary

Performance Management Of The Policy

Responsible for producing action plans if KPI's are Not Met	Who is responsible for monitoring of action plan	Frequency of Monitoring (To be agreed by Committee)
Company Secretary	Executive Management Team (EMT)	Bi-Annually

2. Introduction

2.1 It is important for the provision of safe healthcare services that clinical and non-clinical practice is covered by policies, guidelines and protocols and that there is an understanding within the organisation of the difference between strategies, policies and procedures, where they apply and how they should be utilised. Policies support staff to fulfil their duties and provide supporting guidance to practice where needed. From this point on, The Royal Orthopaedic Hospital NHS Foundation Trust will be referred to as the Trust.

2.2 All proposed documents which fall within the scope of this policy must follow the approach outlined in this policy

2.3 In particular, in addition to policy information, it is important to describe methods for consultation, dissemination and audit in order that policies are consulted on, disseminated and appropriately implemented. It is important that Trust-wide policies, are clear and provide useful reference material to support the delivery of Trust business. Without this, the Trust cannot be assured that practice is appropriate and it will not be possible to meet legislative and best practice required standards which require policies to be in place, compliance with individual policies to be audited and that action plans are established to remedy any deficiencies highlighted by audits.

2.4 The main purpose of Trust policies, is to standardise practice, to reflect the best available evidence, to reduce unnecessary variations and to improve the quality and equality of service delivery and to promote a positive patient experience. Having effective, up to date and easy to follow policies will help to minimise risks to patients, employees and the Trust.

2.5 This policy acknowledges and recognises the distinctions which exist between what is classified as an approved policy, a procedure and a guideline. Definitions of what distinguishes an approved policy, a procedure and a guideline can be found below. Further definitions which are relevant in relation to this policy can be found in Appendix 1.

3. Definitions

CGC Clinical Governance Committee

Guideline A recommended approach, parameter, etc. for conducting an activity or task, or utilising a product.

Policy A document which sets standards, and advises on decision making and actions. Policies constrain employees within bounds prescribed by the organisation's mission, objectives, strategy and values. Policies often reflect statutory legislation and/or NHS mandatory objectives.

Policy Author The individual who will complete all written work on the policy, and describe the processes outlined in the policy.

Policy Coordinator The individual who oversees and coordinates the review of all policies.

Policy Renewal Used when policy content has been reviewed and found to require either minimal or significant change. Amendments will be made following the approved development process.

Policy Roll-over Used when a policy requires no changes. The review date will be amended and the policy will go through the consultation and approval process as normal.

Policy Withdrawal Used when a policy is no longer relevant and is therefore withdrawn from the intranet and from circulation. A policy shall not be withdrawn without the approval of whichever person or Committee is responsible for approving any changes to the policy.

Procedure A set of actions which are the official or accepted way of doing something. Reasons for any deviation from the procedure are required to be recorded.

Protocol A system of rules and expected behaviour that may also form an arrangement between partners or agencies.

Strategy A long term plan of action designed to achieve a particular goal/objective.

Trust means the Royal Orthopaedic Hospital NHS Foundation Trust

4. Scope

4.1 The scope of this document covers all Trust polices.

4.2 This policy applies to all members of staff working within the Trust who are involved in any aspect of policy development.

4.3 If there is uncertainty regarding whether the process outlined in this policy applies to a given procedural document, the Governance Department can offer advice to staff.

5. Duties/Responsibilities for Policy on Policy Documents

5.1 Company Secretary

- Has delegated Executive responsibility for the development, implementation and monitoring of compliance with this Policy and as such is the designated Policy Sponsor.
- Has operational responsibility for development of this policy and as such is the designated Policy Author.

5.2 Governance Manager

- Will receive proposals from staff regarding the development of new policies along with rationale for the development of new policies or the review of existing documents and ascertain what work is required before continuing.
- Is responsible for ensuring this policy is reviewed at least every 3 years or whenever national policy or guideline changes require amendments.

- Will maintain a record of all who have participated and provided feedback on the various drafts of the policy (see Document Control Information at the front of this policy or the Policy Template – **Appendix 3** of this policy - for the Consultation Tracking Sheet).

5.3 Policy Author

- Will ensure adherence to this policy when producing other Trust policies.
- Will ensure all policies they are responsible for producing are updated on a timely basis

5.4 Policy Coordinator (Governance Department)

- Will receive copies of all proposed policies and undertake a final check to ensure all policies comply with the requirements of this policy and are in the appropriate style and format as outlined in this policy prior to submitting directly to the CGC, Chief Executive or Trust Board for approval.
- Will publish policies on the Trust Intranet once approved and notify the policy author and policy sponsor / director if a policy is out of date or due for review.
- Will notify the policy author and policy sponsor / director if policies within their area of responsibility are due for renewal or out-of-date and electronically archive the old policy and accompanying documents in order that they can be accessed for the purposes of audit or litigation.
- Will regularly provide an up-to-date list of policies to the HR Department in order that they may keep track of the Equality Impact Assessments (HR will be be responsible for electronically archiving these in a secure folder in order that they can be accessed for the purposes of audit or litigation).
- Will ensure that all those responsible are aware of the requirement to audit their policies for compliance.
- Will provide the person or group responsible for approving a policy with an approval checklist and details of the previous audit of compliance if applicable.
- Will receive a copy of this policy for a final check and ensure it complies with Trust requirements, submit directly to the Trust Board for approval and publish this policy on the Trust Intranet once approved.

5.5 Managers /Clinical Directors/Senior Nurses/Clinical Leads

Managers, Clinical Directors, Senior Nurses and Clinical Leads at all levels of the organisation are responsible for overseeing the implementation of all Trust policies, procedures, protocols and guidelines within their area of responsibility.

It is the responsibility of Managers/Clinical Directors/Senior Nurses/ Clinical Leads to:

- Ensure staff have the opportunity to read new policies relevant to them or their area of work.

- Ensure that staff sign to confirm they have read and understood any new policy which is relevant to their area of work.

- Deal appropriately with any concerns regarding 'failure to comply' which are escalated to them.

Where education sessions are provided to inform staff about specific policies, it is the responsibility of the Manager or Clinical Director to ensure staff are released to attend these and to keep a record of attendees.

It is the responsibility of each Manager/Clinical Director to ensure that the policies used in their service are:

- Appropriate for their patient groups / staff group.
- Appropriate for the competency levels of staff.
- Authorised for use and reviewed in accordance with the requirements of this policy.
- In line with best practice.

Each Manager/Clinical Director should also escalate any comments regarding future policy amendments to the relevant policy author and/or Executive sponsor.

5.6 Head of Communications

Provides advice on matters such as the process of disseminating policies via cascaded briefings.

5.7 All Staff

All staff have a professional, contractual and legal duty to appraise themselves of, and comply with current Trust policies.

Relevant staff members may be required to sign to indicate that they have read and understood relevant policies.

Failure to comply with Trust policies without justified and documented reason may result in disciplinary action, dismissal and referral to professional regulatory bodies for further sanction.

Apparent justified failure to comply should be escalated to the relevant Manager or Executive at the earliest opportunity.

6. Main Body of Policy - Policy Development

6.1 Style and Format

6.1.1 The template (see Appendix 3) will be used as a model for all Trust policies, guidelines and protocols. Authors of policy documents must use this template.

6.1.2 All Trust policy documents should contain the following sections as outlined in Appendix 1 to this policy:

- Title page
- Executive summary including aim, description and objectives
- Key references
- Introduction
- Definitions
- Duties/Responsibilities

- General Principles (main body of policy)
- Training
- Appendices (document specific)
- Appendices (mandatory)
    - Local Group Endorsement I Checklist
    - Implications for Implementation Form
    - Equality Impact Assessment Form
    - Implementation Plan

6.1.3 All documents must be produced electronically in Arial font, size 12.

6.1.4 Paragraphs must be numbered.

6.1.5 A footer must be included giving the title of the document, a version number, clearly identified page numbers, e.g. Document Control Policy, Version 1, page 1 of 3.

6.1.6 The Trust Logo must be present on the front page.

6.1.7 An explanation of any terms used in the documents development must be evident in the definitions section of the document.

6.1.8 Associated Documents must be listed in the associated documents section of the policy.

6.1.9 Each document should contain a version history and draft number.

6.2 Consultation Process

All Trust policy documents should go through an appropriate consultation process before approval. The policy author should consult with relevant stakeholders prior to developing a draft policy for wider consultation across the Trust in accordance with the consultation list. In order that staff have the opportunity to comment upon the proposed policy content the draft policy must be circulated for a minimum period of **two weeks** prior to approval. The author should consider all submitted comments and make changes to the document as appropriate. Guidance on the appropriate circulation of draft documents may be sought from the Governance Manager or Company Secretary.

6.3 Approval Process

6.3.1 All policies must be endorsed by a designated expert group or individual, and approved by the appropriate authority as set out in this document . It must be documented clearly in the relevant minutes when policies have been approved.

6.3.2 Policy authors must complete the front sheet report (Appendix 2) when requesting that the Policy Coordinator submits policies for approval.

6.3.3 The date of approval should be recorded on the document control information.

6.3.4 Authority to approve policies

6.3.4.1 Clinical policies

The CGC will approve any Trust policy relating to a clinical matter (including any revision to a Trust Policy) except for:

a) Policies which the Chief Executive considers, acting on appropriate clinical advice, need to be approved more quickly than the CGC can accommodate.

b) The approval of policies under (a) will be by the Chief Executive acting on appropriate clinical advice, including at least one clinically qualified Executive Director.

6.3.4.2 Operational and managerial policies not relating to specific powers reserved by the Board of Directors

These policies are approved by the Chief Executive.

6.3.4.3 Policies relating to specific powers reserved by the Board of Directors.

These policies are approved by the Trust Board itself.

6.4 Removal of policies

Removal of Trust policies must be authorised in line with the authority for approval of policies as described in this document.

6.5 Review Process

6.5.1 The date of review should be stated within the policy document.

6.5.2 A document may be reviewed any time before the date stated. This may be prompted by changes in national guidance, research, legislation, organisational structure or following an adverse incident.

6.5.3 As a result of a policy review, the policy may then be "renewed", "rolled over" or "withdrawn" (see definitions in section 4 of this policy).

6.5.4 If the review leads to minor revisions of the document (eg. formatting and/or typographical revisions with no changes to the policy content), these can be managed through version control and approval by the usual approving authorities without full consultation. General dissemination to relevant areas may be done via the email system and other forms of cascaded briefing.

6.5.5 If, following a review of the policy, a change in practice is required, then the policy will require additional consultation prior to approval by the relevant approving authorities.

6.5.6 Managers and Clinical Directors will be notified by the policy author of any new / updated policies. The author will send the policy via email. Managers and Clinical Directors should ensure that they have a system in place to ensure staff have read and understood new or updated policies.

6.5.7 If a policy author leaves the Trust, the responsibility for review of the document transfers to the post holder's successor. If a policy author leaves the Trust and the post is not replaced, it is the responsibility of the accountable director to maintain the policy.

6.5.8 Each policy should have an audit of compliance undertaken a minimum of once every three years and the policy coordinator should be notified of this.

6.6 Control of Documents

6.6.1 All documents must contain a version number.

6.6.2 A **Document Control Information Bundle** should be included within every Trust policy. No policy, guideline or protocol may be published on the intranet without a completed document control sheet. The mandatory details which must appear in the document control sheet for all policies can be found in Appendix 1.

6.6.3 Documents under development or under review must be clearly identified as draft until approved.

6.6.4 Only current versions of documents will be available on the Intranet.

6.6.5 To eliminate the risk of staff following out dated policies, hard copies should be removed from all wards and departments. Staff can access policies, through the 'Policies' section on the intranet.

6.6.6 The policy coordinator will arrange for publication of all policies on the intranet

6.7 Mandatory external reporting requirements

All Trust policies should include details of mandatory reports required for external bodies.

6.8 Archiving of Documents

6.8.1 Following the revision of a policy document the policy coordinator will update the copy of the policy in the Trust's "Incident Control Room."

6.8.2 Intranet versions of Trust policies, guidelines and protocols are 'Read Only' documents.

6.8.3 Photocopying Trust policies is not permitted except for educational and specific reference purposes. Once used for these purposes, copies must be destroyed to ensure out of date policies are not used. However one exception to this is the printing of a copy of the policy for the Incident Control Room for the purposes of emergency planning. This will be done by the policy coordinator once the policy has been finally approved and published.

6.8.4 In accordance with the Freedom of Information Act, release of Trust policies in response to external requests is permitted. The Trust is open to sharing such documents with other healthcare providers and members of the public. All policies (including archived policies) will be made available by the policy coordinator in a "PDF", watermarked form, on the external Trust website as well as internally on the Trust Intranet.

7. Dissemination Process – all policies

7.1 The policy coordinator in conjunction with the policy author will co-ordinate the process of disseminating policies via cascaded briefings on the advice of the Head of Communications.

7.2 Dissemination of policies that require considerable practical application may include workshops, awareness events or specific implementation training session to be arranged at the discretion of the policy author.

7.3 Relevant staff members will sign to show that they have read and understood relevant policies via their line manager (see duties and responsibilities above). The line manager will retain a copy for their records and return a copy to the policy coordinator who will retain in the Governance P/shared drive folder for audit purposes. This can also be done electronically using voting buttons on the email header, should this be appropriate.

8. Key Performance (success) Indicators

All policies, guidelines and protocols will contain defined key performance indicators as part of the Document Control Information Bundle.

9. Equality and Diversity

9.1 The Trust is committed to an environment that promotes equality and embraces diversity both within our workforce and in service delivery. This policy will be implemented with due regard to this commitment.

9.2 Equality Impact Assessments

An Equality Impact Assessment (EqIA) is a tool for identifying potential or actual impact of a policy or service on groups of staff, patients or carers. It can help staff provide and deliver excellent services and policies by making sure these reflect people's needs. There is also a legal requirement to do so in relation to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender/sex and sexual orientation. They must be carried out for policies current and new, services current and new, strategies current and new, and procurement / service level agreements.

The author, or those responsible for the policy, must complete an EqIA and complete the appropriate form in the mandatory policy appendices to reflect this. Once the policy is formally approved the impact assessment must be returned to Human Resources by the author, so that the impact assessment can be logged and uploaded onto the ROH website. It is a legal requirement for all impact assessments to be published.

For full details please see the Equality Impact Assessment Procedure which can be found, along with the relevant screening forms on the Intranet HR site

10. Supporting References

The content of policies, guidelines and protocols must be based on evidence of best practice and research evidence where this exists. They must ensure compliance with statutory legislation, DoH guidance or directives and professional codes of practice. It is recommended that a literature search is made to identify the range and status of documents currently in existence and where possible to obtain information from similar documents in existence from other trusts. These sources of information should be referenced in the 'reference' section of the policy.

11. Training

11.1 The policy document should include information on training requirements if appropriate, for example to ensure that staff are able to meet the standards described within the policy. Where training requirements relate to mandatory training, this is managed through the Trust's mandatory training programme. Where additional and/or specialist training is identified, this is managed through the Trust's training needs analysis and personal development review processes.

11.2 Consideration of both mandatory and specialist training should be contained in all Trust wide policy documentation.

12. Appendices to this policy

12.1 APPENDIX 1- Policy Development Guidance

12.1.1 **Title page** – This should have the Trust logo, title of the policy, version number, review date and date published on the intranet.

12.1.2 **Document Control Information** – This bundle should contain details of the policy author, sponsor, overseeing group or committee, approving committee and date of approval; this is followed by the version tracking sheet, procedural checklist, consultation tracking sheet, compliance monitoring table, and details of performance management of the policy.

12.1.3 **Associated documents** – these will be identified on the Document Control sheet and will refer to other relevant documents available within the organisation that support the policy.

12.1.4 **Key Performance Indicators (Success/ Compliance Monitoring)** – All policies must include key performance/ success indicators. These are a short list of measurable indicators that will show if there is compliance with the policy. These success indicators can be measured, monitored and audited to ensure that a policy is being complied with.

12.1.5 **Contents** – This should be tabulated and linked to headings, sub-headings and page numbers.

12.1.6 **Executive Summary** must contain:

- **Aims** - Overall purpose of the document and what it aims to achieve.
- **Description** – General statement about what is laid out in the policy.
- **Key references** – Documents/ legislation of key importance in relation to the policy.

12.1.7 **Introduction** - This will be a short overview for the rationale behind the policy.

12.1.8 **Objectives** - What will be achieved and measured as a result of the guidance included in the policy.

12.1.9 **Scope** - This defines the staff who are governed by this policy (eg. all nurses, all employees) or the areas that will be impacted by the policy. This will not constitute a definitive list, nor does it preclude managers from identifying additional staff to whose attention the document must be brought.

12.1.10 **Definitions** – Terminology included in the policy and related to the policy will be explained and defined.

12.1.11 **Duties/Responsibilities** - This includes the key responsibilities and expectations of managers, staff groups etc. required by this policy.

12.1.12 **General Principles** – this is the main body of the policy containing the relevant guidance that staff/ visitors/ contractors should follow.

12.1.13 **References** - This section will include references to all material relevant to the content. This may include research, national/regional policy and current legislation.

12.1.14 **Appendices** - Appendices should be used for any additional information that is related to the policy, but is not a procedural step that must be followed. A Mandatory appendices bundle (see 6.1.2) must accompany all policies.

12.1.15 **Implementation Plan** - All policies must contain an implementation plan (**Mandatory appendix M4**). The implementation plan will contain details of targets, timescales and names of responsible individuals. The policy author will be responsible for facilitating the implementation of the policy in line with the requirements and timescales outlined in the implementation plan.

12.2 APPENDIX 2 – Summary of Policy Report to CGC, EMT, Trust Board

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: **ENCLOSURE NUMBER:**

SUMMARY OF POLICY REPORT TO CGC/Chief Executive (advised by EMT)/Trust Board

NAME OF DIRECTOR: (PLUS TITLE)	
NAME OF AUTHOR: (Plus title)	
TITLE OF POLICY:	

Reason for policy coming to CGC/Chief Executive (advised by EMT)/Trust Board for authorisation:

	Yes/No
New Policy	
Renewal of existing policy – no changes	
Full policy review with significant changes (record highlights below)	
Update to existing policy – changes made (please list these below)	

Please specify what and why changes have been made, in brief. If there are a significant number of changes, please just record the highly important details below:
(E.g. due to new legislation, new guidelines, titles being changed etc.)

12.3 APPENDIX 3 – Policy Template

POLICY TEMPLATE

Please double-click on this icon to open the policy template.

If you are unable to open this document please contact the policy coordinator in the Governance Department on ext. 55809

13. Mandatory Appendices Bundle

13.1 APPENDIX M1

Checklist for new or renewed policies

Name of Policy: Development and approval of ROH of Policies
Name of Policy Author / Policy Sponsor: Alison Braham/Julian Denney

Question	Response Y/N
Does the policy have the appropriate approved front cover layout including the ROH NHS Foundation Trust Logo	**Y**
Is the policy written in 12 point Arial font	**Y**
Is the Document Control Information Bundle complete o Author/ Sponsor/ Committee information o Version Tracking o Procedural checklist o Consultation tracking sheet o Compliance monitoring o Performance management o Contents page	**Y**
Has the policy been reviewed for Equality Impact Assessment ?	**Y**
Have Mandatory Appendices M1-M4 been completed and provided to the group?	**Y**
Has a review date that is a maximum of 2 years from the date of ratification / approval been included in the document control information?	**Y**
Are the pages in the policy numbered?	**Y**
Is the policy name included in the footer?	**Y**
If this policy replaces a previous document, have the results of a previous audit of compliance (undertaken in the previous 2 years) been provided to the group	**N** (not considered essential for the previous document but suggest review before next revision of this policy
Does the policy include references	**N** (not considered essential for this revision but suggest review before next revision of this policy)
Has the submission sheet been completed (See Policy on Policy documents **Appendix 2**)	**N** The standard Board submission sheet has been used as the use of the policy submission sheet

	in this document will not have been authorised by the Board until this policy revision is approved
Has the policy been reviewed by an expert? If yes, please include name(s) of expert(s)	**Y** Frances Kirkham, Julian Denney and Alison Braham have expertise in governance
Does the policy comply with national guidance associated with the policy and list this national guidance. Please explain any instances where such guidance has not been complied with	As far as we are aware there is no directly relevant national guidance but suggest review again before next revision of this policy
Does the policy comply with relevant legislation associated with the policy? Please explain any instances where such legislation has not been complied with	As far as we are aware there is no directly relevant legislation but suggest review again before next revision of this policy
Does the policy comply with requirements of any professional bodies? yes, please list professional body and requirements. Please explain any instances where adherence to the requirements of a professional body has not been complied with	As far as we are aware there is no directly relevant requirements of any professional bodies but suggest review again before next revision of this policy
Additional comments from the group approving the policy	
Name of group approving the policy	**Clinical Governance Committee, Chief Executive (on advice of EMT),Board**
Chair of the group approving the policy	**Chair of Clinical Governance Committee, Chief Executive, Chair of the Trust Board**

13.2 VERSION TRACKING

Version	Date	Author Name and Designation	Summary of Main Changes
V2	June 2014	Helen Shoker, Director of Nursing & Governance	Various simplifications plus focus on policies relating to a clinical matter and guidelines etc rather than all policies
V3	Feb 2015	Julian Denney interim Company Secretary	Aligning the approval process with the Feb 2015 Board decision and further simplification
V4	12 Feb 2015	Julian Denney interim Company Secretary and Alison Braham Governance Manager	Post CGC review – focus on all policies rather than clinical policies only
V5	13 Feb 2015	Alison Braham Governance Manager	Continuation of post-CGC review and review of changes in main document to ensure alignment with policy template.
V6	26 Feb 2015	Julian Denney interim Company Secretary and Frances Kirkham non-executive director	Further amends and tidying up
V7	24 March 2015	Alison Braham Governance Manager	Incorporation of feedback received during consultation process
V8	25 March 2015	Julian Denney interim Company Secretary	Further amends and tidying up

13.3 CONSULTATION TRACKING SHEET

This document must be completed and accompany the policy through the final approval process. A copy of this sheet should be included at the front of the final published policy.

NAME OF POLICY: Policy for development of policy documents

Name of person / team / committee asked to provide feedback	**Date request for feedback sent**	**Feedback received Y/N**	**Feedback incorporated into policy Y/N**
Chief Executive	3rd March 2015	N	N/A
Chair	3rd March 2015	N	N/A
Executive Management Team (EMT)	3rd March 2015	Y	Y
Clinical Governance Committee	3rd March 2015	Y	Y
Clinical Directors	3rd March 2015	N	N/A
Directorate Managers	3rd March 2015	N	N/A
Matrons	3rd March 2015	N	N/A
Senior Nurses	3rd March 2015	Y	Y
Learning, Development and Equalities Manager	3rd March 2015	Y	Y
Public and Patient Services Manager	3rd March 2015	Y	Y
Head of Communications	3rd March 2015	Y	Y

13.4 APPENDIX M2 – Implications for implementation of this Policy Implementation

This document must be completed and accompany the policy through the final approval process.

Title of Policy: Policy on the Development and approval of ROH Policies

Policy Author: Governance Manager

Name of Policy Sponsor: Julian Denney Company Secretary

The following points include those aspects that need to be considered prior to the authorisation of this policy:

Staffing issues arising from implementation of this policy:

Dedicated time of Policy Coordinator, no major impact across Trust.

Training issues arising from implementation of this policy:

Staff awareness sessions required.

Awareness and consistent application to be supported and endorsed by EMT and CGC.

Funding / Cost Issues arising from implementation of this policy:

None.

Barriers to implementation of this policy:

None.

Implications on other services or processes from implementation of this policy:

CGC will need to allow sufficient time to consider policies.

13.5 APPENDIX M3 – Equality Impact Assessment Form –

Please refer to the Equality Impact Assessment procedure (in the Equality & Diversity policy) on the intranet for further details.

Stage one – *(all policies and strategies)*

Name of project, policy or activity: Policy on policy documents.

Staff member(s) completing screening assessment:

Name: Alison Braham, Governance Manager

Date: 25/03/2015

Screening decision:

Please delete as applicable*:

~~**No*** We have decided we should proceed with section one (EIA screening).~~
Yes* We have decided it is not necessary to undertake EIA screening after all.

Statement explaining this decision:

There is no impact on any staff, all are treated equally within this policy.

13.6 APPENDIX M4 – Implementation Plan

Implementation Plan - Development of Policy, on the Development of Policy documents

No	Objective	Responsible	Deadline	Status
1	Amended policy to be approved by the Trust Board	Company Secretary	April 2015	
2	Staff awareness campaign to be run to increase staff awareness regarding the process for policy development, including e-mail communications to staff, information to be included in staff newsletters and staff information leaflets to be developed and disseminated.	Policy Coordinator Governance Manager	May to July 2015	
3	6 monthly review to be undertaken	Governance Manager	October 2015	
4	Annual review and audit of compliance to be undertaken	Policy Coordinator	March 2016	

Royal Orthopaedic Hospital

Audit Committee- Informal Report from the Chair

Audit Committee met on the 24 February 2015, matters to brief the Board are:

1. The Committee was preceded by a routine private meeting between the Chair and NED (Tim Pile) with Internal Audit (Baker Tilly), Counter Fraud (Baker Tilly) and External Audit (Deloitte).

2. At this meeting the Chair provided an outline brief on the current control issues relating to the performance of clinical audit, lapsed policies (including clinical policies) and the Non Compliances in the theatre environment relating to the security of controlled drugs.

3. The Chair explained that these provided a very challenging environment for the Trust but the Board and SMT response had been extremely robust and that there was now compliance within the CD arena and that key policies had been reviewed and approved. There was a plan to urgently review all remaining policies.

4. Assurance and investigative work was continuing and KPMG had been supporting the Board and SMT with specialist support relating to the issue of controlled drugs. The regulator and Governors had been briefed and the management response had been supportive.

5. Although not able to discuss the detail, the meeting briefly considered the implications of these matters on:

    a. The Annual Governance Statement
    b. The current Board Assurance Framework
    c. The future work programme for the Committee and in particular supporting the co-operation and closer working between AC and CGC (and its sub committees).

    The committee then turned to the formal agenda

6. The committee received reports from Internal Audit (Baker Tilly), Counter Fraud (Baker Tilly) and Deloitte (external audit). Key points to note are:
    a. Deloitte-
        i. Briefed the committee regarding the likely content of the new enhanced audit report.
        ii. Notified the Committee that the 18 week RTT target was to become a mandatory target from Monitor and performance would be subjected to formal audit in relation to the quality report. They also explained that the Trust would have a choice as to the second mandatory indicator- between 62 Day cancer wait and 28 day re-admissions.
        iii. Briefed the committee that the Trust would need to make a statement in its AGS on how it achieve assurance over the accuracy of its waiting time data.
        iv. Discussed the new Continuity of Service Risk Rating approach- Whilst some Trust might “fall foul” of this change it was felt that this wouldn’t materially impact ROH.
        v. The committee discussed that current situation with regard to the Tariff options. It was acknowledge that the continuation of the Cquin’s was important for the Trust and so it was more likely that the revised Enhanced Tariff offering would be accepted.
        vi. The committee then discussed the Going Concern Statement for the Annual report. The committee agreed that Option 1 (Clear going concern) was the preferred option, but it was acknowledged that it would not take much to slip into option 2 (Going concern but with significant uncertainties that required disclosure).

b. Counter Fraud briefed the committee on the progress made implementing the CF plan for 2014/15. The plan was on track and the Committee considered the proposed plan for 2015/16. The LCFS briefed on 2 referrals that had come to the Trust attention through the Speak Out Safely initiative.

c. Baker Tilly briefed the Committee on the following Internal Audit matters:
    i. The current internal audit plan remains on schedule and a number of reports were in process. There were no material matters to report, although, there were two reports where management responses remained outstanding. PA agreed to follow-up urgently.
    ii. Three reports were made available to the committee- General ledger, Income & Debtors and Payroll. The committee noted that these provide substantiate assurance, substantial assurance and reasonable assurance respectively.
    iii. It was acknowledged, that internal audit (having completed audit work during the year on the control around waiting times), would liaise with external audit regarding the audit of the 18 Week Mandatory Indicator
    iv. The committee reviewed the proposed audit plan for 2015/16. This plan had been aligned to the Trust risk management processes and was therefore fairly robust. The following additional points were noted:
        1. Controlled drugs and clinical engagement was included within the plan (after consultation with Chair of CGC), however the committee might need to consider providing further support to clinical audit processes and support the CGC once current assurance and investigative work was completed.
        2. There are likely to be emerging requirements in relation to the Transformation Programme- for example IT/IS projects benefits realisation.
        3. CQC follow-up may give rise to further recommendations.
        4. It was agreed that we would revisit the plan at the next committee meeting. A joint meeting between AC and CGC might be helpful in defining priorities.

d. The committee reviewed progress with the plan to enhance hospitality registers and declaration of interests.

e. Jonathan Lofthouse joined the meeting and briefed on the losses relating to a private patient case. He also provided a brief update relating to private patients more generally. The Board would be receiving the revised strategy for private patient's.

f. Jonathan also briefed the committee on the matter of a significant over payment to a consultant. The committee was reassured that this had arisen due to understandable circumstances and the full amount was being recovered. However concerns about compliance with HR policies remains.

g. The committee received an update on the current situation for Breeches and Waivers. The Trust benchmarks quite well with these and assurances were generally strong.

h. The Committee discussed the matter the Information Governance toolkit. The committee asked PA to discuss the matter with SMT to get an agreement on the strategy.

7. The committee reviewed its own proposed workplan for the coming year. It was agreed that the committee should consider how it obtains its assurances from other committee and build in to the plan.

8. The committee agreed to timetable a workshop in the summer where it could review its own effectiveness. This to include other committees and executives as appropriates.

9. Lisa Pim joined the meeting to provide a brief update on the BAF process.

Rod.

Enc. 16

Royal Orthopaedic Hospital
Clinical Governance Committee meeting 11 March 2015

The CGC met on 11 March. We were not quorate so took no decisions nor gave any approvals. However, we had a most useful discussion.

1. Pre-operative fasting remains a matter for concern. Written information provided to patients should be clearer and simpler. A further report will be provided for the April CGC meeting.

2. A number of policies/protocols/guidelines needed approval. It was considered that the CEO could deal with approval of these outside the meeting, as it was necessary to deal with these urgently. However, it was agreed that we needed a review of our approach to policies and in particular how all guidelines and protocols could be brought within the scope of Trust policies. GM and JD agreed to report to the April CGC meeting on the scale of the work likely to be needed.

3. William Rae attended to discuss his paper reporting on the Drugs & Therapeutics Committee ("DTC")
    a. A large variety of drugs are kept on different theatres. Some are used infrequently. This results in waste. DTC wish to restrict the ability of consultants to exercise individual choice. WR will report progress at the April CGC meeting.

    b. There are concerns regarding control of unattended drugs in anaesthetic rooms. WR will report further next month, and consider whether the risk register needs to reflect this.

    c. Theatre drug stocks e.g. Hepsal –different strengths of drugs are in theatres despite contrary instructions. WR will identify for AP any individuals whose behaviours have not changed despite this having been drawn to their attention. AP or WR will report to CGC in April.

    d. WR reported that there is now much better understanding of the Trust's response to CD errors and that the response had been proportionate.

    e. CD usage – pharmacy audit has shown that Theatre 5 uses much more remifentanil than others – this is related to spinal deformity work done there

    WR will attend the April CGC meeting.

4. The Hygiene Code sets out the standards expected for infection control and cleanliness. There are particular difficulties with theatres because, for example, of layouts and access to sluices. AP commented that in other trusts the infection control lead is able to stop activity, but in similar circumstances at ROH this is not done.

5. Quality Governance Framework: progress on this is still limited. GM will report to the April CGC meeting.

6. There was no report regarding safe staffing. A report will be prepared for the April Board meeting.

7. There is still no Clinical Audit Committee. AP is dealing with this.

Frances Kirkham 21 March 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 1 April 2015

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 1 April 2015 commencing at 10.15am in the Board Room at the Royal Orthopaedic Hospital NHS Foundation Trust.

Members of the public and press are welcome to attend. The agenda for the public part of the meeting is shown below:

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Alison Newman, Management Offices or via email Alison.Newman3@nhs.net.

Dame Yve Buckland

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
TO BE HELD
ON
WEDNESDAY 1 APRIL 2015 AT 10.15AM
IN THE BOARD ROOM

AGENDA

ITEM	TITLE	NOTES	BOARD ACTION	PAPER
04/15/01	**Apologies & Welcomes** **Rod Anthony, Anne Cholmondeley, Tim Pile, Jonathan Lofthouse**		To Note	
04/15/02	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
04/15/03	**Patient Case – an illustration of the work we do** Director of Nursing and Governance			
04/15/04	**Minutes of Public Board Meeting held on the 4th February 2015** Chairman		For Approval	Enc. 1
04/15/05	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
04/15/06	**Chairman & NED update** **Including:** • Recruitment of additional NED • PAS replacement - contract extension - action by the CEO and Chairman under the urgent decisions rules • Board development including planned visits to Sheffield and Manchester. Chairman & NEDs		For Information	
04/15/07	**Chief Executive's Report** Chief Executive		For Information and Assurance	Enc. 3
04/15/08	**Medical Director's Update** Medical Director		For Information and Assurance	Enc. 4

04/15/09	**2015/2016 Board work plan** Chairman /Interim Company Secretary		For Approval	Enc. 5
	Performance Management / Assurance Reports			
04/15/10	**Corporate Performance Report** Director of Finance		For Assurance	Enc. 6
04/15/11	**Patient Quality Report** Director of Nursing & Governance		For Assurance	Enc. 7
04/15/12	**Safe Staffing Report** Director of Nursing & Governance		For Assurance	Enc. 8
04/15/13	**CQC Action Plan** Director of Nursing & Governance		For Assurance	Enc. 9
04/15/14	**Kate Lampard's report into Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile – initial observations prior to undertaking further work** Director of Nursing & Governance		For Information and Assurance	Enc. 10
	Strategy			
04/15/15	**Update on Five Year Strategic Plan** Director of Strategy and Transformation		For Information	Enc. 11
04/15/16	**1 year Operational Plan and Budget Sign Off** Director of Finance		For approval	Enc. 12

04/15/17	**TOR and Membership of Board Committees** Chairman /Interim Company Secretary		For approval	Enc. 13
04/15/18	**Policy on the development and approval of ROH Policies** Interim Company Secretary		For approval	Enc. 14
	Board Committees/Council of Governors updates			
04/15/19	**Audit Committee**		For Assurance	Enc 15
04/15/20	**Clinical Governance Committee**		For Assurance	Enc 16
04/15/21	**Charitable Funds Committee**		For Assurance	Verbal
04/15/22	**Transformation Committee**		For Assurance	Verbal
04/15/23	**Remuneration Committee**		For Assurance	Verbal
04/15/24	**Council of Governors** Chairman		For Information	Verbal
04/15/25	**Any Other Business**			
	Date of Next Meeting: Wednesday 6 May 2015 at a time to be advised.			

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

Enclosure 1

Minutes of the Trust Board Meeting
held in public on April 1st 2015 in the Boardroom

Present:
Trust Board
Dame Yve Buckland, Chairman - YB
Mrs Jo Chambers, Chief Executive -JC
Mr Andrew Pearson, Medical Director -AP
Professor Tauny Southwood, Non-Executive Director (part of the meeting) -TS
Ms Elizabeth Chignell, Non-Executive Director – EC
HH Frances Kirkham, Non-Executive Director - FK
Mr Paul Athey, Director of Finance –PA
Ms Kathryn Sallah, Non-Executive Director - KS
Mr. Garry Marsh, Director of Nursing and Governance – GM

In attendance:
Mr Julian Denney, Interim Company Secretary-JD
Professor Phil Begg Director of Strategy and Transformation -PB

Apologies:
Mr Rod Anthony Non-Executive Director - RA
Ms Anne Cholmondeley, Director of Workforce & Organisational Development -AC
Mr Jonathan Lofthouse, Director of Operations -JL
Mr Tim Pile Non-Executive Director -TP

Agenda No.	Agenda Item	ACTION
04/15/01	**Apologies and welcomes** The Chairman congratulated Kathryn Sallah on her appointment as a Non-Executive Director by the Council of Governors at their last meeting and welcomed her to the Board. Kathryn is a qualified nurse and midwife with over 35 years' experience in healthcare. She has held three Director of Nursing posts and is currently a Trustee of two Charitable Trusts. She was project Director for the Independent Case Note Review for the Mid Staffordshire Foundation Trust and has acted as a specialist consultant to CQC for reviews on governance and clinical services Apologies were received from Rod Anthony, Anne Cholmondeley, Tim Pile, Jonathan Lofthouse	

04/15/02	**Declarations of Interest** There were no new declarations of interest.	
04/15/03	**Patient Case – an illustration of the work we do** The Chairman welcomed Jody Thompson (Tissue Viability Nurse) from the Tissue Viability team who presented a case about Tissue Viability Improvements There were many valuable learning points around a wide range of issues including the value of MDT Care including the ROCs service and the value of the Tissue Viability team which is often relatively low profile in the Trust. JT said that greater local access for direct referrals would be helpful (e.g. psychological support, dietetics). A case is being made for carbohydrate loading of patients pre operatively which is expected to reduce bone infection. There may be the potential to sell the Tissue Viability service externally which could create the potential to fund internal provision for some of the services desired. The Board requested that an update be provided re the status of the bone infection work in the future in the ROH in the context of these opportunities. There is a need to raise the profile of the Tissue Viability team – especially externally The Board thanked Jody Thompson for the presentation and for the service the team provides.	**AP/JL** **SXB**
04/15/04	**Minutes of the Trust Board meeting held on 4th February 2015** **Resolved:** The Trust Board hereby: 1. Approves the minutes of the above meeting as a true record.	
04/15/05	**Trust Board Action Points** The action notes were updated (see separate sheet):	

Action	Comment
11/14/147 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.	A mailshot was carried out asking Directors, Consultants, Anaesthetists, Council Members and Procurement and Senior Staff to declare any declarations of interest they have, along with any hospitality they may have received. There has been an excellent response (approximately 58) from various members of the Trust, with approximately 50 replies outstanding, the majority of which are from Clinicians. A reminder, chasing responses, will be sent out via email to those concerned. Suggest carry forward to May
11/14/153 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.	Report has been received Trialling now in progress Update the action note to reflect personnel changes Action carry forward.

	11/14/159 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.	In progress. YB has sent letters out to potential partners Phil Begg will be visiting Emory Health Care as a possible partner at the end of April RA is arranging a video conference with a leading orthopaedic surgeon in the US inviting PB and JL		
	11/14/162 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.	Still unresolved: a lead for clinical audit is being sought. Keep on the agenda. Some additional part time support is being sought to help with medical engagement which is relevant to this issue		
	02/15/05 Interim Director of Nursing and Governance to review the CQC action plan and suggest any changes.	On the agenda – close		
	02/15/03 Lisa Newton (Senior Nurse) presented a case about a complaint following a patient's death. There were many valuable learning points … It was agreed that further work including clinical audit			

	should be done to ensure there were no wider systems issues that should be addressed.			
	02/15/06 ***Attendance at Council meetings by NEDs*** A list of Council meeting dates with the suggested programme of NED attendees would be circulated	Done – close		
	02/15/11A ***Cancellations*** There has been an increase in cancellations which will be analysed – often this is due to unfitness on the day and associated POAC related issues. The Board requested an analysis of the impact of improvements on the number of cancellations on the day of the procedure.			
	02/15/11B The Board challenged the understanding of the cost volume relationships which PA agreed to analyse to ensure that additional activity was profitable and it was noted that the Medical	Covered on the agenda (under CPR) – close		

	Director was investigating if there was any relationship between infection rates and activity			
	02/15/15A Signed letters have been received from c 50% of consultants regarding the security of patient sensitive data and the remainder will be followed up.	In progress – report next meeting		
	02/15/15B There is a general issue about a security of Trust data e.g. if there is any patient sensitive data being sent outside of NHS Mail The Board raised concerns about the loss of patient notes and widely circulated emails referring to these	PB has contacted IT to see if there are any automatic alerts to warn individuals if they appear to be sending patient related data outside the NHS system. AP has contacted the Chair of the MSC to emphasise these issues with medical colleagues PA noted that the NHS Mail may be able to provide improved functionality to support greater security with communication outside NHS Mail		
	02/15/15C The security of Board papers was also discussed and it was noted that TP had identified a new system which had the potential for improving security	The new system has considerable potential to improve efficiency and security. However an evaluation of the various options would need to be undertaken and it was agreed to defer this until the permanent company secretary was appointed. KS said that she would		

			talk to PA regarding a systems for Board papers which had the potential tor increase efficiency and would be based on an iPad.	
		02/15/25 Re Charitable funds committee meeting of 26 January 2015 as follows : Greater clarity was required as to why some requests for funding were declined – e.g. because the Trust wishes to mainstream a solution. It may be better to allow more requests through to the CFC.	Noted – close this action	
04/15/06	**<u>Chairman and NEDs' update</u>** Yve Buckland Chairman updated the Board as follows: ***PAS replacement - contract extension - action by the CEO and Chairman under the urgent decisions rules*** The deadline for this is now June so urgent action is not required. ***Board development including planned visits to Sheffield and Manchester.*** The Chairman stated that very positive offers of visits had been received from: · Central Manchester University Hospitals NHS Foundation Trust: Tuesday, 12th May 2015 between 10.00am - 3.45pm (EC can do this date) · Sheffield Teaching Hospitals NHS Foundation Trust possible dates :			

	- 21 April, 10am – 1.30pm - 23 April, 10am – 1.30pm - 30 April, 10am – 2pm (TS can do this date) It was agreed to explore visiting the Nuffield Orthopaedic Centre) at Oxford. AP agreed to progress this with the Medical Director later in the year	**AP**
04/15/07	**<u>Chief Executive's Report</u>** Jo Chambers introduced her report inviting a discussion. A number of points were made in discussion as follows: • There are some internal changes planned and consultation with staff will start shortly • Recruitment to a number of posts currently being held by interims has started : this should provide stability . ***Executive Management Team – March 2015*** Due to the CEO's involvement in the interviews for the new non-executive director, the meeting was chaired by Paul Athey, who gave a verbal update of key points: • Updates were received on Carbon reduction and Emergency planning • The information Governance year-end report was received • Various polices were received for the CEO to approve **Stakeholder and Partnership Engagement** • The CEO and Chair visited the ROH laboratory which does some incredible and exceptional work ; this is often low profile • The Trust hosted the hand diploma examination – this good opportunity to raise the ROHs' profile and is a tribute to the Trust's reputation in this field. **Business Updates** • The Monitor Q3 letter was attached – this shows that the Trust continues to be rated highly. The Board considered this to reflect well upon the work that the CEO and executive team has done and the openness	

	and strong action with which the Trust has handled matters such as recent issues relating to Medicines Management . **Staff Engagement Activities** • C 20 events will be held between now and June – they will be critical in keeping the focus on the Transformation agenda • Two research nurses have been nominated for the Pride of Birmingham award **Resolved:** The Trust Board hereby: 1. Notes the CEO's report	
04/15/08	**<u>Medical Director's Update</u>** Andy Pearson introduced his report inviting a discussion. A number of points were highlighted as follows: ***Exclusions of doctors*** • The longest standing exclusion is coming to a conclusion; the other exclusion has been lifted following an internal review. ***Theatres*** The Board confirmed the view that all issues of behaviour irrespective of job should be treated in the same way. The increased willingness of more junior theatre staff to challenge their senior colleagues was welcomed. ***Near Patient Testing*** Regarding Near Patient testing work is starting in a controlled way, but there was still an internal debate regarding the merits of various approaches. It was agreed that AP and PB would report back at the next meeting ***CQC*** AP has had a constructive meeting with Sir Mike Richards of CQC. The Board thanked the Medical Director for his work in	**AP/PB**

	addressing some very challenging issues. TS gave his apologies at this point and left the meeting **Resolved:** The Trust Board hereby: 1. Notes the Medical Director's report.	
04/15/09	**2015/2016 Board work plan** The Chairman introduced the discussion on the 2015/2016 Board work plan. A number of points were highlighted as follows: • It would be necessary to keep the revised BAF reporting framework under review given the new approach including strategic risks • Strategic people issues are part of Workstream 1 • It would be useful to invite the governors when the staff and patient surveys are discussed at the public Board • The meeting frequency of the Remuneration Committee should be amended to "as and when required" **Resolved:** The Trust Board hereby: 1. Approves the 2015/2016 Board work plan	**JD**
04/15/10	**Corporate Performance report** Paul Athey introduced his report. A number of points were highlighted as follows: **Summary:** • Despite an over-performance on activity, the 18 week backlog has increased in month, and this has largely been driven by an increase in the admitted backlog, which has become red rated. • All 3 RTT targets were met in month. • For the year to date the Trust made a deficit before impairments of £285k compared to a planned surplus of £208k. This had been discussed in the private session of the Board • Both elective and day case performance was above plan, with non-elective behind plan. • Sickness absence has improved in line with seasonal	

	trends (the range has been 4.7-5.3% in the last 5 years in February) but is still higher than target. • Long term absence has decreased since January, partly as a result of better housekeeping in ESR manger self-service. ***Finance – including discussion relating to the impact of additional activity*** • The Trust's financial position reflects the expected out turn forecasted previously • Major variances are associated with locum and agency costs ; a relatively small proportion of this is associated with additional work • There was a c£200k additional contribution in Q3: this justifies the decision to take on additional work. • This was offset by other costs unrelated to additional activity associated with medicines management work, oncology implants' costs and junior doctor locum costs. **Resolved:** The Trust Board hereby: 1. Notes the Corporate Performance report.	
04/15/11	**<u>The Patient Quality Report</u>** Garry Marsh introduced his report highlighting the following: • There was a 31 % decrease in incident reporting. This was across all types of reported incident. GM agreed to keep this under review. • There was 100% compliance regarding falls • There was one reported avoidable pressure ulcer (associated with the absence of nursing documentation). • There was a small increase in the uptake of the flu vaccine • Patient Reported Outcome Measures for knee replacement fell below target – more individuals are now involved in the process and patients are being given wider opportunities to complete the survey. In addition IT is being improved to increase compliance • There were two complaints re agency staff, and one relating to the Patient Advice and Liaison Service	

	• Re page 5 the small increase re knees surgical site infections was not considered a matter for concern. • The reported increase in venous thromboembolism may in part reflect a change in the classification criteria. • The Patient Quality key performance indicator reports are under development- this includes scrutiny of the large number of reds on the Matrons' report. GM agreed to investigate the red rating on Theatre 6 Safety. TS would be invited to join the group scrutinising the rationalisation of data and reporting. • Some feedback would be given from the People Leaders Forum • Consideration should be given to how to "nudge" staff into having a flu injection • Board members congratulated the "April Falls" team who are holding an event on site today **Resolved:** The Trust Board hereby: 1. Notes the Patient Quality report.	**GM** **GM** **AC**
04/15/12	**<u>The Safe Staffing Report</u>** Garry Marsh introduced his report and the following points were noted: • There some issues re adequate documentation but there are no issues creating risks for patients relating to partial compliance • Some further work is needed on policy development. • There are some process deficiencies re NICE " red flags" but no fundamental concerns re patient care. • The described minimum Registered Nurse staffing of a 1:8 ratio is being met within clinical areas with incident reporting occurring when this is not happening and reporting within the monthly staffing reports. This standard is met within the day. • Overnight Trust ward areas are predominantly at a 1:12 Registered Nurse ratio. However, overnight our ward areas are predominantly 1:12 Registered Nurse ratio. • For 2 hours of the night shift the staffing ratio will increase to 1:24 due to break coverage with support provided by a supernumerary night site manager. Whilst this may not be considered ideal it is line with NICE guidance. A separate piece of work is being done to address site risk management issues.	

	• The Unify reports show no concerns • Regarding Safer Nursing Care Tool recommended establishment, the Paediatric variance reflects the fact there has to be at least two nurses on duty. • The bank and agency figures will be reviewed as part of a wider review of nurse establishment. • The 5 safe staffing breaches were often associated with non-arrival of agency nurses. • The Board suggested that further information on training could be helpful • The Board thought the engagement of nurse leaders encouraging. **Resolved:** The Trust Board hereby: 1. Notes the Safe Staffing report.	
04/15/13	**<u>CQC Action Plan</u>** Garry Marsh presented the CQC Action Plan highlighting the following : • Medicines are managed at all times in line with legal requirements – ***no issues*** • A chaperone policy is developed and chaperones made available to support patients' privacy and dignity – ***will be completed in April*** • Equipment is properly checked and maintained in accordance with electrical safety requirements***- work in progress with estates leading. GM to discuss with JL given increase of scale of task*** • Confidential patient information and records are not left unsupervised in unrestricted public areas of the outpatient department- ***now resolved*** • Appointments are organised for all clinics to reduce waiting times for patients and improve their experience in the outpatient department – ***Liz Towell is working as interim improvement manager and is resolving process issues; however more evidence is needed around the cultural shifts expected. The new system being implemented will support this change.***	**GM/JL**

	• Good progress is also been made on a number of specified actions which are non-regulated activities, which were also highlighted during the CQC inspection. **Resolved:** The Trust Board hereby: 1. Notes the CQC Action Plan report, and in particular the additional actions associated with the additional risks identified	
04/15/14	**<u>Kate Lampard's report into Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile -initial observations prior to undertaking further work</u>** Garry Marsh presented this report commenting that the initial RAG report does not highlight any issues that are expected to be problematic to resolve Sally Xerri- Brooks would be asked to highlight the Trust's response to the Savile issues in a positive way on the website **Resolved:** The Trust Board hereby: 1. Notes the above report	**GM/SXB**
04/15/15	**<u>Update on the Five Year Strategic Plan</u>** Phil Begg presented his report highlighting the following points: • Monitor have changed their requirement for this year to request a one year operational plan; a three page summary plan has been attached and a more detailed version will be brought back to the Board • Monitor have asked for a recommitment / refresh to the five year plan – this is expected to be required in summer. **Resolved:** The Trust Board hereby: 1. Notes the Update on the Strategic Plan	

04/15/16	**<u>1 year Operational Plan and Budget Sign Off</u>** Paul Athey introduced his report and gave a presentation on the capital plan. A number of points were highlighted as follows: ***Capital Plan*** • There is the option to bring forward work on theatre replacement and to defer MRI work. • Some aspects of capital expenditure may be suitable for charitable fundraising. • Alternatives to Trust funding will be explored as part of the feasibility work, which would be required if the theatre development is brought forward. **Resolved:** The Trust Board hereby: **1.** Approves the 2015-16 revenue plan, including a planned deficit of £2m to enable planned investments to go ahead **2.** Approves the 2015-16 directorate budgets in line with Appendix 1 **3.** Approves the 2015-16 capital plan in Appendix 4	
04/15/17	**<u>TOR and Membership of Board Committees</u>** Julian Denney introduced his report stating that the paper proposes minor changes in relation to the Trust Board's Committees' Terms of Reference and changes to Trust Committee Membership to reflect the appointment of the new Non-Executive Director and previously discussed revisions to existing NED portfolios **Resolved:** The Trust Board hereby: 1. Approves the revised terms of reference of the Clinical Governance Committee, Transformation Committee and Remuneration Committee as detailed in Appendices 1-3 to the paper 2. Approves or confirms the appointment of Chairmen and	

	Committee members as listed in Appendix 4 to the paper	
04/15/18	**<u>Policy on the development and approval of ROH Policies</u>** Julian Denney introduced his report highlighting the following: This rationale for the proposed revision was to improve the clarity of the above policy and to align it better with recent changes in the powers delegated by the Board to approve policies. Related work is being carried out to update Trust policies and to improve policy governance for example in providing better assurance that updated polices have been cascaded to Trust staff and that over time , all "sub-policy" documents such as protocols and guidelines come under the remit of an existing or new policy. For this reason it is expected that a further review of this policy will be undertaken in around six months' time. **Resolved:** The Trust Board hereby: **1.** Approves the revised Policy on the development and approval of ROH Policies as detailed in Appendix 1 to the paper.	
04/15/19	**<u>Report of the Chair of the Audit Committee</u>** Rod Anthony, Chair of the Audit Committee had provided an informal update. **Resolved:** The Trust Board hereby**:** 1. Notes the update of the Chair of the Audit Committee	
04/15/20	**<u>Report of the Chair of the Clinical Governance Committee</u>** Tauny Southwood, Chair of the Clinical Governance Committee had provided an informal update. **Resolved:** The Trust Board hereby**:** 1. Notes the report of the Chair of the Clinical Governance	

	Committee	
04/15/21	**<u>Report of the Chair of the Charitable Funds committee</u>** Frances Kirkham reported on the Charitable funds committee meeting of as follows : • There was a request for £21k for costs relating to the delivery of a research project with Smith & Nephew. This was to be funded from the Hip research fund, which held 140K funding for the purpose of research. Additional information had been requested to enable a decision to be made. • A request for £20k to support the transfer of outcomes data within the Knowledge Hub was approved • It was also agreed that CFC minutes should always be taken on the public agenda **Resolved:** The Trust Board hereby**:** 1. Notes the report of the Chair of the Charitable Funds Committee 2. Approves the outcomes data proposal	
04/15/22	**<u>Report of the Chair of the Transformation Committee</u>** Tim Pile had given his apologies so there was no update on this occasion.	
04/15/23	**<u>Report of the Chair of the Remuneration committee</u>** There was no update on this occasion.	
04/15/24	**<u>Report of the Chair of the Council of Governors</u>** Yve Buckland reported on the Council of Governors meeting of 24th March 2015 as follows : • The Council appointed Kathryn Sallah as a Non-Executive Director for a term of three years • Members of the Council approved the WHO Safety Checklist as a local indicator to be audited • The Council of Governors nominated Alan Last to cast the Council's vote on its behalf in favour of Kate Archer in the forthcoming election of eight governors to the Governor Policy Board of NHS Providers	

04/15/25	**<u>Any Other Business</u>** None	
<u>Date and Time of Next Trust Board Meeting</u> Date of Next Meeting: Wednesday 06 May 2015 at a time to be advised.		
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

Council of Governors Meeting

Thursday 21st May 2015 at 11.00 a.m.
In the Seminar Room in the Research & Teaching Centre

A G E N D A

1.	Apologies	
2.	Welcome and introductions and declarations of interest	
3.	Minutes of the meetings held on Wednesday 4th February 2015 and Tuesday 24th March 2015 and Matters arising	Enc 1a and 1b
4.	Action Log – including • Communications Plan update (SXB) • Governor training – update (LK) • Meetings of Governors and NEDs (YB)	Enc 2 Enc 3
5.	Governor feedback and issues to raise with the Board (Standing Item) – including: • Trust Offices refurbishment • Appointments – recent advertisement on NHS Jobs • Meetings of Governors and NEDs (See above)	Enc 4
6.	Update by CEO	Enc 5
7.	Patient and Carer's Council – Feedback and other updates by Jean Rookes, Dia Martin and Stella Noon	
8.	Safe Nurse Staffing Report (copy of Board paper) Quality Governance – involvement of Governors	Enc 6
9.	Chair's Items: • Resignation of Elizabeth Chignell • Governor policy board election results • Governor focus conference notes • Forthcoming Governor elections (LK) • Non-audit services provided by the external auditor – Briefing (PA)	Enc 7 Enc 8

10.	Briefing on the annual report and accounts (n.b. private until laid before Parliament on June 25 2015) (copy of Board paper and latest version of annual report and accounts)	Enc 9
11.	Monitor year end declarations (copy of Board paper)	Enc 10
12.	NED attendance at Council meeting • Tauny South wood • Kate Sallah	
13	Calendar and indicative Work plan for 2015/2016	Enc 11
14.	Governors' Award– Mike Barnett – Learning and Development (AC)	Enc 12
15.	Any Other Business	
16.	Date and Time of Next Meeting Provisionally Wednesday 14 Oct 2015 – time tba	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD MEETING
TO BE HELD
ON
WEDNESDAY 1 JULY 2015
AT
11.30 UNTIL 16.00
IN THE BOARD ROOM

AGENDA

ITEM	TITLE	NOTES	BOARD ACTION	PAPER
07/15/01	**Apologies & Welcomes**	11.30	To Note	
07/15/02	**Declarations of Interest** Chairman	Register available on request from Company Secretary		
07/15/03	**Outpatients Improvement Presentation** **(Mrs Liz Towell)**	11.35		
07/15/04	**Patient Case – an illustration of the work we do** **(Ms E O'Kane)** Director of Nursing and Governance	11.55		
07/15/05	**Minutes of Public Board Meeting held on the 06th May 2015** Chairman	12.15	For Approval	Enc. 1
07/15/06	**Trust Board Action Points** Chairman		For Assurance	Enc. 2
07/15/07	**Chairman & NED update** Chairman & NEDs	12.25	For Information	Verbal
07/15/08	**Chief Executive's Update** Chief Executive	12.35	For Information and Assurance	Verbal
07/15/9	**Whistleblowing report**	12.50	For Information	Enc. 3

	Director of Workforce & Organisational Development		and Assurance	
	LUNCH • **Governors / NEDs private meeting**	13.00		
	Performance Management / Assurance Reports			
07/15/10	**Corporate Performance Report** Director of Finance	14.00	For Approval	Enc.4
07/15/11	**Patient Quality Report** Director of Nursing & Governance	14.15	For Assurance	Enc. 5
07/15/12	**CQC Action Plan** Director of Nursing & Governance		For Assurance	Enc. 6
07/15/13	**Safe Staffing Report** Director of Nursing & Governance		For Assurance	Enc. 7
07/15/14	**Board Assurance Framework** Interim Company Secretary	14.50	For Assurance	Enc. 8
	Strategy			
07/15/15	**Update on Five Year Strategic Plan** Director of Strategy and Transformation	15.00	For approval	Enc. 9
07/15/16	**Estates strategy** Head of Estates and Facilities	15.15	For Discussion	Presentation
07/15/17	**Trust Board Committees: TOR and Membership** Chair	15.35	For Approval	Enc. 10
07/15/18	**Charitable Funds Committee**	15.45	For Assurance	Verbal

	Including any minutes of the Committee			
07/15/19	**Other Board Committee verbal updates**		For Assurance	Verbal
07/15/20	**Council of Governors** Chairman		For Information	Verbal
07/15/21	**Any Other Business** To Note – circulation of the Audit Committee Annual report under separate cover	15.55		
	Date of Next Meeting: Wednesday 2 September 2015 at time to be advised.			

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

Date of Trust Board: 1 July 2015 **ENCLOSURE 3**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Anne Cholmondeley**
SUBJECT:	**Whistleblowing Report**

SUMMARY

This is the annual report to the Trust Board on the use of the Whistleblowing Policy. In light of significant national developments in the last year, such as the Francis Review, this report also addresses the related matter of raising concerns. This report outlines the Trust's current position on whistleblowing and raising concerns and proposes further actions to support further development of a patient safety culture.

IMPLICATIONS

Further enhancement of practices in the area of raising concerns will support staff engagement and the development of a patient safety culture.

RECOMMENDATIONS

Trust Board is asked to:

a) Note and discuss the report
b) Agree the proposed actions

Report to Trust Board

Annual Whistleblowing Report

Introduction

The Trust Board is required to receive a report annually on any use of the Trust's Speak out Safely (Whistleblowing) Policy. I can confirm the policy has not been used during the year ending May 2015.

The national context in this area has developed significantly in the last twelve months. The 'Freedom to Speak Up' Review undertaken by Sir Robert Francis, provided advice and recommendations for the NHS about ensuring staff feel safe and confident to raise concerns. There is a suggestion that staff who resort to reporting concerns to external bodies as whistleblowers, have often raised the same concerns within their organisations on more than one occasion. Francis indicated that in organisations where substandard care for patients had been exposed, it was common for many staff to feel unable to speak up or that when doing so that they weren't listened to. It is therefore crucial for the Trust to continue its work on creating a patient safety culture, and within that the confidence and perception of staff about raising concerns. This paper therefore seeks to report how the Trust is progressing in this area and the planned actions for the next year.

Progress to Date

The Trust participated in the Nursing Times' Speak Out Safely (SOS) campaign, which aimed to encourage NHS organisations to develop cultures that are honest and transparent, to actively encourage staff to raise the alarm when they see poor practice and to protect them when they do so. In conjunction with signing the pledge, the Trust revised and re-launched a Speak out Safely (Whistleblowing) Policy in the middle of 2014.

Part of this policy created the role of the 'Speak out Safely' Champions who are individuals able to effectively handle concerns raised with them. Their appointment, together with the role of the Senior Independent Director, was widely publicised. Raising concerns is also featured in the Corporate Induction for all new staff.

The Trust's Counter Fraud team completed a review of the Whistleblowing Policy and practices and a number of 'low' rated recommendations were accepted.

There have been two recent incidents where staff have raised concerns about patient safety and clinical practice, one of which was made with the Chief Executive directly. Both of these were handled in ways which focused on building overall staff confidence in raising concerns. One incident did raise questions concerning the efficacy of handling the concerns by first-line and middle managers, prior to escalation to a more senior level by the staff member concerned.

Feedback from Staff

The National Staff Survey asks a series of questions about staff knowledge of how to report concerns and their confidence to do so. The Trust's responses for the period 2012- 2014 are detailed below, compared to the average for Acute Specialist Trusts:

Percentage of staff who strongly agree/agree	**2012**	**2013**	**2014**
Staff know how to report concerns about fraud, malpractice or wrongdoing	90% (90%)	93% (92%)	94% (94%)
Staff feel safe/secure to report a concern	73% (74%)	69% (74%)	63% (70%)
Staff who would feel confident their organisation would address the concern	60% (61%)	53% (60%)	58% (65%)

This data suggests staff know how to report concerns, but feel less safe/secure to do so, and in the last two years have become less confident than average that the Trust will address their concern.

Staff perception about raising concerns at the ROH has been explored with the circa five hundred staff who have attended the New Beginnings events so far. The qualitative information gained from these sessions is consistent with data from the staff survey, with staff reporting the three barriers to feeling confident and safe to report as:

- A sense of futility; a perception that staff will either not receive any response or one which lacks meaning for them.
- Concerns about repercussions, primarily from peers but also from others with influence over their future career.
- Frustrations with the functionality of the Ulysses incident reporting system. Staff described the process of recording a concern as time consuming and too detailed and therefore being a barrier to action.

Except for the perceptions about the internal reporting system, the other views are consistent with those reflected by the Francis review and by NHS Employers in their own response. NHS Employers have issued helpful resources in this area, focused around a multi-professional generic term of 'Draw the line' under raising concerns, which re-affirms the importance of working together to make a difference. These resources include a self-assessment tool to assist in comparison of practices to the Francis recommendations.

Next Steps

There are three broad areas for change – Culture, handling of concerns and measures to support staff. By adopting these proposed steps, the Board will be reinforcing our values of openness, pride and excellence.

Theme	Action	Responsibility
Culture Change	Adopt the 'Draw the line' brand for raising concerns to encourage greater multi-professional buy-in.	Director of Workforce and OD
	Ensuring corporate communication continues to confirm raising concerns is welcomed and provides prompt and regular feedback on concerns raised and actions taken via Team brief.	Head of Communication
	Communication will articulate the difference between raising concerns about safety incidents and a grievance, identifying the separate channels through which each can be raised.	Head of Communication and Head of Learning and OD All Directors
	Continued communication about the values and standards of behaviour aligned to those.	Head of Learning and OD
	Engage with existing champions to complete a self-assessment of ROH practice against the recommendations of the Francis report, using the NHS Employers toolkit.	All Directors
	As opportunities arise continue to recognise and reward staff who raise concerns about patient safety matters.	
Improving the handling of concerns	Provide training for staff with line management responsibility about their role and responsibility in handling concerns, providing skills development where needed.	Head of Learning and OD
	Ensure performance management approaches for new divisions/services reward both the timeliness and quality of handling	Director of Operations

	staff concerns and as a result the awareness of appropriate channels to raise concerns and grievances.	
Measures of support to staff	Appoint a trust-wide patient safety ambassador with autonomy to report concerns to Directors. Re-affirm the role of champions. Review the format of reporting concerns via Ulysses to simplify.	Director of Workforce and OD Head of Learning and OD Deputy Director of Nursing and Clinical Governance

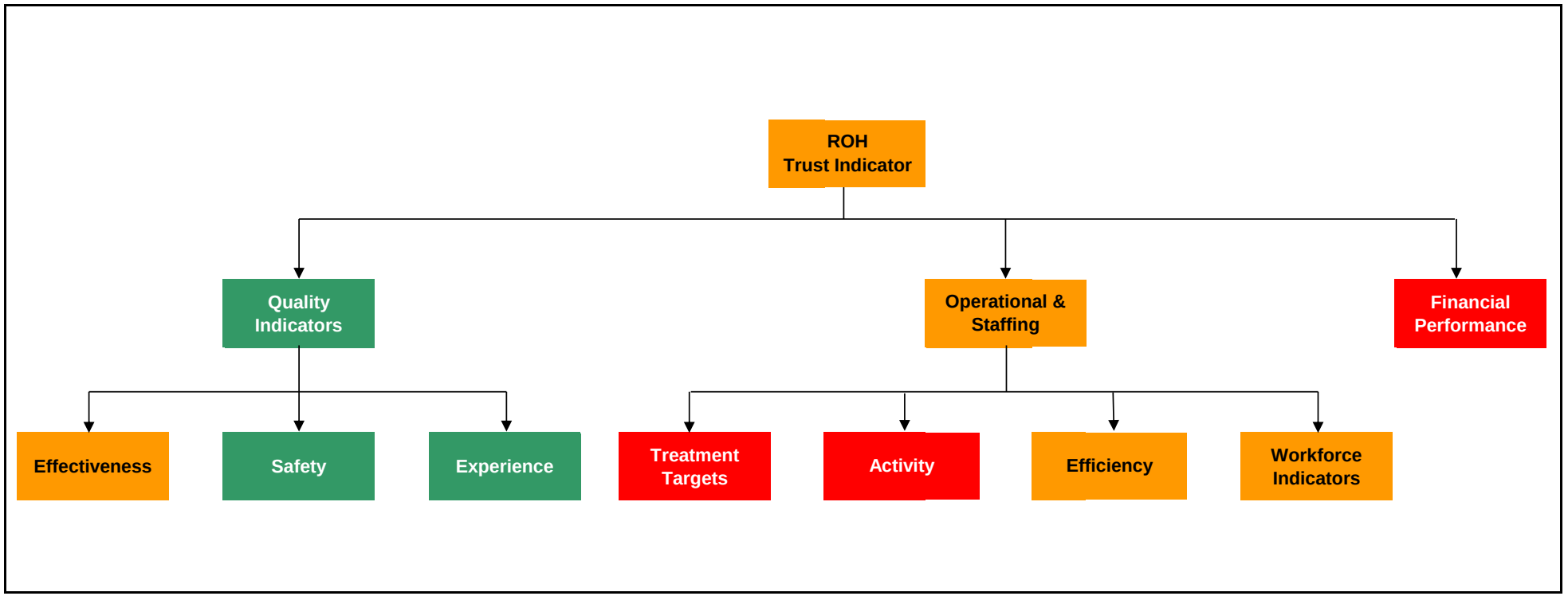
Recommendation

The trust Board is asked to:

a. Note and discuss this report.
b. Agree the proposed actions.

ENCLOSURE 4

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending May 2015



The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of BOARD: 1 July 2015 **ENCLOSURE 5**

SUMMARY REPORT TO BOARD

DIRECTOR LEAD:	Director of Nursing and Governance
AUTHORS:	Ian Billington, Clinical Governance Manager
SUBJECT:	**Patient Quality Report – May 2015**

SUMMARY

This paper provides a monthly update on patient quality, safety and experience activity during May 2015. 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 EMT in bringing together key quality issues for debate, assurance and information.

Key areas of note:-

- 0 unexpected patient deaths
- 1 cases of Clostridium difficile reported during May.
- There were two hospital acquired pressure ulcers during May.
- In May 2 patients were readmitted with infection within 1 year of primary surgery.

RECOMMENDATIONS

BOARD are asked to:

- **note and discuss** the Patient Quality Report
- **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 – May 2015

REPORTING REQUIREMENT: National Incident Reporting Requirement & Quality KPI Contractual Requirement

There were 2 Serious Incidents reported to Commissioners in May 2015: one of these was a VTE incident and the other involved delayed diagnosis/x-ray report. Appendix 1 outlines details of all ongoing Serious Incident investigations

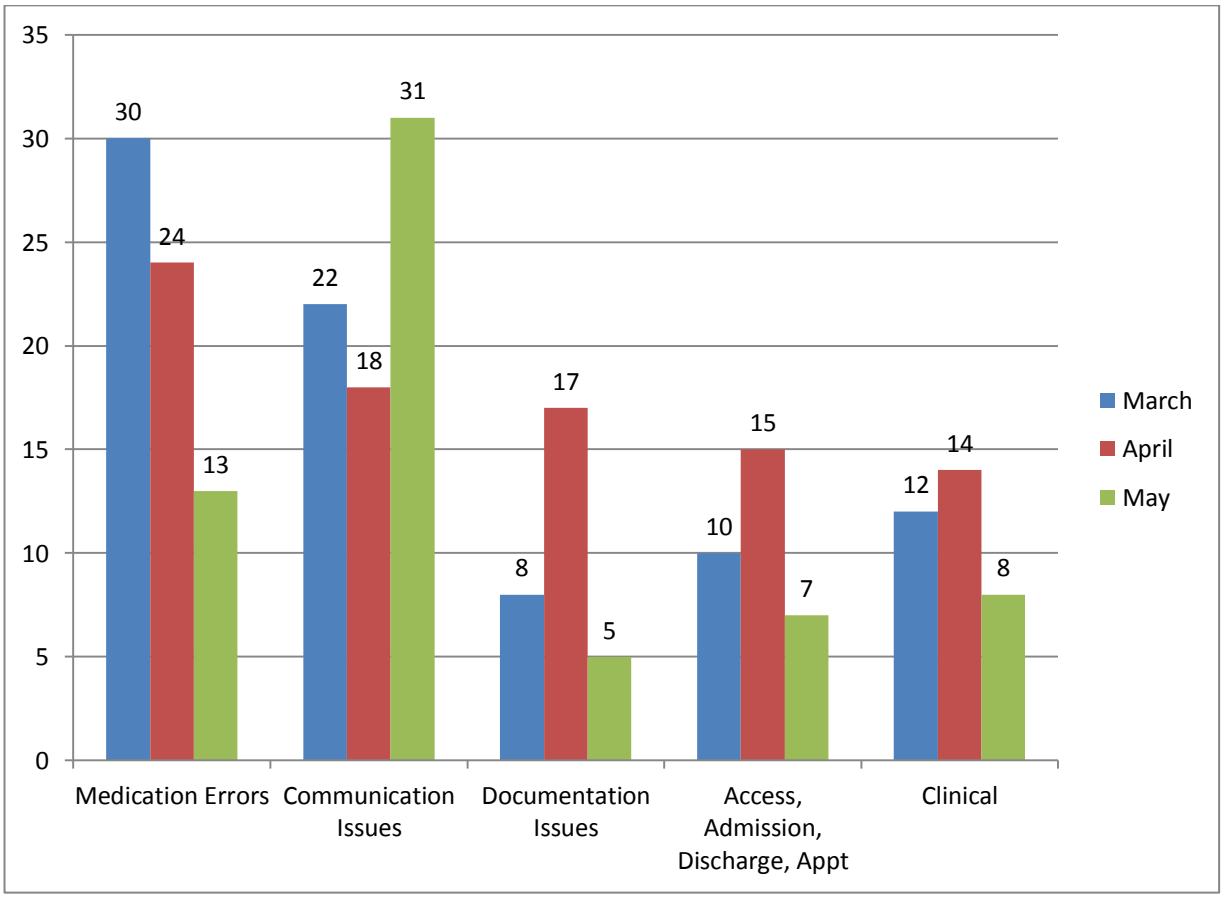
1.1.1 A contract performance notice has been issued by the Trust's lead commissioner, Birmingham Cross City Clinical Commissioning Group. This relates to Serious Incident investigation extension requests and a meeting between Birmingham Cross City and the ROH has now been held. A remedial action plan has also been submitted to commissioners. This action is being progressed and a detailed update will follow in July 2015.

1.2 All other incidents requiring an investigation

Three internal RCA investigations were commenced in May 2015:

Incident Number	Date of Incident	Incident Description	Directorate	Level of Harm
15355	15.5.15	Blood fridge in theatres (non-blood products stored in blood fridge)	Theatres	
15284	6.5.15	Verbally aggressive patient	Oncology	Low harm
15308	4.5.15	Internal management of incident involving MRI scanner failure	Trust-wide	Low harm

The graph below indicates the top five incident trends by incident type:



*The colours in the graph have been selected at randon and do indicate RAG rating.

Examples of Incidents Reported

Type of Incident	Example (May 2015)
Communication	Internal Communication Issues
Medical Error	Wrong Drug/Route/Patient
Clinical	Discharge delay/Failure
Access	Appointment Delay
Documentation	Documentation Missing

1.2.1 Trends

An area that requires further investigation is the reporting of mediciation errors. The Governance team will work with the Chief Pharmacist to understand exactly what is happening. In general there is also a low rate of reporting.

1.3 Deaths

In May 2015 there were no patient deaths reported.

1.4 Safety Thermometer

REPORTING REQUIREMENT: National Reporting Requirement

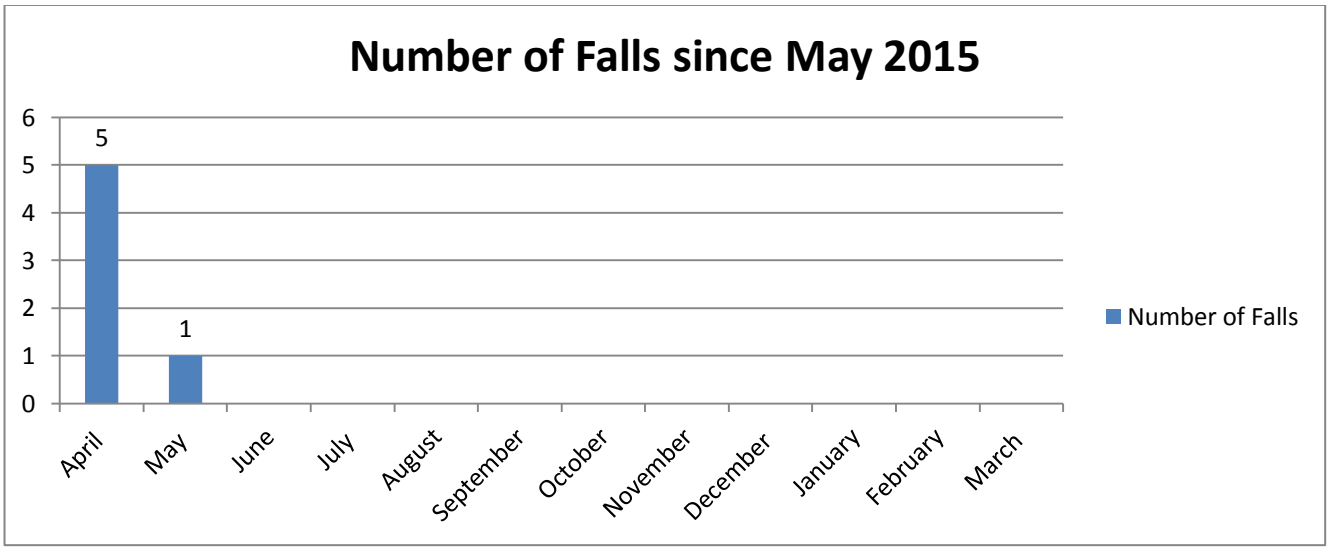
2015-16	April-15	May-15
Pressure Ulcers (All)	1.37%	0.99%
Pressure Ulcers (New)	0%	0%
Falls with harm	1.37%	0%
CAUTI	0%	0.99%
New VTE	0%	0%
Total Harm Free	97.26%	98.02%

*National Targets will be included from August 2015.

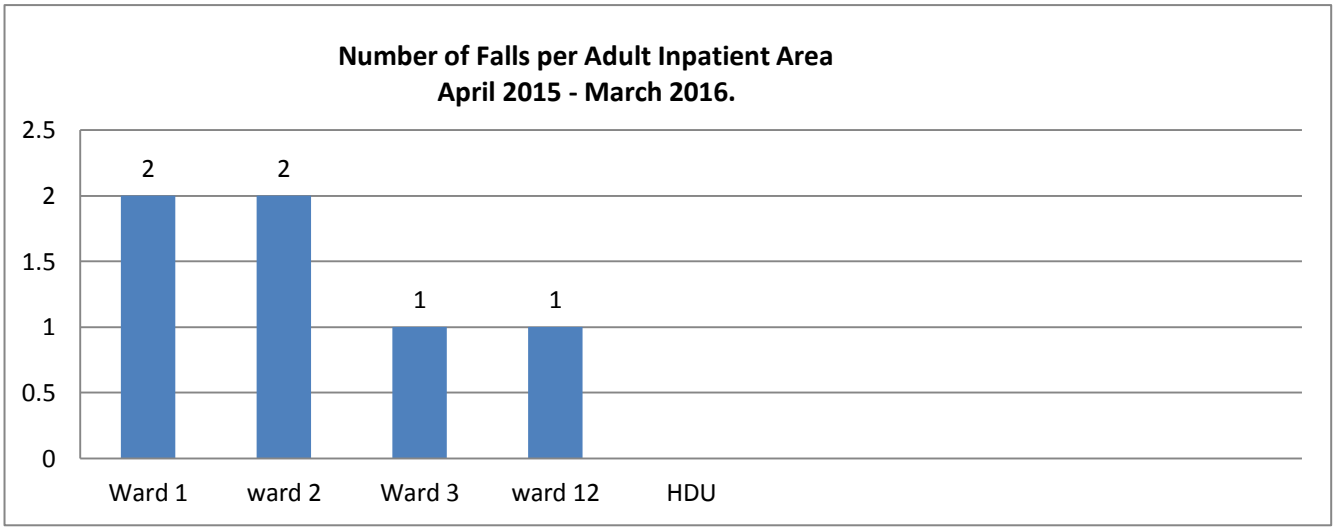
1.5 Falls

REPORTING REQUIREMENT: National Incident Reporting Requirement & Quality KPI Contractual Requirement

There have been 1 (adult) inpatient falls for the month of May 2015.



Only one inpatient fall was reported across the adult inpatient areas in May. This has reviewed by the falls lead. The patient sustained a moderate harm and as such, root cause analysis is required.



The reportable fall for May occurred on Ward 12. Remaining inpatient areas did not report any fall related incidents.

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. The fall reported in May 2015 resulted moderate harm.

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
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

Wards audit their own documentation and are asked to audit 5 individual sets of patient records on which this information is based.

Audit results are from data obtained in the month of May 2015.

Overall Results April 15 – March 16 .

	April	May										
Qu1.	100%	95%										
Qu2.	100%	85%										

*Further breakdown of Falls data will follow in July 2015

May achieved 95% compliance in falls risk assessment and 85% high risk care planning across the inpatient areas. Wards routinely audit their own areas. Ward 1 failed to risk assess one patient of the 5 reviewed and 3 of the 4 patients risk assessed did not have a care plan actioned.

Whilst we have achieved the required quality indicator around risk assessing, we failed to achieve the required threshold for care planning around the risk assessment in May.

The Lead Nurse for Falls will be meeting with the Interim Clinical Governance Manager on the 12/06/15 to discuss the issues of non-compliance. Actions will be reported in the July report.

1.6 Infection Prevention and Control and Tissue Viability

REPORTING REQUIREMENT: Contractual Quality KPI requirement and National Reporting requirement

1.6.1 Infection Prevention and Control

There were zero MRSA bacteraemias reported during May

There was 1 MSSA bacteraemia reported during May – Post Infection review (PIR) identified that this was possibly line related although no deficiencies in care were identified.

There was 1 E.coli bacteraemia reported during May – PIR identified deficiencies in the use of Negative Pressure Wound Therapy (NPWT) also known as VAC therapy by nursing and medical staff. Additional training and support has been provided to prevent the issue reoccurring.

Both patients have recovered well.

There was 1 case of Clostridium difficile reported in May – this was a different ribotype from any of the 3 cases seen in April. All 4 cases have been investigated and reported to the Commissioners within prescribed time scales, the ribotyping results support IPC's view that there has been no cross infection as they are all different.

The 3 cases in April were all discussed in a meeting with the Commissioners who agreed that they were unavoidable, it is anticipated that the May case will also be deemed unavoidable as all appropriate care and treatment was in place.

Thorough analysis of all cases has been written and will be presented at the Infection Control Committee on 24th June. There are some issues with environmental cleaning although these did not contribute to the cases.

1.6.2 MRSA Screening

90% of emergency cases were screened according to Trust policy (1/10 patients) against a target of 90%, this is an improvement from last month.

1.6.3 Infection Prevention and Control Training

Participation in the IPC training programme is contractual KPI. It has been agreed with the commissioners that utilising the data from Ward Manager's KPI's is sufficient to evidence the attendance of front line staff at mandatory training. The WM KPI's identify that 96.2% of frontline staff are up to date with their manadatory training. IPCT have taught at 100% of sessions they are requested to provide. This is an improvement.

1.6.4 Hygiene code compliance

All areas are expected to comply with the Infection Prevention Society 2014 audit requirements. There is an audit calendar in place and compliance targets attached to the following:

- In / Out patient Environment = Target 95% - Target failed: 91%
- Hand Hygiene = Target achieved: 99%
- Peripheral venous catheter (PVC) - on going care = Target achieved 20 observations achieving 95% compliance with care bundle.
- Central Venous catheter (CVC) – ongoing care = Number of observations failed but actual care provided is 100% compliant with the best practice care bundle.

The targets for most were met although the number of observations of CVC ongoing care fell short of the 20 required by the commissioners with only 6 being recorded. This has been raised with the Ward and the Matron for the area.

There are still concerns regarding the lack of storage across the site, exacerbated by the loss of areas including ward 5 & 7.

Theatres is receiving an increased level of scrutiny with joint inspections being undertaken monthly (IPC, Theatre management and Estates / Facilities all take part). The results of these reviews are being overseen by the Theatres Directorate.

The recent increase in Clostridium difficile and occurance of MSSA and an E.coli bacteramia have resulted in the redirection of IPC focus, with additional audit being undertaken. The IPC internal report for May scrutines the audit data collected both by the link team and by IPC undertaking indepth audits.

There are some noticeable themes in the environmental audits and ward managers are being asked to concentrate on these in the next month:

- Dusty nursing equipment
- Overloading / no use of temporary closure mechanisms on sharps boxes
- Lack of storage – items sored on the floor.

1.6.5 Tissue Viability

There were 2 hospital acquired pressure ulcers during May.

1 patient developed a grade 2 pressure ulcer. There was a lack of documentation regarding actions taken when deterioration was identified –It is therefore deemed avoidable as there is insufficient evidence that action was taken in a timely manner.

1 patient has developed what may be a grade 3 although it is not currently possible to grade accurately until the wound is seen again. The patient had a plaster cast insitu and did not report any pain, but when the cast was removed for suture removal a pressure ulcer was identified. Referral has been made to diabetic foot clinic in order to identify any neurovascular deficit that meant the patient couldn't feel pain in that part of her foot.

6 patients were admitted to the Trust with Grade 2 pressure ulcers. These patients are monitored to ensure all appropriate care is in place in order to prevent deterioration.

The new contractual target for avoidable grade 2 pressure ulcers is no more than 18 by year end.

1.6.6 Surgical Site Infection

In May 2 patients were readmitted with infection within 1 year of primary surgery. 1 contacted the trust via the SSI helpline. Both patients have been referred to the Bone Infection Unit for ongoing care.

1.6.7 Bone Infection Unit

Activity within the unit remains fairly static with 47 patients under the care of the team, 11 of whom are inpatients.

Work is underway to analyse outcome data for BIU patients. There is of interest from within and outside the region in the existing BIU database becoming the basis for a National Registry of Bone and Joint Infections. This is in the early stages but has exciting potential for the Trust and the BIU. The first meeting regarding this takes place on 11/6/15.

1.7 Safeguarding Adults and Children
REPORTING REQUIREMENT: Contractual Quality KPI requirement and National Reporting requirement

Adult Safeguarding

- Number of concerns raised to the safeguarding team =8
- Number of Incidents submitted = 2
- Number of concerns requiring alerts to be raised = none
- Level 2 Training for the Trust compliance at 90% target 85%
- Higher Level Training = 100%

Key themes /trends identified are learning disability ensuring staff encourage and support use of hospital passport/book at OPD and POAC appts. Information being shared with other departments /professionals in a timely manner for proactive care management for the patients. Two of the concerns raised were not safeguarding they were regarding post discharge package of care requirements.

Actions undertaken in month :-

- Training for Pre-Operative Assessment Team with regard to Mental Capacity Assessments and Learning Difficulties , open question and answer session held, this is following up on feedback from staff regarding raising concerns and information sharing with medical secretaries.
- Communications strategy for safeguarding has been drafted by the Trusts Communications Lead, work plan to commence June 2015.
- Working with Anaesthetic Lead in Pre-Operative Assessment in development of quick reference guidance for the staff .

Children's Safeguarding

Number of concerns /issues raised with the team= 7
Number of Incidents submitted = 0
Training Level 2= 86% Target 85%
Training Level 3= 75% Target 85%

Work undertaken in month:-

- Right Services Right Time - Training commenced this is being incorporated into Level 2 Enhanced Training for staff and sessions planned for Children Ward team and HDU. Trust has 3 registered trainers.
- Section 11 - Audit tool new electronic update is being upload and required evidence attached by Named Nurse.

Key trends learning identified relate to staff following up on children not brought for OPD appointments and admission for treatment (WNB), working in partnership with GP's and school nurses has resulted in early support for the families. Attendance and input at Team Around the Family meeting (TAF) in preparation for future surgery and post-operative requirements being addressed.

PREVENT- Basic awareness leaflets this month has been distributed with staff payslips to all staff, to update and remind them on the importance that staff duty to act, and how to report and to whom. Training sessions internally have been advertised via L+D department for those staff who have not yet been trained , as this training is no longer covered on the core mandatory training days. Trust currently has 3 trainers who are registered home office trainers.
Current compliance % for the Trust =80%

1.8 Patient Safety Alerts

REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement

A total of 0 Patient Safety alerts were received into the Trust during April 2015 and none of these required any further action.

Please see table below for alerts open beyond deadline.

Alert(s) open beyond deadline

Reference	Alert title	Issue Date	Status	Deadline
NHS/PSA/D/2014/006	* Improving medical device incident reporting and learning	20-Mar-14	Action Required: Ongoing The Medical Director and the Deputy Direct of Governance will work together to set up the Medical Devices Group.	19-Sep-14

1.9 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 compliance figure for May was 99% compliance against a revised and agreed target of 98%. This indicates we have met the agreed and revised target as part of the remedial action plan with Commissioners.

1.10 Blood Safety

REPORTING REQUIREMENT: Legal requirement and ROH NHSFT Good Practice

Blood traceability data. Month of May 100% traceability.

The issue around collecting 2 samples for group and save / crossmatch has been discussed at Blood safety advisory group and Quality Committee. The Options paper was circulated to Quality Committee in May for comment and DON to escalate to Clinical Governance Committee.Blood safety lead awaiting feedback re: approval for pilot.

2. PATIENT EXPERIENCE

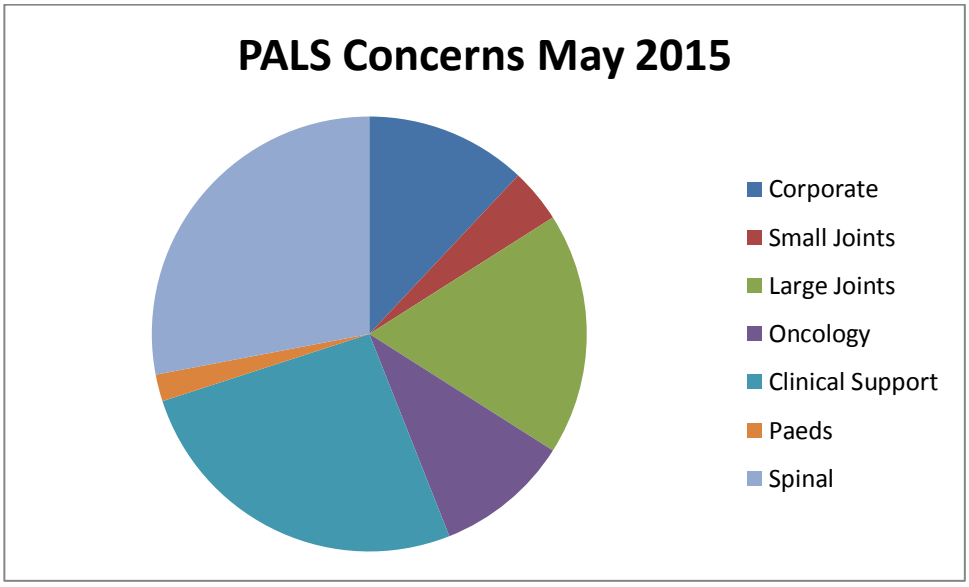
2.1 PALS Contacts, Complaints and Compliments

REPORTING REQUIREMENT: National Reporting Requirement & Quality KPI Contractual Requirement

The department has set new locally agreed KPI's to measure PALs effectiveness from April 2015. Enquires are now logged against a 2 working day target (acknowledgment) and Concerns against a 5 working day target (acknowledgment). The KPI is 80% compliance with these targets for both.

Compliance was achieved in both areas: 86% for Enquiries, 96% for Concerns

There were 107 PALS contacts in May, of which 50 were concerns



PALS Themes for Directorates

All information relayed below is submitted on a monthly basis to the individual directorates, who report on actions in their own Performance meetings and reports. Information about actions taken is not fed back to Public and Patient Services

The trend overall in PALS continues to be lack of information about what is happening with an individuals care and treatment. This includes:

- Waiting for a follow up appointment date
- Waiting for a letter following an appointment
- Waiting for a review appointment after having a diagnostic test
- Not knowing what has happened to a referral
- People not following up conversations when they indicated that they would return a call etc.

These issues are known to the organisation and the Patient Pathway is featuring very heaviliy in the Transformation work as part of the 5 year strategy.

Corporate: Varied general concerns including inability to get through to switchboard and non-arrival of an expected complaint response.

Small Joints: No concerns raised about consultant in last months report. Actions taken by small joints appear to have worked. Only 2 PALS concerns this month which were queries about clinical care and treatment.

Large Joints: Reduction in PALS concerns compared to last month, no trend for any specific consultant but mostly ‘ what’s happening?’ question. Reviewing these does not indicate that there are delays in any specific area as there are no repeated concerns this month.

Oncology: Reduction in PALS concerns compared to last month. Most contacts for concerns this month have some degree of anxiety and are looking for reassurance.

Clinical Support: mainly not being able to contact relevant department (e.g. x-ray or appointments)

Paediatrics: 1 concern this month relating to cancellation of surgery

Spinal: not different from last month**.** Mainly delays, ‘what’s happening?’ question, repeated OPD appointment changes due to rescheduling and awaiting TCI dates

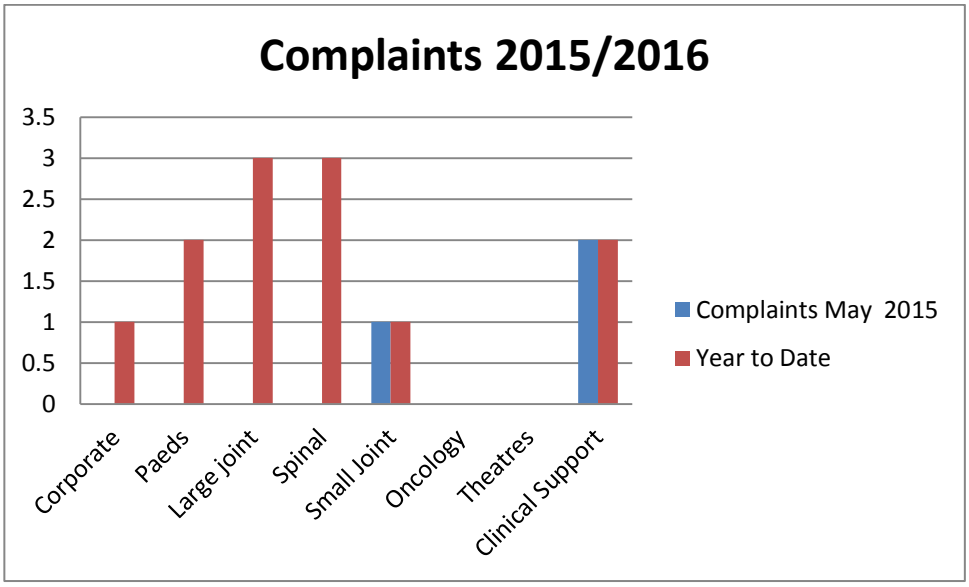
Theatres: none

2.1.2 Complaints

The department has one agreed KPI : 80% of complaints will be handled within the agreed timescale.

This is measured using the number of complaints closed in a given month and we achieved full compliance with this in May. However, it has been identified that the correct process for approval and sign-off has not been followed so a review in being undertaken.

There were 3 complaints made in May 2015



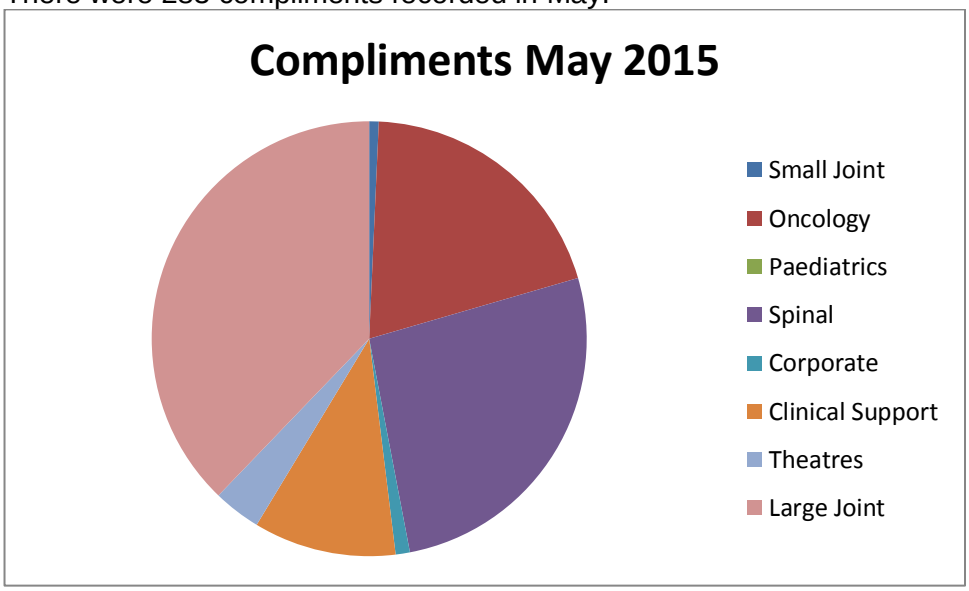
For comparative purposes locally, complaints are assessed as upheld, partially upheld, or not upheld. For national reporting purposes, if any part of a complaint is upheld, then the complaint must be recorded as upheld. The decisions about how a complaint is assessed is made during conversations between the Patient Relations Manager and the Directorate.

Trends this month in complaints:

- Clinical Treatment and Outcome
- Poor Communication.

2.1.3 Compliments

There were 283 compliments recorded in May.



2.1.4 Friends and Family Test

There are no CQUINs attached to Friends and Family for this coming year.

The FFT is being reported in a new way from April 2015. Individuals are identified as Promoters, Passive or Detractors from their response to the single question 'how likely are you to recommend this ward or department to your friends and family if they needed similar care or treatment?'

- Extremeley Likely — are classified as Promoters
- Likely

- Neither likely or unlikely — are classified as Passive
- Don't know

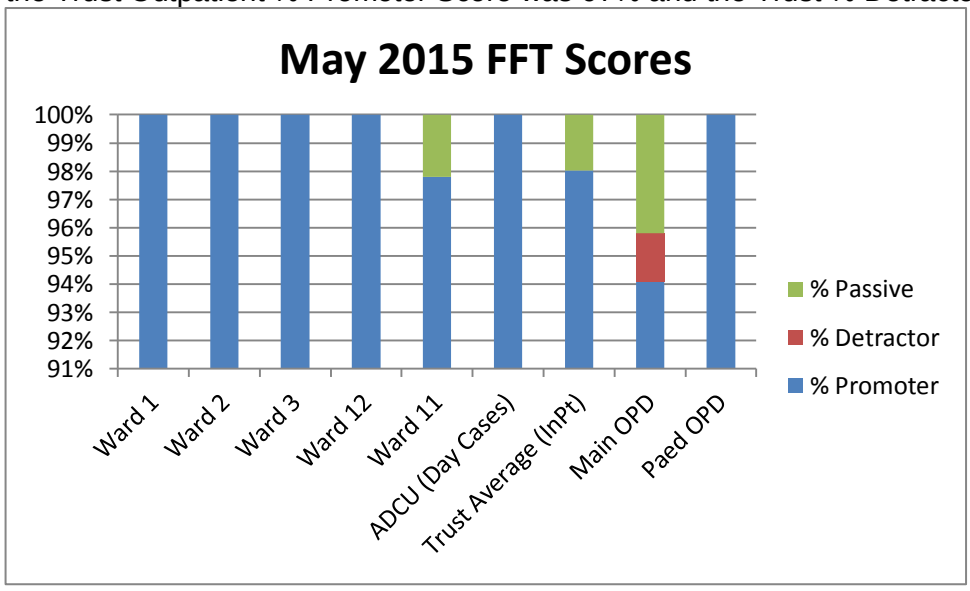
- Unlikely — are classified as Detractors
- Extemely Unlikely

NHS Choices will display the % Promoter monthly score on their website. Our lowest individual area % Promoter Score in April was 97.8%, on Ward 11. This is a better result than last month but still is a relatively small sample size

Inpatient and Outpatient Scores are reported to the Department of Health separately, but have been amalgamated into this chart for comparison purposes.

For May 2015:

- the Trust Inpatient % Promoter Score was 99% and the Trust % Detractor Score was 0%
- the Trust Outpatient % Promoter Score was 97% and the Trust % Detractor Score was 0.85%



The Return Rate for Outpatient Services is much lower than the Inpatient Services and work will continue to improve the collection rate for both Paediatric and Adult Services.

2.1.5 Child Patient Experience

The Ward 11 Inpatient and Outpatient Friends and Family Feedback has been reported in 2.1.4.

In addition to the FFT data collection, a more detailed local survey is available on Ward 11, using a system designed specifically for children. This survey includes questions about the ward environment, communication, pain management and food. There are different questions for children under the age of 13 and over the age of 13, to allow for questions about the different recreational facilities available.

Difficulties over the administration of thiese surveys has been highlighted and a discussion between the Paediatric Matron and the Public and Patient Services Manager is being organised to evaluate whether these issues are related to capacity of the ward staff, administrative or IT related.

2.2 Single Sex Compliance

REPORTING REQUIREMENT: National Reporting Requirement & Contractual Reporting Requirement

There were no single sex compliance breaches during May 2015.

3. EFFECTIVENESS OF CARE

REPORTING REQUIREMENT: National Requirement & ROH NHSFT Good Practice

3.1 National Joint Registry (NJR) Update

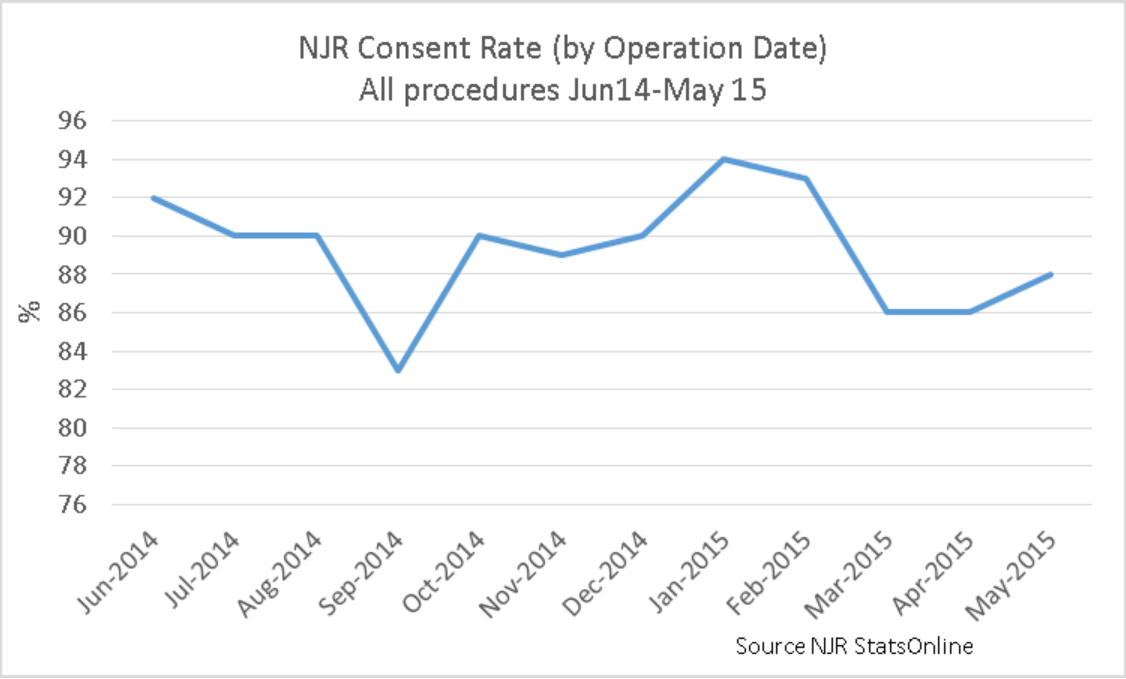
3.1.1 Data Compliance progress 2015

NJR compliance 2015 YTD				
Jan-15	Feb-15	Mar-15	Apr-15	May-15
78%	66%	73%	77%	103%

There still remains some backlog of forms being entered and validated onto the NJR due to incomplete forms being received from Theatres.
Compliance is measured by comparison with PAS coded data. It is possible to be over 100% compliant as NJR forms are completed at the time of the operation, where as coding is completed when a patient is discharged.

3.1.2 Monthly NJR Consent Compliance – All procedures:

Consent has improved recently,the current figure as reprted by the NJR for Jan 15-Apr-15 is approximately 91%. Our own figures which are more up to date show compliance of 95%. The advised target is 95% (and Best Practice Tariff target is 75%).



3.2 Patient Reported Outcome Measures (PROMs)

REPORTING REQUIREMENT: National Requirement & ROH NHSFT Good Practice

3.2.1 PROMs Data

Internal Monitoring of PROMs compliance 2015

PROMS compliance stats for Apr 2015 (internal)

	Indicator	
4A N13ii	PROMs: Hip replacement - % patients completing questionnaires.	92.5%
4A N13iv	PROMs: Knee Replacement- % patients completing questionnaires.	91.8%

Breakdown – May 2015

No patients meeting PROMS criteria	No patients refusing to complete	Q's completed	Q's Missed	% eligible patients completing Q's
168	0	155	13	92.3

PROMs compliance is a contractual requirement and the target compliance rate is 90% for both hip and knee replacement surgery.

PROMs data is updated quarterly the latest available data is as follows (as at May 2015)

2014/15

There is limited data available - at present we are within the expected range for Primary Hip & Primary Knee Replacements for the period Apr 2014 – Dec 2014.

There is insufficient data for comparison for Revision Hip/Knee Replacements.

2013/14

ROH is significantly above the England average for Primary Hip replacements and significantly below the England average for Revision Knee replacements.

Adjusted average Health Gain					
Procedure Type	Measure	No. of Records	ROH	England Average	Position
Hip Replacement Primary	EQ-5D Index	564	0.476	0.436	Significantly **above** national average (99.8% control limit)
Hip Replacement Primary	EQ VAS	448	13.657	11.461	Significantly **above** national average (95% control limit)
Hip Replacement Primary	Oxford Hip Score	593	23.165	21.381	Significantly **above** national average (99.8% control limit)
Hip Replacement Revision	EQ-5D Index	118	0.3	0.259	Above Average
Hip Replacement Revision	EQ VAS	79	6.657	5.16	Above Average
Hip Replacement Revision	Oxford Hip Score	119	13.737	12.242	Above Average
Knee Replacement Primary	EQ-5D Index	391	0.332	0.323	Above Average
Knee Replacement Primary	EQ VAS	293	4.421	5.602	Below Average
Knee	Oxford Knee	419	17.018	16.274	Above Average

Replacement Primary	Score				
Knee Replacement Revision	EQ-5D Index	41	0.116	0.248	Significantly **below** national average (95% control limit)
Knee Replacement Revision	EQ VAS	32	0.11	1.955	Below Average
Knee Replacement Revision	Oxford Knee Score	43	8.342	11.439	Significantly **below** national average (95% control limit)

The data identified with knee replacement revision requires further understanding. This would be undertaken by COEC. This committee has not formlly sat for 12 months.

3.3 Litigation
REPORTING REQUIREMENT: ROH NHSFT Good Practice

New Cases

One new potential clinical negligence cases was received in May 2015.

Ref	Description	Directorate
T460	? metal on metal hip replacement and increased cobalt level	Large joints

Closed Cases

The following ongoing claim was closed in May 2015:

Ref	Date of notification	Details	Settlement	Directorate
T273	Sept 2010	Delay in diagnosis & treatment of spinal compression in 2007/8. Failure to undertake neurological examination & neurosurgical review. Delay in obtaining MRI scan. Also claim against GP	damages: £135k claimant costs: £105k defence costs: £56k	Spinal

The following cases were closed in May 2015 – these did not proceed beyond disclosure of the patient's notes to solicitors

Ref	Date of notification	Details	Directorate
T430	Nov 2013	no details	Spinal
T427	Nov 2013	no details	Large Joints
T417	Aug 2013	femoral neck surgery - subsequent fracture	Oncology
T424	Oct 2013	carpel tunnel surgery, requiring revision	Small Joints

APPENDIX 1a – Ongoing Serious Incidents Requiring Investigation (SI) – May 2015

Ref	Incident date	Date reported to CCG	Type of incident	Level of harm (Prior to completion of RCA investigation)	Directorate	Status	Final RCA due
15309 2015/16739	8.5.15	12.5.15	VTE	Low harm	Large Joints	Investigation underway.	16.7.15
15311 2015/16882	28/1/15	13.5.15	Delay in diagnosis / x-ray report	No harm	X-ray / Large Joints	Investigation underway.	15.7.15
15239 STEIS 2015/15305	28/04/15	29/4/15	Delayed diagnosis	Severe	Spinal	Investigation underway.	3/7/15
15172 STEIS 2015/14257	17/4/15	21/4/15	VTE	Low	Large Joints	Investigation underway.	25/6/15
15137 STEIS 2015/13510	14/4/15	14/4/15	Pt death in Theatres	Death	Theatres/Oncology	Investigation underway. .	18/6/15
15135 STEIS 2015/13494	14/4/15	14/4/15	Pt death on ward	Death	Spinal	Investigation underway.	18/6/15
15098/15082 STEIS 2015/12789	4/4/15	8/4/15	VTE	Moderate	Large Joints	Investigation underway. .	12/6/15
15072 STEIS 2015/12387	31/3/15	2/4/15	VTE	Moderate	Large Joints	Investigation underway.	10/6/15
15058 STEIS 2015/12412	31/3/15	2/4/15	Pt fall/fracture	Moderate	Large Joints	Investigation underway.	10/6/15
14918 STEIS 2015/11725	08/03/15	27/03/15	VTE	Moderate	Spinal	Investigation underway	4/6/15
15062 STEIS 2015/11883	15/12/14	30/03/15	Drug incident	No harm	Theatres/Anaesthetics	Investigation underway	30/09/15
14592 STEIS 2015/2102	18/08/13	16/01/15	Surgical error	Moderate	Spinal	Investigation underway – upgraded to Never Event.	21/4/15. Extension requested 2/6/15.

APPENDIX 1b - Serious Incident investigations completed in May 2015 (submitted to Commissioners)

Ref	Incident date	Description	Directorate	Deadline for submission of RCA investigation report	Progress/ Date submitted
14919 2015/9493	5.3.15	VTE	Oncology	18.5.15	RCA submitted to CCG 8.5.15:
14750 2015/ 5992	9.2.15	Wrong side implant	LJ/theatres	Extension requested to 12.5.15 Originally due 21.4.15	RCA submitted to CCG: 12.5.15

- Twelve RCAs were closed in May 2015, details of all closed RCAs will be included from the August 2015 report.

In conclusion

A number of serious incidents have has issued recently a perfomamance notice and a remedial action plan.

A "deep dive" has currently commenced into the systems and processes surrounding the management of serious incidents and is also looking at the reasons that serious incident investigations are taking such a long time to conclude.

The aim is to ensure that the processes and systems be strengthened and that there will be KPI's set against the management of each serious incident to allow for an quality response that is auditable and timely and demonstrates our Duty of Candour.

This findings of this deep dive will reported to Executive Management Team and Clinical Governance Committee at the beginning of July 2015.

There currently is work being undertaken on delivery of a "new style integrated governance report".
The first draft of this report will be shared with EMT and Clinical Governance Committee during end of July with an approval date estimated during August and for the first report to be available for September 2015 Trust Board.

Recommendation:

Trust Board to note the content of the report.
Trust Board to receive the recommendations of the "Deep Dive".
To receive the newly formatted Governance Integrated report in September 2015.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 July 2015 **ENCLOSURE 7**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	Garry Marsh Interim Director of Nursing & Governance
SUBJECT:	Safer Nurse Staffing Monthly Report

TITLE:

SUMMARY eg. what you want the Board to consider/make decision on

This paper is presented to the Trust Board to give the mandatory monthly update on the position of Nurse Staffing within ROH wards.

It will give evidence that the number of nurses on duty within ROH wards is sufficient to meet our patient's needs, give detail of the external data that has been reported and the utilisation of bank and agency nurses within our wards and our existing nurse vacancies.

IMPLICATIONS eg. financial, operational, risk, etc

Failure to achieve safe nurse staffing levels within our clinical areas will not only see shortfalls in the quality of care delivered to the patients that we serve but also see enhanced scrutiny and potential non-compliance with our Regulators.

RECOMMENDATIONS

That Trust Board is asked note the contents of this paper.

That Trust Board is asked to note that the number of nurses on duty within our wards is sufficient to meet our patients nurse as evidenced by the use of a nationally recognised acuity tool and that an ongoing establishment review is taking place.

1.Publication of Monthly data

ROH completed the NHS England Safe Staffing UNIFY data uplift for the month of May and uploaded it to the ROH website. ROH continues to receive a GREEN rating. This demonstrates the planned nursing levels versus the actual nursing levels. The May submission can be seen within Appendix 1.

2.Nurse Vacancy Levels

Human Resources provide the Director of Nursing & Governance with ward vacancies each month. Details of these vacancies and plans to appoint are detailed within this section.

2.1Registered Nurse Vacancies

Registered Nurse vacancies within ROH are detailed below:

Band 5 Registered Nurse vacancies are detailed in the table below

Band 5 Vacancies	
Ward	
2	2.48
3	0.39
10	2.01
Total	4.88

An external advert for Band 5 Registered Nurses has recently closed with 18 applicants shortlisted which exceeds the current number of vacancies. The recruitment process has taken place on May 9th 2015.

The Senior Sister vacancy within Ward 10/12 has been filled.

2.2 Unregistered Nurse Vacancies

The recruitment of all unregistered nurses has taken place.

2.3 Theatre Vacancies

Theatres are currently undertaking a detailed piece of work to understand the vacancies within the Department.

Recruitment successes have been seen at Band 7 interviews with no vacancies now existing.

The area continues to have vacancies at Band 5 level and a recruitment plan is being developed that is also including the scoping of International recruitment opportunities.

ROH is also attending a Royal College of Nursing recruitment fair in Birmingham in July.

3.Safer Nurse Staffing Tool

The Safer Nursing Care Tool (SNCT) is a nationally developed and validated acuity/dependency tool to measure nursing workload and estimate staffing requirements. The tool is widely used across the NHS. It has been used to assess the dependency and/or acuity of patients across the adult in-patient wards at ROH since September 2014.

The acuity and/or dependency is measured by assessing each patient care needs, chance of deterioration requirement for advanced intervention. These needs are then defined against the 'Levels of Care' required, each patient with a given level of care of has a multiplier for the number of whole time equivalents registered nurses required to Nurse this type of patient .

The Safe Staffing tool continues to be completed by Senior Sisters, checked by Matrons, and submitted to the Director of Nursing & Governance on a weekly basis.

The tool has been further enhanced to recognise the use of 'specialing' shifts for high dependency patients, such as those at high risk/actual falls. The tool has consistent application of methodology across clinical areas. Five months of data is now available.

This data is demonstrating that the number of nursing staff on duty within ROH is at a number that meets the requirements of our patients. This is demonstrated in the table below detailing recommended numbers of WTE on duty vs actual numbers of WTE on duty. Details of the May acuity are detailed in the table below:

Ward	Ward Name	Recommended	Actual	Budgeted
Ward 1	Spinal	23.23	27.09	22.97
Ward 2	Orthopaedics	26.79	26.73	23.15
Ward 3	Oncology	23.32	25.76	24.35
Ward 10 & 12	Private Suite	29.48	38.48	33.91
Ward 11	Paeds	9.14	16.08	17.13
HDU	-	19.25	23.33	26.79

4. Bank & Agency Usage

Wards are permitted to utilise bank and agency to ensure the required numbers of nurses are on duty within clinical areas.

This level of usage of bank and agency nurses is frequently raised by our Nursing Staff as a concern, namely around continuity for our patients and variance in the skill set of some staff provided in particular from agencies.

The table below details May 2015 Bank and Agency usage:

Ward	Permanent	Bank	Agency
Ward 1	70.1%	18.2%	11.7%
Ward 2	75.2%	20.0%	4.7%
Ward 3	71.9%	23.3%	4.8%
Ward 11	84.3%	15.7%	0.0%
Ward 12 & 10	59.7%	31.3%	9.0%
HDU	90.1%	5.0%	5.0%
TOTAL ALL WARDS	73.1%	20.3%	6.5%

There is high reliance on bank and agency within Ward 2 and Ward 10/12 that has increased since the previous months report. The Director of Nursing & Governance has undertaken a review of this usage and the main themes are:

- Additional nurses required associated with the dependency of patients
- Additional nurses covering “specialing” of patients
- Vacancies, sickness and one episode of maternity leave

The Director Of Nursing & Governance will continue to monitor this situation and is currently having a review of quality measures during the period undertaken.

5.Reported Staffing Incidents

In addition to the Safer Nurse Staffing tool being used and interpreted, clinical areas are encouraged to report all Safe Staffing incidents.

An analysis and review of safe staffing incidents reported during the period of May 2015 has been undertaken and is represented in the graph below.

The review highlighted that 5 safe staffing incidents were reported and no incidents involved a breach of minimum safe staffing as defined by NICE.

For all safe staffing incidents reported, patient safety was maintained in all instances with appropriate escalation taking place and no patinet harm reported.

6. Establishment Review

The establishment review described in the Trust Board paper in February is currently being undertaken to deliver permanently funded nurse establishments that reduce the reliance on bank and agency nurses. This review is expected to be completed by the end of July 2015.

7.Conclusion

This paper has given an update of the monthly nurse staffing position within ROH for the period of May 2015.

This paper gives detail of ROH externally reported information. This information demonstrates compliance with the nursing hours required by our patients.

This paper demonstrates that the number of nurses on duty within our wards is correct to meet the needs of our patients by utilising the Safer Nurse Staffing tool.

This paper details the reliance on bank & agency nurses and the causative factors where increased utilisation have occurred.

This paper continues its committment to an establishment review within our clinical areas.

May 2015

			Day				Night							
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Day		Night	
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)
Ward 1	110 - T&O		1525.5	1416	945.5	948.5	682	682	682	671	92.8%	100.3%	100.0%	98.4%
Ward 2	110 - T&O		1476.0	1412.0	989.5	882.0	682.0	693.0	682.0	682.0	95.7%	89.1%	101.6%	100.0%
Ward 3	800 - CLINICAL ONCOLOGY	110 - T&O	1566	1489.5	1057.5	966.5	620	620	540	460	95.1%	91.4%	100.0%	85.2%
Ward 10 & 12	110 - T&O		1820.5	1771	1479.3	1442	1023	1012	1056	1056	97.3%	97.5%	98.9%	100.0%
Ward 11	110 - T&O		1283	1223.5	246	246	682	682	55	55	95.4%	100.0%	100.0%	100.0%
HDU	110 – T&O		1602	1613	232.5	225	1323	1364	0	0	100.7%	96.8%	103.1%	-

BOARD ASSURANCE FRAMEWORK 2014/15 (updated: 16.6.15)

APPENDIX 1

KEY	BAF Themes	Trust-wide risks	Strategic risks	closed risks
		alignment to primary BAF theme	alignment to primary BAF theme	
		alignment to other BAF themes	alignment to other BAF themes	

Executive lead risk owners provide assurance to theme leads on risk mitigation. CGC continues to monitor the 2 clinical themes (1 and 3), EMT oversees the other themes.

Trust-wide risks aligned to the BAF			RAG status	Exec Lead	BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC regis-tration	4. Business continuity	5. Contract with Com-missioners	6. Staff engagement	7. Organi-sational leadership	8. Long-term Viability
					DNG	CSec	DNG	Ops	Ops	WFOD	WFOD	Fin
					16	9	12	16	9	12	16	15
I.D.	RISK	Consequences			ID. 260	ID. 261	ID. 262	ID. 263	ID. 665	ID. 265	ID. 582	ID. 440
					Risks that could lead to unaccept-able stand-ards of care and/or potential harm to patients	Risks that impact on the ability to meet Monitor licence con-ditions	Risks that impact on the achievemen t of CQC stand-ards	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 com-missioners	Risks that impact on the delivery of engagement 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
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	16	Ops								
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	20	MD								
30	Non-compliance with CQC safety domain management of medicines	Potential harm to patients. Breach of CQC essential standads of quality and safety	9	DNG								
33	Insufficient assurance around robust implementation of infection prevention strategies in theatres.		12	MD								
178	Poor completion of WHO safety procedure.	Patient safety through their their experience of the operating department may be compromised, at the mosts severe a never event may occur.	12	DNG								
269	Activity Targets: failure to deliver	June 2015: potential financial impact circa £1m.	16	Ops								
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	FIN								

KEY	BAF Themes	Trust-wide risks	Strategic risks	closed risks
		alignment to primary BAF theme	alignment to primary BAF theme	
		alignment to other BAF themes	alignment to other BAF themes	

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC regis-tration	4. Business continuity	5. Contract with Com-missioners	6. Staff engagement	7. Organi-sational leadership	8. Long-term Viability
				Theme Lead	DNG	CSec	DNG	Ops	Ops	WFOD	WFOD	Fin
275	Learning from serious events/claims/complaints	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	12	DNG								
414	Added December 2014: ROH shows low position for health improvement as measured by PROMs on national Information Centre figures	Patient experience Reputational damage	12	MD								
582	Risk of non-delivery of strategic objectives associated with leaders' ability to lead change, including cultural change.	Care for patients and staff experience that are less than the best; organisational sustainability.	12	WFOD								
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	Ops								
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.	12	Ops								
738	Failure to meet regulatory activity as specified within the CQC Inspection report published on 17.09.14, which detailed 6 compliance actions associated with failure to meet regulatory activity.	Risk of: theft or misuse of controlled drugs; electrical harm to staff and visitors; fire; privacy and dignity not maintained; IG breaches; poor patient experience of Outpatients, poor reputation, poor use of resources within the department; patient information not shared in a timely manner resulting in potential delays in care	12	DNG								
770	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure.	Plant failure would cause significant operational impact on clinical services	12	Ops								
811	Lack of a robust clinical audit plan weakens the Trust's ability to gain assurance across the full range of areas such as; quality, outcomes, safety and patient experience issues. Poorly designed structure with lack of oversight and ownership	The Trust would be unable to provide assurance of compliance with clinical standards, and statutory and mandatory requirements in relation to clinical audit.	12	MD								

KEY	BAF Themes	Trust-wide risks	Strategic risks	closed risks
		alignment to primary BAF theme	alignment to primary BAF theme	
		alignment to other BAF themes	alignment to other BAF themes	

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC regis-tration	4. Business continuity	5. Contract with Com-missioners	6. Staff engagement	7. Organi-sational leadership	8. Long-term Viability
				Theme Lead	DNG	CSec	DNG	Ops	Ops	WFOD	WFOD	Fin
Strategic Risks												
796	The Board and organisation loses its focus on patient care so the ROH is no longer a patient centric organisation	Clinical, operational, financial and workforce decisions are made that do not consider the best interest of the patient, their safety, the quality of our care and the experience of our services throughout their journey. Complaints and PALS concerns increase in number and complexity. The reputation of the organisation is adversely affected. Contract breaches, leading to financial penalties. Commissioner intentions focus away from the ROH to alternative providers. Staff morale and role satisfaction is decreased and professional concerns arise.	5	DNG								
797	The Board and organization is unable to achieve the necessary culture change quickly enough to embed an improvement and learning culture to deliver better quality of care for less money	Failure to achieve strategic goals: Low engagement of staff wanting to make change resulting in low participation, increased staff turnover, failure to recruit a talented workforce; Regulatory action due to failure to address compliance risks; Failure to achieve and/or sustain cost improvement	12	WFOD								
798	The Board and organization does not have adequate capacity or capability to change or does not organize its resources to change effectively	Failure to achieve strategic goals; Regulatory action due to failure to address compliance risks; Low engagement of staff; Failure to provide the best possible care for patients; Failure to achieve or sustain cost improvements	12	WFOD								
799	The Board is unable to create the common beliefs , sense of purpose and ambition across the organisation among clinicians and other staff to deliver the strategy and avoid the diversion of energy into individual agendas	Lack of clinical engagement in change process No improvement in the patient experience within the Trust; Reputational damage – not seen as the first choice for orthopaedic care ; Staff confidence and morale, as seen as more of the same and an ineffective board/directors; Lack of change in processes and innovations	12	Strat & Trans								
800	Governance structure and processes are poorly understood with a result that they become a barrier rather than a tool for delivery	Structure and processes inhibit the delivery of assurance as a result of the disconnect between Trust Board and other groups of the Trust. Difficulties in external bodies gaining confidence about the quality and effectiveness of the Trusts work. Sub Board groups continue to function in a historic manner and are disengaged from the assurance cycle. Risk of over bureaucratic process leading to further inefficiency and negative reaction from clinicians.	9	Csec; DNG								

KEY	BAF Themes	Trust-wide risks	Strategic risks	closed risks
		alignment to primary BAF theme	alignment to primary BAF theme	
		alignment to other BAF themes	alignment to other BAF themes	

					BOARD ASSURANCE FRAMEWORK THEMES							
					1. Standards of care	2. Monitor licence	3. CQC regis-tration	4. Business continuity	5. Contract with Com-missioners	6. Staff engagement	7. Organi-sational leadership	8. Long-term Viability
				Theme Lead	DNG	CSec	DNG	Ops	Ops	WFOD	WFOD	Fin
801	the Trust is adversely affected by the regulatory environment by diverting energy from the strategy, creating a focus on suboptimal targets or creating exposure to policy shifts such as reducing support for single specialty hospitals.	The Trust is unable to deliver its strategic objectives due to focus on short term targets and/ or need to manage regulatory interventions and resultant action plans. The Trust fails to adapt to the emerging regulatory environment resulting in pursuit of wrong strategy/ failure to adapt strategy leading to loss of business or reputation.	12	CEO								
802	The Trust is too small to be viable in the longer term	The Trust will be unable to provide safe sustainable services whilst meetings its financial responsibilities. The Trust would need to consider exiting the market for certain services. The may cease to be a going concern and seek acquisition by another. The overhead costs of independence become disproportionate to the overall costs of the services provided.	12	CEO								
803	Risk to financial viability through the inability to manage internal costs, deliver key programmes or respond to tariff deductions	Unable to fund required volume and quality of clinical care; Unable to pay staff / creditors; Reputational impact; Increased regulation; Long term viability at threat	20	Fin								
804	Information is insufficient in quantity, usefulness or reliability to run the organization, improve service and provide evidence of effectiveness and assurance to the Board	Trust does not understand the strong and weak performing areas of the hospital. Unable to respond appropriately to patient or process concerns. Poor business decisions taken as a result of information gaps. In extreme circumstance, incorrect patient care offered as a result of information gaps. Unable to measure whether transformation is achieving its goals	12	Fin								
805	The Trust is unable to maintain its reputation for excellent work (or has an unwarranted view of its own reputation) with the result that referred work declines	Financial loss, loss of knowledge leader status, loss of viability as 'stand alone' specialist trust. Inability to recruit highly skilled clinicians and resignation of existing experts	12	MD								
806	The Trust is unable to anticipate or respond to disruptive technology which creates a paradigm shift putting the ROH out of business	Trust unable to achieve strategic goals; Closure of 'stand alone' site	8	MD								
832	The Trust is unable to respond rapidly enough to changes in market demand, new offers from competitors or more compelling brands thus losing competitive position	Reputational impact – no longer seen as the speciality brand market leader; Reduces market share, reduces opportunities both with the health economy and in commercial partnership to develop both service and intellectual property; Reduction in successful funding bids; Stagnates care offering that fails to maintain a patient quality advantage; Wider image impact	3	Ops								

KEY	BAF Themes	Trust-wide risks	Strategic risks	closed risks
		alignment to primary BAF theme	alignment to primary BAF theme	
		alignment to other BAF themes	alignment to other BAF themes	

				BOARD ASSURANCE FRAMEWORK THEMES							
				1. Standards of care	2. Monitor licence	3. CQC regis-tration	4. Business continuity	5. Contract with Com-missioners	6. Staff engagement	7. Organi-sational leadership	8. Long-term Viability
			Theme Lead	DNG	CSec	DNG	Ops	Ops	WFOD	WFOD	Fin
Risks downgraded- to be monitored											
782	compliance with Equality Act		WFOD								
779	Bank staff pay		EMT								
32	Surgical Site Infection Rate	closed by CGC Feb 2015	DNG								
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.	DNG								
275	Inability to consistently demonstrate learning from serious events/ claims/ complaints is embedded in practice	poor quality patient experience	DNG								
621	Delays in MRI imaging and reporting	potential delay in diagnosis and treatment. Ineffective outpatient consultations . Repeat visits. Potential complaints/claims	Ops								
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.	Ops								
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	Ops								
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	FIN								

Appendix 2: BAF Update Q1 (2015/16)

Updated 23.6.15 (JM)

BAF Theme 1: Standards of Care (i.d. 260)										
Risk(s) aligned to this theme										
Date added to BAF	**Risk**	**Consequence**	**Lead Exec**	**Strategic Initiative(s)**	**Risk Rating**			**Reason & evidence for risk rating change***	**Update to include gaps in control and assurance**	**Lead Cttee**
					Initial	Current	Target			
TRUST WIDE RISKS ALIGNED TO THIS THEME										
Tbc	(id 33) Infection prevention in theatres		DNG	2 Exceptional patient experience 3 Safe & efficient processes	16	12	4	June 2015: risk rating assessed – remains 12. April 2015: Following discussion at SMT, the current risk rating has been increased from 8 to 12.	June 2015: Monthly walk rounds / inspections with full engagement from the theatre management team underway. Capital investment in theatres improvement planned for 2015, which includes the cost of moving the plaster room out of theatres and providing more storage. It will also fund improvements to the theatre changing facilities and conservatory area. Exec lead now DNG as DIPC(instead of MD). April 2015: This risk links to local risk 559 'theatre environment'. An update on progress with mitigation of this risk was included in the IPCT report to EMT in March 2015. Although there has been an improvement in this area, capital funds and building work are needed to achieve full compliance.	CGC
March 2014	(i.d.178) Poor completion of WHO safety procedure.	Potential compromise to patient safety, possible never event	DNG	3 Safe & efficient processes services 6 Information for excellence	16	12	6	Current risk rating unchanged but underlying position has deteriorated. Risk rating to be reviewed by	June 2015: WHO compliance rate gone down to 97.41% for May 2015. The may be because of a high influx of new agency staff and complacency due to previous high compliance figures. Remedial Action: mid-May increasing in non-compliance noted and an emergency meeting called with all theatre staff before the list started to	CGC

BAF Theme 1: Standards of Care (i.d. 260)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
								lead.	reinforce and remind staff of the importance of completing the WHO at all three stages. MD and DNG notified of actions and concerns with increase in non-compliance. Letters sent to all staff who were non-compliant and theatre staff involved spoken to personally to reinforce importance of maintaining 99% compliance within the Trust. 4.6.15: email sent to MD, DNG and theatre DM to notify them of the 97.41% compliance for May. Activity and performance reported in the Patient Quality Report. Action plan has been developed in May 2015 for implementation in June 2015. Feb 2015: Following actions in Dec we have met CCG compliance target for 4 out of last 5 weeks since end of Dec 14., ie exceeding 99%	
June 2015	(i.d. 275) Learning from serious events/claims/ complaints	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	DNG	1 Culture of excellence, innovation & Service 2 Exceptional patient experience 3 Safe & efficient processes	16	12	6	Escalated to management via the BAF in June 2015	Significant turnover within Directorate Manager structure. Managers currently in post would not have received previous training in local governance and risk management rolled out in 2014. Recurring themes of adverse incidents have been identified.	CGC

Board Assurance Framework Update – Quarter 1 2015-16

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 1: Standards of Care (i.d. 260)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
Dec 2014 (re-instated)	(i.d. 414) ROH shows low position for health improvement as measured by PROMs on national Information Centre figures.	Reputational damage, for example, if Trust deemed to be an outlier.	MD	1 Culture of excellence, innovation & Service 2 Exceptional patient experience 3 Safe & efficient processes	16	12	4	PROMs remains a significant outlier for the Trust. This is the case for many specialist Trusts and might reflect the complexity of some of these cases. Ongoing work in analysing these cases.	Updated June 2015 ROH remains an outlier for TKR and revision TKR (as does the other specialist orthopaedic trusts RNOH and RJAH) The Knowledge hub is working on a process to ensure accurate and full compliance with data collection. A bigger piece of work needs to be conducted by the Specialist Orthopaedic Alliance to see if there is an underlying reason for this outlier status. Jan 2015: no change in position December 2014 Previously de-escalated but following review at November CGC meeting, this risk is to remain under current monitoring via the BAF due to lack of coherent process for monitoring and acting upon data collected in order to successfully effect change.	CGC
Feb 2015	(id 811) Lack of a robust clinical audit plan weakens the Trust's ability to gain assurance across the full range of areas such as; quality,	The Trust would be unable to provide assurance of compliance with clinical standards, and statutory and mandatory requirements in relation to clinical audit.	MD	3 Safe & efficient processes 6 Information for excellence 7 ROH: knowledge leader	12	12	2		May 2015: A clinical audit programme for 2015/16 has been developed with input from the directorates. This is been sent to the medical director, and the director of R&D will be presenting this to the CGC meeting in June. The trust's dedicated clinical audit officer has been redeployed into the governance department and is not focusing on clinical audit due to the short staffing issues within the governance team. Clinical audit support is therefore being provided by the existing R&D team.	CGC

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 1: Standards of Care (i.d. 260)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
	outcomes, safety and patient experience issues. Poorly designed structure with lack of oversight and ownership.								Controls in place Clinical audit database in place. Dedicated member of staff to support clinical audit within the Trust. New operational manager to rectify issues (from January 2015). Interim clinical director in place (from January 2015). Evidence that clinical audits have been undertaken from April 2014. Planned mitigation: To have a robust and comprehensive clinical audit programme for 2015/16, which will be ratified by the appropriate Directorates and Trust Committees. To set up an appropriate oversight committee for clinical audit monitoring within the Trust. This committee will report to CGC. To implement an updated clinical audit policy. To complete a clinical audit report for 2014/15 to provide assurance to the relevant committees within the Trust whether the organization has complied with external requirements.	
STRATEGIC RISKS ALIGNED TO THIS THEME										
Mar 2015	(i.d. 796) The Board and organisation loses its focus on patient care so the ROH is	Clinical, operational, financial and workforce decisions are made that do not consider the best interest of the patient, their safety,	DNG	2 Exceptional patient experience	5	5	5		Update frequency: 6-monthly June 2015: update due Sept 2015 Mitigation/Controls – Patient Quality Report reviewed by the Board in	

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 1: Standards of Care (i.d. 260)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
	no longer a patient centric organisation	the quality of our care and the experience of our services throughout their journey. Complaints and PALS concerns increase in number and complexity. The reputation of the organisation is adversely affected. Contract breaches, leading to financial penalties. Commissioner intentions focus away from the ROH to alternative providers. Staff morale and role satisfaction is decreased and professional concerns arise.							public sessions. CoG review of Corporate Performance Report. Patient stories shared at Board. Director team approach to joint planning of service delivery. Strengthened links between Patient and Carer Council to Quality Committee/EMT. Board members visiting wards and departments speaking directly to patients and staff. Evidence of Assurance: Patient Quality Report; CPR; Patient & Carer Council; Quality Meeting; Patient Harm Reviews; FFT feedback; Complaints & PALS review; Patient Stories.	
Mar 2015	(i.d. 804) Information is insufficient in quantity, usefulness or reliability to run the organization, improve service and	Trust does not understand the strong and weak performing areas of the hospital. Unable to respond appropriately to patient or process concerns. Poor business decisions taken as a result of information	Fin	2 Exceptional patient experience 3 Safe & efficient processes 6 Information for excellence	12	12	4		Update frequency: Quarterly Next Update due: Sept 2015 June 2015: Transformation Committee will be considering a business case to support the development of business intelligence services and systems at its June committee meeting? Mitigation/Controls:- IM&T Strategy developed and being implemented;	

Board Assurance Framework Update – Quarter 1 2015-16

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 1: Standards of Care (i.d. 260)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
	provide evidence of effectiveness and assurance to the Board	gaps. In extreme circumstance, incorrect patient care offered as a result of information gaps. Unable to measure whether transformation is achieving its goals							Informatics strategy to be developed; Upgrade of Informatics infrastructure to SQL 2012 to provide platform for future Informatics developments; Refocus of Informatics team to prioritise business intelligence. Develop culture of good data quality at all levels of the organization; Transformation project to identify, collect and report on a new set of KPIs aligned with Trusts strategic objectives Evidence of Assurance: CPR; Internal Audit reports; Benchmarking; Transformation Board Reports; CQC report; Data Quality Committee Papers; IM&T Programme Board	

De-escalated risks aligned to this theme

i.d.	Description	Lead Committee
32	Surgical Site Infection Rate. De-escalated by CGC Feb 2015	CGC
12	KPIs	CGC
621	Delays in MRI imaging and reporting	CGC

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 2 Monitor Licence (i.d. 261)

Update on progress

June 2015: The current risk rating of this theme has been increased from 8 to 9 because of likely scrutiny of the Trust's financial position and proposed changes to the risk assessment framework.

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 3 CQC Registration (i.d. 262)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
TRUST WIDE RISKS ALIGNED TO THIS THEME										
Jan 2015	(id 30) Non-compliance with CQC safety domain management of medicine	Potential harm to patients. Breach of CQC essential standards of quality and safety	DNG	2 Exceptional patient experience 3 Safe & efficient processes	6	9	8		June2015 The Drugs and Therapeutics Committee accepted the report and the supporting action plan. The report will go before the Clinical Governance Committee on the 10/06/2015. April/May 2015: Audit completed 1 month early in April 2015. The audit report and action plan will be submitted to Drugs and Therapeutics Committee on 18th May and to CGC for June. Updated KPMG response to be presented to CGC by DNG. March/April 2015: Likely to go green after the next audit at the end of April. New SOP is issued, audit done and action plans agreed. Next audit is being pulled forward to April (end of) instead of May. CQC Trust Wide CD Governance Audit tool completed. Action Plan generated. Feb Audit and individual audit plans issued April 2015. Mitigation put in place Dec/Jan 2015: Trust-wide internal audit undertaken reviewing documentation of controlled drugs (CDs). External review by KPMG commissioned to look at documentation	CGC

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 3 CQC Registration (i.d. 262)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
									and prescription/administration of CDs. Zero tolerance letter sent reminding registered practitioners of their roles and responsibilities in the administration and documentation of CDs. SOPs produced to support practice in the administration and documentation of CDs. Matrons commenced spot audit checks on CDs. Joint quarterly audits by pharmacy and theatre staff commenced Sept/Oct 2014. Results show concerns re completion of documentation in theatres re CD registers and Fridge monitoring. Theatres management group led by consultant anaesthetist set up to address these issues.	
Jan 2015	(id 738) Failure to meet regulatory activity as specified within the CQC Inspection report published on 17.09.14, specifically management of controlled drugs.		DNG	2 Exceptional patient experience 3 Safe & efficient processes	9	12	1	June 2015: risk rating increased from 9 to 12 – see commentary	May 2015 – CQC Action Plan continues to be monitored at Board Level. New risk identified and added to CGC risk register involving lack of assurance around medical equipment PAT testing (i.d.. 880). April 2015: Current risk rating reduced due to implementation of task and finish group to roll out KPMG recommendations. Progress made with theatre action plan. Overall, CQC overarching action plan devised and monitored by CGC and Trust Board. Audits conducted in February 2015 show significantly improved compliance with medicines	CGC

BAF Theme 3 CQC Registration (i.d. 262)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
									documentation. Mitigation put in place Dec/Jan 2015 (same as for risk 30 'CQC compliance') Trust-wide internal audit undertaken reviewing documentation of controlled drugs (CDs). External review by KPMG commissioned to look at documentation and prescription/administration of CDs. Zero tolerance letter sent reminding registered practitioners of their roles and responsibilities in the administration and documentation of CDs. SOPs produced to support practice in the administration and documentation of CDs. Matrons commenced spot audit checks on CDs.	
STRATEGIC RISKS ALIGNED TO THIS THEME										
Mar 2015	(i.d. 801) Trust is adversely affected by the regulatory environment by diverting energy from the strategy, creating a focus on suboptimal targets or creating exposure to	The Trust is unable to deliver its strategic objectives due to focus on short term targets and/ or need to manage regulatory interventions and resultant action plans. The Trust fails to adapt to the emerging regulatory environment resulting in pursuit of wrong strategy/ failure to adapt strategy leading to loss of	CEO	1 Culture of excellence, innovation & Service 2 Exceptional patient experience 3 Safe & efficient processes 4 Fully engaged patients & staff 5 Developing	12	12	6		Update frequency: Quarterly Reviewed June 2015 Mitigation/Controls: Engage in the wider NHS nationally and locally to stay on top of changing context and regulatory requirements. Ensure the organization is set up to deliver key requirements of the regulator and commissioner, supported by internal performance management systems to ensure 'business as usual' operational delivery. Strengthen internal operational capability to ensure key requirements are delivered to negate need for regulatory intervention. Adequacy of Controls:	

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 3 CQC Registration (i.d. 262)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
	policy shifts such as reducing support for single specialty hospitals.	business or reputation.		clinical services 6 Information for excellence 7 ROH: knowledge leader					Controls are being put in place and will be further developed through the appointments to the new organizational structure and further development of the governance system which provides assurance to the Board. The Trust will not be able to mitigate against changes in national policy or new target introduced in response to areas of political interest, but must be able to adapt in these circumstances. Evidence of Assurance: Regular engagement in national and local policy and planning events and meetings to maintain and develop an informed understanding of the changing policy context to support ROH response and strategy development: Monitor briefings; FTN Networks; CEO events; SOA; Tripartite events; Unit of Planning processes; NHS Confederation; Kings Fund papers. Evidence through CEO and other Director reports to the Board. Evidence of managing operational delivery through CPR to Board.	

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 4 Business continuity (i.d. 263)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
TRUST WIDE RISKS ALIGNED TO THIS THEME										
June 2014	(i.d.7) Long waiting times for spinal deformity. Impact of BCH capacity on ROH's waiting list potentially causing delays. June 2015: noted that this risk has a potential financial impact of circa £0.5m.	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	1 Culture of excellence, innovation & Service 2 Exceptional patient experience 5 Developing clinical services	20	16	9	June 2015: risk rating increased from 12 to 16	June2015 BCH have cancelled 13 theatre sessions since December 2014; this has exacerbated the difficulty in obtaining alternative theatre capacity. May/June 2015 There remained 6 patients on the admitted spinal deformity/spines waiting list that had been waiting longer than 52-weeks, with a further two expected in May15. Discussions held with BCH in March regarding securing extra capacity, but with no immediate opportunity to increase capacity. Discussions held with UHNM (Stoke) on 21st May; Interested in developing stronger ties with ROH but unable to provide extra capacity before Oct 15, due to ongoing local pressures at UHNM. 40+ week patients reviewed weekly through waiting list meeting and MDT. NHSE confirmed intention to impose fines against the Trust for any 52 week breach, which combined with reduced tariff for spinal deformity possess a significant financial risk to the Trust. Report on waiting list position submitted to NHSE in April, with supplementary information provide in May. Meeting arranged with NHSE 27th May 15.	EMT

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 4 Business continuity (i.d. 263)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
									Mar 2015: There were two 52-week breaches between Jan – Feb 15, and expected to be four breaches in March 15. Discussions held in March with BCH. No immediate opportunities to increase access to capacity at BCH. Discussions opened with Stoke to secure extra sessions aimed at securing longer term alliance to secure extra two lists per month from July 15. 40+ week patients reviewed weekly through waiting list meeting and MDT.	
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 GP trainees or FY2	Increasing locum and agency costs and potential successful banding claims. Following EMT discussion, awaiting further update from Medical Director.	MD/ WFOD	4 Fully engaged patients & staff	20	20	6		June 2015: Overseas recruitment has identified 6 potential candidates for physicians' associate. Formal recruitment from these candidates and potential EU candidates to be undertaken by end of June. Variable start dates to be agreed. Urgent action for June is to agree the final workforce model that addresses all service gaps including overnight junior doctor cover as well as identifying an operational lead as requested by EMT **April 2015:** As flagged at EMT in March 2015, a new project risk (no 828) has been added to the risk register relating to financing of junior doctors. The project risk will feed into this risk.	EMT

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 4 Business continuity (i.d. 263)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
June 2015	(i.d. 269) Activity Targets: There is a risk that the Trust may fail to deliver activity targets	June 2015: potential financial impact circa £1m.	Dir of Ops	1 Culture of excellence, innovation & Service 2 Exceptional patient experience 5 Developing clinical services	12 May 2015	16	4		June 2015: EMT agreed that this risk should be escalated to the BAF. The operations team are in the process of developing a rectification plan to address the activity shortfall. It is expected that this rectification plan will run from August 2015 to March 2016. May/June 2015 With draft May-15 activity the trust is indicating a shortfall of circa. £1M in the first two months. To be reviewed at ARG & with Dir Ops. EMT is asked to advise on escalation of this risk to management via the Board Assurance Framework.	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	2 Exceptional patient experience 3 Safe & efficient processes 6 Information for excellence	12	12	4		May/June 2015 Following assessment of the position of 18 weeks and the management of pathways improvements can and will be made to the data entry and management of waiting lists. However, the provision of information is considered to be a significant risk. The multiple reports and reporting suites which are little understood and are not updated on a reliable schedule, with single points of failure, continue to be unresolved since August-14 when the risk was initially raised. A clear plan is required to identify the steps	EMT

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 4 Business continuity (i.d. 263)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
									to be taken to remove the superfluous and unrequired reporting and a focus on ensuring the basic reporting is robust.	
Aug 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	2 Exceptional patient experience 3 Safe & efficient processes	16	12	4	Jan 2015 current risk rating - confirmed as amber (12)	June: discussed at EMT – active monitoring of the risk to continue until full assurance of mitigation received. April/Mar 2015: Updated SOP awaiting CGC sign off-deferred from Feb EMT. Audit and training completed in Feb. Review of outstanding actions to be discussed at POC meeting 9/3/15. Once new Coagucheck meters in use and POC policy in place consider management of risk at local level.	EMT
Dec 2014	(i.d. 770) Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure,	Significant operational impact on clinical services	Dir Ops	2 Exceptional patient experience 3 Safe & efficient processes 5 Developing clinical services	15	12	4		June 2015: Plan for theatre refurbishment led by Estates and Directorate Management (Theatres) to commence in quarter 3 (2015/16). Feb 2015: Reviewed – no further updates Jan 2015:. Requires review of Trust wide Estates Strategy at EMT, and previous investment decision into proposed new Theatre block Potential impact Currently, 3 theatres share single, and oldest engineering plant, equivalent to 30% of the Trusts overall theatre capacity. Current controls and mitigation: Continue with annual rolling theatre maintenance programme. Introduction of temporary theatre would be limited to single	EMT

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 4 Business continuity (i.d. 263)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
									replacement theatre due to limited on-site space available - dependent on demolition of decommissioned ward block in 2015. New risk December 2014 – agreed at EMT in Dec 2014 to be added to risk register with a score of 20	

De-escalated risks aligned to this theme (awaiting assurance from lead committee on mitigation)

i.d.	Description	Lead Committee
51	Medical Records	CGC

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 5 Contract with Commissioners (i.d. 665)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Committee
					Initial	Current	Target			

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.

De-escalated risks aligned to this theme (awaiting assurance from lead committee on mitigation)

i.d.	Description	Lead Committee
625	Spinal database data corrupt	EMT

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 6 Staff Engagement (i.d. 265)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
STRATEGIC RISKS ALIGNED TO THIS THEME										
Mar 2015	(i.d. 800) Governance structure and processes are poorly understood with a result that they become a barrier rather than a tool for delivery	Structure and processes inhibit the delivery of assurance as a result of the disconnect between Trust Board and other groups of the Trust. Difficulties in external bodies gaining confidence about the quality and effectiveness of the Trusts work. Sub Board groups continue to function in a historic manner and are disengaged from the assurance cycle. Risk of over bureaucratic process leading to further inefficiency and negative reaction from clinicians.	CSec; DNG	1 Culture of excellence, innovation & Service	9	9	4		Update frequency: Quarterly Updated June 2015 Mitigation/Controls: Ensure structure and processes are designed to provide assurance and are easily understood by all groups. Launch and regular reinforcement of the developed structure and processes to raise awareness and develop practical understanding and application by all participants. Be considerate of neither over simplifying or overly complicating the developments whilst being mindful of the need for robust assurance. Work with teams to ensure they understand the role of governance, have work plans that are aligned to reporting dates to overseeing Committees (e.g. CGC) and ensure that those designated as Chairs understand their role , the link to patient benefit and can commit to fulfilling the role Evidence of Assurance: Structure chart; TOR; Awareness, understanding application of organizational structure and processes at sub Board level; effectiveness of the new structure; Quality Governance Framework sections 3 & 4 improvements to scoring.	
Mar 2015	(i.d. 832) The Trust is unable to respond rapidly enough	Reputational impact – no longer seen as the speciality brand market leader; Reduces market	Ops	4 Fully engaged patients & staff	6	3	1	June 2015: Current risk rating reduced from 6 to 3	Update frequency: Quarterly Updated June 2015 Mitigation/Controls :- Membership of unit of planning meetings;	

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 6 Staff Engagement (i.d. 265)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
	to changes in market demand, new offers from competitors or more compelling brands thus losing competitive position	share, reduces opportunities both with the health economy and in commercial partnership to develop both service and intellectual property; Reduction in successful funding bids; Stagnates care offering that fails to maintain a patient quality advantage; Wider image impact							Membership of SOA; Membership of academic health science network; Membership of regional chief operating officers group Evidence of Assurance Transformation Committee meetings and regular reports to board; Quarterly Commissioner review meetings; Activity Review Group; Business Planning Group	

Board Assurance Framework Update – Quarter 1 2015-16

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 7 Organisational Leadership (i.d. 582)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
TRUST WIDE RISKS ALIGNED TO THIS THEME										
March 2014	(i.d. 582) Risk of non-delivery of strategic objectives associated with leaders' ability to lead change, including cultural change.	Care for patients and staff experience that are less than the best; organisational sustainability.	WFOD	1 Culture of excellence, innovation & Service 4 Fully engaged patients & staff 5 Developing clinical services	16	12	4	June 2015: Current risk rating decreased from 16 to 12 by calibration against other red risks.	May/June 2015 Kings Fund reported to Board on 3rd June and due to go to medical workforce at end of June. This has now happened although a presentation was received not the full report Next steps to be taken include design of medical leadership roles, functional responsibilities and leadership strategy Feb 2015: Feedback from the Kings Fund report is due on 5 March and will be reported to the next EMT. Dec 2015: Kings Fund report due end of December and leadership strategy to be developed in Jan 2015	EMT
STRATEGIC RISKS ALIGNED TO THIS THEME										
Mar 2015	(i.d. 797) The Board and organization is unable to achieve the necessary culture change quickly enough to embed an improvement and learning culture to	Failure achieve strategic goals: Low engagement of staff wanting to make change resulting in low participation, increased staff turnover, failure to recruit a talented workforce; Regulatory action due to failure to address compliance	WFOD	1 Culture of excellence, innovation & Service 4 Fully engaged patients & staff	12	12	2		Update frequency: Quarterly Updated June 2015 Mitigation/Controls: Action on-going to improve engagement – improved communication, embedding values, management of sub-optimal performance, staff involvement in improvement activity and increased learning opportunities for whole workforce; New Beginnings events. Engagement scores reviewed by Board quarterly (FFT) and annually (survey)	

BAF Theme 7 Organisational Leadership (i.d. 582)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
	deliver better quality of care for less money	risks; Failure to achieve and/or sustain cost improvement							Work with Kings Fund on medical leadership Evidence of Assurance: Staff Survey results; FFT for staff; Incident numbers; % staff participation in improvement activity; Improvements in high priority patient areas – outpatients + ADCU	
Mar 2015	(i.d. 798) The Board and organization does not have adequate capacity or capability to change or does not organize its resources to change effectively	Failure to achieve strategic goals; Regulatory action due to failure to address compliance risks; Low engagement of staff; Failure to provide the best possible care for patients; Failure to achieve or sustain cost improvements	WFOD	1 Culture of excellence, innovation & Service 2 Exceptional patient experience 3 Safe & efficient processes 4 Fully engaged patients & staff 5 Developing clinical services 6 Information for excellence 7 ROH: knowledge leader	15	12	6	June 2015: current risk score decreased from 15 to 12	Update frequency: Quarterly Updated June 2015 Mitigation/Controls: Investment in transformation capacity; recruitment of Transformation team and other senior managers to lead change in operational areas complete and due to start in post in Q2; existing work on staff communication and engagement via New Beginnings sessions. Work with the Kings Fund on medical leadership; restructure of the operational directorates and some corporate services effective from September 2015. Evidence of Assurance Recruitment decisions; New Beginnings outputs; medical staff engagement event on 29th June 2015; plans for corporate departments.	
Mar 2015	(i.e. 799) The Board is	Lack of clinical engagement in change	Strat & Trans	5 Developing clinical	12	12	6		Update frequency: Quarterly Update due June 2015	

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 7 Organisational Leadership (i.d. 582)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
	unable to create the common beliefs , sense of purpose and ambition across the organisation among clinicians and other staff to deliver the strategy and avoid the diversion of energy into individual agendas	process No improvement in the patient experience within the Trust; Reputational damage – not seen as the first choice for orthopaedic care ; Staff confidence and morale, as seen as more of the same and an ineffective board/directors; Lack of change in processes and innovations		services					Mitigation/Controls - Transformation Committee; Clear work programmes, with Executive leads and a clear reporting structure; Establishment of the RoH Improvement Hub; Evidence of clinical engagement across the Trust; Clear evidence of changing practice and processes, across the Trust Evidence of Assurance Transformation Committee meetings and regular reports to Trust Board; Staff satisfaction; Patient satisfaction; Clinical engagement	

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 8 Long term viability (i.d. 440)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
TRUST WIDE RISKS ALIGNED TO THIS THEME										
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	1 Culture of excellence, innovation & Service 5 Developing clinical services	10	15	5		June 2015 – The Trust was asked to comment on the relativity of a proposed tariff for 2016/17. Whilst Monitor have stated that the exercise was to determine relativities rather than absolute prices, the prices quoted were a significant drop on the current year's tariff. It therefore appears at present that the risk of specialist (and non-specialist) tariffs declining is still very real. Monitor will be releasing a proposed consultation tariff at some point over the summer Mitigation (updated April 2015) The Trust is working with NHS England to ensure contractual baseline is adequate to deliver required level of care to our specialised patients. As part of the Strategic Orthopaedic Alliance, work with Monitor on the long term plans for the funding of specialist orthopaedic care.	EMT
STRATEGIC RISKS ALIGNED TO THIS THEME										
Mar 2015	(i.d. 802) The Trust is too small to be viable in the longer term	The Trust will be unable to provide safe sustainable services whilst meetings its financial responsibilities. The Trust would need to consider exiting the market for certain	CEO	1 Culture of excellence, innovation & Service 2 Exceptional patient experience 3 Safe & efficient	12	12	6		Update frequency: Annual Update due March 2016 Continue to develop the growth strategy and seek multiple opportunities. Ensure robust CIP plans are in place to keep costs within the tariff. Delivery of transformation programme to ensure the most efficient use of resources in meeting the needs of patients. Form strategic alliances to support either	

BAF Theme 8 Long term viability (i.d. 440)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
		services. The may cease to be a going concern and seek acquisition by another. The overhead costs of independence become disproportionate to the overall costs of the services provided.		processes 4 Fully engaged patients & staff 5 Developing clinical services 6 Information for excellence 7 ROH: knowledge leader					cost control and/ or growth strategy. Adequacy of Controls: Controls will require further development and will be strengthened through improved governance and by appointment to the new organizational structure to bring new skills into the Trust. Evidence of Assurance: Viable business plan. Key milestones met – growth, expenditure, CIPs, transformation initiatives. Evidence of alignment with commissioner intentions. Business model adapts to ensure viability. Seek business opportunities. Development of alliances to strengthen core capabilities and create growth opportunities. Evidence through Board review of strategy, operational performance, transformation and business opportunities.	
Mar 2015	(i.d. 803) Risk to financial viability through the inability to manage internal costs, deliver key programmes or respond to tariff deductions	Unable to fund required volume and quality of clinical care; Unable to pay staff / creditors; Reputational impact; Increased regulation; Long term viability at threat	Fin	3 Safe & efficient processes 5 Developing clinical services	20	20	8		Update frequency: Quarterly Next update due: Sept 2015 June 2016: reviewed by Dir Fin – no change. Mitigation/Controls:- Formal programme structure for transformation Detailed financial plan agreed and monitored Involvement in national policy direction (i.e. PbR, Specialist services) Check and challenge of financial performance at all levels of the Trust Evidence of Assurance:	

Board Assurance Framework Update – Quarter 1 2015-16

KEY:	BAF THEME	Trust-wide risks	Strategic risks

BAF Theme 8 Long term viability (i.d. 440)

Risk(s) aligned to this theme

Date added to BAF	Risk	Consequence	Lead Exec	Strategic Initiative(s)	Risk Rating			Reason & evidence for risk rating change*	Update to include gaps in control and assurance	Lead Cttee
					Initial	Current	Target			
									CPR; Quarterly Performance Reviews; Transformation Board Reports; Audit Committee – Review of contract risk; CIP Board reports	
Mar 2015	(i.d. 805) The Trust is unable to maintain its reputation for excellent work (or has an unwarranted view of its own reputation) with the result that referred work declines	Financial loss, loss of knowledge leader status, loss of viability as 'stand alone' specialist trust. Inability to recruit highly skilled clinicians and resignation of existing experts	MD	2 Exceptional patient experience 7 ROH: knowledge leader	12	12	8		Update frequency: six- monthly Next update due Sept 2015 Mitigation/Controls:- Continue to engage constructively with commissioners. Clear and accurate reporting collaboration with stakeholders Evidence of Assurance: Patient Quality Report. PROMS, Registries. Quality Meeting. Patient Harm Reviews. FFT feedback. Staffing skills. Complaints & PALS review.	
Mar 2015	(i.d. 806) The Trust is unable to anticipate or respond to disruptive technology which creates a paradigm shift putting the ROH out of business	Trust unable to achieve strategic goals; Closure of 'stand alone' site	MD	1 Culture of excellence, innovation & Service	8	8	4		Update frequency: Quarterly Next update due: Sept 2015 Mitigation/Controls:- Transformation Committee R+D and Innovation Evidence of Assurance: Transformation Committee meetings Quality meeting	

KEY:	BAF THEME	Trust-wide risks	Strategic risks

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
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
782	Compliance with Equality Act	WFOD
779	Bank staff holiday pay	WFOD

Risk Scoring Matrix

CONSEQUENCE SCORE: what are the actual or potential consequences of the risk?

	1	2	3	4	5
Descriptor	**Insignificant**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Objectives / Projects	Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope / quality	< 1% over budget / schedule slippage. Minor reduction in quality / scope	1 - 5% over budget / schedule slippage. Reduction in scope or quality requiring client approval	5 - 25% over budget / schedule slippage. Doesn't meet secondary objectives	> 25% over budget / schedule slippage. Doesn't meet primary objectives
Injury	Minor injury not requiring first aid	Minor injury or illness, first aid treatment needed	RIDDOR reportable or equivalent. Increased LOS	Major injuries, or long term incapacity / disability (loss of limb)	Death or major permanent incapacity
Patient Experience	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience - readily resolvable	Mismanagement of patient care – short term consequences (1 week or less)	Mismanagement of patient care – Long term consequences (More than 1 week)	Totally unsatisfactory patient outcome or experience
Complaint / Claim Potential	Locally resolved complaint	Justified complaint peripheral to clinical care	Claim < £10 000. Justified complaint involving lack of appropriate care	Claim > £10 000. Multiple justified complaints	Multiple claims or single major claim (e.g. Obstetrics)
Service / Business Interruption	Loss / interruption > 1 hour	Loss / interruption > 8 hours	Loss / interruption > 1 day	Loss / interruption > 1 week	Permanent loss of service or facility
Staffing and Competence	Short term low staffing level temporarily reduces service quality (< 1 day)	Ongoing low staffing level reduces service quality	Unsafe staffing level or competence (< 1day).	Unsafe staffing level or competence (< 1 week)	Ongoing or critical unsafe staffing level or competence
Financial	Small loss(< £500)	Moderate Loss (> £500)	Loss > 0.005% of budget(> £5,000)	Loss > 0.05% of budget(> £50,000)	Loss > 1% of budget(> £1,000,000)
Inspection / Audit	Minor recommendations. Minor non-compliance with standards	Recommendations given. Non-compliance with minor standards	Reduced rating. Challenging recommendations. Non-compliance with core standards	Enforcement Action. Critical report. Multiple challenging recommendations. Major non-compliance with core standards	Prosecution. Zero Rating. Severely critical report
Adverse Publicity / Staff morale	Rumours	Local Media - short term. Minor effect on staff morale	Local Media - long term. Significant effect on staff morale	National Media < 3 Days	National Media > 3 Days MP Concern (Questions in House)
Fire Safety System	Minor short term (<1 day) shortfall in fire safety system	Temporary (<1 month) shortfall in fire safety system / single detector etc (non patient area)	Fire code non-compliance / lack of single detector etc (patient area)	Significant failure of critical component of fire safety system (patient area)	Failure of multiple critical components of fire safety system (high risk patient area)
Environmental Impact	Minor non-compliance with standards Minimal increase in environmental impact	Non-compliance with non-core standards Small increase in environmental impact	Non-compliance with core standards Significant increase in environmental impact	Enforcement Action. Critical report. Major non-compliance with core standards Unacceptable inc. in environmental impact	Prosecution Severely critical report Severe impact on environment
Medication	Incorrect medication dispensed but not taken	Wrong drug or dosage administered with no adverse effects	Wrong drug or dosage administered with potential adverse effects	Wrong drug or dosage administered with adverse effects	Wrong drug or dosage administered with adverse effects leading to death

LIKELIHOOD SCORE: What is the likelihood of the consequence occurring?

	1	2	3	4	5
Descriptor	Remote / None	Possible	Likely	Highly Likely	**Certain**
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	**Expected to occur at least daily**
Probability	< 0.1%	0.1 - 1%	1 - 10%	10 – 50%	**> 50**
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	**More likely to occur than not**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 July 2015 **ENCLOSURE 8**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	Julian Denney, Interim Company Secretary
NAME OF AUTHORS:	Julian Denney, Interim Company Secretary, Jane Moore, Litigation Assistant and Governance Facilitator
SUBJECT:	Board Assurance Framework (BAF) report

SUMMARY eg. what you want the Board to consider/make decision on

This report covers Quarter 1 2015/16 (1st April to 19th June 2015). In order to prepare the Q1 report in time for the July Board meeting, it has been necessary to submit a BAF that reflects the position as of 19th June 2015; this is considered preferable to waiting until the Board meeting in September.

IMPLICATIONS eg. financial, operational, risk, etc.

The BAF is a critical tool to support the Board in its oversight of the Trust's most important risks and the development of the BAF is also important as a response to external feedback from the Good Governance Institute.

BAF risks can cover such areas as Patient Safety, Contractual, Legal, Reputational risks

RECOMMENDATIONS

The Trust Board is asked to consider and note this report and associated appendices.

Board Assurance Framework (BAF) report for Q1 2015/16

Strategic Risks

There is one red rated strategic risk:

- 803 'Risk to financial viability through the inability to manage internal costs, deliver key programmes or respond to tariff deductions' (rated 20).

Trust-Wide Risks

The red rated trust-wide risks are as follows (in descending order):

- 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' (rated 20);
- 7 'spinal waiting times' (rated 16);
- 269 'activity targets' (rated 16) – new to the BAF this quarter;
- 270 'Tariff: national tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist' (rated 15).

CHANGES SINCE LAST QUARTER

Risks Escalated to the BAF:

Two existing risks have been escalated to management via the BAF:

- 269 'activity targets' (current risk rating = 16, previously rated 12 in May 2015)
- 275 Learning from serious events/claims/complaints (current risk rating = 12, previously rated 9 in February 2015).

Increasing risks:

The current risk ratings of the following risks have increased:

- 738 Failure to meet regulatory activity as specified within the CQC Inspection report published on 17.09.14 (current risk rating increased from 9 to 12)
- i.d. 7 'Spinal waiting list '(current risk rating increased from 12 to 16)

Potential Increasing Risks:

The current risk rating of 178 'WHO safety checklist compliance' has not increased (current risk rating 12) but the underlying position has deteriorated:

"WHO compliance rate has gone down to 97.41% for the month of May 2015." In February 2015 it was noted that "we have met CCG compliance target for 4 out of last 5 weeks since end of Dec 2014, ie exceeding 99%".

Decreasing risks:

Trust-wide risk i.d. 582 'Risk of non-delivery of strategic objectives associated with leaders' ability to lead change, including cultural change'. The description of this risk has been broadened (previously the emphasis was on lack of leadership development needs) and the current risk rating decreased from 16 to 12 by calibration against other red risks.

Strategic risk i.d. 832 'The Trust is unable to respond rapidly enough to changes in market demand, new offers from competitors or more compelling brands thus losing competitive position' – current risk rating decreased from 6 to 3.

Strategic risk i.d. 798 'The Board and organization does not have adequate capacity or capability to change or does not organize its resources to change effectively' – current risk rating decreased from 15 to 12.

BAF Themes

Executive Directors have been invited to review the current risk rating of the 8 over-arching BAF themes. The current risk rating of Theme 2 'Monitor Licence' has been increased from 8 to 9 but no changes have been identified for the other themes this quarter. All themes were reviewed and several significant changes made last quarter.

Potential New Risk

The Director of Nursing & Governance is considering whether a new risk is to be added to the BAF relating to pre-operative fasting. This has been raised as a concern at CGC and identified for potential escalation to the Board. This will be reported on further in the next BAF report (Q2/September 2015).

A copy of the Trust's risk scoring matrix is attached to the 'BAF Update' document for information.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ENC 9a

Monitor Visit

02 June 2015

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

Monitor Visit Agenda

Agenda Item	Points for Discussion
Welcome & Introduction	
1. General Overview of Plan	• Main features of the plan (short term resilience) • Key Risks • Longer Term Strategy
2. Finance	• Contracting • Assumptions • Financial Sustainability • CIPs • CQUINs • CAPEX
3. Quality	• Operational target risks • Capacity • Workforce
4. AOB	• Medicines Management

1. General Overview of Plan

Key Strategic Objectives in the Operational Plan

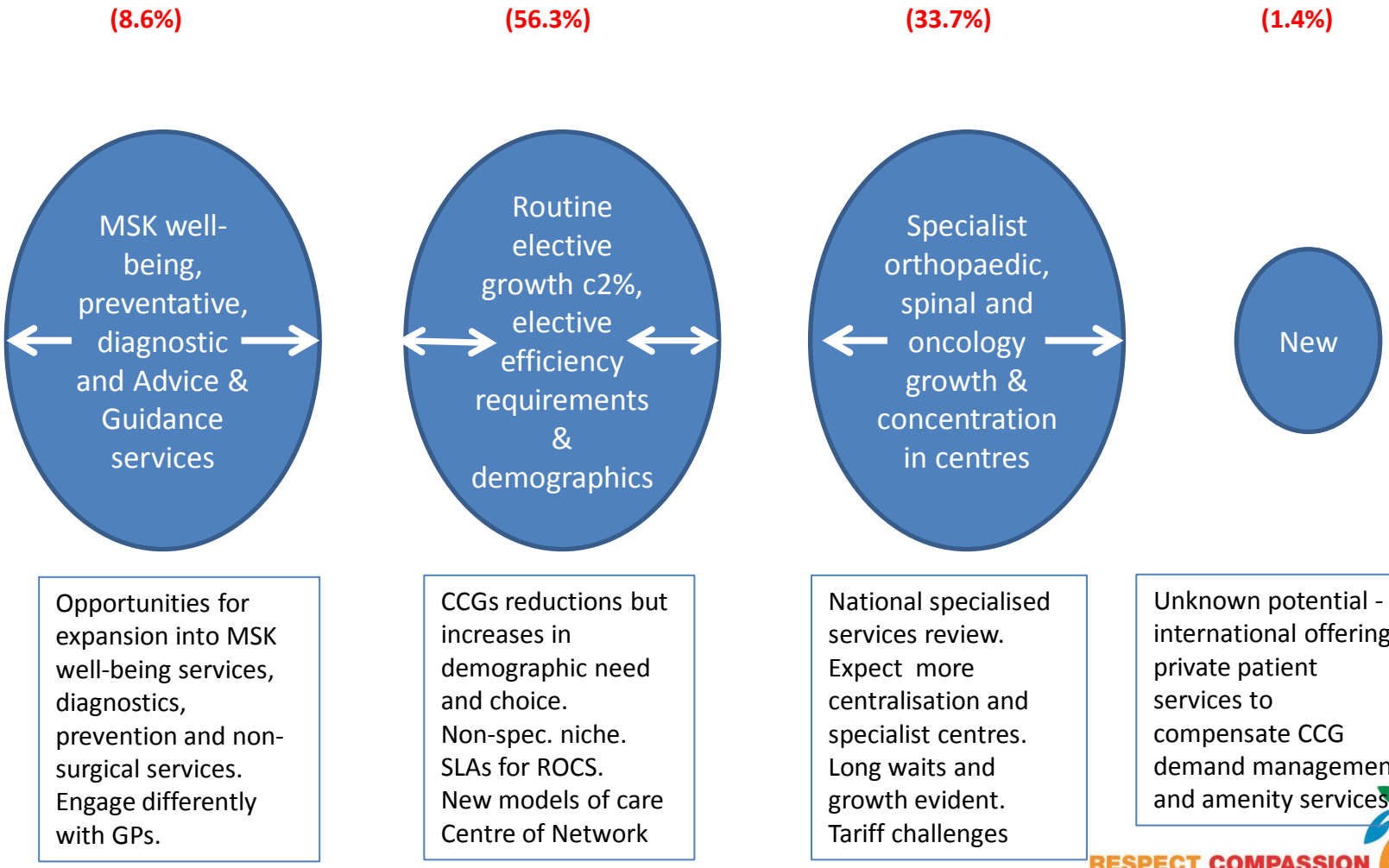
Delivering today and transforming for tomorrow towards these strategic goals:

- Delivering exceptional patient experience and world class outcomes
- Developing services to meet changing needs, through partnership where appropriate
- At the cutting edge of knowledge, education, research and innovation
- With safe, efficient processes that are patient centred
- Delivered by highly motivated, skilled and inspiring colleagues

A year of Change, transformation & investment

- 3% growth
- MSK Health & Well-being
- Working with Partners
- Monitor Project / New Models of Care
- Outpatient Redesign
- Investment in transformation programme
- Workforce Transformation
- Continuing to strengthen our governance approaches
- Organisational redesign
- Integrating our education, research and innovation activity

Our Headline Service Strategies



RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

Strategic Transformation & Operational Plan

Progress Against Delivery Of The Strategy

7 Transformation work streams aligned to the strategy, enabling operational delivery of change have been created. Highlighted progress from across the programme includes:

Capabilities and Culture

- Staff engagement events – “New Beginnings”
- Embedding of our values and behaviour framework
- Kings Fund diagnostic on barriers and enablers to medical leadership

Board Capabilities

- NED’s - strengthen clinical governance & clinical improvement knowledge
- Appointments to key vacancies on the Executive Team
- Board development sessions

Strategic Transformation & Operational Plan

Progress Against Delivery Of The Strategy

Culture

- Empower all staff to deliver transformation in their own areas of work
- New focus on patient safety
- Revised and updated Board Assurance Framework (BAF)
- Root and branch review of governance systems

Processes and Structure

- The Trust Board has overseen a programme of detailed actions to improve critical processes related to quality governance.
- Terms of Reference of all Board Committees have been reviewed
- Ongoing CGC review of all groups reporting to Clinical Governance Committee
- Directorate restructure

Transformation Programme - Delivery workstreams

Work Stream Overview

Work Stream 1. Creating a Culture of Excellence, Innovation and Service

Executive Lead: Director of Workforce and Organisational Development

- Restructure
- Change Leadership Capability
- Leadership Strategy
- Board Development
- Values
  - Awareness
  - Appraisal
  - Recruitment
- Clinical Standards
- Learning Strategy

Work Stream 2. Exceptional patient experience at every step of the way

Executive Lead: Director of Operations

- Outpatients
- Theatres
- Patient Journey
  - Referral Management
  - Pre-Operative Assessment Centre
  - List Planning
  - ADCU
  - Discharge Planning
  - Post Discharge
  - Patient Flow
  - Patient Communication

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

Transformation Programme – Delivery workstreams

Work Stream Overview

Work Stream 3. Safe and efficient care

Executive Leads: Medical Director and Director of Nursing and Governance

- Digital Dictation
- Enhanced Recovery
- Electronic Document Transfer (EDT)
- 7 Day Working / Service
- Medical Workforce Review
- Electronic Prescribing and Medicines Administration (ePMA)
- Organisational Governance
- Nursing Acuity Tool
- Point of Care Testing (POCT)

Work Stream 4. Fully engaged patients and staff

Lead: Head of Communications

- Communication and Engagement Strategy
- Team Development
- Systems and Process
- GP Engagement - ROH First Choice

Transformation Programme – Delivery workstreams

Work Stream Overview

Work Stream 5. Clinical Services Development

Executive Lead: Director of Operations

- West Heath Hospital Project
- Develop Orthopaedic Network
- Private Patient Strategy
- Direct Access Ultra-sound
- Collaborative Service Delivery (e.g. Walsall)
- MSK – Well-being, Advice, Diagnostics (GP's)
- Estates Strategy Review and Update

Work Stream 6. Information for Excellence

Executive Lead: Director of Finance

- PAS Upgrade
- ORMIS Replacement (Theatre System)
- PAS Replacement
- Virtual Desktop Infrastructure (VDI)
- Outcomes (Amplitude)
- Theatre Screen Replacement
- NHS SMS Product Replacement
- IT Infrastructure
- Managed Print Services
- Business Intelligence

Work Stream 7. ROH: the knowledge leader

Executive Lead: Medical Director

- Research + Innovation
- Academic Strategy
- New Models of Care

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

Short-term Delivery Risks

- Delivering today, whilst transforming for sustainable service quality
- Tariff anomalies – especially complex specialist work (spinal, revisions)
- Contractual penalties – esp. national capacity issues (e.g. spinal deformity)
- Reducing 52 week waits
- Maintaining delivery of RTT
- Interim workforce solutions (locum & agency) pending strategic solutions
- Clinical Engagement & Clinical Leadership
- Development of new Board, Executive Team & new operational structure
- Further development of our governance approaches
- Health system planning

2. Finance

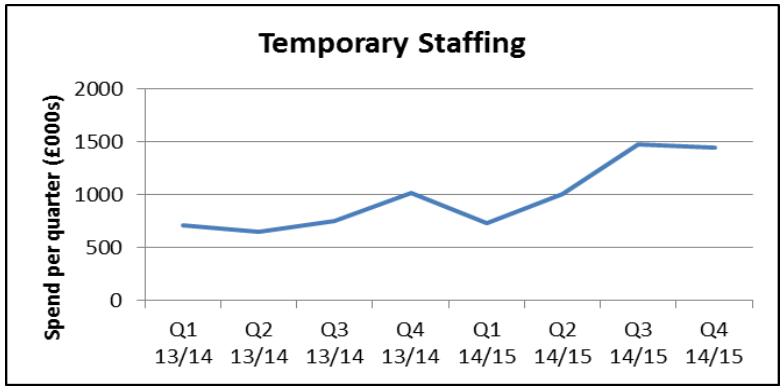
Challenges and Risks

2014/15 proved a difficult financial year - key cost pressures resulting in a deficit of £432,000

- Increased reliance on locum and agency staffing from £2.8m in 2013/14 to £4.7m in 2014/15 (Medical Workforce Review project will seek to reduce this reliance)
- 63% of 2014/15 costs were incurred in the last 6 months of the year

Causes

- Challenges in recruiting to junior doctor and theatre practitioner posts
- Changes in ward rotas to comply with safe staffing levels
- Vacancy costs in some senior and middle management posts



Modelling into 2015/16 the full year effect of these costs, alongside a number of non-recurrent items in the 2014/15 position, results in the Trust starting the new financial year with a recurrent baseline deficit of £1.2m on a like-for-like basis

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

Challenges and Risks

Tariff reductions in addition to efficiencies add further pressure in 2015/16

There remain a number of uncertainties in this planning:-

- Future plans for funding based upon a reasonable resolution with regards to some of the anomalies within the orthopaedics tariff
- Delivery of sustainable staffing solutions in our key clinical areas and the efficiency opportunities resulting from our transformation agenda being delivered

The Trust anticipates being able to reach a breakeven financial position by 2017/18. The cash impact of the deficit position in 2015/16 and 2016/17 has been reviewed, and appropriate alterations to the Trust's capital programme have been made to ensure that cash is maintained at a level in line with the original five year financial plan

Headlines & Financial Sustainability

- Planned deficit of £2m for 2015/16
- Plan to return to breakeven by 2017/18
- Continuity of Services rating of 3 for 2015/16

Contracting

- Contracts agreed and signed with CCGs. NHS England contract not yet signed, but anticipated this will take place in next week. No major concerns.

- Growth of 3% included within CCG contracts

Assumptions

- In line with Monitor guidelines, however increased financial pressure driven by £1.5m loss of tariff before the impact of the tariff deflator

CIPs

- CIP target of £2.8m (3.55)
- £2.3m of expenditure schemes, plus £0.5m of income schemes
- Main expenditure schemes:
  - Reduced LOS (West Heath repatriation) - £375,000
  - Prosthesis savings - £300,000
  - Digital Dictation (Removing agency and outsourcing) - £200,000
  - Reduced locum spend (mainly POAC) - £150,000
- Various efficiency schemes, building on Newton work (Cancellations, List Utilisation, DNAs etc.) - £615,000

CQUINs

- All agreed, with delivery plans being monitored through the transformation team and programme management process

CAPEX

- Planned Capital Spend of £8.1m in 15/16
- Funded from £2.8m of depreciation and £5.3m of cash reserves and creditor movements
- Main schemes (ePMA - £2m, Radiology Equipment - £1.2m, Theatre feasibility and foundations £1.2m, Theatre improvements £0.5m)

3. Quality

Operational Target Risks

- Q1 concerns for non-admitted target – stability will be returned Q2
- 62 day cancer tertiary referrals will continue to challenge, recognising local commissioner expectations
- As relationship with Walsall Healthcare grows and new referrals are forthcoming, attention will be focused on maintaining target clarity
- There will be an enhanced risk to delivery during the introduction of the revised operating structure
- 52 week waits for spinal and spinal deformity
- Consultant recruitment risk with ortho-oncology, spinal and young adult

Capacity

- Outpatient 6 week milestone both during restructuring of outpatient flow and mirroring the pace of market share growth
- Fast track stream to pre-operative assessment currently resulting in missed table opportunities
- Mainstreaming enhanced recovery/ early supported discharge
- Increasing operative restrictions being introduced by Birmingham Children's Hospital
- Consultant productivity modelling
- Strategic estates considerations
- Ability to influence Birmingham Children's Hospital and its continued under-provision of SLA contracted theatre sessions

Workforce

1. **Workforce Numbers/Capacity**

- Planned areas of growth – **physicians associates** (part of the solution to a sustainable workforce model & as a result, reduce agency spend on locum doctors in POAC by year end) , **MSK service** (ESP and sports physician – service growth), **Nursing** (10 – 15 WTE conversion of bank/agency to permanent roles expected by year end) .

- Potential for redundancy of 1 - 2 individuals linked to corporate restructuring and ending of external funding (research monies)

- Sickness absence remains cause for concern as higher than specialist trusts. Focus will be on holding managers to account for their performance and implementation of well-being initiatives.

Workforce (2)

2. Culture and Capability

- **Staff Engagement** – new beginnings events ; staff involved in pathway re-design & actions to build confidence to raise concerns. Feedback from events to be presented at EMT in August
- **Leadership Development** – report from Kings Fund awaited – will be used to design clinical roles and the development interventions for new appointees. Leading change is a key priority area.
- **Creating a culture of improvement** – key first step is building staff confidence in raising concerns (key improvement area from staff survey). Intention is to adopt 'Raising Concerns' campaign as successor to 'speak out safely' - include management development and internal communications of learning from incidents

Workforce (3)

2. Culture and Capability

- **Organisational Structure** – appointments made to operational roles and structure on plan to be live from 1 August. Focus needed on preparation to ensure success and appointment to AMD roles to lead Divisions.
- **Values** – roll-out of embedding into recruitment, appraisal and reward. How to tackle inappropriate behaviour is a key part of the 'new beginnings' sessions.

Workforce (4)

3. **Key Operational Risks**

- **Theatre staffing** – residual vacancy position is circa 9 WTE for band 5 practitioners plus predicted retirements during 2016. Engaged an overseas partner Medi-placements and will recruit from Philippines for new starters in Q4. Agency reduction likely to be realised at end Q1 2016/17.
- **Retirement of sub-specialty consultants** – opportunity to bring in modernised thinking but threat to continuity. Advanced planning for replacements and potential international search will reduce likelihood of risk materialising in practice.
- **New medical workforce model** – design of all new model, changes to rotas for junior doctors and recruitment of physicians associates. Purpose is to improve care for patients and reduce expenditure. Expect implementation in POAC in year, but in other areas in 2016/17

GGI Action Plan

Progress against our Good Governance Institute Action Plan continues, and we are on target with delivery having recently delivered on the following actions:

- Recalibration of the BAF – including incorporation of strategic risks etc.
- Annual Board cycle approved at April Board
- TOR of all Committees reviewed and revised structure diagrams completed for discussion
- EMT status clarified
- Recruitment of substantives on target
- Policy on Policies approved (revise again in October)

CQC

- Monthly Board updates on actions from the previous inspection
  - Embedded delivery plans
- Return CQC Visit 28 & 29 July 2015 – focus HDU & OPD
- Assurance visits recently strengthened – including NEDs and Governors and aligned to KLOE
- Education of our staff with KPMG
- Working beyond boundaries:
  - Stanmore Peer Review of Nurse Staffing
  - Active in Critical Care Network and peer reviewed by them
  - Paediatrics HDU Nurses now have honorary contracts with BCH

4. Any Other Business

- Medicines Management

Medicines Management

- Response to Coroner
- Reviewed and revised our Controlled Drugs audits and SOPs
- Revised the Terms of Reference for the Medicines Safety Group (extending the membership)
- Revised the Terms of Reference for the Drugs and Therapeutics Committee
  - making Controlled Drugs a standing item on the agenda
  - Revised the frequency of reporting to the CGC and the Board from quarterly to bi-monthly
- Our routine checks are now showing compliance

Questions?

TRANSFORMATION

Becoming first choice

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1st July 2015 **ENCLOSURE 9**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Professor Phil Begg Director of Strategy and Transformation**
SUBJECT:	**Update on 5 Year Strategic Plan Progress**

SUMMARY

This report provides an update to Board members of key issues and Progress on the development of the Strategic Plan.

IMPLICATIONS

To ensure Board members are appraised of the requirements from Monitor on the 2015/16 cycle of strategic planning.

RECOMMENDATIONS

- The Board is asked to accept the report and acknowledge the progress to date.
- Trust Board is asked to note the contents of the report and discuss items as appropriate.

Report To:	Trust Board
Report of:	Director of Strategy and Transformation
Purpose of the Report:	To update Trust Board on the progress of the Strategic Plan 2015/16.
Recommendation:	Trust Board is asked to note the contents of the report and discuss items as appropriate.

This report provides the Board with an overview of key developments in the development of the 5 year strategic plan.

1 The 2015/16 Monitor Requirements.

Following the submission of the 1 year Operational Plan in May, we are still awaiting formal feedback from Monitor which is due in July 2015.

2. Trust Monitor visit 2nd June 2015

Monitor had an arranged visit to the Trust on 2nd June 2015, to essentially discuss our annual plan. The Trust Executive Team presented the current position and the Trust plan in detail; this was well received by the visiting team and is appended to this report for information.

The tone of the meeting was positive, although Monitor did inform us that there are 43 Trusts that will be having formal Board to Board meetings, they did reassure us that Royal Orthopaedic Hospital was not on of these Trusts.

Monitor were generally impressed with our progress since submitting our strategy and noted several times that they could see a noticeable difference over the last 12 months. They could see a movement from talking about what we want to do to talking about what we are doing and what we are delivering

It was also clear from the discussions that there will be a greater focus on finance and particularly financial sustainability. In particular, what are we doing about our current pressures, tariff pressures, increased scrutiny on CIPs, how detailed are our plans to return to financial balance etc.

The other main areas of interest were centred on:

- Continued focus on clinical engagement and also engagement with the wider health economy.

- Interest in performance against targets, particularly where we had flagged that we may not meet some RTT targets in Q1.

5 Recommendation

Trust Board is asked to note the contents of the report.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 1 July 2015 **ENCLOSURE 10 and Appendix 1**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Julian Denney, Interim Company Secretary**
SUBJECT:	**Trust Board Committees : TOR and Membership**

This paper proposes changes in relation to two of the Trust Board's Committees' Terms of Reference and changes to Trust Board Committee Membership to reflect recommendations from the June Clinical Governance Committee (CGC) Workshop, and an expansion of the role of the Transformation Committee proposed in relation to overseeing the work of the Innovation Review Panel.

IMPLICATIONS

. In summary it is proposed to:

1. Increase the membership of the CGC to include all Non-Executive Directors and the Director of Operations , following discussions at the June 2015 CGC workshop
2. Appoint Kathryn Sallah as Chair of CGC in place of Tauny Southwood and appoint Tauny Southwood as Vice Chair of CGC
3. Expand the reference to those " in attendance by invitation " at CGC to include Clinical Directors
4. Revise the Terms of Reference of the CGC to reflect the above changes
5. Revise the terms of reference of the Transformation Committee by adding the following duties

    - To oversee the work of the Innovation review panel (IRP) and to provide assurance to the Board regarding its operation and decisions in accordance with the Trust's Intellectual Property Policy and any other relevant decisions of the Trust Board
    - To approve business cases to be funded from the Transformation Fund below any delegated limits

The first of these revisions is a requirement of the revised Intellectual Property Policy, which proposes the creation of an Innovation Review Panel (IRP).

The IRP will be a group which will make recommendations to the Chief Executive of the Trust and will be accountable and provide assurance to the Trust's Transformation Committee.

The purpose of the IRP will be to review internal innovation projects and advise on the next stages of development and/or consider possible routes to commercialisation.

The IRP will also monitor the progress of all current 'live' innovation projects and provide oversight and expertise in maximising their development.

The second revision is intended to provide greater clarity regarding an existing Transformation Committee responsibility.

RECOMMENDATIONS

The Board is asked to:

1. Approve or confirm the appointment of Chairmen and Committee members as listed in Appendix 1 including the appointment of Kathryn Sallah as Chair of the CGC in place of Tauny Southwood and the appointment of Tauny Southwood as Vice Chair of the CGC
2. Approve the revised terms of reference of the Clinical Governance Committee and Transformation Committee as detailed in Appendices 2 and 3

Appendix 1

Committee Chairmen and Membership: Existing

The membership of the Board's Committees following the May 06 2015 Board meeting was as follows (C = Chair, M= Member):

	Aud	Rem	Noms	CGC	Trans
YB		C	C		M
TP	M	M	M		C
FK		M	M	M	
TS		M	M	C	
RA	C	M	M		M
KS	M	M	M	M	
CE			M	M	M
MD				M	M
DN				M	M
DF					M
DO					M

Committee Chairmen and Membership: Proposed

With the proposed changes to the membership of the Clinical Governance Committee, the Chairman and Membership of Board Committees will be as follows: (C = Chair, VC = Vice Chair. M= Member):

	Aud	Rem	Noms	CGC	Trans
YB		C	C	M	M
TP	M	M	M	M	C
FK		M	M	M	
TS		M	M	VC	
RA	C	M	M	M	M
KS	M	M	M	C	
CE			M	M	M
MD				M	M
DN				M	M
DF					M
DO				M	M

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

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.

The Royal Orthopaedic Hospital NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Clinical Governance Committee
Terms of reference
Revised July 2015

1 Constitution

The Constitution of the Trust provides that 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

The Constitution states that “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.

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; this includes the authority to approve any Trust policy (including any revision to a Trust Policy) relating to a clinical matter except for policies which the Chief Executive considered, acting on appropriate clinical advice, needed to be approved more quickly than the Clinical Governance Committee could accommodate
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 establish Advisory Groups including forums. The Committee shall determine the membership and terms of reference of those Advisory Groups including forums.

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, clinical policies 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 The committee will oversee, by appropriate monitoring of actions taken by responsible officers the provision of evidence of trust performance in line with contractual requirements commissioners.

6.2 **Leadership for quality**
6.2.1 Provide oversight to maintain a focus on quality by the Trust's leadership provide assurance to the Board regarding the adequacy of 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

6.2.3 The committee will review and approve the Trusts' clinical policies subject to the exclusion explained in paragraph 2.1.2

6.3 **Regulatory Assurance** – Monitor and CQC (review of guidance, CQC outcome assurance report, quarterly governance declaration)
6.3.1 The committee will oversee, by appropriate monitoring of actions taken by responsible officers, 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 receive reports on cases which are dealt with by the NHSLA or any successor body and will seek to monitor lessons learnt.

7 Permanency

The Committee is permanent

8 Membership

Chair
A non-executive Director with a clinical background.

Vice Chair
A non-executive Director with a clinical background.
The Vice Chair will take on the Chair's duties in their capacity as chairman of the Clinical Governance Committee if the Chair is absent for any reason.

Other members
All other NEDs
Medical Director
Chief Executive
Director of Nursing and Governance
Director of Operations
.

9 Quorum

At least 2 NEDs and one from Medical Director or Director of Nursing and Governance

10 Secretariat
Company Secretary

11 In attendance, by invitation

Deputy Director of Nursing
Others relevant to the agenda of the meeting such as chairs of advisory groups and Clinical Directors

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 July 1st 2015
Date of review July 2016

The Royal Orthopaedic Hospital NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Transformation Committee
Terms of Reference –July 2015

1 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 and other groups 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
6.11 To oversee the work of the Innovation review panel (IRP) and to provide assurance to the Board regarding its operation and decisions in accordance with the Trust's Intellectual Property Policy and any other relevant decisions of the Trust Board
6.12 To approve business cases to be funded from the Transformation Fund below any delegated limits

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. Members of the committee have the power to elect one of their non-executive members as Vice Chairman to act as the Chairman in the absence of the substantive Chairman. This should ideally be 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
At least 1 and up to 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
01 July 2015

16 Date of review
July 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 1 July 2015

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 1 July 2015 commencing at **11.30 a.m.** in the Board Room at the Royal Orthopaedic Hospital NHS Foundation Trust.

Members of the public and press are welcome to attend. The agenda for the public part of the meeting available on the website.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Lynn Plane, Management Offices or via email Lynn.Plane@nhs.net.

Dame Yve Buckland

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD

Venue Board Room, Trust Headquarters **Date** 2 September 2015: 1100h – 1500h

Members attending

Dame Yve Buckland	Trust Chair	(YB)
Mr Tim Pile	Vice Chair	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Prof Tauny Southwood	Non Executive Director	(TS)
Mr Rod Anthony	Non Executive Director	(RA)
HH Frances Kirkham	Non Executive Director	(FK)
Mrs Jo Chambers	Chief Executive	(JC)
Mr Jonathan Lofthouse	Chief Operating Officer	(JL)
Mr Paul Athey	Finance Director	(PA)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(ACh)	
Ms Anne Crompton	Deputy Director of Nursing & Clinical Governance	(ACr)	
Mr Julian Denney	Interim Company Secretary	(JD)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	
Ms Sally Xerri-Brooks	Head of Communications	(SXB)	[Item 09/15/08]

Apologies

Mr Andrew Pearson	Medical Director	(AP)
Prof Phil Begg	Director of Strategy and Transformation	(PG)
Mr Garry Marsh	Director of Nursing & Clinical Governance	(GM)

TIME	ITEM	TITLE	PURPOSE	PAPER	LEAD
1100h	09/15/01	Apologies & welcomes	For noting	Verbal	Chair
1102h	09/15/02	Declarations of Interest *Register available on request from Company Secretary*	For noting	Verbal	Chair
1105h	09/15/03	Patient Case – an illustration of the work we do	For assurance	Presentation	ACr
1125h	09/15/04	Minutes of Public Board Meeting held on the 1 July 2015	For approval	Enc 1	Chair
1135h	09/15/05	Trust Board action points	For assurance	Enc 2	Chair
1145h	09/15/06	Chairman & NED update	For information	Verbal	Chair & NEDs

TIME	ITEM	TITLE	PURPOSE	PAPER	LEAD
1155h	09/15/07	Chief Executive's update	For information and assurance	Enc 3	JC
STRATEGY & POLICY					
1210h	09/15/08	Communications and Engagement Strategic Framework initial report and quarterly update	For discussion	Enc 4	SXB
1225h	09/15/09	The Well Led Framework	For discussion	Enc 5	JD/SGL
LUNCH					
CORPORATE PERFORMANCE & ASSURANCE					
1315h	09/15/10	Corporate Performance Report	For assurance	Enc 6	PA/ACr
1340h	09/15/11	Safe Staffing Report	For assurance	Enc 7	ACr
1350h	09/15/12	Self-assessment against the NHS England Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	For information	Enc 8	JL
1400h	09/15/13	Monitor Quarterly Declaration	For information	Enc 9	JC
1410h	09/15/14	Annual statement of compliance – medical staff revalidation & appraisal	For assurance	Enc 10	JC
UPDATES FROM THE BOARD COMMITTEES					
1420h	09/15/15	Charitable Funds Committee, including any minutes of the Committee	For assurance	Enc 11	FK
1425h	09/15/16	Other Board Committee verbal updates		Verbal	NEDs
1435h	09/15/17	Council of Governors		Verbal	Chairman
1440h	09/15/18	Any Other Business		Verbal	ALL

Date of next meeting: Wednesday 4th November 2015 at time to be advised, Board Room, Trust Headquarters

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

Notice of Public Board Meeting on Wednesday 2 September 2015

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 2 September 2015 commencing at **1100h** in the Board Room at the Royal Orthopaedic Hospital NHS Foundation Trust Headquarters.

Members of the public and press are welcome to attend. The agenda for the public part of the meeting is available on the website.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Lynn Plane, Management Offices or via email Lynn.Plane@nhs.net.

Y. H Buckland.

Dame Yve Buckland

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD

Venue Board Room, Trust Headquarters **Date** 2 September 2015: 1100h – 1500h

Members attending

Dame Yve Buckland	Trust Chair	(YB)
Mr Tim Pile	Vice Chair	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Prof Tauny Southwood	Non Executive Director	(TS)
Mr Rod Anthony	Non Executive Director	(RA)
HH Frances Kirkham	Non Executive Director	(FK)
Mrs Jo Chambers	Chief Executive	(JC)
Mr Jonathan Lofthouse	Chief Operating Officer	(JL)
Mr Paul Athey	Finance Director	(PA)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(ACh)	
Ms Anne Crompton	Deputy Director of Nursing & Clinical Governance	(ACr)	
Mr Julian Denney	Interim Company Secretary	(JD)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	
Ms Sally Xerri-Brooks	Head of Communications	(SXB)	[Item 09/15/08]

Apologies

Mr Andrew Pearson	Medical Director	(AP)
Prof Phil Begg	Director of Strategy and Transformation	(PG)
Mr Garry Marsh	Director of Nursing & Clinical Governance	(GM)

TIME	ITEM	TITLE	PURPOSE	PAPER	LEAD
1100h	09/15/01	Apologies & welcomes	For noting	Verbal	Chair
1102h	09/15/02	Declarations of Interest *Register available on request from Company Secretary*	For noting	Verbal	Chair
1105h	09/15/03	Patient Case – an illustration of the work we do	For assurance	Presentation	ACr
1125h	09/15/04	Minutes of Public Board Meeting held on the 1 July 2015	For approval	Enc 1	Chair
1135h	09/15/05	Trust Board action points	For assurance	Enc 2	Chair
1145h	09/15/06	Chairman & NED update	For information	Verbal	Chair & NEDs

TIME	ITEM	TITLE	PURPOSE	PAPER	LEAD
1155h	09/15/07	Chief Executive's update	For information and assurance	Enc 3	JC
STRATEGY & POLICY					
1210h	09/15/08	Communications and Engagement Strategic Framework initial report and quarterly update	For discussion	Enc 4	SXB
1225h	09/15/09	The Well Led Framework	For discussion	Enc 5	JD/SGL
LUNCH					
CORPORATE PERFORMANCE & ASSURANCE					
1315h	09/15/10	Corporate Performance Report	For assurance	Enc 6	PA/ACr
1340h	09/15/11	Safe Staffing Report	For assurance	Enc 7	ACr
1350h	09/15/12	Self-assessment against the NHS England Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	For information	Enc 8	JL
1400h	09/15/13	Monitor Quarterly Declaration	For information	Enc 9	JC
1410h	09/15/14	Annual statement of compliance – medical staff revalidation & appraisal	For assurance	Enc 10	JC
UPDATES FROM THE BOARD COMMITTEES					
1420h	09/15/15	Charitable Funds Committee, including any minutes of the Committee	For assurance	Enc 11	FK
1425h	09/15/16	Other Board Committee verbal updates		Verbal	NEDs
1435h	09/15/17	Council of Governors		Verbal	Chairman
1440h	09/15/18	Any Other Business		Verbal	ALL

Date of next meeting: Wednesday 4th November 2015 at time to be advised, Board Room, Trust Headquarters

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

Enclosure 1

Minutes of the Trust Board Meeting
held in public on July 01st 2015 in the Boardroom

Present:
Trust Board
Dame Yve Buckland, Chairman - YB
Mrs Jo Chambers, Chief Executive -JC
Professor Tauny Southwood, Non-Executive Director –TS (part)
HH Frances Kirkham, Non-Executive Director – FK (part)
Ms Kathryn Sallah, Non-Executive Director - KS
Mr Jonathan Lofthouse, Director of Operations -JL
Mr Tim Pile Non-Executive Director -TP
Mr Rod Anthony Non-Executive Director – RA
Mr Garry Marsh interim Director of Nursing and Governance –GM
Mr Andrew Pearson, Medical Director -AP
Mr Paul Athey, Director of Finance –PA

In attendance:
Mr Julian Denney, Interim Company Secretary-JD
Professor Phil Begg Director of Strategy and Transformation -PB
Ms Anne Cholmondeley, Director of Workforce & Organisational Development -AC

Invited Governors:
Sue Arnott , Public Governor -SA
Marion Betteridge, Public Governor -MB
Karen Hughes, Staff Governor -KH
Alan Last, Public Governor-AL
Dia Martin, Public Governor-DM
Jean Rookes, Public Governor-JR
Yvonne Scott , Public Governor-YS
Paul Sabapathy, Appointed Governor –PB
Ronan Treacy – RT – part

Members of the Public

Mr Maxwell

Apologies:

Agenda No.	Agenda Item	ACTION
07/15/01	**Apologies and welcomes**	

	There were no apologies from Board members. Apologies were received from Richard Burden, Sue Lococo, Stella Noon, Rod Talboys and Tony Thomas (Invited Governors). The Chairman welcomed Mr Maxwell, a member of the public, to the meeting and members of the Council The Chairman said that this was one of Yvonne Scott's last meetings as a governor. She said that Yvonne had made a made a great contribution, and that Yvonne is and will continue to be a member of the ROH family and will be a hard act to follow. The Chairman made a presentation to Yvonne who thanked the Trust for her gift and said that she had really enjoyed her period as a governor and was delighted to see the development of the governing body during her time with the Trust. She intended to continue to be involved in supporting the Trust in other ways.	
07/15/02	**<u>Declarations of Interest</u>** There were no new declarations of interest.	
07/15/03	**<u>Patient Case – an illustration of the work we do</u>** The Chairman welcomed Evelyn O'Kane, Matron who presented a video about safeguarding. The video covered family and patient experience, which was less positive initially but improved. The learning points included the importance of listening to carer and family members for those with learning disabilities and complex needs, and understanding the perspective of the patient's mother. It highlighted the importance of learning disabilities care and partnership working with health facilitation team (community) staff. The outcome overall was positive for the patient, and the Trust has used this case study in safeguarding and learning disability training for staff . Points made in discussion: • Board members felt that the video made a very powerful impact • The film raised a number of issues which related to individualised patient care which were not specifically about safeguarding • While patient choices are important it is essential to recognise that the right to ask for professional advice is also a choice	

	• Preparation is key – e.g. preparing the environment before a patient with special needs arrives • The consent for the video was wide including the patient , family and staff • If the video is shown to a wider forum it will be important to emphasise the consent process and to consider removing the references to named individuals from it • Regarding the Trust's approach to supporting patients with dementia, this Saturday, the 4th of July the Trust will be launching and developing the Dementia strategy involving patients, carers and the Alzheimer's Society • It was important to make sure that patients were given full explanations of any delay to treatment • The team were commended for creating the video with a candid approach, but were asked to give careful consideration to the use of named individuals in the future. The Board thanked Evelyn O'Kane for the video and for her team's work in using it to develop learning for the rest of the Trust.	
07/15/04	**<u>Outpatients Improvement Presentation</u>** The Chairman welcomed Liz Towell from the Transformation team who presented a progress update regarding Outpatients Improvement. ***Points made in discussion:*** • Regarding chaperones – It was noted that these are for the protection of doctors as well as patients and some thought should be given to the implications of making the use of chaperones an automatic default position. • The performance dashboard is a great idea but should include patient feedback. PROMS and Friends and Family test results will be linked up to it as far as possible • There is a project timeline to address those areas currently not rated green • The timeline for the roll out of the electronic system is c12-16 weeks post purchase. There have been improvements already associated with the increased focus on this area. • It is clear that patients really value the care given and an update will be provided to the Board subsequently. • A park and ride solution (among other things) is being	**JL**

	considered to ease pressures on car parking – this could be brought to the Council of Governors or the Patient and Carer's Forum. • Where there is a consistent issue e.g. if a clinic is persistently late starting this is addressed by referral upwards once the reasons have been investigated • Most staff in outpatients are in a positon to talk quite articulately about progress in the improvement programme. The CQC inspection is an opportunity to showcase the Trust's achievements as well a chance to be open about future areas being worked on for improvement. • There are still frustrations regarding waiting for X Rays – especially on Tuesdays where demand is very high. This is being looked at as part of the patient flow improvement project and the job planning process. The Chair invited comments from the Governors: • Marion Betteridge said that her feedback was that in general patients were reasonably happy as long as they were kept informed – even if there was a wait. • The plan is to alert patients via mobiles or pagers to give them the flexibility not to have to stay in one place while waiting • Sue Arnott reported a positive incident where she had received very prompt treatment • Yvonne Scott said that in her experience choosing how you dress could speed up the consultation process – this might be a matter to bring up at the Patients' and Carer's Forum as part of a wider discussion about preparation to visit the hospital • The CEO stressed the importance of hydration. The Trust will be ordering more facilities for the first floor. The Trust would consider what could be done today – given the very warm weather, and more drinks would be available for patients in waiting areas. • Sue Arnott asked about the availability of seating following an X Ray and it was noted that this is still work in progress. • In some cases chaperones have to be asked to stand to allow patients to sit • Paul Sabapathy asked about whether the scheduling of X Rays had been fully thought through. • Clinicians review the referral letter and identify diagnostics such as X-rays ; however more had to be done around capacity planning for diagnostics • The patient journey presentation could be made to the Governors and to a wider audience.	**JD** **JD**

	The Board thanked Liz Towell for the presentation and for the progress made by the Transformation team.	
07/15/05	**<u>Minutes of the Trust Board meeting held on 06 May 2015</u>** It was noted that Garry Marsh had been omitted from the list of attendees at the Board meeting held on April 01 2015 and it was agreed that this should be corrected. It was also noted that there were a small number of minor typographical errors in the minutes of the Trust Board meeting held on 06 May 2015 which would be corrected after this meeting. Regarding page 19 of the minutes of the meeting held on 06 May 2015 reference should be to the Safer Nurse staffing tool capturing ward attenders to Ward 1 not the NICE tool **Resolved:** The Trust Board hereby: 1. Approves the minutes of the meeting held on 06 May 2015 as a true record subject to the amendments above 2. Agrees to the amendment of the minutes of the April 01 2015 public meeting as noted above	
07/15/06	**<u>Trust Board Action Points</u>** The Board discussed, updated and agreed the action points (see separate sheet)	
07/15/07	**<u>Chairman and NEDs' update</u>** Yve Buckland, Chairman updated the Board as follows: ***Wider Financial Position*** The Chair reported on a recent event she had attended in which the CEO of NHS England had made it clear that financial constraints will become a major issue over the next period, and that all providers would need to think innovatively and collaboratively about meeting patients' needs. ***Board development - visits to Sheffield and Manchester.*** • Both visits were really valuable- there were many	

	learning points. • Both Trusts have a strong emphasis on nurse lead improvement including both traditional improvement techniques and simulation approaches • Sheffield had outsourced their routine elective work to an external contract with Care UK ***Other matters*** • A Governors and NEDs lunch had just been held today ; another lunch is planned at a public Board meeting in the autumn • The Chair had attended a fascinating presentation on the use of MRI in operations by a US Consultant, Wilson Chimbira, introduced by EJ DaSilva – the equipment had been provided by charitable funds **Resolved:** The Trust Board hereby notes the Chairman and NEDs' update	
07/15/08	**<u>Chief Executive's Update</u>** Having just returned from annual leave, Jo Chambers gave a verbal report inviting a discussion. ***Recognising Leadership in Patient Safety*** The Trust continues to prioritise its efforts in improving patient safety. As part of our approach to rewarding and recognising leadership in patient safety we are inviting some staff who have shown leadership on behalf of patients to join the "HSJ 100 best places to work" awards event on the 7th of July. Eight members of staff together with the Chair and CEO will be attending to represent the Trust. They include the winner of the first Patient Safety Award, a radiographer who raised a concern about the MRI safety check process and one of the presenters of a patient story. Their achievement will be publicised in ROH Live. In the radiography example the CEO called an urgent round table meeting of the key players. A whole series of actions resulted including targeted discussions with key individuals involved and a change in the design of the referral form. The original person who raised the concern has undertaken an audit of those who are completing information correctly and	

	those who are not. Publicity has been given in ROH Live. This is part of a broader cultural change process to ensure that leaders model the right behaviours, reward, recognise and celebrate those who raise concerns and make sure those concerns are followed up with meaningful actions . ***NHS Confederation Conference*** The next stage of the Five Year Forward View was discussed. There is great pressure on the provider sector to deliver results including the £22Bn efficiency savings and increased activity. Spending controls are being introduced. There is a big focus on quality, prevention and closing the health gap. This latter point fits well with a range of MSK services provided by the ROH. There was also a major focus on redesigning services – this also illustrates how the ROH can demonstrate system leadership –e.g. via the work being done with Walsall, and as expert provider of orthopaedic care. ***Conference Presentation*** The CEO will be speaking at a national conference to share the Trust's experience of the CQC inspection and to talk about our improvement journey from the perspective of a Trust with a "requires improvement" rating. Primarily this will be about how the CQC inspection led to some surprises and challenges for the Trust which led to a determination to improve and the greater challenges and learning from the controlled drugs situation. When questioned about whether some of the issues regarding factual accuracy checks and difficulties giving feedback to the CQC on the pilot process, the CEO said this may come up as a minor point but the focus of her presentation was going to be on the positive changes made at the Trust since the inspection and the improvement journey the Trust is on. **Partnerships** The CEO has signed the Trust up to be part of a partnership within a UHB led proposal to be a test bed for a Birmingham "Digital City" – this a key theme within the AHSN agenda.	

	Resolved: The Trust Board hereby notes the CEO's report	
07/15/09	**<u>Whistleblowing report</u>** Anne Cholmondeley presented her report and stated that the survey data suggests staff know how to report concerns, but feel less safe/ or secure in doing so, and in the last two years have become less confident than average that the Trust will address their concerns. She said that work was being done to change the culture to encourage staff to raise concerns. The key issues appear to be: -A perception from staff that they will either not receive any response or one which lacks meaning for them. -Concerns about repercussions, primarily from peers but also from others with influence over their future career (these are perception issues rather than based on any known facts) The paper reports on approaches used to raise confidence among staff. There have been some really great examples of good practice – e.g. within Outpatients and Physiotherapy where staff are very happy to raise concerns. ***Points Made in Discussion*** • The relative decline in willingness to raise issues is significant. We should consider asking staff why they feel the situation has got worse • It is important to know what level of staff are most wary of raising issues but the data suggests that all level are similarly affected. • There may be greater scope to publicise more how staff concerns have been acted on – this has been done successfully in relation to matters raised by a radiographer as previously noted. • In some cases more feedback may be given if it is anonymous. • For those who seek anonymity this is provided through the whistleblowing process - staff may need to be reminded of this route • The positive reward and recognitions of staff who raise patient safety issues, such as the invitation to represent the Trust at the awards ceremony, were noted as part of the strategy to encourage reporting and build confidence that the Board will support staff. **Resolved:**	**AC**

	The Trust Board hereby notes the Whistleblowing report.	
07/15/10	**<u>Corporate Performance Report</u>** Paul Athey presented his report and explained that it has been a difficult start to the year – from both a financial and activity perspective. ***Activity*** • There has been a lower than anticipated operative activity for the last three months. Some reasons include Trust Business and Learning Days (TBALD) (planned) and sickness. • 50 table spaces a month have been allocated for Walsall work- actual usage over 2 months has been 32 (vs 100). • There has also been quite slow operating in theatres and a higher proportion of day cases. • A rectification plan has been put in place from August onwards • There is reasonable confidence that we will be on track by Q2 • There has been strong participation in efforts to address the problem • Walsall have been in discussion about the potential for ROH to increase support to them with their workflow management - if this can be stabilised this will give confidence that activity will return to planned levels. • There are specific issues relating to spinal deformity: o Regarding the 52 week target most breaches are children or under 18s waiting for treatment. o The root cause is generally lack of operating table capacity at BCH with the appropriate back up of paediatric intensive care (PICU) beds – recent cancellations by BCH have caused a deterioration in our position with one patient waiting 62 weeks. o NHS England were minded to levy fines and the Trust took a robust line in the negotiations with them, seeking agreement to reinvest the fines in finding solutions. It appears likely this approach will be successful with the potential for top up funding; NHS England may pay for up to 30 operations in private sector o NHS England are brokering a return of the table slots lost while our surgeons are on leave	

	(at BCH the Paediatric table spaces are currently surgeon specific) • NHS England are also brokering access to table slots at the University Hospitals North Midlands NHS Trust, which also has PICU beds on site. • The Trust believes that over time there will a number of units where operations are possible and that families will come to expect and accept this, which will be explicit in our Access Policy. ***Points Made in Discussion- Activity*** • The main issues are flow and capacity related rather than an overall decline in demand, in fact, referrals continue to grow and some other providers have closed their lists. • There are a lot of empty beds and this is becoming noticed by patients. This may be due to reducing length of stay or case mix and the impact of fewer than anticipated Walsall patients. This is being reviewed. • There is good performance around diagnostics • The expectation is that activity will be on track in 4-6 weeks. • One 62 day cancer target breach related to a tertiary referral patient from Robert Jones Agnes Hunt Orthopaedic Hospital (RJAH) who had put the wrong date on the referral letter. It is expected that this breach will be removed from ROH and transferred to RJAH ***Finances*** • We are c £450k behind our financial targets after two months. This is largely driven by a shortfall in income of around £1m, linked to reduced activity and a less complex casemix. The underperformance in activity has led to some underspends in pay and non-pay that go some way to offsetting the shortfall. • We are analysing the root causes, for example the direct costs ratio is very similar to that in previous years (with a slight reduction in the proportion of direct costs). • Bed occupancy is about 10% down – nursing costs only show a c3% fall. A similar picture appears in theatres. • Meetings are being held with nurses – e.g. around the opportunity to close a ward in periods of low demand	**TP/PA**

	• CIPs are behind target to date. There has been good progress on some of the transformational schemes but these will take a while to deliver benefits e.g. Managed Print. • TP and PA to meet to discuss the forward financial projections **Resolved:** The Trust Board hereby: Notes the Corporate Performance Report.	
07/15/11	**<u>Patient Quality Report</u>** Gary Marsh invited comments on his report: ***Points Made in Discussion*** • The Safety Thermometer measures are snapshots on particular days- this explains why figures for hospital acquired pressure ulcers and VTEs are different for the Safety thermometer (which is a nationally defined data set) and compared to other measures in the Patient Quality Report • Education may be required to ensure all senior nurses understand how the Safety Thermometer works • On Adult Safeguarding there are issues around the admission process; work within the learning disability strategy should help improve the position • There may be value in doing work on the passive responders under the Friends and Family test • There are 19 serious incidents open of which 9 relate to VTEs; the backlog has been reduced from 7 to 4 • It is intended to use July and August to review the format of the report • The National Joint Registry data still gives a confused message – e.g. a difference between national and local figures and a graph which appears not to match the data (**Action:** to be reviewed) • In PROMS the Trust is above average in all areas except primary knee replacements and this needs to be understood better and then discussed at Clinical Governance Committee (CGC). Primary knees appear to be an issue for the first time. • A trial is planned nationally regarding the role of physiotherapy in knee replacement	**GM** **GM**

	It was noted that these issues fell within the remit of the CGC **Resolved:** The Trust Board hereby: Notes the Patient Quality Report	
07/15/12	**<u>CQC Action Plan</u>** Diane Halliley gave a presentation on the Quality Improvement Plan (formerly the CQC Action Plan), which updates actions from the 2014 CQC inspection report – to be circulated afterwards. The following points were made in discussion: • Effort has gone in to help staff better understand the process in order that they will feel confident when responding to inspectors. KPMG had delivered a series of workshops to help staff understand the new inspection framework. • Noted that there is likely to be a requirement from CQC to meet the Governors as in the last inspection visit • Tim Pile agreed to deputise for the Chair (who will be on annual leave), if required. • The Trust will focus on the substance of the improvements that it has made and wider learning • Staff have been made aware that the CQC inspection is a critical part of the Trust's licence to operate and the agreed system of judging our services. Patients will take confidence from higher ratings and the inspection will be an opportunity for everyone to display their professional pride in successes and improvements made and be open about further plans for improvement **Resolved:** The Trust Board hereby: Notes the presentation on the Quality Improvement Plan update	
07/15/13	**<u>The Safe Staffing Report</u>** Garry Marsh introduced his report inviting a discussion and the following points were noted:	

	• Regarding the red flag issues it will be possible to add them directly onto the system in the near future. • The Trust appears to be over the required staff levels in some areas despite anecdotal evidence that staff feel we are under staffed. This should be investigated. • The areas with the highest number of staff seem to have the highest level of agency staff and this is being looked at. • There is better occupancy data which allows better planning for staff and opportunities in recruitment e.g. term time only nursing staff. • With regard to Wards 10 and 12 (now merged) we need to understand whether the geographical lay out for the area is driving the additional staffing levels reported. • Need to investigate whether there is a correlation with improved nursing and quality improvement • Need to consider whether some tasks can be done by healthcare assistants. • There an education requirement so staff understand that Safe Staffing data is used at the Board and incidents are scrutinised. • In some other organisations nurses are seen as belonging to the institution not to a particular ward. There were cases in the ROH when one Ward was very busy and another ward had spare staff, which suggest nurses might be used more flexibly. • There have been some concerns voiced about the possible role of physician associates – some education is needed to help staff understand that a multi-disciplinary solution is what is being proposed to address workforce challenges, to include physician associates (trained in a medical model) and Advanced Nurse Practitioners and Extended Scope Practitioners. • It will be essential to ensure the cost and quality effectiveness of any new model **Resolved:** The Trust Board hereby: 1. Notes the Safe Staffing report.	**GM** **GM** **GM(and following points)**
02/15/14	**<u>Board Assurance framework (BAF)</u>** The interim Company Secretary presented the BAF and highlighted the following key risks:	

	Strategic Risks There is one red rated strategic risk: • 803 'Risk to financial viability through the inability to manage internal costs, deliver key programmes or respond to tariff deductions' (rated 20). **Trust-Wide Risks** The red rated trust-wide risks are as follows (in descending order): • 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' (rated 20); • 7 'spinal waiting times' (rated 16) – this had deteriorated due to difficulties in securing operating space with partner organisations ; • 269 'activity targets' (rated 16) – new to the BAF this quarter; • 270 'Tariff: national tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist' (rated 15). The Board was satisfied with the updates given on each of these risks and will continue to monitor them closely. **Potential New Risk** The Director of Nursing & Governance is considering whether a new risk is to be added to the BAF relating to pre-operative fasting. This has been raised as a concern at CGC and identified for potential escalation to the Board. This will be reported on further in the next BAF report (Q2/September 2015). This risk should be broadened to take account of the wider issue regarding how new knowledge gets disseminated and embedded within the organisation and the systems to make this happen. ***Points Made in Discussion*** • Regarding the comment on Page 8 "The Drugs and Therapeutics Committee (DTC) accepted the report and the supporting action plan" it was noted that the	**JD/GM**

	DTC had seen an abridged version of the report from KPMG rather than the full version. **Action:** GM to explain the situation to Karen Hughes **Resolved:** The Trust Board hereby: 1. Notes the Board Assurance Framework.	**GM**
07/15/15	**<u>Update on Five Year Strategic Plan</u>** Phil Begg introduced the update as follows: • There had been a very successful meeting with Monitor who were pleased with the changes they had seen in the organisation and progress since the strategy was submitted. This compares well with many other organisations whose strategic plans they have received. • AP and PB visited Monitor last week with colleagues from the Transformation team as a co-production site for a review of elective orthopaedic models of care, including international benchmarking- there was no single best model. • Monitor have praised the work of the bone infection unit and ROCS. **Resolved:** The Trust Board hereby: 1. Notes the Update on Five Year Strategic Plan	
07/15/16	**<u>Estates strategy</u>** The Chairman thanked Stuart Lovack for preparing for the meeting but apologised on behalf of the Board that it would be necessary to defer this item until a workshop in August owing to time pressures and the need to allow for proper consideration and discussion of this important area. **Action :** Create workshop programme for August	**JD**
07/15/17	**<u>Trust Board Committees : TOR and Membership</u>** Julian Denney explained that the paper proposed changes in relation to two of the Trust Board's Committees' Terms of Reference and changes to Trust Board Committee Membership to reflect recommendations from the June Clinical Governance Committee (CGC) Workshop, and an	

expansion of the role of the Transformation Committee proposed in relation to overseeing the work of the Innovation Review Panel. In summary the proposals were to

1. Increase the membership of the CGC to include all Non-Executive Directors and the Director of Operations , following discussions at the June 2015 CGC workshop
2. Appoint Kathryn Sallah as Chair of CGC in place of Tauny Southwood and appoint Tauny Southwood as Vice Chair of CGC
3. Expand the reference to those " in attendance by invitation " at CGC to include Clinical Directors
4. Revise the Terms of Reference of the CGC to reflect the above changes
5. Revise the terms of reference of the Transformation Committee by adding the following duties

    - To oversee the work of the Innovation Review panel (IRP) and to provide assurance to the Board regarding its operation and decisions in accordance with the Trust's Intellectual Property Policy and any other relevant decisions of the Trust Board
    - To approve business cases to be funded from the Transformation Fund below any delegated limits

Points made in discussion

The Chairman stated thanked Tauny Southwood for his extensive and highly valued contribution as Chairman of the CGC. She said that one if the purposes of the changes was to free up time to allow Tauny to focus his contribution on providing clinical challenge , scrutinising evidence and assurances being given to CGC and overseeing the research and clinical audit agenda .

The Board discussed the proposal to add the duty *To approve business cases to be funded from the Transformation Fund below any delegated limits to* the terms of reference of the Transformation Committee. It was agreed that this should not be added at this stage as more work was required to be done by officers to clarify the intended limits of the Transformation Committee's delegated authority

The Board also agreed that within the CGC TOR reference to Clinical Directors should be expanded to include "

	successor roles" **Resolved:** The Trust Board hereby: 1. Approves or confirms the appointment of Chairmen and Committee members as listed in Appendix 1 to the paper including the appointment of Kathryn Sallah as Chair of the CGC in place of Tauny Southwood and the appointment of Tauny Southwood as Vice Chair of the CGC 2. Approves the revised terms of reference of the Clinical Governance Committee and Transformation Committee as detailed in Appendices 2 and 3 to the paper with the modifications above included i.e. : a. In the case of the Transformation Committee the duty to approve business cases to be funded from the Transformation Fund below any delegated limits should not be added **b.** In the case of the Clinical Governance Committee reference to Clinical Directors should be expanded to include " successor roles"	
07/15/18	**<u>Report of the Chair of the Charitable Funds Committee (CFC)</u>** Frances Kirkham gave a verbal report as follows : The Committee had not met since the last Board meeting. The next meeting is the autumn. There will be an informal meeting shortly to discuss the cancer research legacy The Chair said there may be a request for funds to support sports based rehabilitation. FK welcomed this bid for funds and said the CFC continue to encourage bids for support. **Resolved:** The Trust Board hereby**:** 1. Notes the report of the Chair of the Charitable Funds Committee	

07/1519	**Other Board Committee verbal updates** Committee Chairs updates from the work of each Committee were deferred to September.	
07/15/20	**Report of the Chair of the Council of Governors** Yve Buckland reported that the business of the last Council meeting would be reported on in September.	
07/15/21	**Any Other Business** It was noted that the circulation of the Audit Committee Annual report had taken place under separate cover	
Date and Time of Next Trust Board Meeting Date of Next Meeting: Wednesday 2 September 2015 at time to be advised		
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 01 July 2015

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
11/14/147	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.	**SGL/PA/AC**	~~July 1st 2015~~ November 4th 2015		In progress: Declarations of interest and hospitality being coordinated by Company Secretary and Director of Finance A mailshot was carried out asking Directors, Consultants, Anaesthetists, Council Members and Procurement and Senior Staff to declare any declarations of interest they have, along with any hospitality they may have received. Regarding declarations of interest the Trust sent a mailshot out to 119 colleagues and have received 73 responses to date. This equates to 61%. A reminder, chasing responses, will be sent out via email to those concerned and approaches will also be made to individuals by the Director of Operations. **Update 8/15:** There are only 8 outstanding responses regarding declarations of interests; the Director of Finance is in the process of dialogue with the relevant individuals. Fit and Proper – completed
11/14/153	Possibility of 'near' patient testing for INR –it was agreed	**AP/GM/JL**	~~July 1st 2015~~ 4 November 2015		Report has been received. Trialling now in progress

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	that this should be looked at as part of a wider issue which had multiple consequences for patient quality and length of stay.				**Update 8/15:** Further review at November meeting
11/14/162	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.	**TS/AP**	July 31st 2015	√	**Update 8/15:** The annual clinical audit plan was presented to CGC at its August meeting and it suggested that this action should be closed from a Board perspective and further scrutiny of the clinical audit plan continue to be remitted to CGC.
02/15/03	Lisa Newton (Senior Nurse) presented a case about a complaint following a patient's death. There were many valuable learning points … It was agreed that further work including clinical audit should be done to ensure there were no wider systems issues that should be addressed.	**AP**	July 31st 2015		**Update 8/15:** The annual clinical audit plan was presented to CGC at its August meeting.
02/15/11A	***Cancellations*** There has been an increase	**JL**	July 1st 2015	√	This is planned to be discussed at EMT in July and at the Board in September.

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	in cancellations which will be analysed – often this is due to unfitness on the day and associated POAC related issues. The Board requested an analysis of the impact of improvements on the number of cancellations on the day of the procedure.				**Update 8/15:** a review of the attributed allocation of the recorded cancellations has been carried out. This has shown that the "Not a Cancellation" reason and the "Patient initiated" reason have been inconsistently applied in the past. This was corrected from February 2015 creating an apparent increase in the "Hospital" initiated reason. An action plan has been created to ensure that the reliability of cancellation statistics is optimised in future and progress will be monitored by EMT. The Director of Operations considers that the underlying level of "Hospital" initiated cancellations is not a cause for concern. Suggest close this action from a Board perspective and devolve monitoring of the issue to EMT.
02/15/15A	Signed letters have been received from c 50% of consultants regarding the security of patient sensitive data and the remainder will be followed up.	~~**AP**~~	~~July 1st 2015~~ November 04th 2015		In progress – report next meeting. There has been some improvement but this is not sufficient. **Update 8/15:** Request to roll over to November 4th for an update (AP on leave on the date of the September Board meeting)
02/15/15C	The security of Board papers	~~**PA/JD**~~	~~September 02nd~~		**Update 8/15:** August 26th 2015 – a

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	was also discussed and it was noted that TP had identified a new system which had the potential for improving security	**SGL**	~~2015~~ November 4th 2015		demonstration by three providers of paperless board systems was given to a number of Board members and other stakeholders. It was agreed that a business case would be prepared for the November Board recommending a preferred solution, having done further work on reference sites within the NHS.
04/15/03 (B)	There is a need to raise the profile of the Tissue Viability team – especially externally.	**SXB**	July 31 2015	√	**Update 8/15:** SXB has written an award nomination for this team which was submitted to the HSJ as part of their annual awards. The response is awaited. In addition, the team has been shortlisted by the Nursing Times for their work. SXB will continue to work with the team to promote the work they have done around the wound helpline and related work in the coming months. Suggest this action can now be closed
04/15/06	It was agreed to explore visiting the Nuffield Orthopaedic Centre) at Oxford. AP agreed to progress this with the Medical Director later in the year	**AP**	~~Oct 31 2015~~ November 04th 2015		**Update 8/15:** Request to roll over to November 4th for an update (AP on leave on the date of the September Board meeting)
04/15/11 (C)	Consideration should be given to how to "nudge" staff into having a flu injection	**AC**	October 2015	√	**Update 8/15:** Flu campaign being designed to include communication about the value of the vaccination to

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
					patients and staff. Flu plan agreed at EMT in August including the use of communications methods to influence a wider take up. Suggest action now complete
04/15/14	SXB would be asked to highlight the Trust's response to the Savile issues in a positive way on the website	**GM/SXB**	July 1st 2015	√	The declaration to Monitor was completed mid-June. There is a statement on the website that the Trust is compliant with the Savile recommendations and a link to the document demonstrating that. **Update 8/15:** An update on the Saville issues will be given a forthcoming meeting of the CGC and it is suggested that this action should be closed from a Board perspective and remitted to CGC for ongoing monitoring.
05/15/03(A)	**Patient Case** Work needs to be done to progress the SLA with St Mary's Hospice.	**JL**	July 1st 2015		**Update 8/15:** Agreed meeting date pending between ROH contract team and hospice.
05/15/03 (B)	**Patient Case** The translation service will be looked at to see if improvements can be made.	**GM**	~~July 1st 2015~~ 4 November 2015		We have a policy in place and can book interpreters. There is also a list of staff who can be utilised within the guidelines. There is also a telephone helpline service. More work will be done with SXB on staff communications.

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
					Update 8/15: Further work to do to complete this action
05/15/03 (C)	**Patient Case** The EOLC policy and guidelines will be reviewed	**GM**	July 1st 2015		Anita Killingworth is working on this under the remit of the relevant supporting Committee
05/15/07	The CEO has awarded the first Patient Safety Award (Nia Reeves) and Patient Champion Award (to be announced shortly). It was agreed that a letter would be sent from the Board to congratulate the winners.	**YB/JD**	July 1st 2015	√	**Update 8/15:** Letter has been sent to Patient Safety Award winner (Nia Reeves) and Patient Champion Award winner (Alan Wallis)
05/15/10 (B)	Staff have suggested that a vacant store room could used for servicing equipment and JC has asked JL to investigate this as part of the theatre redesign work.	**JL**	July 1st 2015	Action to be closed as non-viable	There is currently a SLA with UHB to provide this facility. As part of the estate strategy additional onsite facilities will be considered **Update 8/15:** This has now been investigated and is no longer a viable option.
05/15/10 (C)	The current outpatient improvement work was looking at standardised ways of working and pre-booking x-rays required during outpatient appointments to	~~**GM**~~ **JL**	Sep 2015	√	**Update 8/15:** agreed that this part of ongoing Outpatients improvement work and that JL is the lead Director Suggested this should be remitted to the Transformation Committee to monitor

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	enable better planning of resources; this would require some clinicians to change the way they currently work.				and closed as a Board action
05/15/11	The two Safe Staffing breaches were both on Ward 1 and the CEO asked GM to review the use of the Safer Staffing tool to see if it could be adapted to reflect more closely the particular requirements of the Ward 1 environment.	**GM**	July 1st 2015	√	**Update 8/15:** This action was about emergency admissions to Ward 1 which the tool does not cover. Anne Crompton is currently reviewing the tool to ensure it is being used appropriately in all areas. Suggest that this action is now complete from a Board perspective and that ongoing monitoring of the use of the tool continue to be monitored by CGC.
05/15/15	The meeting frequency of the Drugs and Therapeutics Committee would be looked at given the profile of the issues it provides assurance on.	**GM**	July 1st 2015	√	**Update 8/15:** This was discussed at the DTC and it was agreed that bi monthly meetings were adequate as the controlled drugs issue had been brought under sufficient control. Suggest close
05/15/15	It is hoped that funds of approximately £1.3M from the Dubrowsky bequest would be received over the summer. Ideas have been put forward for example the creation of a Foundation in Dubrowsky's name. It is believed that there may be a number of other	**FK/Executives**	~~July 1st 2015~~ 4 November 2015		Update: Initial scoping has been carried out for a Wet Lab. Further work will be required to develop this proposal and to consider other ideas to use this bequest. A meeting is scheduled with the next two to three week to discuss the Dubrowsky bequest further.

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	ideas or plans about how the money might be used. The CFC considered that what was needed was a discussion with the Executive about the various possibilities and how these might help advance the Trust's strategy.				
07/15/04 (B)	A park and ride solution (among other things) is being considered to ease pressures on car parking – this could be brought to the Council of Governors or the Patient and Carer's Forum.	**JL**	October 2015		
07/15/04 (B)	Yvonne Scott said that in her experience choosing how you dress could speed up the consultation process – this might be a matter to bring up at the Patients' and Carer's Forum as part of a wider discussion about preparation to visit the hospital	**SGL**	October 2015		
07/15/04 (C)	The patient journey presentation could be made to the Governors and to a wider audience.	**SGL**	October 2015		
07/15/09	The relative decline in	**AC**	October 2015		In self-assessment for "draw the line"

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	willingness to raise issues is significant. We should consider asking staff why they feel the situation has got worse				staff views are being sought as to why the position has deteriorated.
07/15/10	TP and PA to discuss the forward financial projections	**TP/PA**	September 2015		Update at meeting required
07/15/11 (A)	The National Joint registry data still gives a confused message – e.g. a difference between national and local figures and a graph which appears not to match the data (Action : to be reviewed)	**GM**	September 2015	√	**Update 8/15:** Suggest remit to CGC in October and close from a Board perspective
07/15/11 (B)	In PROMS the Trust is above average in all areas except primary knee replacements and this needs to be understood better and then discussed at CGC. Primary knees appear to be an issue for the first time.	**GM**	September 2015	√	**Update 8/15:** Suggest remit to CGC in October and close from a Board perspective
07/15/13 (A)	• The Trust appears to be over the required staff levels in some areas despite anecdotal evidence that staff feel we	**GM**	~~September 2015~~ November 2015		• Wider communication regarding ward staffing has been carried out -ward managers to cascade further. • The establishment review will be brought to the November Board

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	are under staffed. This should be investigated. • The areas with the highest number of staff seem to have the highest level of agency staff and this is being looked at.				meeting.
07/15/13 (B)	Points relating to new models of care • Need to investigate whether there is a correlation with improved nursing and quality improvement • Need to consider whether some tasks can be done by healthcare assistants. • In some other organisations nurses are seen as belonging to the institution not to a particular ward. There were cases in the ROH when one Ward was very busy and another ward had spare staff, which suggest nurses might	**GM**	October 2015		

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	be used more flexibly. • There have been some concerns voiced about the possible role of physician assistants – some education is needed to help staff understand that a multi-disciplinary solution is what is being proposed to address workforce challenges, to include physician associates (trained in a medical model) and Advanced Nurse Practitioners and Extended Scope Practitioners. • It be essential to ensure the cost and quality effectiveness of any new model				
07/15/14 (A)	The Director of Nursing & Governance is considering whether a new risk is to be added to the BAF relating to pre-operative fasting. This has been raised as a concern at CGC and identified for	**SGL/GM**	~~September 2015~~ November 4th 2015		The relevant risks are in development and will be reviewed at CGC prior to potential inclusion in the Q2 BAF report

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	potential escalation to the Board. This will be reported on further in the next BAF report (Q2/September 2015). This risk should be broadened to take account of the wider issue regarding how new knowledge gets disseminated and embedded within the organisation and the systems to make this happen				
07/15/14 (B)	Regarding the comment on Page 8 "The Drugs and Therapeutics Committee (DTC) accepted the report and the supporting action plan" it was noted that the DTC had seen an abridged version of the report from KPMG rather than the full version. **Action:** GM to explain the situation to Karen Hughes.	**GM**	End July 2015	√	**Update 8/15:** Full report now shared with DTC members – action can be closed
07/15/16	**Action :** Create workshop programme for August	**JD/ SGL**	~~End July 2015~~ October 7th 2015		**Update 8/15:** August workshop deferred due to annual leave of some key attendees. Estates strategy is covered on the private agenda of the September Board;

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
					the other proposed agenda item (Commercial Strategy) will be brought to the September meeting of the Transformation Committee. To be considered as part of the agenda planning of the October Trust Board workshop

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD COMPLETED ACTION POINTS FROM A MEETING HELD ON 01 July 2015

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
11/14/159	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.	**ALL/TP**	July 1st 2015	√	**Complete** Visits have been made to Central Manchester University Hospitals NHS Foundation Trust and Sheffield Teaching Hospitals NHS Foundation Trust Phil Begg has visited Emory Health Care in the US. RA has arranged a video conference with a leading orthopaedic surgeon in the US inviting PB and JL
02/15/15B	There is a general issue about a security of Trust data e.g. if there is any patient sensitive data being sent outside of NHS Mail The Board raised concerns about the loss of patient notes and widely circulated emails referring to these	**PA/PB**	July 1st 2015	√	**Complete** - it is understood that NHS Mail is being used for all sensitive communications by all Trust staff
04/15/03 (A)	There may be the potential to sell the Tissue Viability service externally which could create the potential to fund internal provision for some of the services desired. The Board requested that an update be provided re the	**AP/JL**	September 30 2015	Transfer to TC	To be transferred to the Transformation Committee for action in September- Remove from this action list

Minute No.	Action	Responsibility	Completion Date	Resolved	Action Taken
	status of the bone Infection work in the future in the ROH in the context of these opportunities.				
04/15/08	It would be useful to invite the governors when the staff and patient surveys are discussed at the public Board.	**JD**	July 2015 and Feb 2016	√	Governors have bene invited to the July Board and will be invited to one other public Board meeting this financial year.
05/15/01	It was agreed that name plates would be provided for public meetings in future.	**JD**	July 1st 2015	√	Was done for the July Board
05/15/10 (A)	The chaperone policy needs to be carefully worded to avoid unintended patient perceptions.	**GM**	July 1st 2015	√	Policy revised and approved by CGC
05/15/10 (D)	It was agreed that Mrs Liz Towell, Interim Outpatients Improvement Manager would be invited to the July meeting of the Board to talk about this work.	**PB**	July 1st 2015	√	On agenda for July Board

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 2 September 2015 **ENCLOSURE NUMBER: 3**

SUMMARY OF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Jo Chambers, Chief Executive Officer**
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 The National Context

1.1 There continues to be much concern regarding the national financial position of the NHS. Early indications have been that a 2015/16 forecast deficit of £2.1bn was likely; this compared with a 2014/15 outturn of £0.82bn deficit. All providers have been asked to re-assess plans and to identify improvements that can be made to the current forecasts.

1.2 The Carter Review has identified a range of potential savings which a group of hospitals are developing over the summer months to create a 'model hospital' programme which is likely to be launched in September.

1.3 Additionally, new central controls have been introduced in relation to agency spend, very senior managers pay and procurement initiatives. Commissioners have been asked to suspend contractual fines relating to the admitted and non-admitted Referral to Treatment standards and to be transparent about uncommitted reserves.

1.4 It is reported that one quarter of all foundation trusts are in breach of their licences and face regulatory intervention. The majority of breaches include financial issues but a number are also experiencing governance or care standard concerns. Monitor has introduced a new Risk Assessment Framework in response to the increasingly difficult financial context and will strengthen the regulatory regime by expanding the range of financial metrics that will be considered. Monthly financial monitoring has been re-introduced to enable closer scrutiny of foundation trust financial performance.

1.5 It is unclear at present how the additional £8bn investment in the NHS will be phased over the life of this parliament and more information is expected as part of the Autumn statement.

1.6 The process to develop the 2016/17 tariff has begun and providers now have the opportunity to undertake modelling of the proposed new package of amendments. Monitor and NHS England have also commenced a consultation that will change the rules which enable providers to formally object to the tariff.

1.7 The position for specialised services continues to be a concern with demand and cost pressures outstripping available funding. The tariff for more complex cases in services

with some of the longest waiting lists continues to be a concern, for example in spinal deformity services.

1.8 The Five Year Forward View (FYFV) remains the guiding strategic framework for the service moving forward and includes exploration of new models of care. In support of this direction of travel the first round of 'Vanguards' have been approved. A second round of Vanguard proposals were received during July and the three stand-alone specialist orthopaedic trusts have put a joint proposal in to test the development of a national 'chain of excellence' for orthopaedic care. The proposals will be subject to further review by NHS England in September. The combined proposals through the Specialist Orthopaedic Alliance will build on the existing collaborations, offer potential opportunities to deliver efficiencies and establish quality-based outcome standards for orthopaedics. This opportunity is consistent with the Trust's strategic intention and the work already undertaken as a co-production site for Monitor's national and international benchmarking project that we have recently contributed to. If the vanguard bid is successful it would secure additional resources to accelerate the pace of development to test the concept.

1.9 It has now been confirmed that Monitor and the Trust Development Authority (TDA) will come together under one chair and one chief executive and form a new body called NHS Improvement. Ed Smith, currently vice chair of NHS England, will be the chair of the new organisation.

1.10 The safety function of NHS England will also transfer to NHS Improvement, which will also host the new independent patient safety investigation service to distil and share learning from serious incidents when they occur.

1.11 These changes signal a move towards more alignment in regulation and oversight across foundation trusts and NHS trusts. The new organisation will have responsibility for regulation and support for improvement; the details of how this will be operationalised will be issued in due course.

1.12 There is continued discussion about system leadership and following the devolution agreement for Manchester, other systems will be exploring the concept in different geographies. Regulators will be challenged to consider how to review complex systems. The new 'success regime' will focus more on system level changes to address longstanding challenged health and social care systems.

1.13 Contract reform in support of developing more comprehensive 7 day services has been profiled through announcements made by the Secretary of State. The BMA is currently in negotiations with NHS Employers which is expected to establish a new pay framework for medical staff to support services to meet this ambition. New guidance has been received by providers which will require a submission of readiness to move towards five of the 10 standards set out; this includes elective care and the availability of medical review and diagnostic services at weekends.

2 Annual Plan Review and Quarterly Monitoring

Monitor has completed its review of the Trust's 2014/15 quarter 4 performance and 2015/16 annual plan. Attachment 1 is a copy of the letter received from Monitor following the review meeting held in June 2015.

Key points to note are:

- the Trust has been assigned a 'Green' governance rating for Quarter 4
- the financial risk rating for Quarter 4 is a 4 (the lowest risk level)*
- No undue concerns were raised from the review of the 2015/16 operational plan

*Board members will remember that from Quarter 2 in 2015/16 there will be a new set of risk rating indicators following a consultation undertaken by Monitor.

In relation to the current pressures in the NHS generally and the request for all organisations to review their forecast position, Monitor has confirmed that the Trust is not in breach of its licence and should continue to review opportunities to generate additional efficiencies. It should be noted that the Risk Assessment Framework is due to change for future quarterly monitoring reviews.

3 HSJ and Nursing Times Best Places to Work Awards 2015

As reported previously, the Trust was named by the HSJ and Nursing Times as being among the best places to work for 2015. A group of staff accompanied the Chairman and CEO to the awards ceremony to represent the organisation. Staff were selected based on their contribution to improving patient safety in the hospital and supporting our approach to learning from incidents; this is part of our on-going recognition schemes. The event took place at the national Patient Safety Congress and all attendees benefited from the experience as well as enjoying the awards ceremony.

Attachment 2 is a letter of congratulations received from the NHS Confederation and NHS Employers.

4 EMT Update

4.1 20 May 2015

- Strategy and clinical service strategies discussed
- BAF (EMT items) and risk register reviewed. There was particular discussion regarding long waits for spinal deformity services and concerns about the timing of pre-operative assessment appointments; clinical directors and directorate managers to review further.
- Draft annual report reviewed.
- Quality improvement priorities reviewed for the Quality Account – it was particularly noted that key priority commitments for 2014/15 had not been

brought into mainstream monitoring and this would be an important development for 2015/16 priorities to ensure appropriate focus going forward.
- An updated Carbon Reduction Strategy was received and noted.

4.2 17 June 2015

- An update was received on key workforce transformation initiatives, including a successful attempt to recruit Physician Associates. Formal interviews would follow on from the recruitment fair.
- Key senior appointments had been made to the new operational structure which was intended to go live from 1 September 2015.
- EMT reviewed the new rules introduced by the Department of Health and Monitor in regard to the use of agency staff and very senior manager pay restraint. The ROH is voluntarily following all of the guidelines as best practice; any trust in breach of its licence is required to adhere to the new rules.
- Arrangements for the CQC inspection were confirmed.
- BAF (EMT risks) and the risk register were reviewed and revised as appropriate. Of particular concern was the proposal by NHS England to levy contractual fines for long waits in spinal deformity. The Trust has continued to raise concerns with commissioners regarding the availability of paediatric intensive care beds to enable some of the more complex cases to be undertaken safely at Birmingham Children's Hospital – discussions are continuing.
- The latest patient survey, Friends and Family Test results were reviewed which indicated the ROH is in the top 20 Trust's in 5 out of 9 sections.
- New Terms of Reference were agreed for the Multi-professional Education and Training Group which will oversee the delivery and accountability for learning and development funds received from Health Education West Midlands.
- Upon advice from members of EMT, the CEO approved the following policies:
    - Relocation Expenses Application Policy
    - Volunteer Policy
    - Corporate and Local Induction Policy
    - Recruitment and Selection Policy and Procedure
- The Intellectual Property Policy revision was still a work in progress and would be consulted upon in July.

4.3 15 July 2015

- The BAF (EMT risks) and risk register were reviewed. This incorporated a discussion about the early themes emerging from the King's Fund diagnostic work into medical engagement and leadership which would help to address the Management of Change risk; ideas were sought from existing leaders on how to progress this work as part of Transformation workstream 1.
- EMT were advised about the trust-wide action plan to strengthen approaches to CQC fundamental standards and provide greater assurance of compliance. There is also an action plan in place in relation to duty of candour. Quality assurance visits to clinical areas are providing an opportunity to remind all staff of this important requirement.
- New staff members working in the governance team have highlighted that there are a number of incidents not yet closed on the reporting system. Further work is required to determine whether the incidents are still open or whether work is required on the recording system.

- The priorities arising from the New Beginnings: Moving Forward sessions were discussed.
- In support of our ambition to increase recruitment into NIHR portfolio research studies it was agreed to include 'research activity' in directorate reports and ask clinical teams to take responsibility in their own areas, support involvement and provide KPIs in the new divisional structures. EMT asked the Director of Research & Development to provide information to help inform future job planning processes.
- A business case for a senior knee fellow was approved in principle subject to further detail to be addressed outside of the meeting. The post will be in partnership with University Hospitals Birmingham.
- On the advice of EMT, the CEO approved the following policies:
    - Overpayments and Underpayments Policy
    - Resuscitation Policy
    - Transfer Policy
    - Media Policy
- The Intellectual Property Policy was recommended for approval subject to further discussions by the CEO outside of the meeting to resolve some outstanding issues.

4.4 19 August 2015

- Discussions about the initial CQC verbal feedback and subsequent data requests.
- Follow up work noted on medical engagement and leadership following the Kings Fund project.
- Vanguard proposal with SOA.
- BAF (EMT risks) and risk register reviewed.
- Discussed Quality Account priorities.
- Received the Department of Anaesthetics Annual Report for 2014/15 and noted the progress made towards Royal College Gold Standards. There would be benefit in all departments or services producing a similar report.
- On the advice of EMT, the CEO approved the following policies (subject to minor changes):
    - Freedom of Information
    - Credit Card Usage Policy
    - Bomb Policy
- EMT noted that following further negotiations between the CEO and key clinical innovators, the Intellectual Property Policy has been finalised and approved.

5 Stakeholder and Partnership Engagement

Key stakeholder and partnership engagement activities over the period include:

- Meeting with Professor Dion Morton to launch our participation in phase 2 of the West Midlands Genomics project as part of the national 100,000 Genome Project.
- With the Chairman, met with Dame Julie Moore and Jacqui Smith as part of our continuing partnership with University Hospitals Birmingham.
- HSJ Leadership Summit and Patient Safety Congress, including the 'Top Places to Work 2015' Awards

- West Midlands Leadership Transformation Theme (as Deputy Chair to the Health Education England West Midlands initiative).
- Birmingham Cross City CCG – strategic discussions
- Speaking engagement – Capita Health Conference: CQC Inspections
- University of Birmingham Vice Chancellor's Dinner and Awards
- West Midlands CEOs Forum
- Medical Staff Committee – open session, with the Chairman
- Partnership meeting with Sarah-Jane Marsh, CEO of Birmingham Children's Hospital.
- Richard Burden MP, with the Chairman

Additionally, I have undertaken a number of quality assurance and staff engagement visits to theatres, High Dependency Unit, ward areas, outpatients and the imaging department.

6 Business Updates

a. Regulation – Care Quality Commission

The Care Quality Commission undertook a limited re-inspection on 28/29 July 2015. Additional data sets/ evidence is being provided upon request to assist the inspectors compile their report which is expected to be received in draft form later in the autumn.

b. Senior Appointments

Garry Marsh has been appointed Director of Nursing and Clinical Governance following a national search and competitive recruitment process.

Simon Grainger-Lloyd has commenced as Associate Director of Governance & Company Secretary.

The new divisional structure is being implemented and new general managers will be arriving during September to enable the transition. Appointments will be made to new clinical leadership roles later in the autumn taking into account feedback received from medical staff through the diagnostic work facilitated by the King's Fund.

7 Recommendation

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

Monitor
Making the health sector work for patients

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: enquiries@monitor.gov.uk
W: www.GOV.UK/monitor

03/08/2015

Ms Jo Chambers
Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham
B31 2AP

Dear Jo,

The Royal Orthopaedic Hospital NHS Foundation Trust

2014/15 Q4 monitoring and 2015/16 Annual Plan Review (APR)

I am writing in response to the one-year 2015/16 operational plan and the 2014/15 Q4 return both submitted by the trust in May 2015.

As noted in the separate letter from David Bennett, we are asking all trusts to look at their 2015/16 plans again with the aim of reducing the unaffordable sector deficit. Therefore the purpose of this letter is to:

- Confirm the trust's current and forecast continuity of services risk ratings
- Confirm the trust's governance rating
- Feed back on any specific concerns identified from our review of your 2014/15 Q4 and 2015/16 operational plan review submissions (over and above those outlined in David Bennett's letter to the sector).

We appreciate the efforts undertaken by you and the sector as a whole during the planning round this year, especially given the introduction of a draft plan phase, the changes to the timetable, and the need to update plans with short timeframes to reflect the tariff.

As previously communicated in our 2015/16 guidance[1], the 2016/17 planning round is likely to include a multi-year strategic element and this is still our intention. These plans will need to both build on the strategy submitted to Monitor in June 2014 and reflect your response to the 'Five Year Forward View'.

Further guidance will be issued in due course, but in the meantime you may wish to refer to the Strategy Development Toolkit[2] made available last autumn.

Foundation trust risk ratings

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/390070/APR_guidance_Dec14.pdf
[2] https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers

We have now completed the review of your one-year operational plan and Q4 submission. Based on this work, the trust's current and forecast risk ratings are:

	Q4 14/15 (actual)	Q1 15/16 (plan)	Q2 15/16 (plan)	Q3 15/16 (plan)	Q4 15/16 (plan)
Continuity of service risk rating	4	3	3	4	3
Governance rating	Green				

Under the Risk Assessment Framework[3], the governance rating indicates whether Monitor is currently taking any action; this rating therefore reflects the outcome of both the operational plan review and Q4 monitoring.

As explained in our letter of 13 May 2015, governance ratings and continuity of services ratings will be published on Monitor's website for all trusts shortly.

Regulatory response

Quarterly monitoring

The trust has been assigned a 'Green' governance rating.

A report on the FT sector aggregate performance from Q4 2014/15 is now available on our website[4], which I hope you will find of interest.

We have also issued a press release[5] setting out a summary of the key findings across the FT sector from the Q4 monitoring cycle.

Annual plan review

No undue concerns were raised from our review of your operational plan. We will continue to monitor ongoing delivery as normal.

However, as explained in the separate letter from David Bennett, given the unaffordable sector-wide deficit being forecast for 2015/16 all trusts are being asked to look at their plans again to determine whether the options outlined in that letter may present opportunities to improve their financial position. Please refer to the separate letter for further details and required actions.

[3] www.monitor.gov.uk/raf

[4] https://www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-4-201415

[5] https://www.gov.uk/government/news/foundation-trusts-face-challenging-year-as-pressures-mount

If you have any queries relating to the above, please contact me by telephone on 02037470617 or by email Rebecca.Farmer@Monitor.gov.uk

Yours sincerely

Rebecca Farmer

Senior Regional Manager

CC. Paul Athey, Finance Director

Yve Buckland, Chair

NHS CONFEDERATION

NHS Employers

Jo Chambers
Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham

B31 2AP

14 July 2015

Dear Jo

HSJ and Nursing Times Best Places to Work awards

We are writing to congratulate you on your organisation's inclusion on the HSJ and Nursing Times Best Places to Work list.

To be named as one of the best organisations to work for across the NHS is a significant achievement, and you and your team should be extremely proud.

Once again, very many congratulations,

Yours sincerely

Rob Webster
Chief Executive
NHS Confederation

Daniel Mortimer
Chief Executive
NHS Employers

NHS Confederation, Floor 4, 50 Broadway, London, SW1H 0DB
020 7799 6666
enquiries@nhsconfed.org
www.nhsconfed.org
@nhsconfed YouTube NHSConfed LinkedIn NHS Confederation

Date of Trust Board: 2 September 2015 **ENCLOSURE NUMBER: 4**

SUMMARY OF REPORT TO TRUST BOARD

SPONSORING DIRECTOR:	**Chief Executive, Jo Chambers**
AUTHOR(S):	**Sally Xerri-Brooks, Head of Communications**
SUBJECT:	**Communications and Engagement Strategic Framework, initial update and quarterly report**

SUMMARY

This report aims to share with the Board the Communications and Engagement Strategic Framework, which was received and approved by the Transformation Committee in June 2015.

The report goes on to chart progress in communications and engagement, and set out measures for success that can be reported to the Board on a quarterly basis.

IMPLICATIONS

Continued support from Directors and departments across the Trust is critical if this work is to continue in gathering momentum.

RECOMMENDATIONS

The Board is asked to:

- RECEIVE and NOTE the Communications and Engagement Strategic Framework
- DISCUSS the initial report on progress to date
- DISCUSS and AGREE the information it would like to receive on a quarterly basis

ROH NHS FT COMMUNICATIONS DEPARTMENT

RECRUITMENT

Head of Communications
Senior Communications Officer
Media and Graphics Officer (Sept start)
Senior Web and Systems Developer (2.5 WTE)

CHANNEL DEVELOPMENT

x20 The approximate number of 'all staff' emails saved by the e-bulletin each week

- 93% of staff surveyed read ROH Life
- 79% found ROH Life to be either quite or very useful
- 61% found the new look and feel to be either a little or a lot better than previous editions

ROH life: Engagement is increasing, with staff regularly making requests for information

New website will launch Jan 2016

MEDIA

Since December 2014, 85% of all media coverage of ROH has been either positive or neutral, with 15% being negative.

85%

Our 'mentions' in news media have increased significantly since 2014. Compared to similar Trusts, our profile now compares more favourably.

SOCIAL

Around 3,000 people saw Twitter posts about nurse recruitment, with a high proportion clicking through to the web pages.

3,811 people saw Facebook posts about our nurse recruitment campaign. 86% were women, and most were aged between 25 and 54.

391 people read Vicky Hatton's blog, which was created to support recruitment, on the trust website.

Communications and Engagement Strategic Framework, initial update and quarterly report

1. Introduction

This report has two main functions:

a. To share with the Board the Communications and Engagement Strategic Framework, which was received and approved by the Transformation Committee in June 2015.
b. To provide an update on communications and engagement activities against the strategy, and more generally, since the inception of the new communications team in December 2014. This will then be revisited on a quarterly basis to provide the Board with information and assurance on the delivery of the strategy in support of the organisation's five year strategy.

2. The Communications and Engagement Strategic Framework

The Communications and Strategic Framework is a summary document which is aligned with the organisation's five year strategy. It is underpinned by four, more detailed strategies, which focus in turn on:

a. Patients, the public, Governors and Members
b. Staff, specifically around the transformation of ROHNHSFT towards achieving its five year strategy
c. GPs
d. Digital communications, including web and social media.

Included for discussion today is the strategic framework document alone. However, should Board members wish to see any of the abovementioned detailed strategies, these will happily be provided on request.

3. Establishing a communications function at ROHNHSFT

In addition to developing the new Communications and Engagement Strategic Framework, a major task has been to establish an effective and efficient communications function for the Trust. In December 2014 the Head of Communications was appointed. After taking some time to review the organisation, the context and specific needs, two roles were developed and put out to advert:

- Senior Communications Officer – this post has now been recruited to, and the successful candidate began work on 17th August
- Media and Graphics Officer – this post has been recruited to, and subject to clearances the successful candidate will begin in early September.

In addition, the Senior Web and Systems Developer in the Informatics Team devotes 2.5 days a week to the Communications Team. What this allows is the development of a multi-disciplinary in-house team, able to take on all but the most specialised tasks – from strategy, to message creation, content creation, web development, photography, film, design and more. This has allowed the Trust to withdraw from a costly SLA with an external provider, and redirect funds to be used more efficiently, to support the development of the new website and creation of print and display materials, as well as the initial technological equipment needed to establish the infrastructure for the new team.

4. Initial update

Key communications and engagement outcomes, indicators and actions will be reported to the Board on a quarterly basis. Given this is the first report of its nature, it makes sense to frame this report to cover the period since the inception of the new communications team, which was established in December 2014. Therefore, the information presented here represents eight months of activity, starting from a context of limited communications systems in place. While the timeframe is different, it is planned that the measures detailed here will remain the same in order to aid consistent reporting and offer a sense of trends developing. Should the Board feel there are any areas omitted, the report will be updated to reflect these needs.

4.1 Patients, the public, Governors and Members

4.1.1 Key actions taken

Work has been done to engage with the media to enable ROHNHSFT to share positive stories locally and nationally. A recent example is the Functional Restoration Programme – a chronic back pain rehab programme – which received a full page article in the Daily Mail, plus coverage on BBC Radio WM and BBC Radio Hereford and Worcester, as well as a feature on BBC Midlands Today on BBC1.

This activity took place in June and July 2015. It is understood that there has been a subsequent spike in referrals to this service.

Promotion externally via the website, social media and press releases of successes such as the achievement of the Park Mark, the hospital's contribution to Talent for Care and the related Partnership Pledge, Dementia Stakeholder Day, improvements in catering for patients flagged in the annual inpatient survey.

22 poster boards have been erected across the organisation to publicly show CQC ratings, give a strategic message from Jo and also detail localised improvement works.

A series of basic poster and presentation templates have been created and made available to all staff to raise the quality of in-house materials displayed to patients and other external audiences.

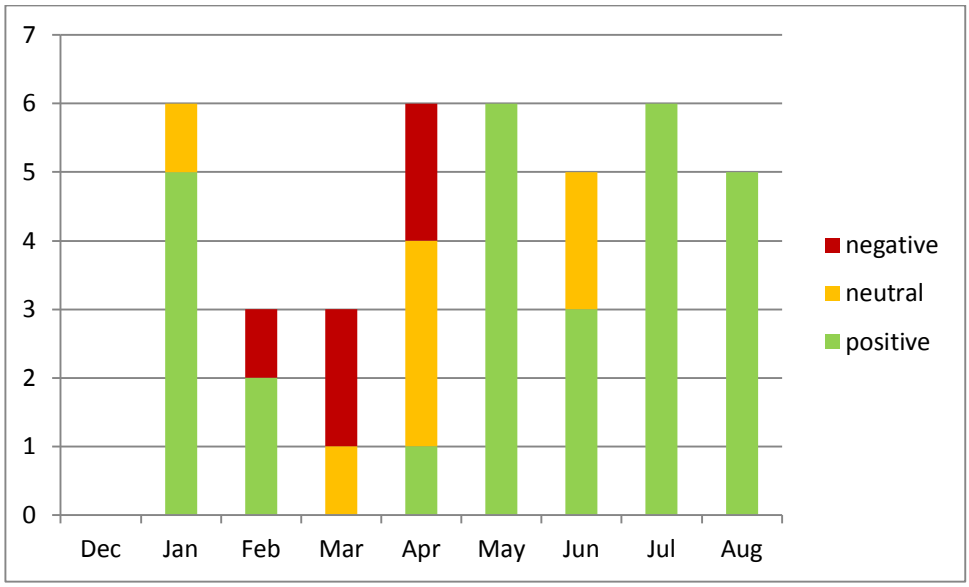
Specific work has been carried out to promote the role of Governors, with dedicated space on the website, intranet and in ROH Life, with more plans in the pipeline.

Recruitment campaign support has been provided to teams seeking new Physician Associates and nurses in recent months, with leaflets, banners and social media marketing being created. This has supported a number of successful appointments.

4.1.2 Indicators and measures

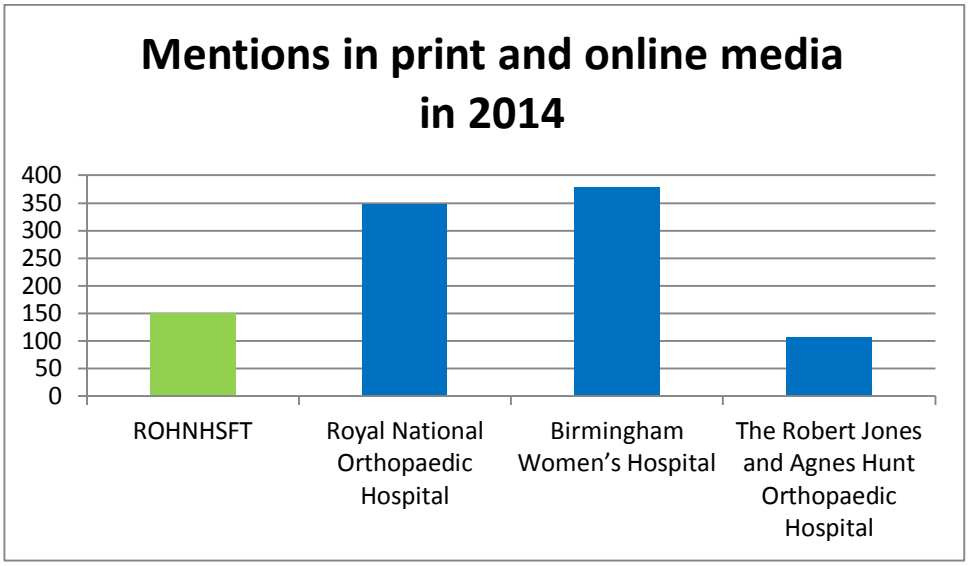
Since December 2014, 85% of all media coverage of ROHNHSFT has been either positive or neutral, with 15% being negative. Much of this negative coverage can be associated with a specific issue experienced by the Trust in Spring 2015 which received press attention.

A distribution of the stories and their classification can be found below:

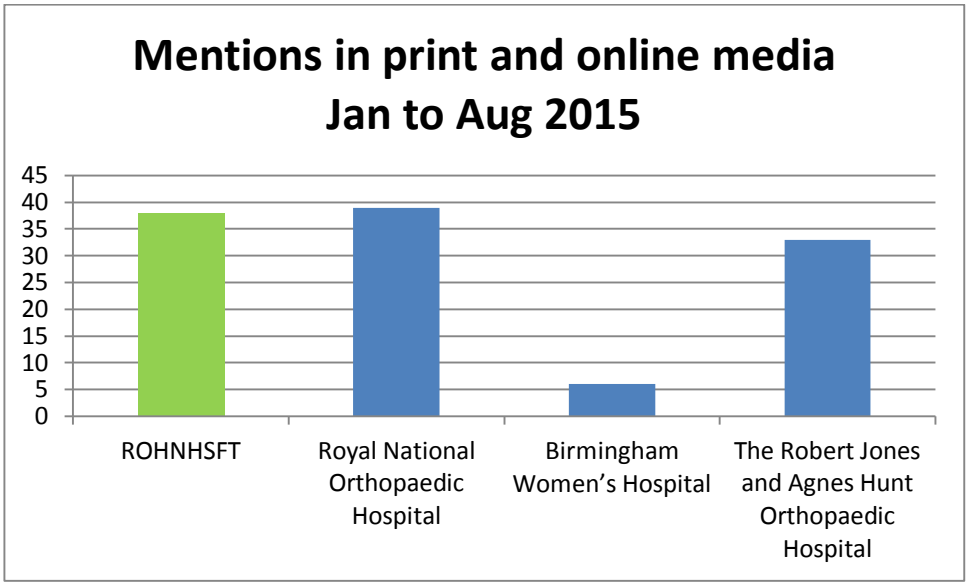


Source: ROHNHSFT internal media cuttings database.

It is worth noting the change in number of mentions in news media compared to 2014 in comparison with similar Trusts in size or function. The charts below demonstrate that from a position of being significantly behind in media mentions, it is now comparing more favourably with others from a quantitative perspective.



[1]



Source: Google News search carried out 19/8/15.

[1] Birmingham Women's Hospital has been selected as a comparator due to it being in the same geographical location, of a similar size and having a defined specialism, although clearly not related to orthopaedics.

4.2 Staff communications and engagement

4.2.1 Key actions taken

Significant work has been undertaken in this area, specifically around the creation and development of a diverse range of internal communications materials:

- Creation of a weekly E-bulletin to draw together key messages for all staff, and reduce inconsistent and ineffective 'all staff' emails that were able to be sent by anyone. On average this reduces the size of every member's inbox by 20 emails a week. Feedback from staff has been good, with strong evidence that managers of teams who are not desk based are printing out copies and putting them on noticeboards.
- Increased use of the intranet means that if messages are missed through other internal means, they are all now contained in the news pages, which were historically poorly used. The E-bulletin also links through to them.
- Development of ROH Life, which is available on paper and electronically to all staff. This is physically taken to every department and hand delivered by communications staff to ensure penetration. Engagement is increasing, with staff regularly making requests for information to be included.
- Jo's Journal is now established as a monthly update direct from Jo, which echoes messages she shares in TBALD and Team Brief, again, ensuring a diversity of the methods of communication.

In addition, significant support has been provided to the Transformation Team to support the promotion of this important programme within the organisation. Also, there has been a great deal of support offered to the Learning and Development Team responsible for delivering the New Beginnings sessions.

4.2.2 Indicators and measures

It is harder to measure staff engagement at present, as there is no clear empirical means to do so. The staff survey gives some good indications of engagement, but as this is an annual activity, this data will not provide quarterly progress. However it is positive to report that:

- Working in partnership with Learning and Development, 38% of staff surveyed completed the Friends and Family Test in Q1 of 2015 compared with 23% in 2014[2].
- NHS Change Day in March was well attended following partnership work between Communications and the Transformation Team – more than 100 people came to find out more about Transformation, many of whom signed up to be more involved.

[2] Note that in Q1 2015 all staff were invited to take part. In 2014 a different group of staff were invited to participate in each quarter. The 2014 percentage is therefore an aggregate of the whole year's FFT surveys.

- Working in partnership with Learning and Development, more than 500 staff attended the New Beginnings events, which were publicised across all the major internal communications channels and supported with display and giveaway collateral.

In addition, a survey was carried out in January 2015 on the publication of the first 'new look and feel' edition of ROH Life. The headline figures were as follows:

- 93% of staff surveyed read ROH Life
- 79% found ROH Life to be either quite or very useful
- 61% found the new look and feel to be either a little or a lot better than previous editions

Source: Internal online survey.

Feedback from this survey has informed the subsequent development of the magazine, with a regular slot on finances and a forthcoming feature on 'my proudest moment'.

4.3 Digital Communications and Engagement

4.3.1 Key actions taken

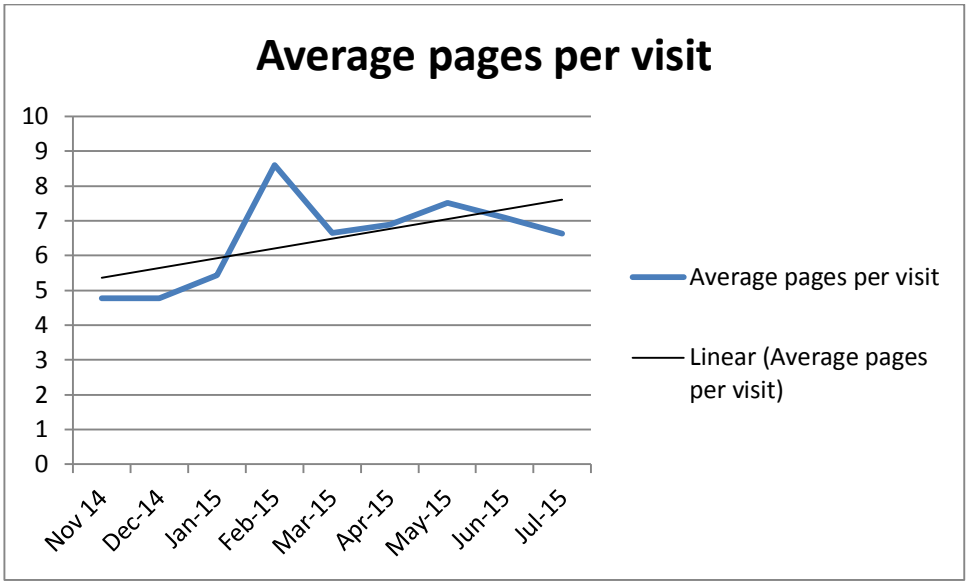
Without a dedicated focus on digital communication in the past, ROHNHSFT now has a big opportunity to embrace, and significant work is being done in this space.

The Trust social media accounts, including Facebook, Twitter and LinkedIn are now regularly being updated with appropriate and targeted content. Many hundreds of people are now engaging with the Trust via this means every day.

The organisation's website does not meet the needs of a 21st century organisation looking to transform. With that in mind, a large piece of analytical and strategic work has been undertaken, in conjunction with consultation with patients, staff and the public, to radically redesign and update ROHNHSFT's website. A clear plan has now been drawn up for the creation and completion of the new ROHNHSFT website, which will be delivered at the beginning of the 2016 calendar year. Further consultation will continue throughout the next few months to ensure that the content is fit for purpose and the design meets the needs of the users, with consideration for people of all backgrounds and age groups. Remedial work has been carried out on the existing website to improve what is there in the interim.

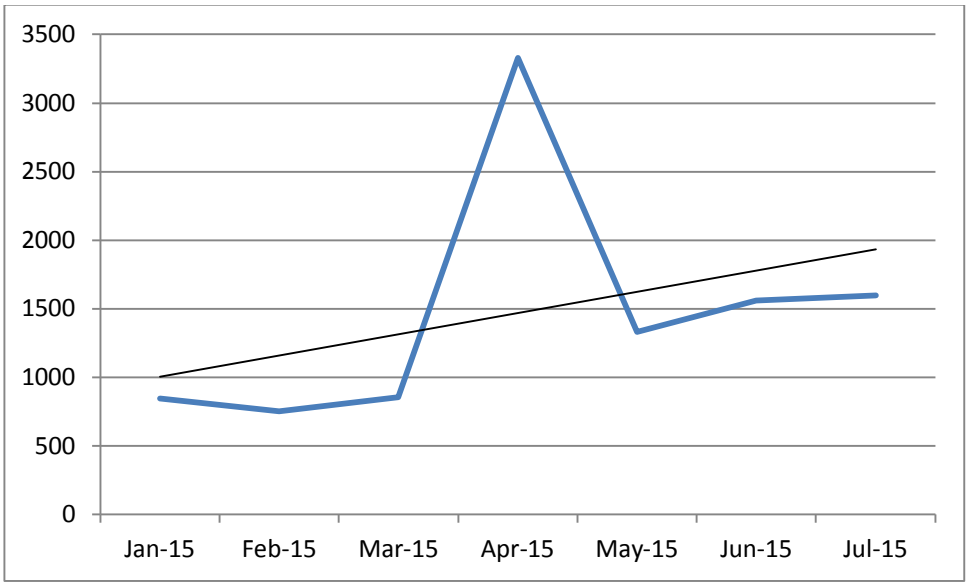
4.3.2 Indicators and measures

The website is our digital shop window, and with between 15k and 20k visits each month, it draws a big audience. With work to develop the existing website's content, there has been an increase in pages people view per visit, as demonstrated in the chart overleaf:



Source: Web statistics from www.roh.nhs.uk, provided by Advanced Web Statistics 7.3

One of the new areas developed on the existing website is the Working With Us section, which has been redesigned and rewritten in partnership with the Workforce Team. This work was undertaken in early 2015, and was launched in March 2015 with an immediate result. In July 2015, hits were 89% higher than in January 2015. The following chart shows the trend – as well as the significant spike that took place on launch. This has provided a model for the new website to aspire to.



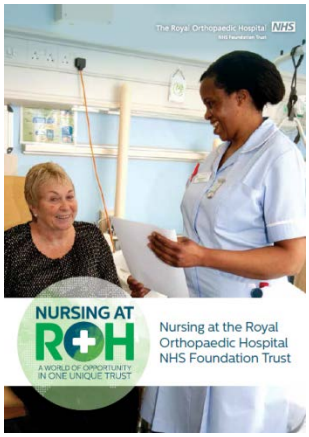
Source: Web statistics from www.roh.nhs.uk, provided by Advanced Web Statistics 7.3

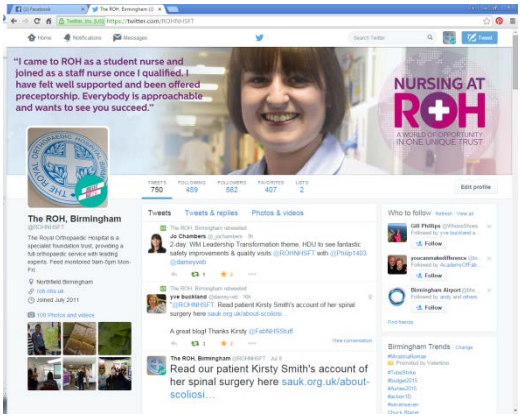
Social media activity is also increasing, with Facebook 'likes' increasing by 16% to 1,670, Twitter followers increasing by 76% to 617 and LinkedIn followers increasing by 29% to 553. In reality, this means a significantly larger reach for stories that are posted by the organisation that are seen not just by those directly interested in ROHNHSFT, but also by the people they share with. This can be demonstrated by recent work undertaken to raise the profile of nurse recruitment at ROHNHSFT:

- 3,811 people saw Facebook posts about our nurse recruitment campaign. 86% were women, and most were aged between 25 and 54.
- Around 3,000 people saw Twitter posts about nurse recruitment, with a high proportion clicking through to the web pages.
- 391 people read Vicky Hatton's blog, which was created to support recruitment, on the trust website.
- 86 people visited the nurse information page on the website.

Source: Facebook Insights

See below some of the campaign imagery, which is still being used.





4.4 GP communications and engagement

To date this area has not been prioritised due to capacity challenges, and a need to focus on internal communications and media management in the first six months. However, the improvement in media coverage for ROHNHSFT will have an impact on this audience – for example the spike in referrals for the Functional Restoration Service.

The new Senior Communications Officer has a background working with GPs in a commissioning environment, and will be using his knowledge and expertise in this area to take forward this area of work in the coming months, consistent with the strategy.

5. Looking ahead

The next six months are critical if the momentum of recent months is to be maintained. Key activities include:

- Creation and launch of the new ROHNHSFT website – due to be delivered in early 2016. This will be integrated with Patient Opinion, and in due course with Amplitude and InTouch. A provider has been sourced to carry out the specialist web design aspects of work, while the content generation, photography and routine web development will be carried out by the in-house team, cutting the cost of this task dramatically.
- Focus on patient communications and information as part of the Transformation agenda – this will ensure that patient information provided on paper is consistent with online information. It will also ensure that all patient information is centrally controlled and quality assured and provided in an appropriate format. Early thinking is that all patients will receive a hospital handbook with all the basic information in, with space for additional specialised information to be included. This will also be made available electronically for those who prefer it in that format.
- Pilot of the patient diary – a simple booklet given to a patient after surgery to give them a sense of what will happen and when, to reduce anxiety and confusion for this group following patient feedback.
- Promotion of feedback following the New Beginnings events. This will be in a variety of formats – online, in a dedicated booklet and through direct contact with staff. This will also in turn promote the staff awards and forthcoming staff survey.

6. Recommendations

The Board is asked to:

- RECEIVE and NOTE the Communications and Engagement Strategic Framework
- DISCUSS the initial report on progress to date
- DISCUSS and AGREE the information it would like to receive on a quarterly basis

Sally Xerri-Brooks
Head of Communications

21 August 2015

Royal Orthopaedic Hospital NHS Foundation Trust

Communications and Engagement Strategic Framework

1 Introduction

1.1 The Royal Orthopaedic Hospital NHS Foundation Trust (ROHNHSFT) has a clear vision – to be the first choice for orthopaedic care. This is supported by a Five year Strategic Plan[1]. Underpinning this vision is a set of actions that will support the Trust to achieve this vision:

- Creating a culture of excellence, innovation and service
- Exceptional patient experience every step of the way
- Safe and efficient processes
- Fully engaged patients and staff
- Developing clinical services
- Information for excellence
- ROH: the knowledge leader

1.2 The actions detailed in the Five Year Strategic Plan run in parallel with a set of six values which were developed in partnership with colleagues across ROHNHSFT:

- 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

1.3 None of these actions or values can be carried out without effective communications and engagement mechanisms. Communications and engagement is at the heart of any effective organisation because people operate through relationships with others and

[1] ROHNHSFT Five Year Strategic plan, 2014

these relationships are facilitated through communication, be that in person, on the telephone or via online or mass media connection.

1.4 We learnt from the Francis Report on Mid Staffordshire in 2013 that the situation there was caused in part by a failure to communicate and engage effectively with patients. More broadly, the general culture and failings were exacerbated by a lack of effective communication across healthcare systems in sharing information and concerns, a lack of openness, transparency and candour.[2]

1.5 This demonstrates that communicating and engaging effectively is at the heart of healthcare and its provision.

1.6 The key action relevant to this strategic framework is 'Fully engaged patients and staff.' The projects and outcomes of this action are:

1.6.1 Develop a communications and engagement strategy to establish a coherent approach to all relevant activity, aligning with other strategies as required, notably the Organisational Development strategy.

1.6.2 Develop a communications team capable of delivering the strategy effectively.

1.6.3 Embed the right systems and process to deliver high quality communications and engagement, including a refreshed website and tools for use of digital media.

1.6.4 Develop and implement a plan for strengthening engagement with GPs, to raise awareness of the ROH as the first choice for orthopaedic care.

1.6.5 In addition to communications related drivers such as these, it is also critical that there is meaningful involvement by all staff at every level of the organisation, a real integrity between saying and doing and a critical role for leadership.

1.7 This strategic framework will outline how these outcomes will be achieved. It will provide a high level plan for communications and engagement at ROHNHSFT, and will be underpinned by four, more detailed strategies:

- Staff Communications and Engagement Strategy
- Patient and Public Communications and Engagement Strategy
- GP Communications and Engagement Strategy
- Digital Strategy

[2] The Mid Staffordshire NHS Foundation Trust Public Inquiry, Robert Francis QC, 2013

2 Background

2.1 The ROHNHSFT has been in existence since 1817 and has a rich heritage in Birmingham and the West Midlands.

2.2 Historically the ROHNHSFT has a very good reputation in the local community and among patients, clinicians and partner organisations.

2.3 Latterly there has been less in the way of proactive communication with key stakeholders, with the result that the profile of the Trust has reduced. While its reputation remains good, it is not at the forefront of any of Birmingham or the UK's major health discussions or stories.

2.4 Anecdotally, the Trust has been described as a 'sleeping giant' by those working in other parts of the health economy and also those internally who work clinically, with untapped potential.

2.5 Internally there is evidence of a perceived disconnect between senior management and operational staff. This is justified in some cases but largely as a result of significant change in the top team in recent years, with several different Chief Executives. The new top team has been in place for over a year and is dedicated to full engagement with all colleagues, but anxiety from operational staff about the Trust and its future remains a factor in pockets of the Trust.

2.6 There is a concern among the executive team that information that is being shared with some middle managers is being lost. It may be that it is simply being shared no further, or it is being shared in such a ways that the original key aims and objectives aren't clearly articulated. This is also a challenge in terms of staff having the opportunity to feed back to executive colleagues via their line managers. This disconnect is proving a critical challenge in terms of effectively disseminating information and effectively engaging with staff.

3 Objectives

3.1 This strategic framework is an overarching document. Therefore, the objectives are wide-ranging, and they are to:

3.1.1 Support ROHNHSFT to become first choice in orthopaedic care by creating an environment of excellence for communications and engagement with patients, partners, the public and staff.

3.1.2 Identify the key audiences and stakeholders with which ROHNHSFT engages and the most effective mechanisms for each.

3.1.3 Benchmark existing communications and engagement activities in comparison with similar organisations in order to create a line in the sand and a comparison point in future. It is important however to look beyond being simply as good as others, and start to work towards best practise.

3.1.4 Raise the profile of ROHNHSFT locally, regionally, nationally and internationally.

3.1.5 Deliver excellent patient and public information and support which is delivered in a variety of easily accessible ways.

3.1.6 Become synonymous with excellent communication and engagement with staff, providing innovative and useful mechanisms to support daily work.

3.1.7 Ultimately better engagement is known to drive up patient experience, drive down mortality and reduce absenteeism, which must also be an objective.

3.1.8 Support the creation of specific strategies around the following areas and/or audiences:

- Patients, the public, Governors and Members
- Staff, specifically around the transformation of ROHNHSFT towards achieving its five year strategy
- GPs
- Digital communications, including web and social media.

3.1.9 In order to achieve excellence, we need to establish what it looks / feels like. The points below summarise these aims:

- Patients and staff knowing where to get information from both on and off line.
- Staff feeling informed and involved in the transformation process – feedback regularly received. This will be delivered through a system of staff engagement and involvement.
- GPs know how to refer to ROHNHSFT, and choose ROHNHSFT before other providers.
- Staff and patients acting as advocates, creating valuable word of mouth promotion.
- Strong and identifiable visual brand that unites all communications collateral.
- A clear, professional, recognisable presence in Birmingham, West Midlands, UK and the World in the field of orthopaedic care.
- Patients knowing where and how to feedback positive and negative views.

- Anyone can expect a consistent approach to communicating with ROHNHSFT whether it is in person, online, via social media, on paper or by telephone – professional, high quality and clear.

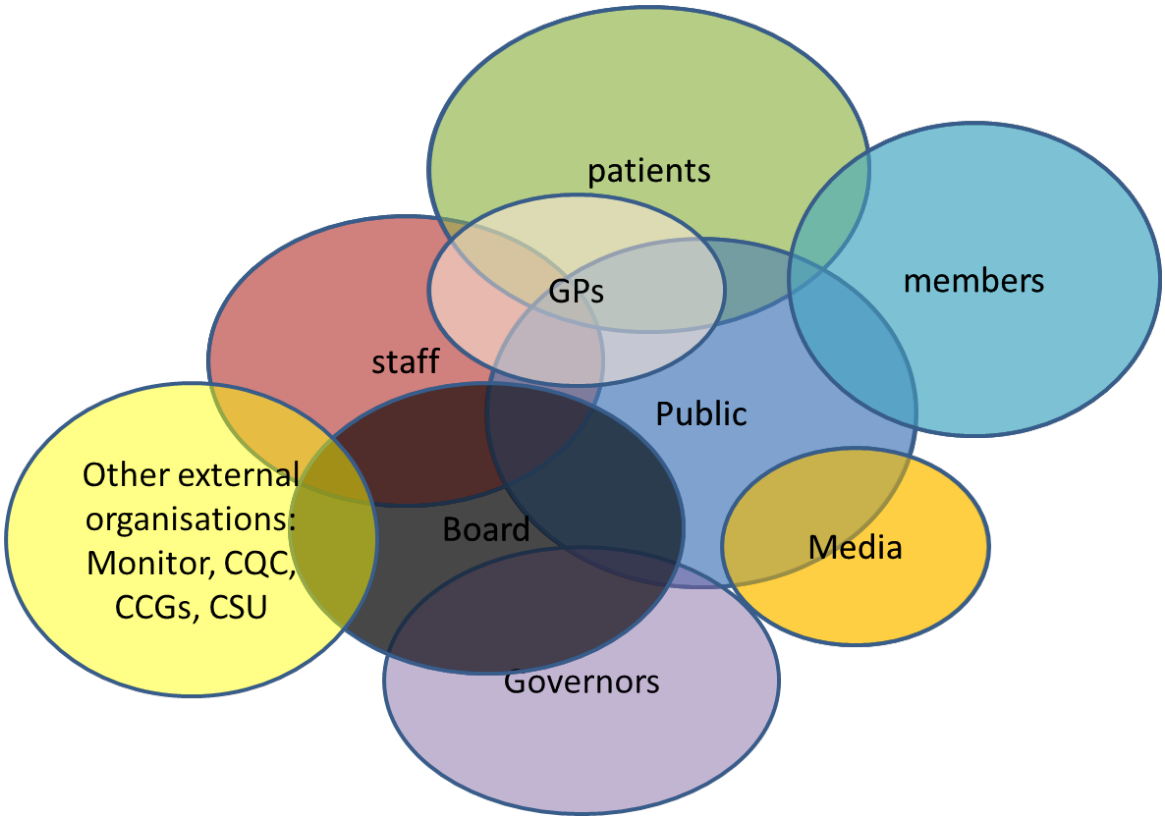
4 Stakeholders and communications channels

4.1 There are many different groups of stakeholders who communicate and engage with ROHNHSFT on a regular basis.

4.2 Key stakeholders

- Patients – this is the most obvious group of stakeholders, as this is the group the hospital was established to care for. A lot of direct communication is in existence for this group of people in the format of letters and phone calls.
- Public / visitors – less of our communication with this group will be direct, and more will be mediated through other people or channels.
- Future recruits – ROH's future workforce is already out there, so it is critical that communication for example through social media promotes the organisation to this important and valuable group, which will cover a wide geographical and demographic area.
- Staff – colleagues working at the ROHNHSFT are the public face of the organisation, so communication and engagement with them is critical.
- Board members – these include Non-Executive members (NEDs) who take an active part in seeking assurance on the work of the hospital, having both internal and external perspectives. They also have the opportunity for private challenge where appropriate.
- Governors – these are interested parties who dedicate time to supporting the Board through Governor meetings, representing groups of constituents.
- Members – these are patients and members of the public who feel an affinity with ROHNHSFT and have signed up to receive more regular updates from the Trust and to be more involved with developments
- GPs – GPs lead on referring patients to the ROHNHSFT, so who they refer, why and how is of importance to the daily running of the hospital.
- Media / press – the media provide a prism through which the public and staff learn about the organisation, and relationships with outlets such as local television news and papers are very valuable.
- External bodies such as CCGs, Monitor, CQC, CSU, Health Education West Midlands (HEWM) and others.

4.3 These stakeholder groups are not mutually exclusive. The diagram below shows how they interact and cross over in places.



4.4 There are a variety of communications channels which are currently used and the table at 4.5 demonstrates how each group of stakeholders is reached presently. The 'other external organisations' as detailed in 4.3 has been left out of this table as all communications with these stakeholders is done through direct contact with senior staff at ROHNHSFT on a case by case or theme basis.

4.5 Green indicates targeted communication, whereas amber represents communication which relies on the audience to engage.

Channel / audience	patients	public	staff	Board	members	governors	GPs	media
Team brief			x	X				
ROH Life magazine			x	x		X		
E-bulletin			x	x				
Website	x	x	x	x	x	x	X	x
Facebook	x	x	x	x	x	x	X	x
Twitter	x	x	x	x	x	x	x	x
Intranet			X	X				
All staff emails			x	X				
Jo's Journal			x	x		X		
Outpatients screens	x							
Patient information leaflets	x							
Mailing					x	X		
Media/press release	x	x	x	x	x	x	x	x
Board papers	x	X	x	x	x	x	x	x
Notice boards on site	x		x	x				

4.6 The table above shows that while all groups have access to some of the ROHNHSFT communications channels, they rely on the audience to be proactive – for example, GPs need to choose to use the website or social media to find out information, or contact the hospital directly. Nothing is proactively sent to them specifically. This is also the case for members of the public.

4.7 There is a clear need for more targeted communications work, specifically for patients, the public, members and GPs.

4.8 While there are a variety of methods of communicating with staff in place, all are in their infancy, so attention must be paid to evaluation and development.

5 Benchmarking – where we are now in comparison with others?

5.1 In January and February 2015 a detailed benchmarking study was carried out, looking at communications and engagement at ROHNHSFT and how it compares to similar and competing organisations. The full study is included at Appendix A on page 17.

5.2 The study demonstrates that the ROHNHSFT lags significantly behind organisations such as the Royal National Orthopaedic Hospital, The Queen Elizabeth Hospital and Birmingham Children's Hospital (BCH) in terms of the amount of news and media coverage it receives, with just 151 mentioned in news media in 2014, compared to BCH with 3,870.

5.3 Social media is now more influential than it has ever been before, but due to lack of proactive input ROHNHSFT has not been in a position to make the most of the opportunity. Once again, comparing the Trust with other organisations shows there is much to be done to more effectively engage with patients and the public, who we know use this as a key means of gaining information about organisations such as hospitals.

5.4 The ROHNHSFT website is well used by the public, with around 16,000 visits every month. However, analytical data shows that 65% of those visitors leave the site within 30 seconds, which, coupled with the fact that many in a recent survey said they found it difficult to find information and it took too much time, suggests they may not be easily finding the information they want.

5.5 In January 2015 a survey was undertaken among staff, patients and the public. The survey gave the website a Net Promotor Score (NPS) of -11, against a benchmark for this kind of industry of +28. In simple terms, this means more people would actively not recommend the ROHNHSFT website to others than would recommend it.

5.6 More detailed feedback showed that many users do not feel the website meets their needs. They say it takes too long to find information and it is not easy to understand. In contrast however, many people who use the website say they trust the information provided there, which is excellent for the ROHNHSFT brand.

5.7 Staff communications and engagement is not always easy to benchmark. However, the annual NHS Staff Survey does give some indication of how staff feel about engagement. Often, staff at ROHNHSFT respond less positively to questions around their engagement with senior management than other acute specialist trusts in the UK, with just 8% of respondents in 2014 strongly agreeing that communication between senior management and staff was effective. It is also important to acknowledge that the survey also highlights

that staff perceive the organisation to not be good at listening to feedback from patients – this is one of the poorest scoring areas.

5.8 Anecdotally and through other pieces of research, engagement from staff has been patchy. For example, some staff engaged with the website survey, and significantly two of them (4% of staff respondents) specifically stated they would not take part in a focus group about the website because there was no chance of change as a result. They felt there was no point.

6 SWOT analysis

6.1 The information in section 5 and the Benchmarking Study has been used, alongside anecdotal evidence and observation to create the following SWOT analysis, demonstrating Strengths, Weaknesses, Opportunities and Threats.

6.2

Strengths: • Good feedback from patients about care • Traditionally good reputation externally • Strong history in Birmingham • Single site • Well defined specialist service • Clear five year strategy for ROH and transformation plan • Identified values • Crest • Buy-in from senior team • Strong buy-in from staff to ROH brand	Weaknesses: • No up to date comms and engagement strategy • Out of date website which is not user friendly • No staff comms protocol – anyone can email all staff • No effective social media plan • No clear brand identity beyond the crest and the NHS lozenge • Relationships with media need improvement • No easy way for patients to get information beyond what they are sent by their clinic • No dedicated GP communications • Little proactive press work • Little profile locally, regionally and nationally • Minimal specific comms for governors and members • Low reported levels of staff engagement
Opportunities • Starting from a clean sheet where creativity can be used • New strategy and values mean there is something great to communicate • Putting ROH back on the map locally, regionally, nationally and internationally • New dedicated communications team • Chance to unite the whole staff body • Create an innovative, effective and practical web presence for the benefit of staff and patients • Simple quick wins are possible – like a weekly e-news letter to reduce ad hoc staff emails, social media activity • Strong staff buy-in to the brand is a platform to build on • Anecdotal feedback about confidence in senior team shows there are signs of change.	Threats: • Buy-in from clinical staff is patchy and in some cases there is animosity from staff • Press enquiries have not been consistently dealt with, risking negative publicity • ROH's profile remains low, threatening its aim to become first choice • Patients cannot find information they need to support their experience • Different parts of the hospital communicating in different ways, resulting in a fragmented and inconsistent image of the trust • Lack of awareness among GPs is a threat to referrals • Change ahead which can negatively impact on staff engagement • Perception that effective staff engagement equals happy staff is not always the case.

7 Key messages

7.1 For each specific area of communications, there will be a particular set of key messages developed. However, a central set of key messages must be at the heart of all communications, and they are set out in the following points.

- The Royal Orthopaedic Hospital NHS Foundation Trust has a vision to be first choice for orthopaedic care.
- ROHNHSFT is proud to be creating a culture of service, excellence and innovation.
- Patients of ROHNHSFT should experience an excellent service every step of the way.
- Services at ROHNHSFT are safe, efficient and high quality.
- ROHNHSFT is keen to hear the views of patients, the public and partner organisations about future developments.
- ROHNHSFT is working to create and develop innovative and cutting edge clinical services which are world leading in orthopaedic care.
- ROHNHSFT believes in openness and honesty, and if something goes wrong, we will tell you about it.
- Staff at ROHNHSFT matter and are the people who deliver great care.

8 Key actions

8.1 Create a communications team

8.1.1 In order to deliver quality communications and engagement activities, a full team is required. In December 2014 a new Head of Communications began work at ROHNHSFT.

8.1.2 Two new posts have been designed, to support the delivery of communications activities at ROH, which are:

- Senior Communications Officer (Band 6). This individual will carry out the day to day operational communications activities such as writing press releases, putting together the staff magazine, updating the website and intranet and creating communications plans for specific Trust projects.

- Graphics and Media Officer (Band 5). The post holder will lead on the visual identity of the Trust, providing professional graphic design, branding, photography, film and editing skills. The individual will also be in a position to support the development of new communications tools.

8.1.3 In addition, the Senior Web Developer (Band 6) who is currently working as part of the Informatics Team, will spend 50% of her working time supporting the work of the Communications Team, supervised by the Head of Communications. This will involve the redevelopment and management of the website, along with management and development of the intranet.

8.1.4 This team will then be in a position to support colleagues across ROHNHSFT with their communications needs. This will always take the form of looking at the specific objectives of a request, forming a short communications and engagement strategy and agreeing a joint action plan.

8.2 The ROHNHSFT brand

8.2.1 Branding is about more than a logo or an image, it is about the feel, visual identity and ethos of an organisation. A good brand means that one only has to mention the name of a company and immediately the user or customer has a sense of the kind of organisation it is, what it cares about and what it does.

8.2.2 Currently ROHNHSFT does not have a clear, unique and consistent brand. The fact that it now has a defined vision and values means the process has begun. The challenge now is to bring that together with the visual identity of the organisation.

8.2.3 The trust has the crest thanks to its Royal Charter which confers history, heritage, respect, trustworthiness, pride, consistency and strength. It draws immensely warm feelings from the public. An example of this can be seen at Appendix B.

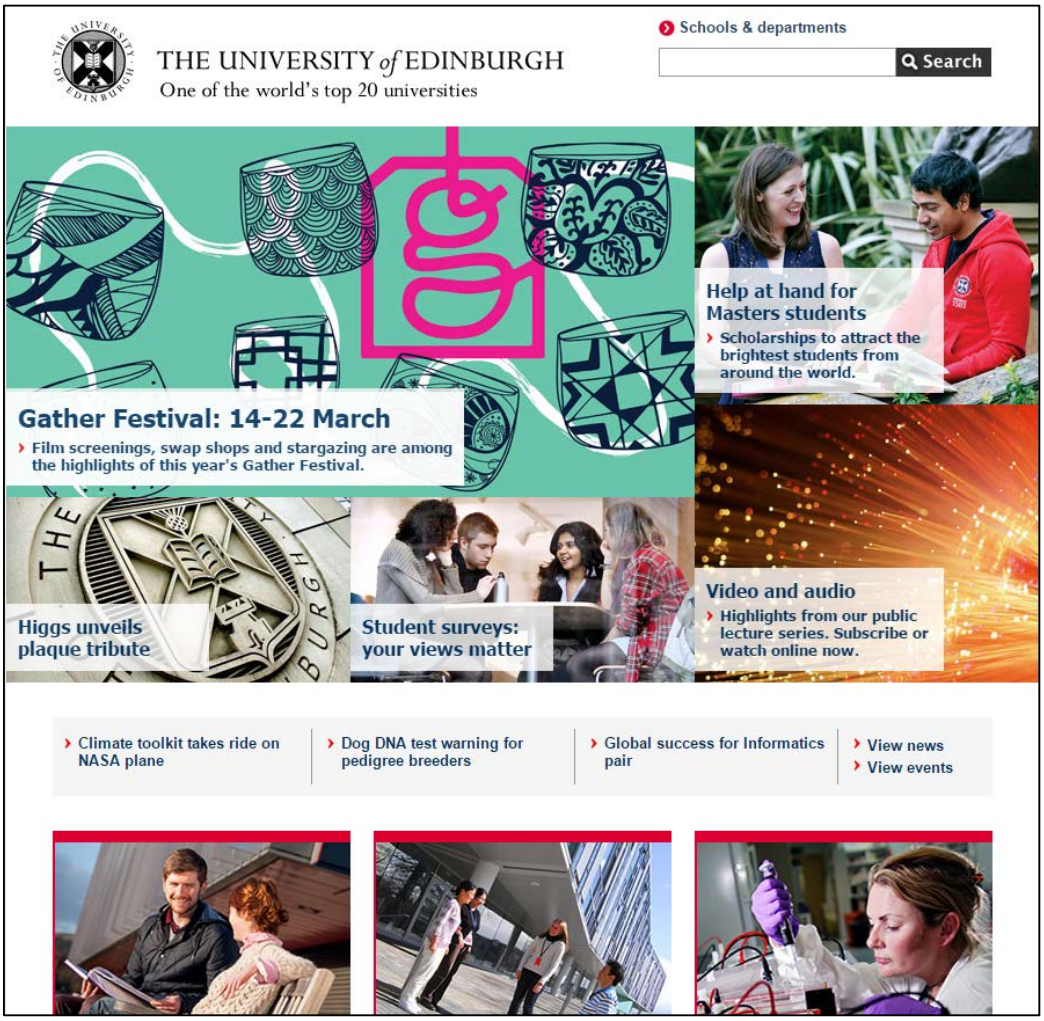
8.2.4 In addition to the crest, there is the standard NHS logo. While this is shared by all NHS organisations, it is highly valuable – one of the most recognisable logos in the world. It confers respectability, familiarity and safety, but also bureaucracy and predictability. Existing branding imagery can be found at Appendix C.

8.2.5 What is lacking in the visual identity of the hospital currently is a sense of innovation, the future, ambition, confidence and development. The crest and the logo give a firm foundation, but a wrap-around identity which is clean, corporate, modern and consistent will give the brand of the organisation a new lease of life.

8.2.6 A piece of design work will be undertaken to overhaul the visual identity of the organisation, incorporating the existing imagery and introducing new design features

to take the brand into the 21st Century. This does not mean replacing the crest or the logo as it stands, but bringing these together with a unifying brand.

8.2.7 An example of an organisation that is embracing heritage along with innovation and the future is the University of Edinburgh. Overleaf is a screengrab of the institution's website. The original logo is still prominent, but a clear colour scheme – red, black and dark blue, along with a modern font and high quality photography bring together a striking visual of a forward thinking organisation with pedigree. This is what ROHNHSFT should aspire to.



8.2.8 ROHNHSFT needs a visual identity that promotes the values of ROH, alongside innovation and the future. Something which will build on the fondness already invoked by the crest and the establishment trustworthiness of the NHS lozenge. This would allow the consistent visual creation of:

- The ROHNHSFT website
- Patient information
- Site signage

- Powerpoint templates
- Poster templates
- Staff communications
- External communications
- Trust publications

8.2.9 A unified visual identity and brand will set the ROH apart from other hospital trusts and healthcare providers nationally, and enhance public understanding of the organisation, as well as promoting its clinical reputation.

8.3 Staff communications and engagement

8.3.1 Internal communications and engagement is critical in any organisation. It is the wider staff team who engage with patients. At ROHNHSFT there are around 900 staff and every year they directly engage with tens of thousands of patients and members of the public. They are therefore the most valuable external communications and engagement tool the organisation has. This means that engaging this group must be treated as a priority, particularly in such a public facing organisation.

8.3.2 The Transformation Programme, which has been set up to deliver the organisation's Five Year Strategic Plan relies heavily on engagement, commitment and contribution of staff from across the Trust.

8.3.3 Data in Appendix A demonstrates that there are improvements to be made in terms of staff engagement. The programme of transformation as laid out by the five year strategy is a means by which staff can engage with the trust as it moves forwards. The challenge is to facilitate this engagement in a constructive and effective way which staff find meaningful. As part of this, the process of change is being used to engage staff – how work is organised and staff's control over design will be a major driver.

8.3.4 In addition the ROH has a recent history of significant change, with several senior changes in the last few years. This presents challenges to a relatively new senior management team looking to engender confidence and positivity.

8.3.5 Ultimately, the key objective is that all staff feel involved, empowered, listened to and informed. Communications mechanisms such as emails, the intranet, noticeboards, text messaging, meetings and engagement sessions are just some of the tools that will be used to facilitate this aim.

8.3.6 The Staff Communications and Engagement Strategy, which underpins this Strategic Framework will go into more detail on how work with staff will be taken forwards, with sections including:

- Objectives
- Staff groups
- Key messages for staff
- Challenges
- A values approach
- Segmentation model
- Communications channels
- Strategic actions

8.4 Patient and public communications and engagement

8.4.1 Many thousands of patients and members of the public pass through or come into contact with the ROHNHSFT every week and evidence suggests that there is a great deal of good will towards the organisation.

8.4.2 Person to person contact is the most valuable way of communicating, and is how many people experience us - through appointments. Other channels are then brought into play to support this, for example letters, phone calls, emails, publications, website, social media.

8.4.3 Work with the press and media is an important area of communications, ensuring that the organisation's reputation is protected and built on as it contributes to the public's sense of how the Trust is doing.

8.4.4 It is critical that all patients and members of the public are able to find information quickly and easily, no matter what means they use – telephone, website, printed document.

8.4.5 Governors and members are an important group within this area of communications, and they need to feel they have the information and communications channels they need at their fingertips to carry out their roles.

8.4.6 The main objective is that people find it easy to find information and give feedback and can be confident of the organisation's honesty and openness.

8.4.7 Data suggests that ROHNHSFT can do better in terms of how it communicates and engages with these audiences, and a strategy of how this can be taken forwards underpins this Strategic Framework. It will include the following sections:

- Objectives
- Patient and public groupings
- Key messages

- Challenges
- Communications channels
- Emergency planning
- Key strategic actions

8.5 Strengthened engagement with GPs

8.5.1 ROHNHSFT relies in large part on referrals from GPs in the greater Birmingham area and beyond for its activity. Given the tariff payment system, it is critical that GPs understand the benefit of referring their patients to a specialist trust such as ROHNHSFT as opposed to another.

8.5.2 There is presently no centralised mechanism for communicating with local, regional and national GPs. Some departments in the hospital do have contacts, but there is not a Trust wide approach. This now needs to be developed.

8.5.3 The key aim here is for ROHNHSFT to be the 'go-to' provider for orthopaedic surgery, whether it is routine or specialist, with GPs clear on the value of working with the hospital, and knowing how to refer patients easily.

8.5.4 The GP Communications and Engagement Strategy which underpins this Strategic Framework contains the following sections:

- Objectives
- Key messages
- Challenges
- Communications channels
- Key strategic actions

8.6 Digital communications and engagement

8.6.1 Digital communications and engagement at ROHNHSFT is in its infancy, and includes the following existing channels:

- ROHNHSFT website plus three or four department specific websites which are not aligned to the central website
- ROHNHSFT intranet for staff use only
- Facebook presence
- Twitter presence
- LinkedIn presence
- Youtube presence
- Text messaging patients

8.6.2 Fragmentation is a big risk with so many digital presences, each of which are managed differently. Alignment is very important, to ensure that wherever people access the hospital, whether physically or digitally, via the web or social media, they have a seamless, consistent impression. Digital communications should form a supportive part of the patient journey, enabling the core work of ROHNHSFT.

8.6.3 The data in Appendix A demonstrates this is a key area of opportunity for the trust and given its growing significance in communications worldwide, it is right that there is a dedicated Digital Strategy. It will contain the following sections:

- Objectives
- Audiences
- Channels
- Website
- Social media
- Mobile phones
- Intranet
- Alignment

Appendices

Appendix A

Benchmarking – where we are now in comparison with others?

ROHNHSFT in the news and media

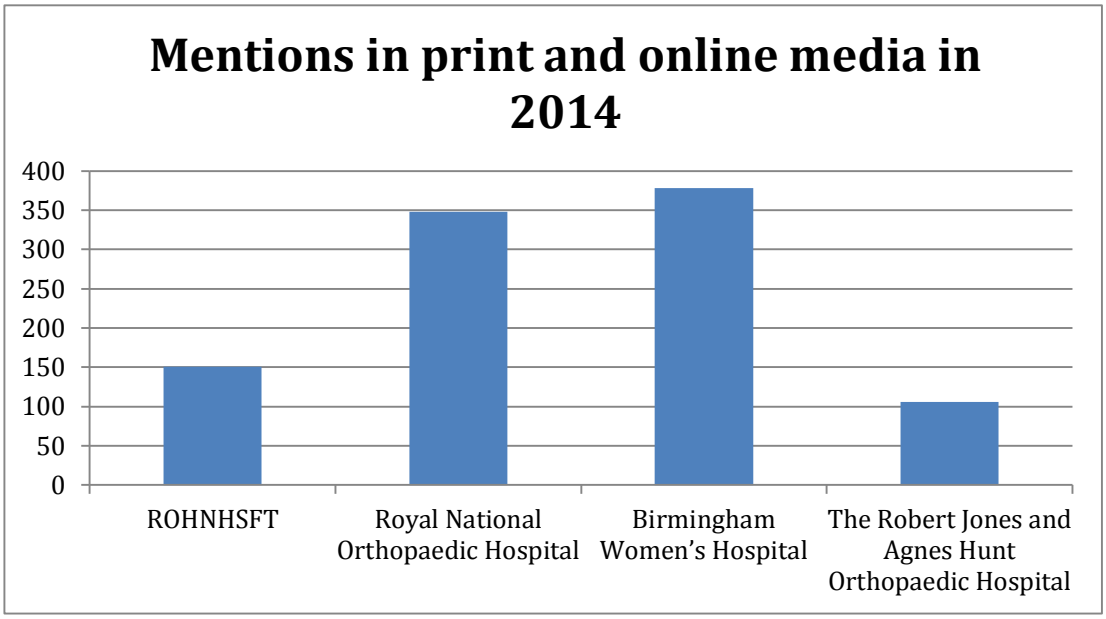
In 2014, the Trust was featured in newspaper and online news stories 151 times, with many of those being reactive stories of a negative nature. In comparison, the Royal National Orthopaedic Hospital was mentioned 348 times and the Birmingham Women's Hospital 348 times – both with more positive stories alongside the reactive ones.

Chart detailing the figures

	ROHNHSFT	Royal National Orthopaedic Hospital	Birmingham Women's Hospital	The Robert Jones and Agnes Hunt Orthopaedic Hospital
Mentions in print and online media in 2014	151	348	378	106

[Data taken from Google News search carried out 27/4/15]

Graphic illustration of figures



ROHNHSFT in social media

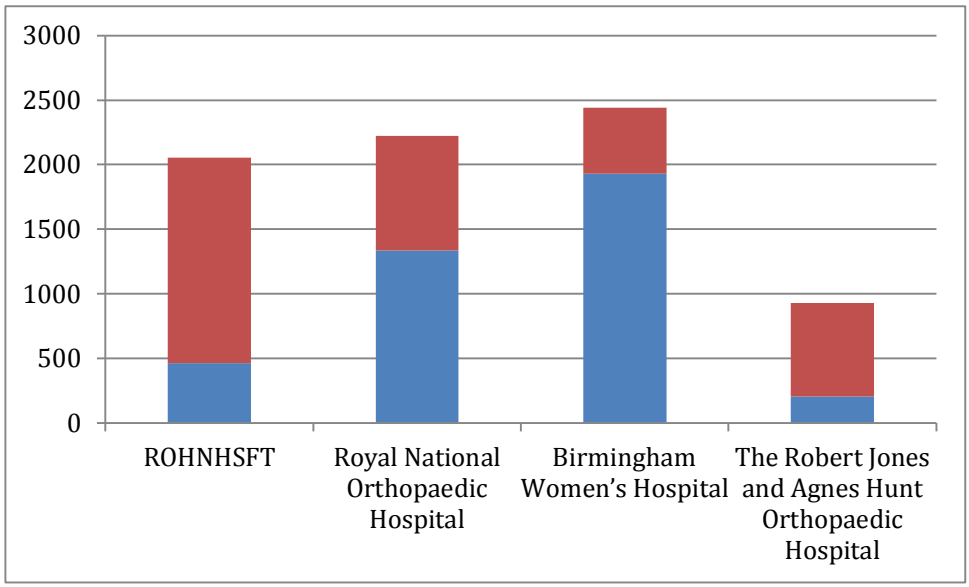
Social media is now more influential than it has ever been before, but due to a lack of proactive input ROHNHSFT has a challenge to pick up the pace.

This table demonstrates a comparison with other similar organisations

	ROHNHSFT	Royal National Orthopaedic Hospital	Birmingham Women's Hospital	The Robert Jones and Agnes Hunt Orthopaedic Hospital
Twitter followers April 2015	462	1333	1929	204
Facebook likes April 2015	1594	892	514	726

[Data gathered at twitter.com and facebook.com April 2015]

This is a graphic illustration of those figures with red representing Facebook likes and blue representing Twitter followers.



Inevitably, the size of institutions and the numbers of patients they see have an impact on the number of people engaging with them, but at ROHNHSFT 1,595 patients visit the hospital every week, and 3,000 people access the website. The fact that less than 2,000 people are engaging through social media would suggest that there is an audience there that is not being reached.

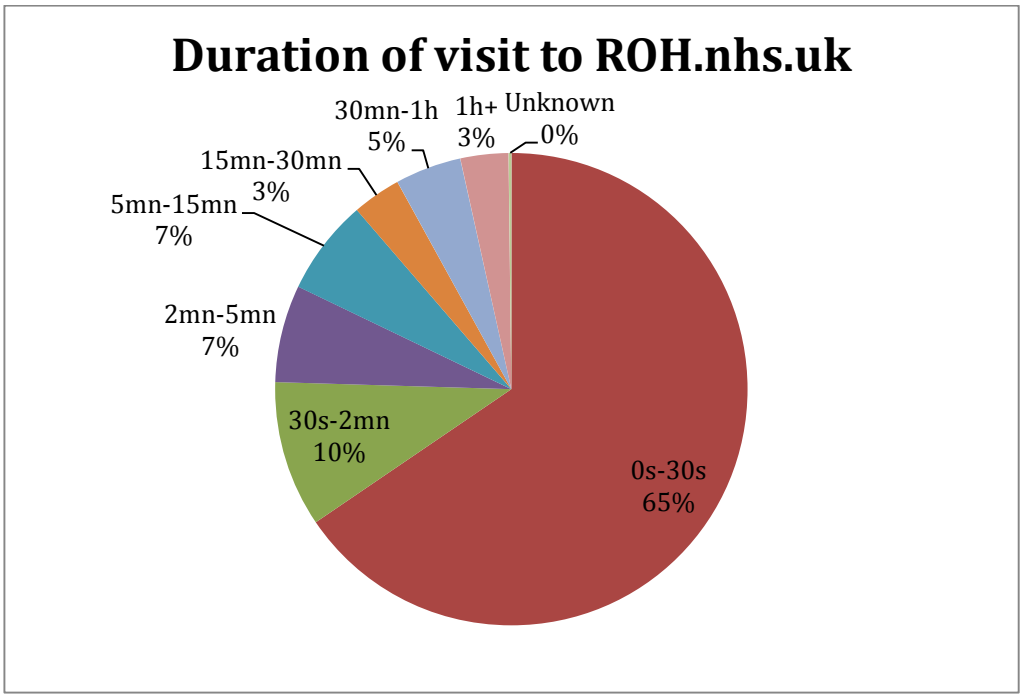
The ROHNHSFT website

It is harder to benchmark a website against others as data is very rarely shared between organisations as standard, and isn't as transparent as that in social media. However, there are measures that can be demonstrated for the Trust website.

The table below details some basic figures for the Trust website. It is worth noting that more people visit the website than visit the hospital site in any given day.

December 2014	ROHNHSFT
Website visits	15,651
Website visitors	8,096
Website hits	57,0377
Average pages viewed per visit	4.77

It is not purely about how many people access the website, it is also important to look at how long people spend on the website. The chart below details this for December 2014.



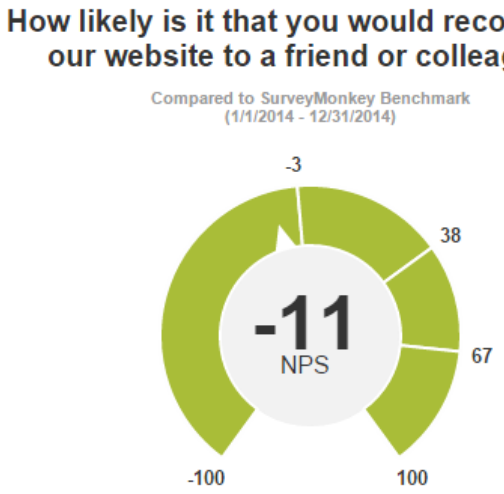
More than half of all visits to the ROHNHSFT website are for less than 30 seconds. This would suggest that some people visit the website and very quickly move onto somewhere else. It could be argued this means they are not easily finding the information they want and looking elsewhere.

In January 2015 a survey was undertaken using standardised questions which are used worldwide to reduce bias in responses. In addition, a Net Promoter Score was also introduced, allowing benchmarking with similar organisations.

The Net Promoter Score (NPS) is calculated as a result of a question which asks how likely a respondent is to recommend an organisation or product – in this case a website – to others. The resulting score can be anywhere from -100 (bad) to +100 (excellent). Benchmarking the ROHNHSFT result with more than 20,000 other similar organisations worldwide shows that it should expect to meet a benchmark score of 28.

One of the most striking responses from the survey is that the ROHNHSFT website has an NPS of -11, which is very poor. In simple terms, this means more people would actively not recommend it to others than would recommend it.

The NPS is shown in more detail here:

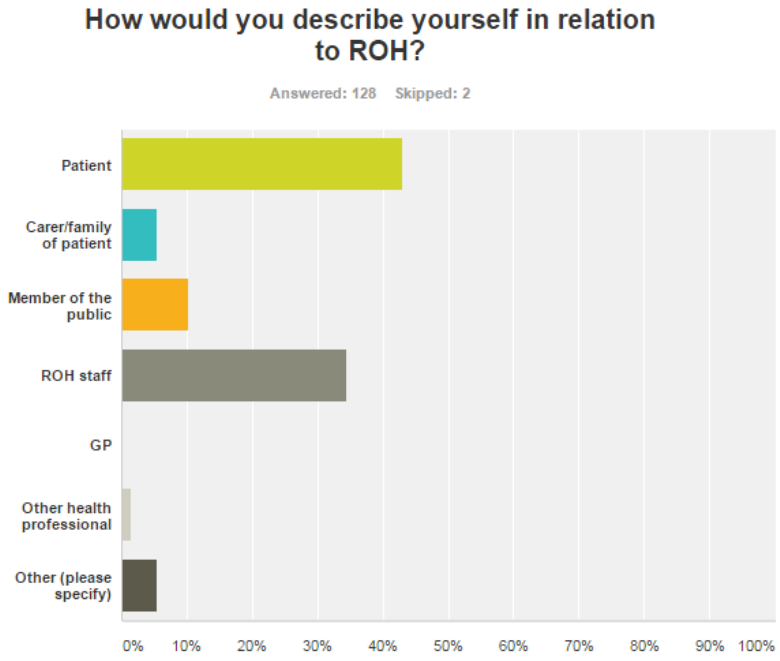


Net Promoter ® Score Quartiles

Minimum	Lower Quartile	Median	Upper Quartile	Maximum
-100	-3.45	37.5	66.67	100

	Detractors (0-6)	Passives (7-8)	Promoters (9-10)	Net Promoter ® Score
Your Score	**40.63%** 52	**29.69%** 38	**29.69%** 38	**-11**
SurveyMonkey Benchmark 20,265 Organizations	**23.53%** 375,034	**24.60%** 392,112	**51.87%** 826,787	**28**

141 people responded to the survey, and were divided as demonstrated here:



58% of all respondents were external, so they were from patients, carers, families and the public. This is significant, as it gives a sense of the external view of the website.

15% of all respondents felt the website did not meet their needs.

22% - more than 1 in 5 – did not find it easy to find what they were looking for on the website.

31% - more than 3 in 10 – found it took them more time than expected to find what they were looking for.

20% - 1 in 5 – did not find the website visually appealing.

9% - almost 1 in 10 – did not find the information on the website easy to understand.

The vast majority of respondents trust the content on the website – 99% - showing that trust in the ROHNHSFT brand is strong, giving a good basis to work from.

53 of the respondents took the time to make comments on where they felt that improvements could be made. These comments focussed on four themes predominantly:

Content (43%) – for example "As first time visitors we can find no information about the layout of the site and where to find wards etc. the interactive site map is none existent so I am left with no idea where to find the ward where my daughter is."

Design (26%) – for example "Not so intuitive for patients and service users. Staff have a small advantage but things still sometimes where you'd expect them to be! An overhaul of

branding and look as well as current content being up to date will be great and I look forward to it."

Navigation (23%) – for example "the look of the website needs to be improved. Streaming video of patient information could be included. The website needs to be more intuitive."

Accessibility (11%)- for example " I looked at it on both a PC and an android phone, and although the site was optimised for mobile viewing the menu button didn't function when viewing it on the phone, which made navigating problematic. Couldn't find anything about the governance of the hospital"

Engagement with the survey was good, with 27 people volunteering to give further information in a forthcoming focus group.

Staff communications and engagement

The NHS Staff survey is carried out each year, and a random selection of staff at the Trust take part. The results provide a useful benchmark. One question in particular is a good barometer in terms of how well an organisation is communicating, and that is question 11, which measures awareness and communication between staff senior managers. It is not a perfect measure, but it gives a comparison with other similar NHS organisations across the UK. The areas shaded in red are where ROHNHSFT is performing worse than similar organisations, the areas shaded green indicate ROHNHSFT performing better than similar organisations.

Question 11(a) 2014 results

		a) I know who the senior managers are here				
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
		%	%	%	%	%
	ACUTE (SPECIALIST) TRUSTS	2	7	8	53	31
RRJ	The Royal Orthopaedic Hospital NHS Foundation Trust	3	7	14	50	26

Question 11(b) 2014 results

		b) Communication between senior management and staff is effective				
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
		%	%	%	%	%
	ACUTE (SPECIALIST) TRUSTS	8	20	30	33	9
RRJ	The Royal Orthopaedic Hospital NHS Foundation Trust	9	21	29	34	8

Question 11(c) 2014 results

		c) Senior managers here try to involve staff in important decisions				
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
		%	%	%	%	%
	ACUTE (SPECIALIST) TRUSTS	10	21	33	28	8
RRJ	The Royal Orthopaedic Hospital NHS Foundation Trust	13	20	32	26	9

Question 11(d) 2014 results

		d) Senior managers act on staff feedback.				
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
		%	%	%	%	%
	ACUTE (SPECIALIST) TRUSTS	9	17	40	27	7
RRJ	The Royal Orthopaedic Hospital NHS Foundation Trust	11	20	36	25	8

Question 11(e) 2014 results

		e) Senior manager are committed to patient care				
		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
		%	%	%	%	%
	ACUTE (SPECIALIST) TRUSTS	4	6	27	44	19
RRJ	The Royal Orthopaedic Hospital NHS Foundation Trust	5	5	30	45	16

These results along with many others in the staff survey are amalgamated and turned into an overall staff engagement score. In 2013 for ROH the score was 3.80 and in 2014 the score was 3.81. This is against a national average for a specialist acute trust of 3.95.

Anecdotally and through other pieces of research, engagement from staff has been patchy, with some examples of that below:

Some staff engaged with the website survey, and significantly two of them (4% of staff respondents) specifically stated they would not take part in a focus group about the website because they believed there was no chance of change as a result.

A survey was released with the new and improved ROH Life staff magazine, which was emailed to all staff, promoted on the intranet, and placed in hard copy in all departments. Just 18 staff took the time to complete the survey, which is around 2% of the workforce.

Appendix B

Feedback from the public when the ROHNHSFT crest was shared on Facebook

Appendix C

Existing branding imagery

The ROHNHSFT crest

The ROHNHSFT NHS logo

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

The NHS colour palette

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 2 September 2015 **ENCLOSURE NUMBER: 5**

SUMMARY OF REPORT TO TRUST BOARD

SPONSORING DIRECTOR:	**Jo Chambers, Chief Executive**
AUTHOR(S):	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
SUBJECT:	**Well-Led Framework**

SUMMARY

This paper outlines the key implications of the publication of the revised Monitor Well Led Framework guidance and the proposed actions the Trust should take, together with the associated timescales to satisfy the guidance.

IMPLICATIONS

The Trust is required to undertake a review of its governance arrangements every three years. Failure to do this will provoke additional scrutiny and potential enforcement action under the Risk Assessment Framework regulations.

RECOMMENDATIONS

- NOTE in retrospect the plans for the introduction of the Well led Framework for governance reviews
- DISCUSS the proposed timetable and approach to the Trust's governance review
- AGREE to discuss an initial self-assessment against Well Led in the Board workshop planned for January 2016

FOR DISCUSSION

Enc 5 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

THE WELL LED FRAMEWORK FOR GOVERNANCE REVIEWS

Report to Trust Board on 2 September 2015

1 EXECUTIVE SUMMARY

1.1 Monitor published an updated version of the 'Well Led Framework for Governance Reviews: guidance for NHS foundation trusts' in April 2015. The guidance provides a harmonised view from the perspective of Monitor, the National Trust Development Authority (TDA) and the Care Quality Commission (CQC) as to what constitutes a well-led organisation in terms of its leadership, management and governance arrangements.

The Well Led Framework links closely to the Monitor's Risk Assessment Framework, which sets out the expectation that NHS foundation trusts carry out an external review of their governance every three years.

This paper outlines the key implications of the publication of the revised Well Led Framework guidance and the proposed actions the Trust should take, together with the associated timescales to satisfy the guidance.

It is suggested that the review should commence in the summer of 2016 and be concluded by Quarter 4 of 2016/17 to satisfy the timescales set out in the Well Led Framework guidance.

2 BACKGROUND

2.1 The Well Led Framework was first published by Monitor in May 2014, in response to the increase in governance concerns across the FT sector, with 1 in 4 FTs at the time having been subject to formal regulatory action and a finding that the majority of issues leading to regulatory action occurred at least two years post-authorisation.

2.2 Updated guidance was published in April 2015, which followed consultation with providers and work undertaken between Monitor, CQC and TDA to harmonise their view of a well led organisation, including the tools and processes by which this might be tested. The benefits of the aligned view were set out to be that:

- The framework helps organisations to improve as it clearly outlines expectations and allow them to benchmark themselves against a common expectation of what good looks like.

- NHS providers can be confident that Monitor, TDA and CQC all have a consistent view which forms the basis of regulatory judgements on well led. As a regulatory tool it allows an independent check of how an organisation is performing and facilitates the development action plans to turn around performance.

- Having a joined-up approach ensures regulatory coordination and a streamlined approach for NHS providers.

3 THE WELL LED ASSESSMENT PROCESS

3.1 The Well Led Framework builds on, and replaces the Board Governance Assurance Framework (BGAF) for aspirant FTs and the Quality Governance Framework (QGF) with which the Board may be familiar, as these are now effectively incorporated within the framework.

3.2 The assessment process set out in Monitor's guidance summarised in Figure 1 below:

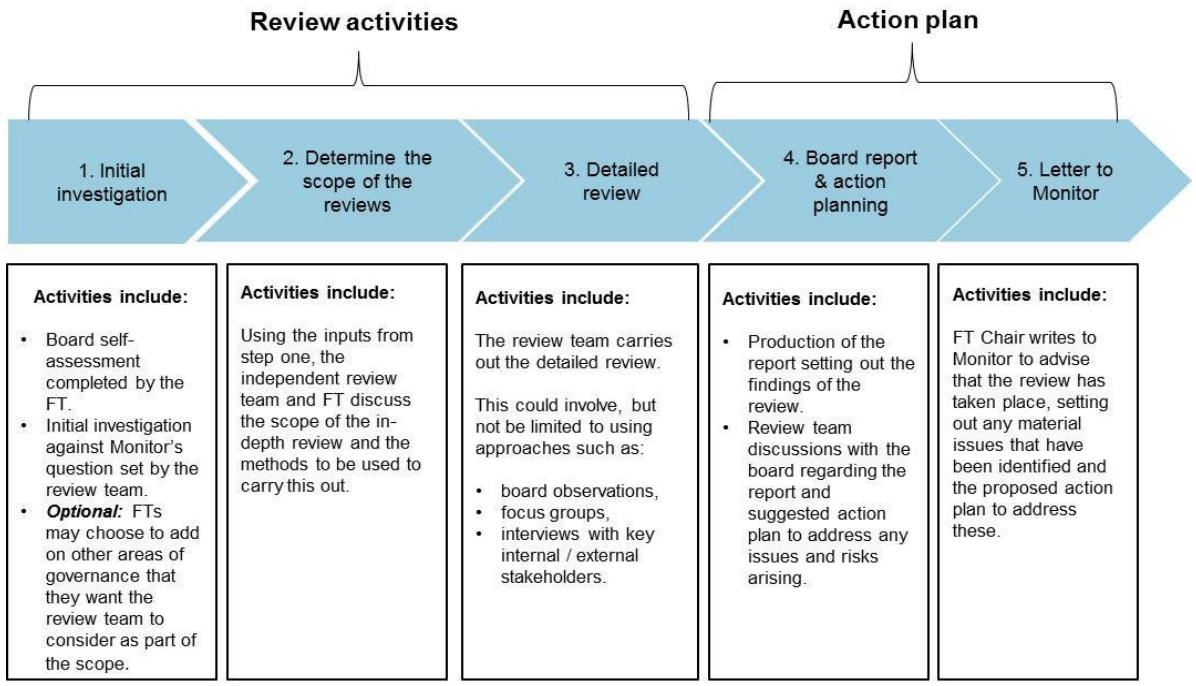


Figure 1: Monitor's Well-Led assessment process

3.3 The process comprises an initial self-assessment by the Board against ten question areas within four domains. The use of these domains and questions is mandatory, although Monitor makes it clear that trust may choose to add questions to cover any other known areas of concern or test the robustness of other elements of the governance framework. Where trusts choose to exclude core elements of the

framework, Monitor asks that they be notified, in line with a 'comply or explain' approach, which is defined as:

- **comply** – Monitor strongly encourages all NHS foundation trusts to carry out board governance reviews every three years using the guidance

- **explain** – means that a foundation trust should give a considered explanation if it uses alternative means to assure itself regarding its governance, or if it chooses to omit material components of the framework (eg one or more of the ten questions)

3.4 The Monitor question set to be used during the review is set out below in Table 1, and as the Board will note, it closely resembles the approach taken within the QGF assessments. Monitor provides a set of outcomes and examples of good practice to help organisations form a view of the strength of their arrangements against each domain and whether there are any gaps that need to be addressed.

Table 1: The four domains of the well-led framework for governance reviews

STRATEGY & PLANNING	CAPABILITY & CULTURE	PROCESS & STRUCTURES	MEASUREMENT
Does the board have a credible strategy to provide high-quality, sustainable services to patients and is there a robust plan to deliver? Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	Does the board have the skills and capability to lead the organisation? Does the board shape an open, transparent and quality-focused culture? Does the board support continuous learning and development across the organization?	Are there clear roles and accountabilities in relation to board governance (including quality governance?) Are there clearly defined, well understood processes for escalating and resolving issues and managing performance? Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	Is appropriate information on organisational and operational performance being analysed and challenged? Is the board assured of the robustness of information?

3.5 Monitor suggests that trusts complete the self-assessment as the first part of the process, and use the findings to inform the procurement of an external reviewer. In terms of making the assessment, it is proposed that a scoring mechanism be adopted in a way analogous that that of QGF, with the ambition to achieve a score

of 3.5 or below to mirror the requirement of aspirant FTs to progress the process for authorisation.

3.6 The external reviewer should be independent of the Board, and should not have been involved in audit or governance work with the Trust in the past three years. While Monitor's guidance gives a number of methods that the external reviewer may use to carry out the review, the precise methods used are for agreement between the reviewer and the Trust, and will depend on whether the reviewer has their own diagnostic tools and methods to carry out a robust review.

3.7 Monitor does not have any plans to set up an accredited list of reviewers, and it is for trusts to procure a suitable independent reviewer to carry out this stage of the process. Monitor does, however, set out a number of criteria which trusts should consider when choosing an independent reviewer to carry out reviews against the framework which are related to capacity, objectivity & independence, an understanding of the Monitor licence & wider healthcare, relevant experience and credibility.

3.8 There is no prescribed method for rating the reviews. However, Monitor suggests rating the self-assessment stage using a red/amber/green rating as used in the Quality Governance Framework.

3.9 Findings from the detailed review are then included in a report for discussion by the Board, and action plans are developed where appropriate to address any risks and issues arising from the review.

3.10 Following the review, Trusts have 60 days to write to Monitor confirming 'no material governance concerns' or explaining what the concerns are and the actions planned to address those concerns.

4 ENGAGEMENT OF GOVERNORS WITH THE WELL-LED FRAMEWORK ASSESSMENT

4.1 There are a number of opportunities to involve the Trust's Council of Governors with the preparations for the assessment against the Well-Led framework, including:

- Involvement in the appointment of the external review team;
- Interview with Lead Governor;
- External review team observing a Council of Governor Meeting;
- Convening a Focus Group with Council of Governors

Additionally, there would be an expectation that members of the Council of Governors would contribute to the responses to the ten questions that form the assessment, including for instance:

- Confirming that the planning process takes account of regular engagement with external and internal stakeholders.
- Providing a view on whether the Board has regular and transparent engagement on strategy and direction with patient groups and the Council of Governors
- Commenting on whether Board members spend time developing the relationship with Governors.
- Confirming that governors are trained and supported in holding non-executive directors to account and asking them the right questions to check they are in turn holding the Executive Directors to account for quality and operational delivery.
- Providing a view as to whether governors consider that they receive sufficient information in a timely fashion to carry out their role

5 FINANCIAL IMPLICATIONS

5.1 Given that there will be a need to procure the services of an external reviewer, this will attract a cost that will need to be factored into the annual planning work, which if the Board agree to the proposed timetable below, will fall into the third and final quarters of 2016/17.

5.2 Research from organisations who have already engaged a partner to undertake the independent review would suggest that a provision of £50k - £70k will need to made for the work.

6 TIMETABLE AND RECOMMENDED ACTIONS

6.1 The Trust has three years from the publication of the initial Well-Led framework guidance in May 2014 to conduct a governance review, meaning that the latest that the review must be held in May 2017.

6.2 Some key posts which will oversee plans to strengthen the Trust's governance arrangements over the next 12-18 months have recently been filled, namely those to the substantive role of Director of Nursing & Clinical Governance, Deputy Director of Nursing & Clinical Governance and the Associate Director of Governance & Company Secretary. It is envisaged that these individuals will form a key part of the plans to organise the Well-Led governance review.

6.3 To allow the measures to strengthen key governance processes to embed and to avoid the year end activities associated with finalising the prior year accounts and preparation of the annual report, it is proposed that the governance review be concluded by February 2017.

6.4 Taking the above into account, the timetable for the preparation and undertaking of the Well-Led governance review is proposed to be:

Activity	Timescale
Early view self-assessment and action plan at Board workshop	January 2016
Initial presentation of the plans to the Board of Governors & Trust Board	May 2016
Register intent to undertake review with Monitor	Before June 2016
Evidence gathering and self-assessment against framework	June – July 2016
Develop action plan to address gaps identified	August
Self-assessment & action plan presented to Trust Board	September 2016
Select and procure external independent reviewer	September – October 2016
External reviewer commences & undertakes field work	October – December 2016
External review report and action plan presented to Trust Board	January 2017
Delivery of action plan to address any material issues	January 2017 onwards
Chair writes to Monitor to advise review has taken place and to outline any plans to address material issues & gaps	January – February 2017
Work informs the Annual Governance Statement and the end of year declaration to Monitor	April 2017

6.5 The plans and proposed timetable above do not factor in the current ongoing work around the Quality Governance Framework, however this is expected to map over tightly into the new framework and therefore there is benefit in continuing to deliver the key activities contained in the QGF action plan pending the commencement of the well-led assessment.

7 RECOMMENDATIONS

7.1 The Trust Board is asked to:

- NOTE in retrospect the plans for the introduction of the Well led Framework for governance reviews
- DISCUSS the proposed timetable and approach to the Trust's governance review
- AGREE to discuss an initial self-assessment against Well Led in the Board workshop planned for January 2016

Simon Grainger-Lloyd
Associate Director of Governance & Company Secretary

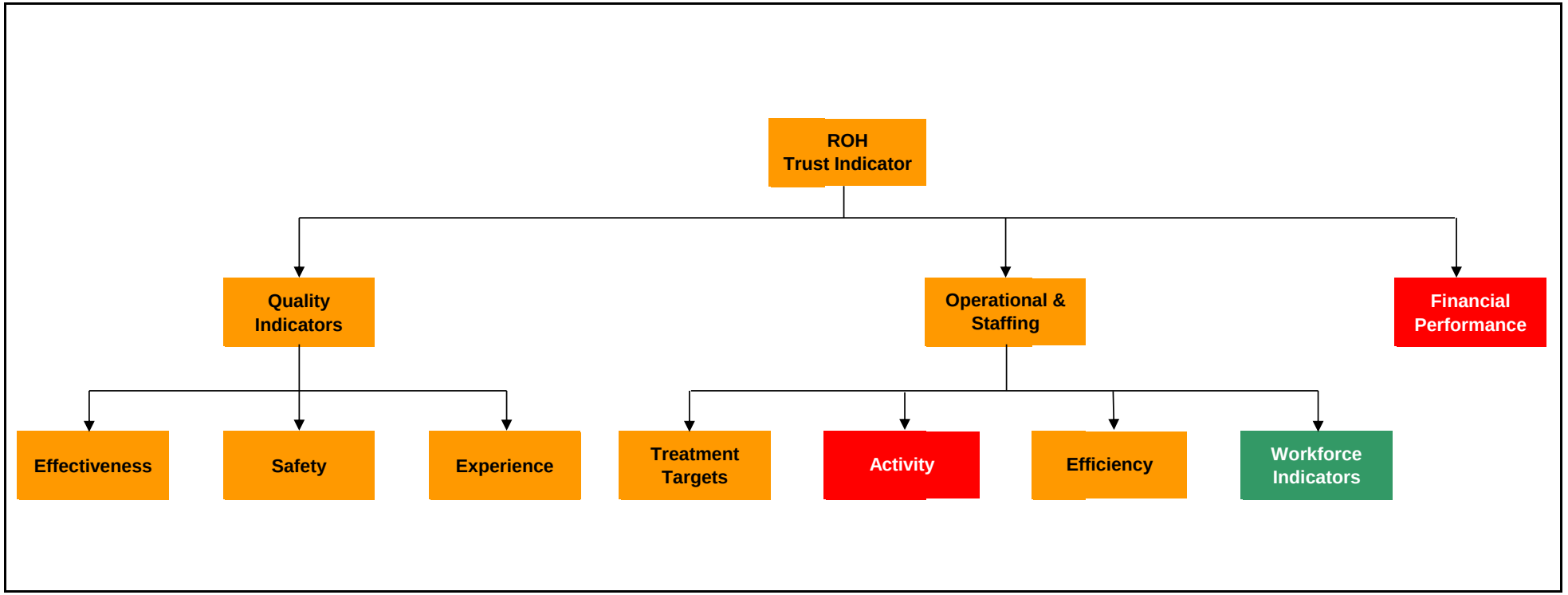
24 August 2015

Appendix A

The Monitor Well Led guidance can be found at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/422057/Well-led_framework_April_2015.pdf

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending July 2015



Quarterly Detailed Report
Executive Summary as at July 2015

Headlines

- NHSE has removed sanctions on the Admitted & Non Admitted standards (ANAS), advised that they are being abolished, and asked all providers to focus on the incomplete standard. ROH is clearing backlogs where clinically appropriate to do so; this has necessitated the breaching of the ANAS in this period .
- The backlog has improved, but is still red rated.
- For the year to date the Trust made a deficit of £1,571k compared to a planned deficit of £477k.

	July 2015				
Monitor Compliance Framework Targets	**Target**	**Actual - Month**	**Actual - Quarter**	**Score**	**Detail Page**
Referral to treatment time - Non Admitted %	95%	93.91%	93.91%	1	6
Referral to treatment time - Admitted %	90%	89.48%	89.48%	1	6
Referral to treatment time - Incomplete Pathways %	92%	93.59%	93.59%	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%	97.8%*	97.8%*	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	Amber
Indicative Monitor Financial Risk Rating	3

		July 2015			
Key Trust Targets		**Target**	**Actual**	**Trend**	**Detail Page**
Safety, Experience & Effectiveness	SIRIs	0-2	2	↑	3
	Complaints	<=12	6	↓	4
	CQUINS	100%	90%	→	11
	Total Unexpected Hospital Deaths	0	0	→	5
Efficiency & Workforce	Total Backlog Patients	<400	468	↑	6
	Incomplete 14 - 18 Week Waiters	<450	421	↑	6
	Total Admitted Patient Care Patients vs Plan	100%	96.5%	↑	7
	Unused Theatre Sessions	<44	40	↑	8
	Sickness	3.7%	4.0%	↑	9
Financial	Surplus	(£477k)	(£1,571k)	↓	10
	CIP	£744k	£454k	↓	10
	Agency Expenditure	£295k	£431k	↓	11
	Locum Doctor Expenditure	£145k	£159k	↓	11

Trust Summary

The non-admitted and admitted RTT targets were missed, although the Trust is no longer fined against these targets.The backlog has improved, but is still red rated.

For the year to date the Trust made a deficit of £1,571k compared to a planned deficit of £477k.

All admitted and outpatient activity was behind plan except day cases.

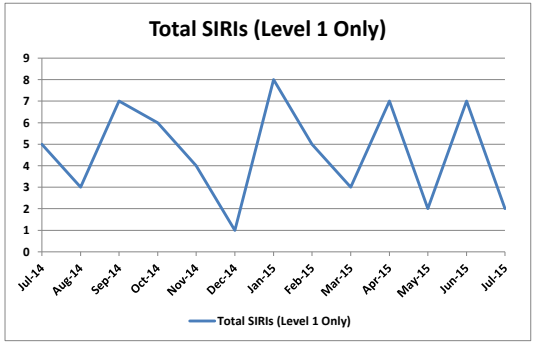
Sickness absence has improved and is now green rated.

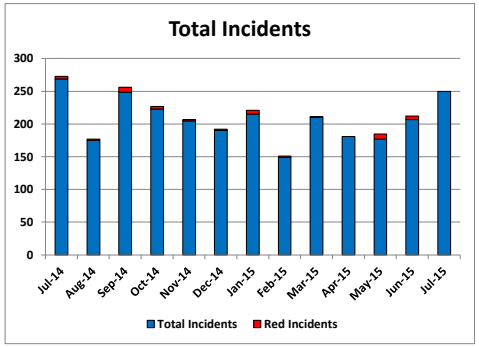
Quarterly Detailed Report
Safety Indicators as at July 2015

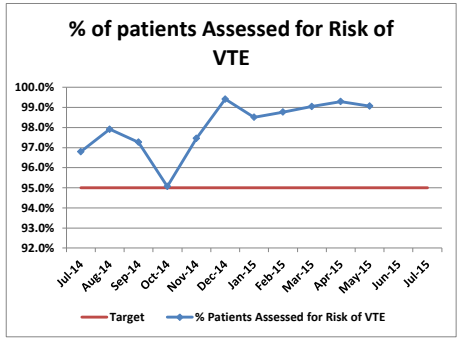
Headlines

- Patient falls have increased and remain red.
- The total incidents has increased and remains green rated.
- The level of SIRIs this month has decreased from 7 to 2, and has therefore become returned to being green.

	Monitor	National	CQC Standard		Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	15/16 Full Year Position
Safety		N	4,16	Never Events	0	0	0	0	0	1	0	0	0	0	0	0	0	0
			4,16	Total SIRIs (Level 1 Only)	5	3	7	6	4	1	8	5	3	7	2	7	2	5
			4,16	SIRI per 1000 bed days	1.30	0.86	1.90	1.58	1.07	0.31	2.35	1.67	0.88	2.20	0.60	1.98	0.48	**1.31**
			4,16	Total Incidents	269	175	249	223	205	190	215	149	210	181	177	207	250	**204**
			4,16	Incidents per 1000 bed days	69.74	50.23	67.52	58.73	54.71	59.69	63.05	49.73	61.67	56.83	53.43	58.41	60.10	**57.19**
			4,16	Red Incidents	4	2	7	4	2	2	6	2	1	0	8	5	0	**3**
			9,16	Total Medicine Incidents Reported	22	17	12	16	16	20	15	18	30	24	13	26	39	26
			9,16	Medicine Incidents Reported per 1000 bed days	5.70	4.88	3.25	4.21	4.27	6.28	4.40	6.01	8.81	7.54	3.92	7.34	9.38	**7.04**
				Medicine Incidents with Harm	7	6	4	0	5	5	2	2	3	5	0	0	0	**5**
		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	96.80%	97.91%	97.27%	95.07%	97.46%	99.41%	98.51%	98.77%	99.04%	99.29%	99.06%	98.33%		**98.89%**
			9	Incidence of Hospital Related VTE	2	2	3	2	1	1	5	1	3	3	4	6	2	**15**
			4	Patient Falls - Inpatients	6	5	13	12	7	5	3	4	9	5	1	5	7	**5**
			4	Patient Falls per 1000 bed days	1.56	1.44	3.52	3.16	1.87	1.57	0.88	1.34	2.64	1.57	0.30	1.41	1.68	**1.24**
				Avoidable Patient Falls with Harm	2	2	2	0	0	0	0	1	2	1	0	0	1	**1**
			4,16	% Harm Free Care	95.88%	98.25%	98.04%	97.96%	94.50%	91.95%	97.89%	98.94%	97.14%	97.26%	98.02%	95.05%	95.24%	**96.39%**







Safety Commentary

VTE Risk Assessment - Reported one month in arrears

The level of SIRIs this month has decreased from 7 to 2, and has therefore become returned to being green.

The total incidents has increased and remains green rated.

Medicine incidents have increased and remain green rated.

Patient falls have increased and remain red.

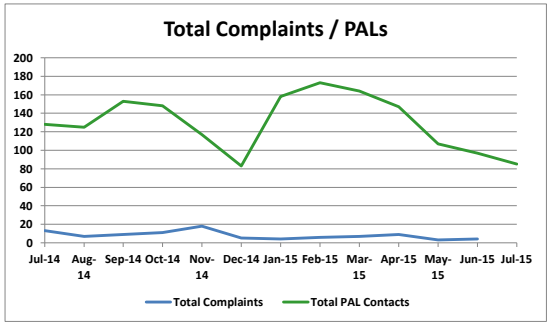
Additional information on all of the above is included in the Quality Report.

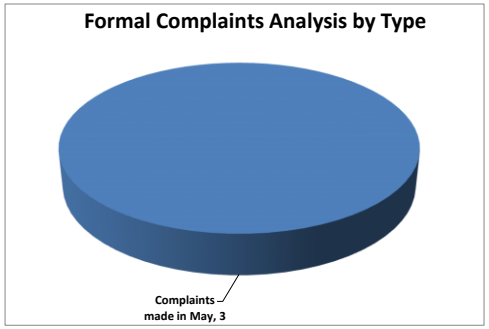
Quarterly Detailed Report
Experience Indicators as at July 2015

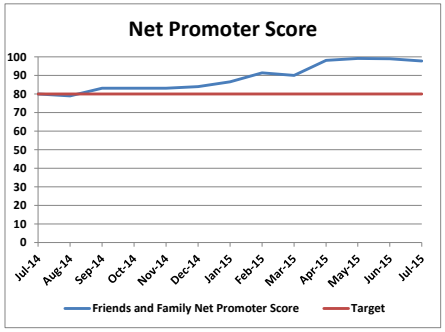
Headlines

- Total compliments increased from 106 to 251.
- Complaints have increased, although remain green rated.
- PALs contacts are down from 97 to 85.

	Monitor	National	CQC Standard		Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	15/16 Full Year Position
Experience			17	Complaints to Compliments Ratio	1:31	1:73	1:31	1:42	1:29	1:107	1:108	1:75	1:60	1:69	1:94	1:27	1:42	**1:57**
			17	Total Complaints	13	7	9	11	18	5	4	6	7	9	3	4	6	**6**
			17	Complaints reverted to informal <48 hrs	0	0	1	1	0	0	0	0	0	0	0	0	0	**0.0**
			17	Formal	13	7	8	10	18	5	4	6	7	9	3	4	6	**6**
			17	Complaints per 1000 bed days	3.37	2.01	2.44	2.90	4.80	1.57	1.17	2.00	2.06	2.83	0.91	1.13	1.44	**0.39**
				Complaints Response Time (Average No of Days)	41	24		109	67	69	24	27	39	35	48	83	77	**61**
			17	Total PAL Contacts	128	125	153	148	117	83	158	173	164	147	107	97	85	**109**
			17	PALS Contacts per 1000 bed days	33.19	35.88	41.49	38.98	31.22	26.08	46.33	57.74	48.16	46.15	32.30	27.37	20.43	**31.56**
				Total PALS Concerns	88	73	84	68	67	52	79	96	86	59	50	64	55	**57**
			17	Total Compliments	409	511	276	465	522	534	433	449	418	619	283	106	251	**315**
			17	Compliments per 1000 bed days	106.04	146.67	74.84	122.47	139.31	167.77	126.98	149.87	122.76	194.35	85.42	29.91	60.34	**22.16**
				Food - Real Time Patient Survey	94.2%	95.0%	95.5%	98.3%	96.8%	96.5%	96.4%	98.8%	94.7%	98.8%	98.8%	96.2%	98.8%	**98.2%**
			17	Friends and Family Net Promoter Score	80	79	83	83	83	84	87	91	90	98	99	99	98	**98**
				Friends and Family Response Rate	53.0%	52.0%	46.5%	51.7%	58.0%	50.3%	61.0%	59.6%	52.0%	45.3%	48.0%		34.4%	**42.6%**







COMPLAINTS
Complaints increased from 4 to 6, although this remains green rated.

COMPLIMENTS
Total compliments increased from 106 to 251.

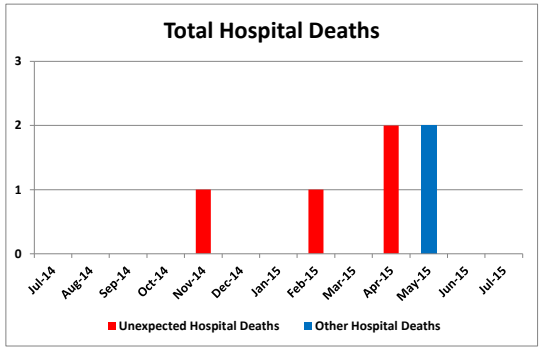
Further information on experience is included in the Quality Report.

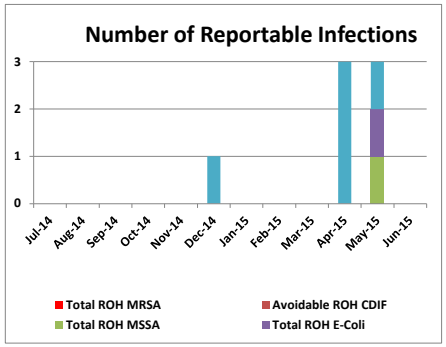
Quarterly Detailed Report
Effectiveness Indicators as at July 2015

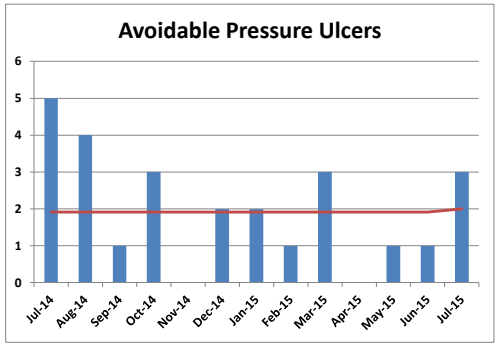
Headlines

- There were no patient deaths in month.
- There were no cases of C diff or MRSA in month
- The Trust had 1 grade 3 or 4 pressure ulcer in month

	Monitor	National	CQC Standard		Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	15/16 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	0	0	0	1	0	0	1	0	2	2	0	0	1.0
			4,18	Hospital Deaths per 1000 bed days	0.00	0.00	0.00	0.00	0.27	0.00	0.00	0.33	0.00	0.63	0.60	0.00	0.00	0.07
			4,18	Unexpected Hospital Deaths	0	0	0	0	1	0	0	1	0	2	0	0	0	0.5
				Other Hospital Deaths	0	0	0	0	0	0	0	0	0	0	2	0	0	2
			8	MRSA % Screened	122.20%	107.00%	103.00%	124.90%	125.30%	111.00%	118.40%	121.80%	131.80%	175.00%	173.03%	169.60%	192.00%	177%
	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	0	0	0	0	0	0	0
				Unavoidable ROH CDIF	0	0	0	0	0	1	0	0	0	3	1	0	0	4
			8	Total ROH MSSA	0	0	0	0	0	0	0	0	0	0	1	0	0	1
			8	Total ROH E-Coli	0	0	0	0	0	0	0	0	0	0	1	0	0	1
			8	HCAIs not attributable to ROH	0	0	1	0	0	0	0	0	0	0	0	0	0	0
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	1	0	0	2	0	0	0	0	0	0	0	0	1	1
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	4	4	1	1	0	2	2	1	3	0	1	1	2	4
			4	Avoidable Pressure Ulcers per 1000 bed days	1.30	1.15	0.27	0.79	0.00	0.63	0.59	0.33	0.88	0.00	0.30	0.28	0.72	0.35
				% Completion of WHO Checklist	96.23%	97.69%	95.92%	97.96%	98.23%	97.81%	99.36%	98.90%	99.57%	99.64%	97.42%	99.12%	99.15%	98.83%







Effectiveness Commentary

There were no patient deaths in month.

There were no cases of C diff or MRSA in month.

There was 1 level 3 or 4 pressure ulcer in month.

The percentage completion of the WHO checklist remains green.

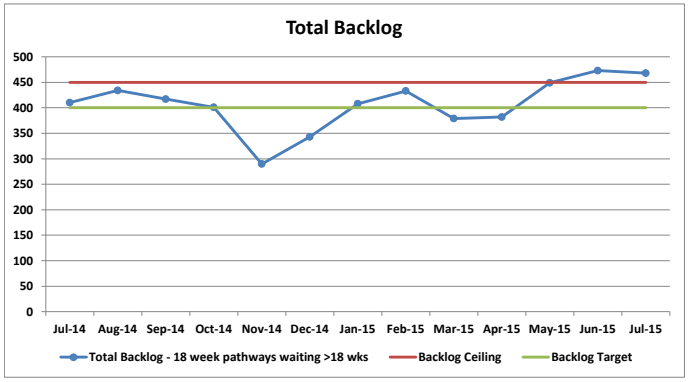
Further information on effectiveness is included in the Quality Report.

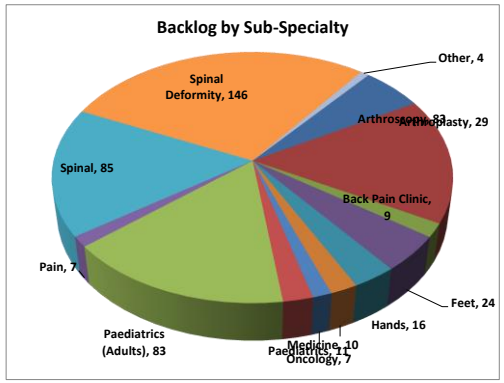
Quarterly Detailed Report
Treatment Targets as at July 2015

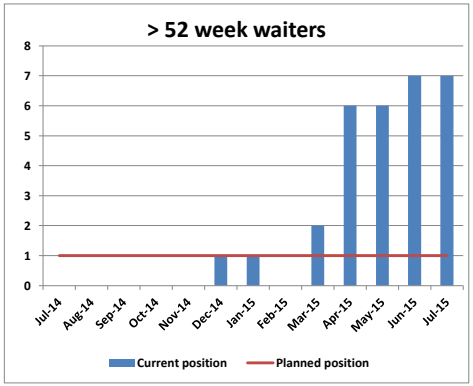
Headlines

- All cancer targets were met
- The non-admitted and admitted RTT targets were missed, although the Trust is no longer fined against these targets.
- The backlog has improved, but is still red rated.

	Monitor	National	CQC Standard		Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	15/16 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	0					1	1		2	6	6	7	7	7
				Referral to treatment waits over 45 weeks	4	4	8	11	6	12	13	11	10	11	22	16	19	19
	M	N	4	Referral to treatment time - Non Admitted %	95.75%	95.24%	95.05%	92.68%	92.65%	95.52%	95.58%	95.11%	95.07%	93.49%	96.12%	95.36%	93.91%	94.95%
	M	N	4	Referral to treatment time - Admitted %	93.21%	91.57%	91.96%	91.63%	86.32%	93.05%	92.17%	91.61%	90.17%	90.12%	91.47%	90.58%	89.48%	90.71%
	M	N	4	Referral to treatment time - Incomplete Pathways %	94.52%	94.09%	94.26%	94.67%	95.96%	95.20%	94.27%	93.94%	94.55%	94.38%	93.78%	93.69%	93.59%	93.94%
			4	Non admitted Backlog - Pathways waiting >18 wks	173	168	168	137	110	119	149	153	124	115	115	144	176	176
			4	Admitted Backlog - Pathways waiting >18 wks	237	266	249	264	180	224	259	280	255	267	334	329	292	292
			4	Total Backlog - 18 week pathways waiting >18 wks	410	434	417	401	290	343	408	433	379	382	449	473	468	468
			4	Incomplete 14 -18 Week Waiters	536	471	594	531	438	520	581	540	522	396	466	461	421	421
				Non Admitted Median Wait (Weeks)	8.39	8.46	9.00	8.92	8.10	8.45	9.21	9.07	7.72	8.59	8.64	8.43	8.22	8.22
				Admitted Median Wait (Weeks)	9.54	9.69	10.64	10.06	10.79	10.61	11.12	11.59	10.63	9.60	9.98	9.50	9.33	9.33
				Incomplete Median Wait (Weeks)	5.81	6.24	6.30	5.63	5.44	6.40	6.66	5.53	5.60	5.65	5.50	5.43	5.75	5.75
	M	N	4	Cancer 2 week (all cancers)	100.00%	100.00%	100.00%	100.00%	100.00%	97.30%	100.00%	100.00%	100.00%	100.00%	97.20%	100.00%	97.8%*	98.61%
	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%*	100.00%	100%*	100.00%	100%*	100.00%
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	94.12%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100%*	100.00%	100%*	100.00%
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	93.30%	85.70%	90.90%	75.00%	100.00%	83.33%	100.00%	100.00%	87.5%*	100.00%	66.70%	75.00%	100%*	87.50%
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	99.09%	99.58%	99.06%	99.33%	99.25%	99.79%	99.49%	99.87%	99.68%	99.53%	99.47%	99.38%	99.57%	99.49%
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	0	1	0	0	0	2	0	2	0	0	1	3
			1,21	Data Quality on Ethnic Group - Inpatients	95.75%	97.23%	96.74%	95.67%	94.19%	94.24%	97.56%	97.13%	95.80%	96.86%	97.90%	95.84%	97.04%	96.89%







Treatment Targets Commentary

Since the last CPR report, the Trust has received confirmation that it will no longer be fined against the RTT non admitted and admitted targets, although it will still be required to report against them. The Trust will therefore focus on meeting the incomplete target, which will allow greater equity of care based on clinical need. This approach has been actively encouraged by NHS England.

There are some specialisms within the Trust which are capacity restricted, and this may result in vulnerability in the RTT incomplete target later in the year. This situation is being closely monitored. Discussions are currently ongoing with commissioners to increase access to capacity in order to stabilise this situation.

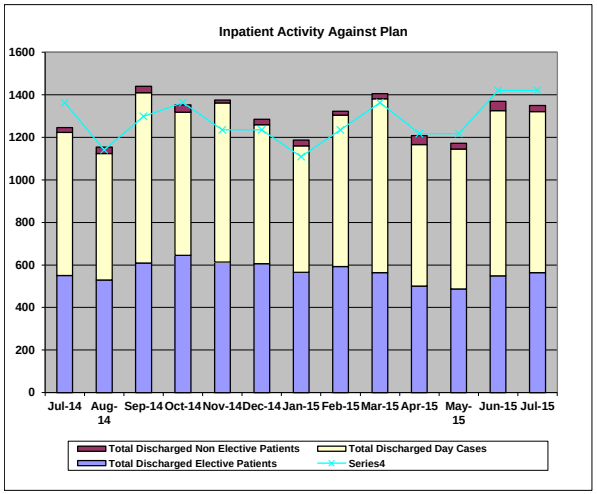
The cancelled operation not admitted within 28 days is in relation to a patient who needed nickel free equipment, which had not arrived by either the first or second admission date.

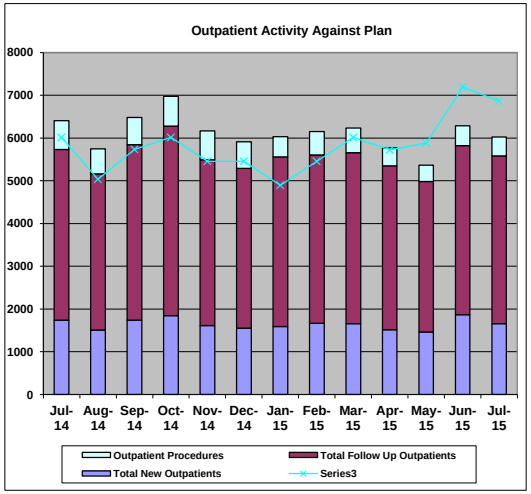
Quarterly Detailed Report
Activity Targets as at July 2015

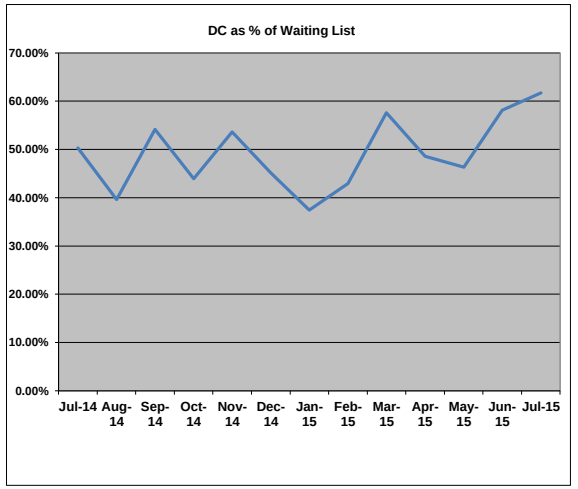
Headlines

- Elective activity has improved in month, but is still significantly below plan. A rectification plan has been put in place.
- Day case activity has been above plan.
- Outpatient performance continues to be significantly below plan.

	Monitor	National	CQC Standard		Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	15/16 Full Year Position
Activity			4	Total Discharged Elective Patients	551	530	609	646	614	606	565	592	564	501	487	549	564	2101
			4	Total Discharged Non Elective Patients	23	30	30	34	14	25	27	18	24	41	28	44	28	141
			4	Total Discharged Day Cases	672	594	801	673	748	654	595	713	817	666	658	777	758	2859
			4	Total New Outpatients	1742	1506	1740	1848	1611	1552	1591	1668	1658	1518	1466	1872	1656	6512
			4	Total Follow Up Outpatients	3993	3656	4107	4433	3882	3739	3968	3941	4000	3830	3516	3948	3930	15224
			4	Outpatient Procedures	671	585	634	697	671	621	471	543	573	420	386	467	442	1715
				DC as a % of WL	50.30%	39.60%	54.12%	43.93%	53.62%	45.13%	37.47%	42.93%	57.62%	48.61%	46.31%	58.12%	61.73%	44.20%
			4	Elective as % Against Plan	86.5%	99.4%	100.3%	101.4%	106.4%	105.0%	109.1%	102.6%	88.5%	90.8%	88.3%	85.3%	87.6%	87.9%
			4	Non Elective as % Against Plan	63.9%	100.0%	88.2%	94.4%	43.8%	78.1%	93.1%	56.3%	66.7%	169.0%	115.4%	155.5%	98.9%	134.1%
			4	Day Cases as % Against Plan	97.4%	102.8%	121.7%	97.5%	119.5%	104.5%	105.9%	113.9%	118.4%	103.9%	102.6%	103.9%	101.3%	102.9%
			4	% New Outpatients Against Plan	105.0%	108.4%	110.0%	111.4%	107.1%	103.1%	117.8%	110.8%	99.9%	96.5%	90.6%	94.7%	87.7%	92.3%
			4	% Follow Up Outpatients Against Plan	108.4%	118.5%	116.9%	120.3%	116.2%	111.9%	132.3%	117.9%	108.6%	106.4%	94.9%	87.2%	91.0%	94.3%
			4	% Outpatient Procedures Against Plan	99.9%	104.0%	99.0%	103.7%	110.1%	101.9%	86.1%	89.1%	85.3%	76.7%	68.5%	67.8%	67.2%	69.8%







Activity Commentary

Elective activity for the year remains behind plan, despite increased activity in the month. A weekly rectification plan has been developed, and is being monitored against each week. One of the key issues resulting in activity being behind plan is that discussions with Walsall Trust had taken place and it was expected that approximately 40-50 cases a month would be treated on their behalf. In reality this has been at the level of approximately 15-20 cases a month.

There are ongoing discussions at present with Coventry and Rugby CCG regarding performing a number of large and small joint p rocedures over the remainder of the year. The activity level expected as a result of initial discussions is approximately 200.

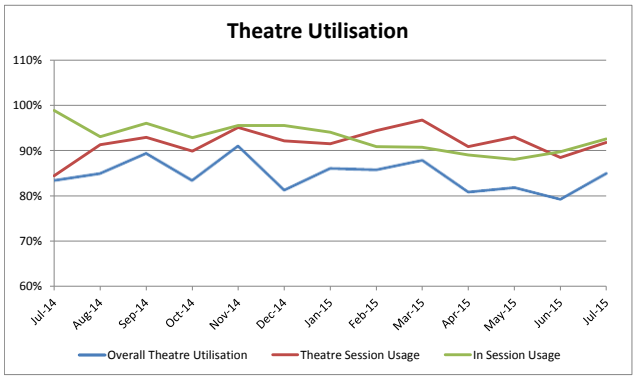
There are also very early discussions with HEFT around taking on some reconstructive hip and knee procedures, but it is curre ntly too early to speculate on activity numbers.

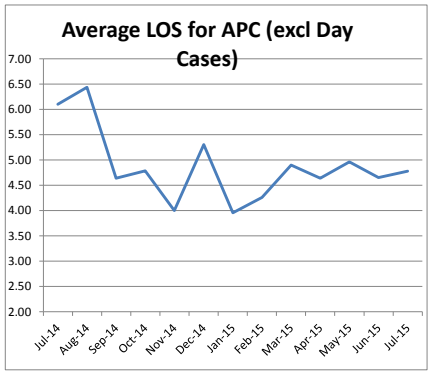
Quarterly Detailed Report
Efficiency Indicators as at July 2015

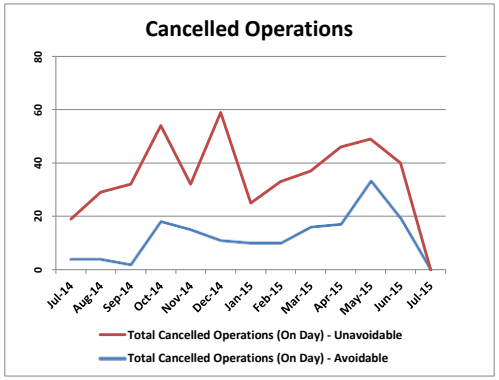
Headlines

- AVLOS has worsened and become red rated once more.
- Hospital cancellations remain high. The measurement of the cancellation metrics has changed in month.
- Theatre utilisation metrics have improved and are now largely green rated.

	Monitor	National	CQC Standard		Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	15/16 Full Year Position
Efficiency			4	Overall Theatre Utilisation	83.48%	84.97%	89.30%	83.47%	90.91%	81.38%	86.08%	85.77%	87.80%	80.97%	81.94%	79.42%	85.00%	81.83%
			4	Theatre Session Usage	84.42%	91.29%	92.94%	89.88%	95.12%	92.14%	91.54%	94.41%	96.74%	90.92%	93.04%	88.49%	91.82%	91.07%
			4	In Session Usage	98.88%	93.07%	96.09%	92.87%	95.58%	95.58%	94.04%	90.85%	90.76%	89.06%	88.06%	89.75%	92.56%	89.86%
			4	Unused Theatre Sessions	74	33	32	50	21	21	38	24	14	36	27	55	40	40
			4	Number of Cases per Theatre Session	2.97	3.15	3.27	2.88	3.20	2.97	2.72	3.07	3.20	3.09	3.12	3.08	2.81	3.01
			4	Total Cancelled Operations (On Day or Day Before)	54	56	39	54	74	88	53	60	62	46		79		63
			4	Total Cancelled Operations (On Day) - Avoidable	4	4	2	18	15	11	10	10	16	17	33	19		23
			4	Total Cancelled Operations (On Day) - Unavoidable	15	25	30	36	17	48	15	23	21	29	16	21		22
			4	% Cancelled Operations by Hospital	0.67%	0.73%	0.80%	1.17%	0.84%	0.58%	0.27%		2.78%	2.77%	4.35%	2.40%		3.17%
			4	Patient DNA													24	24
			4	Pat Cancelled on the day													19	19
			4	Pat Cancelled 1-3 days before													40	40
			4	Pat Cancelled 4-7 days before													25	25
			4	Total Cancelled Operations by Hospital (On Day)	8	8	11	15	11	7	3		37	31	49	31	10	30
			4	Hospital Cancelled 1-3 days before													36	36
				Hospital Cancelled 4-7 days before													46	46
			4	Total T&O Review-To-New Ratio (including Spinal)	2.43	2.54	2.41	2.49	2.39	2.43	2.67	2.42	2.55	2.85	2.62	2.53	2.77	2.69
			4	Pain Review-To-New Ratio	2.63	4.33	3.55	3.36	2.85	3.69	2.71	2.69	3.85	3.45	3.23	2.58	2.46	2.93
			4	Outpatient DNAs	8.78%	9.21%	8.13%	8.23%	8.13%	9.21%	8.41%	7.82%	8.50%	10.07%	8.49%	8.42%	10.50%	9.37%
			4	Bed Occupancy - Adults	86.40%	80.63%	84.25%	83.17%	79.45%	69.20%	76.02%	79.93%	77.35%	67.10%	70.44%	78.83%	91.37%	77.00%
			4	Bed Occupancy - Paediatrics	89.96%	88.17%	50.00%	44.44%	60.74%	55.36%	55.36%	65.08%	74.91%	68.86%	66.67%	66.67%	88.42%	72.76%
			4	Bed Occupancy - HDU	69.85%	63.64%	73.39%	68.15%	70.46%	55.70%	67.42%	68.22%	75.56%	55.74%	58.74%	47.54%	62.99%	56.22%
			4	Bed Occupancy - Private Patients	84.33%	76.04%	82.86%	80.65%	84.33%	83.67%	84.29%	83.33%	54.25%	74.29%	76.96%	88.10%	82.03%	80.33%
			4	Admissions on the Day of Surgery	392	393	477	503	478	464	421	445	411	359	379	414	402	1554
			4	AVLOS for APC (excl day cases)	6.10	6.43	4.64	4.79	4.00	5.30	3.96	4.26	4.90	4.64	4.96	4.65	4.78	4.76







Efficiency Commentary

The measurement of theatre cancellations has changed during the month to give more accurate data, and will be reported in this format going forwards. The theatre efficiency improvement programme is due to commence this month.

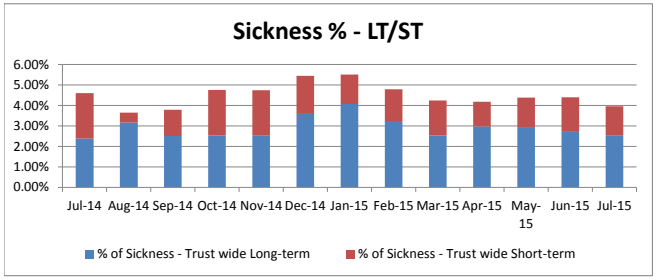
The other theatre metrics have been largely positive in month, although AVLOS has worsened and become red rated.

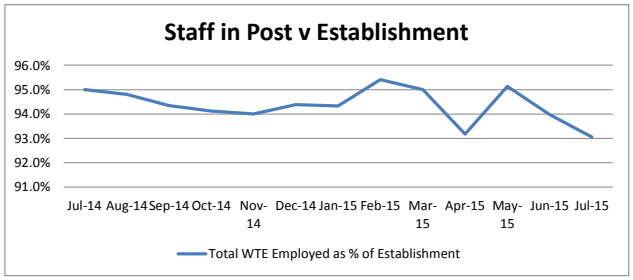
Monthly Report
Workforce Indicators as at July 15

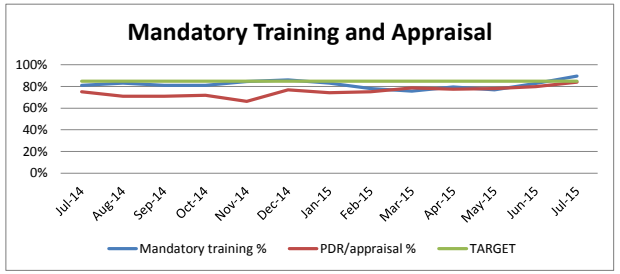
Headlines

- Mandatory training has significantly improved
- Sickness absence has reduced
- Appraisal highest rate for over 12 months

	Monitor	Contract	CQC Standard		Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	14/15 Full Year Position
Workforce				Total WTE Employed as % of Establishment	95.0%	94.8%	94.3%	94.1%	94.0%	94.4%	94.3%	95.4%	95.0%	93.2%	95.1%	94.0%	93.1%	93.8%
				Staff Turnover (%) - Unadjusted	12.7%	12.8%	10.8%	11.4%	11.8%	1059.2%	10.3%	10.6%	11.1%	10.6%	10.9%	11.0%	11.4%	10.9%
				Staff Turnover (%) - Adjusted	8.4%	8.4%	8.4%	8.9%	9.5%	926.9%	9.0%	8.9%	9.3%	8.6%	8.9%	7.9%	8.3%	8.4%
				% of Sickness - Trust wide	4.6%	3.7%	3.8%	4.8%	4.7%	5.4%	5.5%	4.8%	4.2%	4.2%	4.4%	4.4%	4.0%	4.2%
				% Staff received mandatory training last 12 months	81%	83%	81%	81%	84%	86%	83%	78%	76%	80%	77%	83%	90%	82%
				% Staff received formal PDR/appraisal last 12 months	75%	71%	71%	72%	66%	77%	74%	75%	79%	77%	78%	80%	84%	80%







Workforce Commentary

Sickness absence fell to its lowest level since September 2014, as a result of a decrease in both short and long term absence. The in month figure is correct at the time of running a report: however, in February in particular there was a lot of late manager onto the system, perhaps due to a transition with ESR self service. The result of this is that the moving annual average figure now shows as red, as was covered in the narrative last month.

The vacancy position taken from the ledger remains green, although the slight increase in turnover is matched this month by a corresponding decrease of staff in post.

The turnover figures, both adjusted (true leavers) and unadjusted (all leavers minus junior medical staff) remained green for the month. Whilst not currently a cause for concern, there were 3 qualified radiographers who left in month, which is being explored with the relevant manager. The pattern of overall leavers is consistent with last year - but this will be monitored.

The mandatory training position showed a further increase on last month and is now green for July, with a combination of significant local data validation and an increase in numbers physically attending training.

The appraisal position remains just slightly below target, although there is a 4% improvement on June's position. Managers will be contacted during August 2015 to ensure PDR's are carried out promptly and that the information is recorded in ESR in a timely manner.

Monthly Report

Finance Dashboard as at 31st July 2015

	Surplus £	Cash £	Capital spend £
Plan	(477k)	12,789k	1,598k
Actual	(1,571k)	13,824k	501k
Forecast for next month (YTD)	(1,831k)	12,595k	637k

Year to date			
	Actual	Plan	Risk Rating
Capital Servicing Capacity	- 0.7	1.6	1
Liquidity Ratio	44.6	45.3	4
Overall Continuity of services ratio			3

Debtors are lower than expected. This is due to income being significantly lower than plan as a result of lower than expected activity.

The Trust's Capital Servicing Capacity is a 1, which is as expected given the initial year to date.
However, the increased deficit to expectation, in addition to slightly lower depreciation than planned, results in a lower ratio than expected. However, the Trust's liquidity rating results in an overall COSRR of 3.

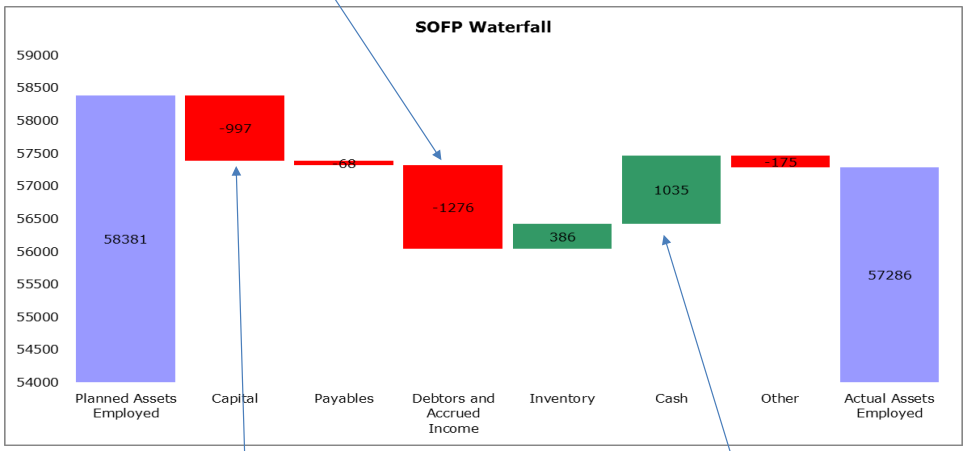
The income position has been down significantly this month compared to plan, resulting in a year to date variance of £2.4m.

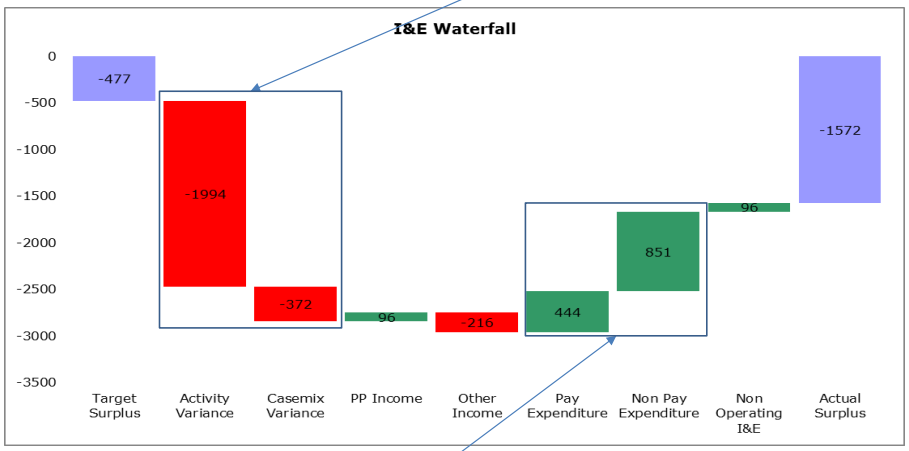
£372k of this year to date variance is due to case mix being behind plan. The impact in month has been less significant than prior month, with an improvement in case mix, particularly in spinal, but has still been behind expectation year to date.

The majority of the year to date variance, however, is due to activity being behind plan. For the month of July, the Trust were down;
- 80 elective cases;
- 231 new OP cases;
- 391 follow up OP; and
- 215 OP procedures.

This has also added to the financial impact of being behind plan last month.

A rectification plan for activity has been created, and the Director of Operations is continuing to work with the Directorate Managers and DDOF to discuss the best way to deliver the plan over the coming months.





Capital spend is lower than plan due largely to the theatre feasiblity review not occurring at the timing expected. This represents £891k of the difference, with the remainder being due to other small areas of slippage.

Cash is higher than plan largely due to the capital spend being lower than expected.

The non-pay expenditure continues to be behind plan, but is in line approximately with the underperformance in activity as discussed above.

Whilst pay costs are slightly behind plan, they are significantly higher than would be expected with the underperformance in activity.

Agency costs have increased by £52k to £431k in July, locum pay is up £19k to £159k, and bank payments up by £47k to £216k. Monitor has recently released a consultation on the introduction of stricter control measures around nursing agency spend, which the DoWOD, DoN and DDOF will be responding to over the coming days.

Monthly Report

CIP Dashboard as at 31st July 2015

Plan for YTD	£744k
Actual for YTD	£454k
Difference	-£290k

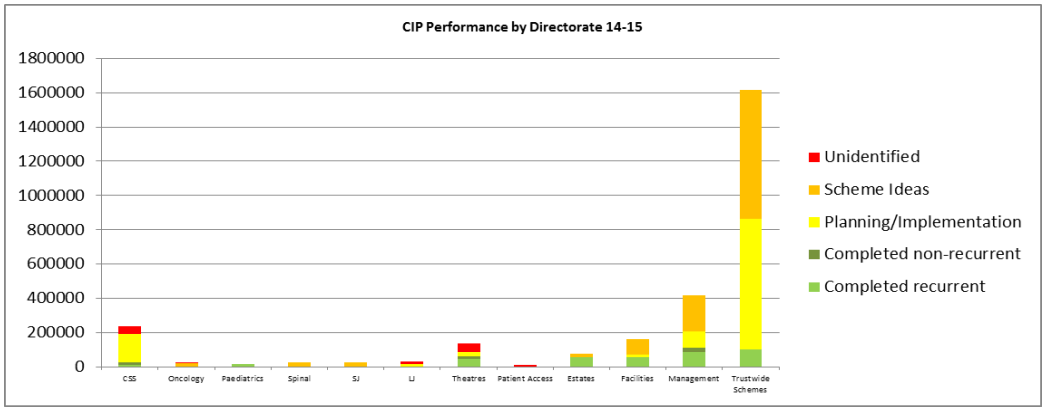
Estates, facilities and management have the largest achieved balance thus far this year. Achieved schemes include largely the reduction in budget for areas such as window cleaning, in addition to an increase in income from catering.

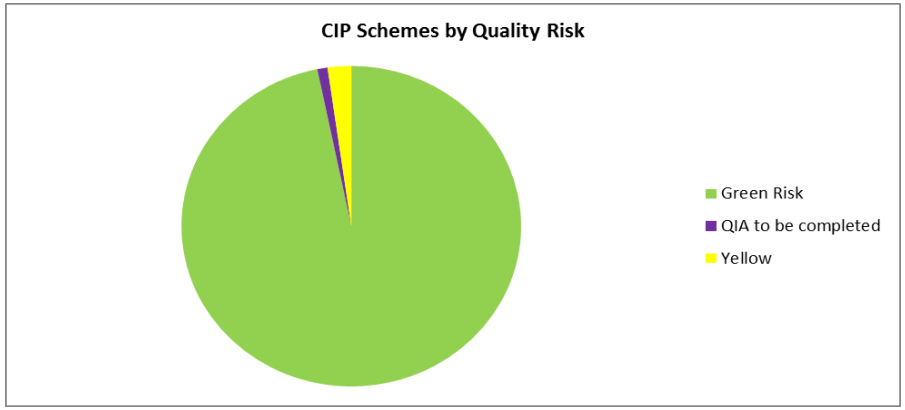
In addition, some of the Trust wide schemes such as reducing length of stay, negotiation of prosthesis savings and digital dictation are beginning to deliver strong savings.

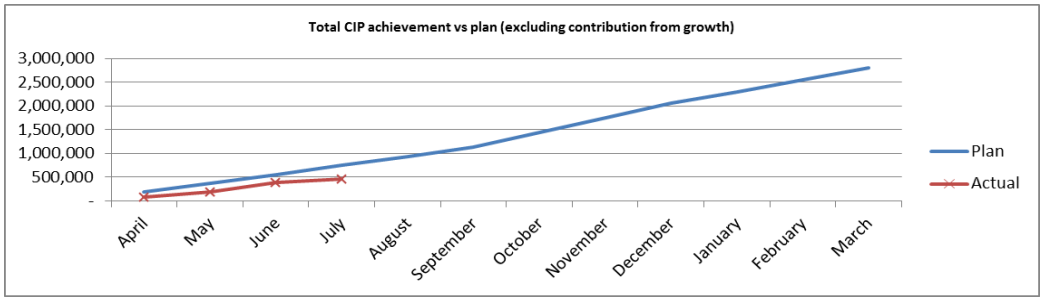
Theatres continue to have the largest unidentified balance.

A drive on completion of the QIA templates has resulted in them all being completed. There is one QIA currently outstanding, which is being progressed with the particular Directorate Manager responsible for the scheme.

It will be important to continue assessing schemes for quality impact over a regular basis, and ensuring that schemes currently in planning or scheme ideas are QIA'd in advance of putting the schemes into action.







Overall performance by category

	£'000
Completed recurrent	387
Completed non-recurrent	67
Benefits realisation	222
Planning/Implementation	1074
Scheme Ideas	1138
Contingency	-87
Total CIP target	**2801**

The current overall position shows a significant proportion of this year's schemes included within scheme ideas.

In addition, some £600k of these schemes are in relation to delivering efficiencies in the Trust. These schemes may now be required to recover the financial position from the lower than planned activity in the year to date. The Trust may essentially have to identify a further £600k of schemes.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 2 September 2015 **ENCLOSURE NUMBER: 7**

SUMMARY OF REPORT TO TRUST BOARD

SPONSORING DIRECTOR:	**Garry Marsh, Director of Nursing and Governance**
AUTHOR(S):	**Anne Crompton, Deputy Director of Nursing and Governance**
SUBJECT:	**Safe Nurse Staffing**

SUMMARY

This paper is presented to the Trust Board to give the mandatory monthly update on the position of Nurse Staffing within ROH wards. The data period presented is June and July 2015.

The paper provides evidence that the number of nurses on duty within ROH wards is sufficient to meet our patient's needs, gives detail of the external data that has been reported, provides an update on current vacancies and details the utilisation of bank and agency nurses across the Trust.

IMPLICATIONS

Failure to provide safe staffing levels in all ward areas has a direct impact on the quality of patient care. The development of 'red flag shift' reports will strengthen the level of assurance provided to the Trust Board about the safety of nurse staffing levels in in patient areas across the Trust.

RECOMMENDATIONS

The Trust Board is asked to:

- note the contents of the paper
- support the development of reporting of NICE Red flag shifts by October 2015

1.0 UNIFY Upload

ROH completed the NHS England Safe Staffing UNIFY data uplift for the month of June and July 2015 and uploaded it to the ROH website. This shows the planned nursing levels versus the actual nursing levels. The June and July submissions can be seen within Appendix 1. During the month of July 2015 fill rate for nurses at ROH was greater than 98% on both day and night shifts.

2.0 Nurse Vacancy Levels

Human Resources provide the Director of Nursing & Governance with ward vacancies each month. Details of these vacancies and plans to appoint are detailed within this section.

2.1 Registered Nurse Vacancies

At the end of July 2015 there were 4 permanent WTE Band 5 Registered Nurse Vacancies across the Trust (excluding Theatres).The Trust has recently interviewed for Band 5 posts, five applicants were interviewed, of which four were successful. The Trust Band 5 vacancies are shown in Table 1 below:

Table 1: Trust Wide Vacancies (excluding Theatres)

Ward	Number of Vacancies
HDU	1 paediatric
1	2 vacancies
2	1 (maternity cover)
3	1 possible (maternity cover)
11	1 permanent post & 1 fixed term
12/10	0 vacancies

2.2 Theatres and Overseas Recruitment

Much progress has been made in recruiting to the vacant theatre posts during July 2015 following a successful overseas recruitment campaign. 3 Senior Nurses from the Trust recently travelled to the Philippines and 51 people were interviewed over 2 days. Posts were offered to 19 applicants, all of who have Orthopaedic 'Scrub' and 'Recovery' experience. It is anticipated that the new members of staff will join the trust in late 2015/16.

3.0 Safer Nurse Staffing Tool

The Safer Nursing Care Tool (SNCT) is a nationally developed and validated acuity/dependency tool to measure nursing workload and estimate staffing requirements. The tool is widely used across the NHS. It has been used to assess the dependency and/or acuity of patients across the adult in-patient wards at ROH since September 2014. The Safe Staffing tool is completed by Senior Sisters, checked by Matrons, and submitted to the Director of Nursing & Governance on a weekly basis.

During June and July 2015 the continued use of the tool confirms that the number of nursing staff on duty within ROH is sufficient to meet the requirements of our patients. This is demonstrated in Table 2 below which details the recommended nurse establishment by ward against the actual ward establishment.

Table 2: Outcome of Safer Nursing Care Tool by ward - June and July 2015

Jun-15				
Staffing				
Ward	Ward Name	Recommended	Actual	Budgeted
Ward 1	Spinal	26.47	28.28	22.97
Ward 2	Orthopaedics	30.9	26.99	23.35
Ward 3	Oncology	26.57	29.72	24.35
Ward 10 & 12	Private Suite	33.18	39.29	33.91
Ward 11	Paeds	10.22	15.83	17.13
HDU	-	23.9	25.95	26.79

Jul-15				
Staffing				
Ward	Ward Name	Recommended	Actual	Budgeted
Ward 1	Spinal	30.13	28.44	22.97
Ward 2	Orthopaedics	27.92	26.5	23.35
Ward 3	Oncology	30.28	28.86	24.35
Ward 10 & 12	Private Suite	32.19	28.64	33.91
Ward 11	Paeds	12.01	17.18	17.13
HDU	-	21.94	22.99	26.79

4.0 Bank & Agency Usage

Wards are permitted to utilise bank and agency to ensure the required numbers of nurses are on duty within clinical areas.

Table 3 below provides detail of bank and agency use by ward during June and July 2015 whilst Table 4 provides agency use over time by ward.

Table 3: Bank and agency use in June and July 2015

Jun-15	Permanent	Bank	Agency
Ward 1	71.4%	20.6%	7.9%
Ward 2	74.0%	16.3%	9.7%
Ward 3	64.4%	24.3%	11.3%
Ward 11	79.1%	20.9%	0.0%
Ward 12 & 10	64.2%	26.9%	8.8%
HDU	77.2%	7.8%	15.0%
TOTAL ALL WARDS	70.5%	20.1%	9.4%

ALL STAFF

Jul-15	Permanent	Bank	Agency
Ward 1	65.4%	26.1%	8.4%
Ward 2	72.9%	18.0%	9.0%
Ward 3	70.8%	22.5%	6.7%
Ward 11	86.3%	12.3%	1.4%
Ward 12 & 10	58.3%	31.0%	10.7%
HDU	80.6%	8.7%	10.6%
TOTAL ALL WARDS	70.3%	21.4%	8.3%

Table 4: Bank and Agency use over time (all wards)

Month	July	June	May	April	March
% bank use	21.4	20.1	20.3	19.0	20.3
% agency use	8.3	9.4	8.9	5.9	6.5

It can be seen that there has been little change over time in the overall use of bank and agency staff. One of the key drivers for this is the use of additional staff to provide one to one support for patients. During September 2015 the Deputy Director of Nursing and Governance will work with colleagues to review current practice in ward area and to develop standards for safe and supportive observation of patients. An update against progress of this will be provided in the October report

5.0 . Establishment Review

The Director of Nursing and Governance has now met with all ward managers, matrons and colleagues from finance to review all ward based establishments.

Peer review by colleagues from Stanmore Orthopaedic Hospital has enabled benchmarking of staffing and acuity levels in a comparable organisation and feedback from the Stanmore report will be incorporated in a report to Trust Board in October.

6.0 NICE Safe Staffing Guidelines

The NICE (2014) safe staffing for nursing in adult inpatient wards in acute hospitals describes 'red flag shifts' and state that '*hospitals need to have a system in place for nursing red flag events to be reported by any member of the nursing team, patients, relatives or carers to the registered nurse in charge of the ward or shift'.*

Red Flag Shifts are defined as:

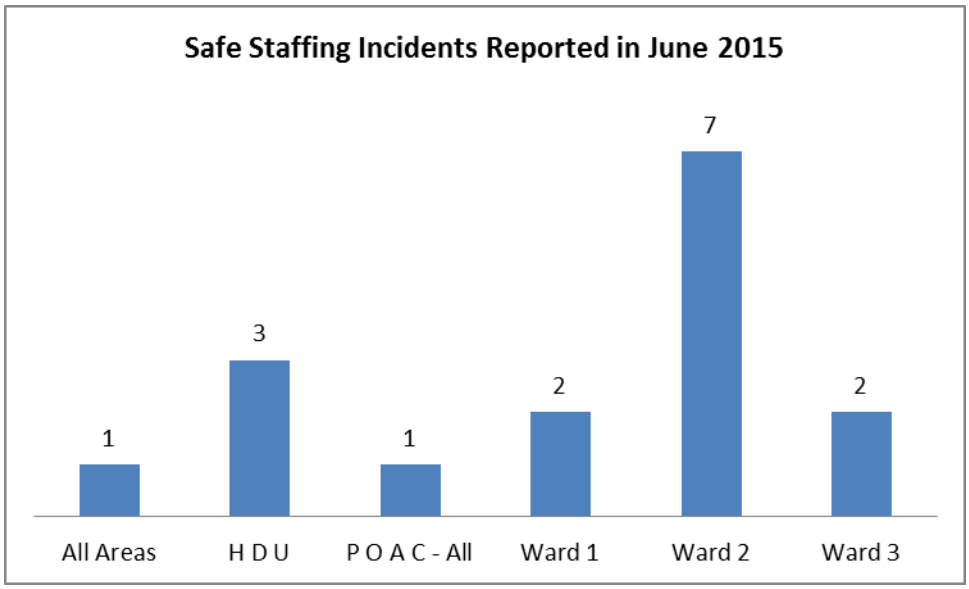
- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift.
- Less than 2 registered nurses present on a ward during any shift.

During September 2015 the Deputy Director of Nursing and Governance will undertake a review of the way acuity data is captured within the Trust and provide EMT with a suggested plan for capture of red flag shifts on a regular basis by October 2015.

7. 0. Reported Staffing Incidents

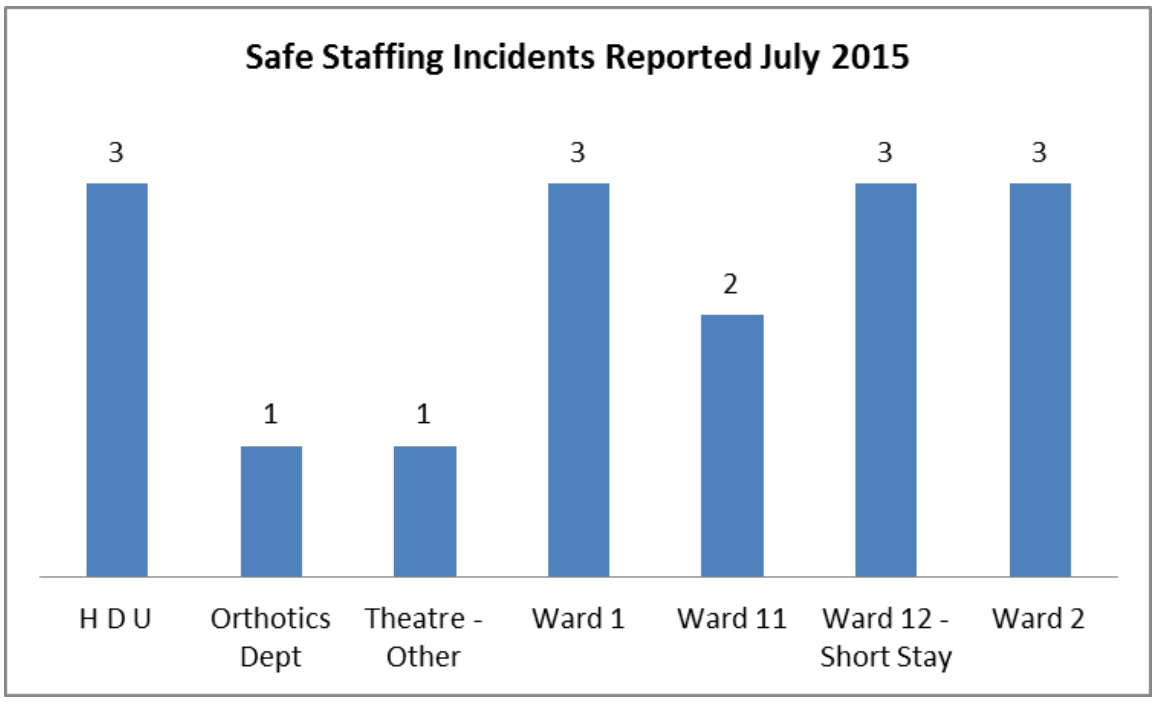
In addition to the Safer Nurse Staffing tool being used and interpreted, clinical areas are encouraged to report all Safe Staffing incidents. An analysis and review of safe staffing incidents reported during the period of June and July 2015 has been undertaken and is represented in the Table 5 and 6 below.

Table 5: JUNE 2015



The review highlighted that 16 safe staffing incidents were reported in June and no incidents involved a breach of minimum safe staffing as defined by NICE. The incidents on ward 2 related to staff sickness (agency, bank and substantive staff) and bank/agency staff not turning up. All incidents were graded 'no' or 'low' patient harm.

TABLE 6: JULY 2015



The review highlighted that 16 safe staffing incidents were reported in July and no incidents involved a breach of minimum safe staffing as defined by NICE. However, 2 of the 16 incidents were reported as 'moderate' patient harm incidents: these were both reported on HDU and related to lack of suitably skilled staff. Further review of the incidents showed that no patient harm had actually occurred and the incident summary will be amended to reflect this finding.

8.0 Conclusion

This paper has given an update of the monthly nurse staffing position to EMT within ROH for the data periods June and July 2015.

This paper gives detail of ROH externally reported information (UNIFY return) demonstrating that the RN shift fill rate is greater than 98% on both day and night shifts.

Use of the Safer Nursing Care Tool demonstrates that the number of nurses on duty within our wards is sufficient to meet the needs of our patients.

This paper shows that there continues to be reliance on the use of bank & agency nurses and committs to a review of the use of additional staff to provide one to one care.

The paper provides an outline of NICE Red flag shifts and committs to providing an outline plan to capture this information by October 2015.

A peer review of staffing and acuity will contribute to the development of a ROH staffing model.

9.0 Recommendation

The Trust Board is asked to:

- note the contents of the paper
- support the development of reporting of NICE Red flag shifts by October 2015

APPENDIX 1 UNIFY UPLOAD

July 2015

Only complete sites your organisation is accountable for			Day				Night				Day		Night	
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Ward 1	110 - TRAUMA & ORTHOPAEDICS		1597	1535	984	994	682	682	693	693	96.1%	101.0%	100.0%	100.0%
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1444	1380	985	912	682	719	682	627	95.6%	92.6%	105.4%	91.9%
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1718	1721	1110	1050	620	620	600	570	100.2%	94.6%	100.0%	95.0%
Ward 10 & 12	110 - TRAUMA & ORTHOPAEDICS		1771	1778	1483	1482	1023	1012	1023	1031	100.4%	100.0%	98.9%	100.8%
Ward 11	110 - TRAUMA & ORTHOPAEDICS		1199	1199	338	345	682	682	121	132	100.0%	102.2%	100.0%	109.1%
HDU	110 - TRAUMA & ORTHOPAEDICS		1609	1589	218	120	1423	1447	0	0	98.8%	55.2%	101.7%	-

June 2015

Only complete sites your organisation is accountable for			Day				Night				Day		Night	
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
Ward 1	110 - TRAUMA & ORTHOPAEDICS		1531	1449	947	939	680	662	660	707	94.6%	99.2%	97.4%	107.1%
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1390	1338	949.5	949.5	660	680	660	638	96.3%	100.0%	100.0%	96.7%
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1703	1580	1080	1068	600	600	660	700	92.8%	98.8%	100.0%	106.1%
Ward 10 & 12	110 - TRAUMA & ORTHOPAEDICS		1807	1807	1518	1443	990	990	990	980	100.0%	95.0%	100.0%	99.0%
Ward 11	110 - TRAUMA & ORTHOPAEDICS		1140	1140	303	303	660	660	0	0	100.0%	100.0%	100.0%	-
HDU	110 - TRAUMA & ORTHOPAEDICS		1764	1700	278	218	1498	1518	11	11	96.4%	78.4%	101.3%	100.0%

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 2nd September 2015 **ENCLOSURE NUMBER: 8**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Mr Jonathan Lofthouse, Executive Director of Operations**
SUBJECT:	**2015 NHS Core Standards**

TITLE: 2015 NHS Core Standards (EPRR)

SUMMARY

The NHS needs to plan for and respond to a wide range of emergencies that could affect health and patient safety. As part of the Civil Contingencies Act (2004) the Royal Orthopaedic Hospital NHS Foundation Trust has reviewed its Emergency Preparedness, Resilience and Response (EPRR) using the 2015 NHS Core Standards profile.

The review process has identified 31 areas of compliance (Green) and 6 areas of partial compliance (Amber).

IMPLICATIONS

An Action Plan has been developed for the areas of partial compliance which predominantly relates to additional training requirements. The delivery of the training requirements is currently being considered, this will likely require financial support.

RECOMMENDATIONS

The Trust Board is asked to note and approve the content of this report which has been assessed against the 2015 NHS Core Standards.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

JL/SWL

30 July 2015

Karen Helliwell
Locality Director (Birmingham, Solihull & Black Country)
NHS England (West Midlands)
St. Chads Court
213 Hagley Road
Edgbaston
Birmingham
B16 9RG

Dear Karen

Re: **EPRR Assurance Process 2015**

Please find enclosed the Royal Orthopaedic Hospital NHS Foundation Trust's updated assessment based on the 2015 NHS Core Standards. In assessing against the EPRR core standards, the Trust has identified 31 areas of compliance (Green) and 6 areas of partial compliance (Amber).

The Royal Orthopaedic Hospital NHS Foundation Trust based on this assessment would confirm it is overall substantially compliant with the 2015 core standards.

The areas of non-compliance are as follows:

Core Standard 7 – Sharing of local risk register with relevant partners – it is proposed to share our risk register for Emergency Planning with the Local Health Resilience Forum and review any comments. Timescale: Six months.

Core Standard 8b – Effective arrangements are in place for maintaining Business continuity – the Trust's Business Continuity Plan is currently under review when complete this will be shared with wards/departments to develop their knowledge. Timescale: Six months.

Core Standard 8e – Effective arrangements are in place for Pandemic Influenza – the EPRR Locality Team are in the process of arranging a multi-agency exercise before January 2016 and all member Trust's will participate in the exercise. Timescale: Six months.

Core Standard 16 – Competency training for key on-call staff – a package of training is being considered for On-call Directors/Managers in line with National Occupation Standards. Timescale: Twelve months.

Core Standard 34 – Training plan for key hospital staff – a tabletop exercise at the hospital is currently being organised with the EPRR Locality Team. Timescale: Six months.

Core Standard 36 – Participation in multi-agency exercise – Emergency Planning Lead is engaging with EPRR Locality Team for multi-agency training event participation. Timescale: Twelve months.

Core Standard 37 – Demonstrating Continuous Professional Development for all Incident Commanders – linked to core standard 16, package of training is being considered for On-call Directors/Managers in line with National Occupation Standards. Timescale: Twelve months.

I can confirm that the Trust self-assessment against the 2015 NHS Core Standards will be presented to the Trust Board meeting scheduled for 2nd September 2015.

I trust this meets your requirements. Should you need any further information, please do not hesitate to contact me.

Yours sincerely

Jonathan Lofthouse
Director of Operations
(Accountable Emergency Officer)

Enc

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Y	Y	Y	Y	Y	Y	Y			Y	• Ensuring accountable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergency Preparedness Resilience and Response, and Business Continuity Management agendas	**Accountable Emergency Officer - Jonathan Lofthouse, Emergency Planning Lead - Stuart Lovack**			
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y	Y	Y	Y	Y	Y	Y	Y			Y	• Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	**Memorandum of Understanding for mutual aid agreed with local Trusts. Trust is part of the LHRF. Work plans in place to review current procedures and documentation.**			
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y	Y	Y	Y	Y	Y	Y	Y			Y		**Major Incident Plan developed and in operation, supporting documentation in circulation. (Hospital Evacuation and Shelter Plan, Emergency Response Information Pack, Establishment of the ICC, etc.)**			
4	The accountable emergency officer will ensure that the Board and/or Governing Body will receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y	Y	Y	Y	Y	Y	Y	Y			Y		**Core Standards reported to Trust Board and Executive Management Team. Live exercise reported to EMT and Trust Board. Reports developed after any major incident with action taken and lessons learned.**			
Duty to assess risk																		
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages;	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages	**Risk register process in operation throughout the Trust, local risk register for Emergency Planning developed, Business Continuity Plan currently under review. Risk assessments undertaken by wards/departments in relation to business continuity.**			
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	• surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc..	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	**Local risk register is developed in conjunction with the LHRP and Community Risk Register (relevant risks being influenza type disease, loss of critical infrastructure and fuel shortage.**			
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Risk register has been shared internally however wider consultation is required.**			
Duty to maintain plans – emergency plans and business continuity plans																		
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	**Major Incident Plan and establishment of ICC in place.**			
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Business Continuity Plan under review.**			
		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y	Y	Y					Y			**Not a receiving hospital, no ED. (Specialist Hospital)**			
		Severe Weather (heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Heatwave and Cold Weather plans in place.**			
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Pandemic Influenza exercise to be organised by locality team before January 2016.**			
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y	Y		Y	Y				Y		**Mutual aid arrangements in place with local hospitals, ability to scale up to deal with vaccinations.**			
		Mass Casualties	Y	Y	Y	Y		Y	Y				Y		**Mutual aid arrangements in place with local hospitals.**			
		Fuel Disruption	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Fuel Shortage Plan in place.**			
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		**Mutual aid arrangements in place, hospital has ability to**			
		Infectious Disease Outbreak	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		**Mutual aid arrangements in place.**			
		Evacuation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Hospital Evacuation and Shelter Plan in place.**			
		Lockdown	Y	Y	Y	Y	Y	Y	Y			Y	Y		**Lockdown procedures in place.**			
		Utilities, IT and Telecommunications Failure	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Local hospital procedures in place to deal with infrastructure failures.**			
		Excess Deaths/ Mass Fatalities	Y	Y	Y			Y	Y				Y		**Limited body storage facilities on site, arrangements in place with local undertakers.**			
		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			Y										**N/a**			
		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			Y										**N/a**			
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	**Major Incident Plan, Hospital Evacuation and Shelter Plan, Establishment of ICC and Director/Bleep Holder Information Packs available.**			
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	**Executive Director On-call Rota and Bleep Holder Rota in operation 24/7. Switchboard has cascade procedure in place in the event of an emergency.**			
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Executive Director and Operational Team through establishment of the ICC would review activity / capacity.**			
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y	Y	Y	Y	Y								**Communication plan developed, media training undertaken for key staff, VIP area identified on site, action card in development.**			
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Specify who has been consulted on the relevant documents/ plans etc.	**Major Incident and Business Continuity Plans are shared internally with all stakeholders, externally plans are shared with NHS England - West Midlands.**			
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Form part of MI procedures, hot and cold debriefs and lessons learned action plan**			
Command and Control (C2)																		
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Y	Y	Y	Y	Y	Y	Y			Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	**Executive Director On-call 24/7 rota in operation also Bleep Holder 24/7 rota on operation.**			
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England published competencies are based upon National Occupation Standards .	Y	Y	Y	Y	Y	Y	Y	Y			Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	**Accountable Emergency Officer is Gold Commander trained, Emergency Planning Lead currently undertaking the DIpHEP programme, further training programmes for key staff to be scheduled.**			
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.	**Major Incident Plan in place.**			
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Directors and Bleep Holders have information pack incorporating a decision log. Loggists are listed in MI plan.**			
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Situation reports are used to communication externally with NHS England - West Midlands and can be used internally if required.**			
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		Y										**First responder would be to dial 999 and seek help and advice from the Emergency Services. Second repsonse would be to contact neighbouring hospital (QEHB) for further advice.**			
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		Y										**Contact number 24/7 for advice on radiation incident/NAIR incident in place through QEHB.**			
Duty to communicate with the public																		

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	**Media Policy in place detailing internal and external communication arrangements. Escalation procedure in place for informing EPRR Locality Team for Birmingham, Solihull and the Black Country.**			
23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	**Telephone landlines, mobile telephones, digital bleep system and separate radio system available.**			
Information Sharing – mandatory requirements																		
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and include DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supersedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). •Social networking tools may be of use here.	**Best practice reviews (peer to peer) have been undertaken. Trust is signed up to Resilience Direct.**			
Co-operation																		
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and membership is quorate. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements •Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues •Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	**Trust is an active member of the LHRF and LHRP.**			
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		**Multi-agency representation at LHRF's and sharing of information.**			
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		**Mutual aid arrangements in place through EPRR Locality team for Birmingham, Solihull and the Black Country**			
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				Y			Y	Y				Y		**N/a**			
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y				Y				Y		**N/a**			
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y	Y	Y	Y	Y			Y		Y			**Good links with EPRR locality team, communication tests occur on a regular basis, good networking throughout**			
31	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared								Y						**N/a**			
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months							Y	Y						**N/a**			
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y	Y	Y	Y	Y	Y		Y			Y		**Trust has good attendance at LHRF and LHRP.**			
Training And Exercising																		
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs.	**Bleep holder training undertaken, live exercise training undertaken, table top exercise training to be planned.**			
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidents have been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	**Communication exercise undertaken in September 2104 and March 2015, Live exercise undertaken in November 2014, reports and lessons learnt communicated through committee structures.**			
36	Demonstrate organisation wide (including on call personnel) appropriate participation in multi-agency exercises		Y	Y	Y	Y	Y	Y	Y	Y			Y		**Multi-agency exercise to be planned and senior Trust staff required to engage in exercise.**			
37	Preparedness ensures all incident commanders (on call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y	Y	Y	Y	Y	Y	Y	Y			Y		**Training to be organised for senior Trust staff to ensures requirements of CPD is maintained.**			

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date of Trust Board: 2 September 2015 **ENCLOSURE NUMBER: Enc 9**

REPORT TO TRUST BOARD

NAME OF DIRECTOR PRESENTING	**Jo Chambers, Chief Executive**
AUTHOR(S)	**Jo Chambers, Julian Denney**
TITLE	**Governance Declaration – Quarter 1 2015/16**

SUMMARY

To provide assurance on behalf of the Trust Board in relation to the Governance Declaration for Quarter 1 2015/16 to Monitor.

RISK & IMPLICATIONS

The implications for the Trust relate to national policy/legislation and performance ratings, as well as compliance with our licence.

RECOMMENDATIONS

It is recommended that the Board note the following submissions to Monitor made on its behalf by a committee of the CEO and Chairman:

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 Trust **cannot** confirm compliance with the following statement:*
"The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets 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 2015/16 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 (RAF). The Q1 submission was due on the 31st July 2015.

Monitor initiated a process of consultation on the RAF which ended on 31st July 2015 and to which the Trust contributed. However they have indicated that any proposed changes will not come into effect until after the Q1 submission.

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 April 2015 to 30th June 2015 is contained in the Trust's Corporate Performance Report.

The Trust's deficit stands at £1.428m at the end of Quarter 1, against a planned deficit of £0.565m. This has largely been driven by a significant underperformance on elective activity, which is 217 spells behind target in Quarter 1. This, along with underperformance on outpatients, has driven the Trust to a shortfall of £1.9m on planned income during the quarter. Whilst there are some savings from underspends on pay and non-pay, this leaves an overall shortfall on the planned financial position.

The Trust had planned to deliver a Capital Service Capacity ratio of 1 and a liquidity ratio of 4 for Quarter 1. These ratings have been delivered, however the overall ratios are lower than planned given the increased deficit. These rating combine to deliver an overall Continuity of Services Risk Rating of 3.

The quarterly governance declaration requires the Trust to declare that we will continue to achieve of Continuity of Services Risk Rating of 3 for the next 12 months. Based on our planned liquidity, and under the current rating calculations, this continues to be the case. It should be noted that if the consultation on changes to the Risk Assessment Framework result in the introduction of a Sustainability and Financial performance financial risk rating as it is defined in the consultation, our rating would

drop to a 2 based on our current and forecast performance.

There is no requirement to rebase the capital programme following Quarter 1.

2. Service Performance Targets

Summary

The table of Monitor requirements and evidence is attached as Appendix 1 of this report.

The governance return includes a requirement to either respond 'complied' or 'not complied' to the following statement;
"The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards."

In this quarter's declaration, it has been considered appropriate to respond as **not complied** on the basis that all targets have been met for quarter 1 with the exception of the Non Admitted RTT target for April-15 and the 62 Day target for Quarter 1**.**

Further detail regarding the reason for any non-compliance (and any actions being taken to address this) are detailed in subsequent paragraphs.

Non Admitted RTT

The quarter 4 report for 2014/15 detailed the potential for breaches of this standard through Q1 & Q2 of the current year as the Trust addressed Non Admit Waiting times and backlog. This has generally been avoided with a single failure in April-15 at 93.49% which was a result of the Trust clearing a volume of backlog patients which brought performance below the 95% target.
The objective is to improve patient experience and access by clearing backlogs even if the Non Admitted RTT target is breached; this is in line with recently realised national guidance. The expectation is that any such breaches are likely to occur in Q2 or Q3; it is not expected that there will be breaches in subsequent quarters because the incomplete RTT is expected to be robust at that point.

Work is ongoing to reduce waiting times in those specialties which are specifically challenged in their new appointment times (Spinal services & Young Adult).

In the spirit of the changing national position, contractual fines levied by lead commissioners have been returned with no compliance sanctions imposed.

Admitted RTT

As with the Non Admitted standard the 2014/15 Q4 report highlighted the potential risk to the management of the Admitted target with the need to balance our backlog clearance and maintaining the Incomplete RTT performance. In line with national

guidance we are now working to clear the Admitted backlogs where it is clinically appropriate to do so; a consequence of the national guidance is that the Admitted RTT may be breached in future. The expectation is that any such breaches are likely to occur in Q2 or Q3; it is not expected that there will be breaches in subsequent quarters because the incomplete RTT is expected to be robust at that point.

Incomplete RTT

It was previously stated that the compound position of active waits has reported a healthy, albeit deteriorating position over the last 6 months with our modelling indicating this trend will continue through Q1 and into Q2. However with the announcement and subsequent released guidance for RTT we are working to stabilise that decline by the treatment of a greater proportion of our Admitted backlog. This may not prevent the continued reduction in performance towards the 92% threshold in the short term but should enable a more rapid recovery in the medium to long term. The Trust is confident that it will not breach the 92% target.

The Board is satisfied that the capacity tools recently invested in by the Trust show a more accurate picture of the pressures faced over the coming year and thus will enable it ensure continued achievement of the Incomplete target and the reduction of Trust backlogs.

Cancer 62 Day target

The breach of the target was associated with very small numbers of patients as explained in the table below; in this table :

- A score of 0.5 is given for a patient with a shared pathway with another provider.
- A score of 1.0 is given for an ROH only patient.
- In Q1 2015 there were two patients with a shared pathway with another provider associated with a breach of this target giving an aggregate patients breached score of 1.0 (= 0.5*2)

In the last five quarters the numbers of patients breached were in the range 0.5 -1.5 and Q1 2015 was in the middle of this range (see highlight in green). However the "ROH Accountable" row in the table was particularly low in Q1 (see highlight in blue) giving rise to the low overall % for patients treated within target and therefore a breach for the quarter.

Cancer 62 Days	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
Total No Treated	**14**	**22**	**14**	**11**	**7**
ROH Accountable	10.5	15	10.5	7.5	**4.5**
ROH Patients Treated in Target	9.5	13.5	9	7	3.5
No ROH Patients Breached	1	1.5	1.5	0.5	**1.0**
%	**90.5%**	**90.0%**	**85.7%**	**93.3%**	**77.8%**

Regarding the two patients with a shared pathway with another provider associated

with a breach of this target:

- Initial investigations suggest that the first breach arose because the patient declined the date they were due to have a biopsy because they were on holiday delaying treatment by one week and it is not considered that there is anything further the ROH could have done to avoid this breach.

- The second breach arose because the patient was on a particularly complex cancer pathway requiring extensive diagnosis partly at the ROH and partly at another centre necessitating a long period before treatment could be started. The referral was forwarded to the other centre by the ROH by day 35 which was agreed by both organisations as timely.

The expectation is that any such breaches are less likely to occur in future quarters as activity in Q1 was lower than usual (low numbers as explained above amplify the impact of any breach) . However, it is difficult to predict the future with any degree of accuracy because the numbers of cancer patients being referred are unpredictable and within these the incidence of patients with complex cancer pathways are also unpredictable.

<u>52 week RTT</u>
The Trust has experienced several patient treatments' time breaches of the 52 week RTT standard during quarter 1 (note this is not a target included within Appendix A). All of the patients breaching the standard are children or young adults requiring complex Spinal Deformity surgery.

NHS England have been continuing to work with ROH to expand the service and provide reinvestment of penalties to support additional activity to be commissioned with independent sector providers.

NHS England as specialist services commissioners are currently undertaking a review of work to try to identify strategic solutions for the national capacity constraints in these services. The ROH has participated in the expert working group review.

The operational issues regarding the 62 Day Cancer and 52 Week RTT metrics have been highlighted to Monitor outside the quarterly reporting schedule.

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.

    - In April 2015 Kathryn Sallah took up her appointment as a Non-Executive Director following her appointment by the Council of Governors at their March meeting. Ms Sallah is a qualified nurse and midwife with over 35 years' experience in healthcare. She has held three Director of Nursing posts and is currently a Trustee of two Charitable Trusts. She was project Director for the Independent Case Note Review for the Mid Staffordshire Foundation Trust and

has acted as a specialist consultant to CQC for reviews on governance and clinical services.

- In May 2015 Ms Elizabeth Chignell, a Non-Executive Director, resigned from the Trust Board, the Chairmanship of the Remuneration Committee and the membership of the Nominations and Clinical Governance Committees with immediate effect for personal reasons; she had previously indicated her intention to resign to the Chairman in April. The Council of Governors were advised as soon as possible after this and have begun to take steps, with input from Board members, to consider the process for replacing Ms Elizabeth Chignell. The Board agreed that Dame Yve Buckland would be appointed to be Chairman of the Remuneration Committee
- 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 (CGC) has met three times during the quarter and reviewed the relevant assurances that risks to compliance are being managed. In addition the CGC held a workshop during the quarter which covered such matters as:
    - The role of CGC
    - The structure for reporting / clinical audit
    - Clinical engagement in governance
    - Learning
    - CGC supporting processes
- On the 28th and 29th July 2015 there was a limited CQC re-inspection which followed the full CQC inspection during 2014. Verbal comments have been received but formal written feedback is not due until later this year.
- The Trust is addressing a number of matters relating to clinical governance as summarised in the table below:

Issue	Actions taken	Work in progress
Serious Incidents There have been some issues identified relating to the Trust's response times to serious Incidents and systems and processes following a serious incident.	The Serious Incident tracker has been redesigned and other processes to manage serious incidents are being improved. A high level action plan has been created and was discussed at the July meeting of the Clinical Governance Committee (CGC)	The CGC will review the outputs of the action plan in September.
Equipment A planned review by internal audit highlighted the need to improve equipment training,	A Trust wide action plan responding to the review has been created and the majority of actions have been completed.	The outputs from the action plan will be reviewed by the Audit Committee in September.

maintenance and documentation.		
Policies Policy Management within the Trust have undertaken a review and "deep dive". This highlighted areas of improvement within the systems and processes.	The Trust has established a robust action plan with timelines to ensure that the systems and processes are strengthened and the policies are brought in line with these timelines.	This work is expected to be completed by October; progress will be reviewed by the CGC in August and September.

- The Audit Committee met in May in respect to this declaration and can offer the following assurance:

  - The committee received and considered External Audit's final reports on the audit of the Trust's annual report & annual accounts and quality accounts. Both audits delivered an unmodified opinion.
  - The report on the audit of the quality accounts included audit findings from the review of 18 week RTT targets, 62 day cancer targets and compliance with the WHO checklist. RTT and cancer targets both received strong assurance, with some recommendations put in place around the WHO checklist.
  - The committee received and discussed the annual risk report for 2014/15. The committee challenged performance around incidents, never events and litigation, noting ongoing work regarding the strengthening of governance processes.
  - The committee received and considered a comprehensive annual report from Counter Fraud, and took assurance from the processes in place to report and investigate potential fraud, and the regular communication with staff at all levels around fraud awareness.
  - The committee agreed to hold a workshop in September for all board members and other key stakeholders to perform a routine review of the effectiveness of the Audit Committee and priorities for the next 12 months.

APPENDIX ONE

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.

A limited CQC re-inspection was carried out on July 28th and 29th 2015.

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 2015/16

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	Not met (93.5%)
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	Not met (77.8%)
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
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0		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: 2 September 2015 **ENCLOSURE NUMBER: 10**

SUMMARYOF REPORT TO TRUST BOARD

NAME OF DIRECTOR:	**Andrew Pearson, Medical Director & Responsible Officer**
SUBJECT:	**Designated Body Statement of Compliance - September 2015**

SUMMARY

NHS England requires each designated body to make an annual statement of compliance with The Medical Profession Regulation 2010 (amended 2013). Following submission of the Medical Revalidation Annual Organisational Audit (AOA) for the Trust in June, we have received the Comparator report and the Statement of Compliance to complete and submit.

IMPLICATIONS

Reputational

RECOMMENDATIONS

Approve sign-off of the annual Statement of compliance with appraisal and revalidation of doctors with a connection to the ROH FT as their designated body by the CEO

Report To	Trust Board
Report Of	Medical Director
Purpose of the Report	To update the Board on the Trust's position in relation to medical revalidation and appraisal compared to other acute trusts and propose an action plan to address any shortcomings
Recommendation	The Board is asked to approve sign-off of the annual Statement of compliance with appraisal and revalidation of doctors with a connection to the ROH FT as their designated body by the CEO

Background

The Trust Board is required to make an annual declaration that they are compliant with the requirements of The Medical Profession (Responsible Officers) Regulations 2010 (amended 2013). This declaration is made to the Senior Responsible Officer for NHS England, Simon Bennett.

I reported to the Board on 3rd July 2015 the results of the annual audit that would inform the *Quality Assurance Report 2014-15* that would be sent to NHS England.

Following receipt of our AOA (Annual Organisational Audit) return, NHS England sent a Comparator Report which allows the Trust to see how it compares to other Acute Trusts in England. From this a *Designated Body Statement of Compliance* is generated requiring sign-off by the CEO (appendix 1) and an Action Plan developed to address any short-comings.

Findings

The 'outlier' findings of the Comparator Report are:

1. The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation (*including peer review, internal audit or externally commissioned assessment)

Comment: An independent review has not been commissioned undertaken. Only 67.3% of Acute Trusts have complied with this requirement.

2. Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded

Comment: The ROH response was no. The Trust had 12 (19.4% of total) consultants and 1 (11.1% of total) temporary contract holder who had *Unapproved incomplete or missed annual appraisal 01.04.14-31.03.15.*

24.5% of Acute Trusts answered no to this question

3. The responsible officer ensures that a 'responding to concerns' policy is in place (which includes arrangements for investigation and intervention for capacity, conduct, health and fitness to practice concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)

Comment: The ROH response was no. Although there is provision within the Disciplinary Policy to cover responding to concerns, following enquiries I am informed that there is a requirement for the Trust to have a specific 'stand-alone' policy.

Action Plan

Non-Compliance	Action	Completion Date	Resolved	Action Taken
The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation (*including peer review, internal audit or externally commissioned assessment)	Trust Internal Auditors to be instructed to perform audit of Trust appraisal and revalidation processes in 2015-16	By March end of 2016		
Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded	The AOA report gave the Trust position as of 31.03.15. The situation has now been resolved and there are no outstanding appraisals	August 2015	Yes	
The responsible officer ensures that a 'responding to concerns' policy is in place (which includes arrangements for investigation and	Responding to Concerns Policy to be written	October 2015		I am currently writing the policy (close to completion) ready for Board ratification in October 2015

Non-Compliance	Action	Completion Date	Resolved	Action Taken
intervention for capacity, conduct, health and fitness to practice concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)				

Recommendations

Based on the above Action Plan and assurances I ask that the 'Designated Body Statement of Compliance' be ratified by the Board for sign-off by the CEO.

Appendix 1

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Designated Body Statement of Compliance September 2015

The Board of the Royal Orthopaedic Hospital NHS Foundation Trust has carried out and submitted an Annual Organisation Audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulation 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Dr A Pearson is the responsible officer and has undergone training in all required modules.

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: The Trust used the ™Equiniti RMS and through this maintains an up-to-date record of the licensed medical practitioners with a prescribed connection.

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: The Trust has 15 trained appraisers, one of which is the responsible officer who does not at present appraise doctors to avoid any conflict or bias in his role as RO.

4. Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent)

   Comments: There is a quality assurance mechanism which samples the inputs and outputs of the medical appraisal process for 10% of appraisals to ensure that they comply with GMC requirements. Further work is underway to further strengthen the quality of medical appraisal in the Trust including peer review and regular training events.

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken.

   Comments: Yes

[1] Doctors with a prescribed connection to the designated body on the date of reporting

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: All of this information is collected by the Trust and made available to the appraisee by the Appraisal & Revalidation Manager to inform the appraisal process.

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practice;

   Comments: Yes. The Trust policy on *Responding to Concerns* is currently being refreshed and updated.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

   Comments: Yes informally through the regional RO Network and formally using the NHS England MPIT form processes.

9. The appropriate pre-employment background checks)including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed;

   Comments: Yes

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations;

    Comments: If there were deficiencies or gaps, an action plan would be developed to address them.

Signed on behalf of the designated body

Mrs Jo Chambers
Chief Executive Officer

Dated: September 2015

[2]Doctors with a prescribed connection to the designated body on the date of reporting

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Charitable Funds Sub-Committee Meeting
Held on 29 May 2015
Board Room

Present:

Frances Kirkham (FK)	Non-Executive Director (Chair)
Jo Chambers (JC)	Chief Executive
Paul Athey (PA)	Director of Finance
Jonathan Lofthouse (JL)	Director of Operations
Stella Noon (SN)	Patient Representative
Yvonne Scott (YS)	Patient Representative
Lin Russell (LR)	Consultant Nurse
Rod Anthony (RA)	Non-Executive Director
Claire Kettle (CK)	PA – Minute Taker

Agenda Item No.		Action
1.0	**Apologies** Garry Marsh – Director of Nursing & Governance Hannah Molloy – Head of Financial Accounting	
2.0	**Minutes from the Meeting of 26 January 2015**	
	The Minutes were agreed as true record of the meeting.	
3.0	**Actions from the Meeting of 26 January 2015**	
	Members of the Charitable Funds discussed, updated and agreed the action points on Enclosure 2.	
4.0	**Annual Report & Accounts 2014-15**	
	PA referred to Enclosure 3 entitled "Charitable Funds Trustees' Annual Report & Accounts for the year Ended 31 March 2015" and explained to the Committee that they were reviewing the accounts at an earlier stage this year as the numbers form part of the Trust's overall Consolidated Accounts.	
	PA highlighted the Review of the Financial Performance & Achievements on Page 4 and explained to the Committee how the fund balances has decreased in the year by £37,000.	

Agenda Item No.		Action
	PA commented that Page 9 onwards of this enclosure detailed the financial figures and gave a brief overview.	
	PA concluded by commenting that this enclosure will be brought back to a future meeting with Audit's opinion.	
	No further questions were raised in respect of the Annual Report & Accounts.	
5.0	**Review of Financial Position to 31 March 2015**	
	PA presented Enclosure 4 and updated members of the committee on the financial position as at 31 March 2015.	
	PA highlighted on Page 1 the closing balance of £873,000.	
	PA went through the income donations on Page 3 and commented that the total donations received was £27,000.	
	The process of checking expenditure was discussed, with regards to whether appropriate challenge was in place to ensure that all use of funds was in line with the terms of the fund. PA stated that this was the responsibility of the trust fund signatories to check, and to challenge where appropriate. He also stated that finance staff supported signatories in this matter on an ad-hoc basis. FK asked about the audit process and PA responded that the Charitable Funds Accounts are audited by Deloitte. He stated that this audit reviews the accuracy of the figures and information within the accounts, but would not generally cover whether money had been spent in line with the terms of particular trust funds. FK raised concerns around how assurance could be provided that donations were being used for the purpose that they were intended. RA noted that there was no independent audit into this factor. PA commented that there is a record of the income received and that the expenditure was being spent appropriately. PA suggested to pull this together and have a rolling review and incorporate a workplan within this Committee.	**PA**
	YS asked if the Trust goes back to the donor to say how the money has been spent. It was discussed that information could be put into a Newsletter and PA agreed to speak to Sally Xerri-Brooks, Head of Communications.	
	FK asked if the £27,000 were all new donations and PA confirmed that they were. FK also asked if these are all documented and the purposes are recorded. PA responded that where the donor is specific on the purpose of the donation, then this is added to an appropriate trust fund.	

Agenda Item No.		Action
	Where the donor does not specific a purpose, the money is allocated to the general fund. He stated that letters go out to the donors to acknowledge receipt and to confirm a high level purpose for who the money will be spent.	
	PA went through the Expenditure on Page 4. PA explained the money returned to the funds related to an accrual for additional functionality in the Clarity outpatients system that the supplier was unable to provide.	
	PA stated that the Investments Portfolio ended in a value of £735,354, an increase of 7.6%.	
	PA went through the Future Plans section on Page 5 and highlighted the comparison to the 5 year plan sent to Monitor, in Quarter 4 of 2014/15 there has been a major underspend of £125,000. FK said that she had written out to fund holders asking for their responses by 12 June 2015. Her letter had stated that if fund holders were not able to provide clarity on how the money would be spent, then the committee would consider whether their funding should be transferred into the general fund.	
	No further questions were raised in respect of this report.	
6.0	**Cazenove Market Update & Review of Investments**	
	PA referred to Enclosure 5 entitled "Charity Multi-Asset - Quarterly Report" and commented that this provides a review of the investments.	
	FK asked if we have reviewed this to obtain better investments. PA confirmed that we had and that, while there were a handful of other competitors in the market, there review had highlighted no major differences between the offerings. The Charitable Funds sub-committee had therefore decided to stay with Cazenove.	
	PA commented that the requirements for reporting and audit will be greater once the expected legacy has been received. There would also be a requirement to report on our approach to ethical investments within our annual report. It was suggested that Cazenove speak to Committee Members with regard to this.	**PA**
	FK asked about the timing of the legacy. PA responded that the original expectation was that the first payment was due in June/July time. HM to follow up.	**HM**
7.0	**Administration Fee 2015/16**	
	PA presented Enclosure 6 entitled "Review of Charitable Funds Administrative Fee". PA commented that the committee has approved a new methodology for 2014/15, and that this methodology has been rolled forward for 15/16.	

Agenda Item No.		Action
	PA asked Members of the Charitable Funds Committee to approve the admin fee of £13,000 and this was approved.	
8.0	**2015/16 Plan**	
	PA presented Enclosure 7 with regard to the proposed charitable funds activity plan for 2015/16 and explained that this was for discussion and approval in line with the Monitor Plan requirements for the Main Trust.	
	PA commented that most of the larger funds have plans in place but there was scope for a wider discussion with regard to General Funds.	
	PA highlighted the expected legacy of £1.6 million in 2015/16 and stated that no assumptions have been made around this this large legacy other than the initial bid approved for an on-site lab.	
	It was discussed that Philip Begg and Andrew Pearson should view any proposal from a clinical/requirement point of view.	
	SN asked about revenue costs for the proposed on-site lab. JC responded that the previously approved bid had some initial running costs that may need prime-pumping but that it would be expected to become self-sufficient within a certain time. JC agreed to put a meeting group together to include JL, PA, FK and report back to Members of this Committee.	**JC**
	It was agreed to add a standing agenda item entitled “Legacy”.	**HM**
	JL asked how broad the uses of the Chapel trust fund was. PA responded that this was very broad and needed to meet the needs of multi-faith offering.	
	A discussion took place around the Multi-Faith room and JL suggested to attract a change in balance around patient population and introduce something more than we are currently offering. It was questioned if the Chaplains are asking, do we have the needs to do this. PA agreed to look into the purpose of this fund.	**PA**
9.0	**Governance Arrangements**	
	PA presented Enclosure 8 with regard to the governance arrangements. PA advised the committee of changes in relation to the governance of NHS Charities and advised that this paper was just for information at this stage.	
	Members of the Charitable Funds Committee were in agreement that changing the organisational form of the charity would have no benefits to the Trust at this moment in time. Members of the Charitable Funds Committee thanked HM for a helpful paper.	
10.0	**Bids for Funding**	

Agenda Item No.		**Action**
a)	Dementia Event	
	LR presented Enclosure 9 and explained that this bid came in from the Matron of Large Joints and the purpose was to raise the profile and awareness of dementia across the organisation.	
	JC commented that she would be happy to raise and support awareness and stated that this should be a piece of work the Trust should be carrying out. It was however discussed that the Committee would like to see more information to justify the request, with particular regard to as to what and who will be involved. LR further commented that it was hoped that the funding would be spent on advertising. LR agreed to ask Stacey Keegan to update this request and HM to recirculate it to the Members of this Group.	**LR/HM**
	Following discussion, the Charitable Funds Committee were in agreement to support this request following receipt further detailed information.	
	JL commented that the Estates Department are working on dementia adaptions and he anticipates a further bid coming to this Committee to fund the work. SN asked if future bids could be screened for more information before being presented at this group. FK asked if this could come out any specific funds.	
b)	Mindfulness Training	
	LR presented Enclosure 10 and explained that this was a bid from the Pre-Operative Assessment Ward to support a Mindfulness Training Programme around the clinical supervision for staff.	
	JC stated as a general comment, mindfulness is a technique and asked what extent does this link to HR. PA had spoken to AC who felt that the committee should consider a) if mindfulness had benefits for the staff and if so, b) whether this should be available more generally. SN commented that it would be more effective if more areas were targeted. JL commented that the beneficial impact should be able to be measured. JL further commented that the concept might be worth testing out. JL mentioned the future portfolio of stress awareness and context from HR jointly on where this fits. JL stated that it would be difficult to approve this in isolation but it could be looked at with a few other things on the back of it.	
	SN asked if there was evidence of a department that was in need of this. YS asked does this monitor if sickness rates go down with this in place.	
	Following discussion, it was agreed that a conversation would take place with Anne Cholmondeley to see how it fits in with other schemes and how it's set up in the appropriate way. It was agreed to invite Anne Cholmondeley and Connie Blunt to	

Agenda Item No.		Action
	the next Charitable Funds Meeting. FK to write to Dr Blunt. AC & Dr Blunt to meet before the next meeting.	**FK**
11.0	**Items Approved Outside of the Committee for Minuting**	
a)	Changes to SORP & Accounting Standards	
	PA presented Enclosure 11 in relation to the Standing Operational Reporting Practices (SORP's) and explained the changes to the accounting standards for charitable funds.	
	PA commented that the Trust will have a choice for how we account for our charities going forward.	
	PA highlighted the changes to the Trustee's Annual Report under Section 2.01 on Page 2 and flagged the number of new additional requirements that will require discussion with the Trustee's.	
	The Members of the Charitable Funds agreed to recommend to the Board that we approve the recommendations in this paper.	
12.0	**New Fund Request**	
	PA referred to Enclosure 12 and explained that the purpose of this paper was to seek Committee Members approval to set up a new fund based on funding received from UHB.	
	PA explained the transfer from UHB to our funds and the request was to transfer this sum from the general funds to a new descriptive fund.	
	FK asked if there is a specific fund that this could be transferred to and PA responded that there are none that are that specific as this is for orthopaedic teaching.	
	SN asked if there is a separate R&T charity. PA confirmed that there was a separate charity, but that this request related to our own ROH Trust funds. PA highlighted what the department wished to spend the money on and suggested they put some bids together for the Charitable Funds Committee to consider.	
	A discussion took place if Members should refuse this request and leave these funds in the general fund and have a strategy in place and for this Committee to monitor this particular fund. Following this discussion RA highlighted that the paperwork has a restriction on it which specifies the funds are allocated to a specific purpose.	
	Following the above conversation, a decision was taken to agree to the request to set up a separate fund to deliver teaching and general development and training. It was requested that appropriate fund holders be in place and Khalid Baloch and the new Associate Medical Director for education were suggested. It was questioned how much this fund would be set up with and a request was for them to demonstrate how much funding they have. PA to action this.	**PA**

Agenda Item No.		**Action**
13.0	**Date of Future Meetings** 14 October 2015, 1:00 pm, Board Room 14 December 2015, 1:30 pm, Board Room	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Friday 09 October 2015

Notice of a meeting of the Council of Governors

Notice is hereby given to all members of the Council of Governors of the Royal Orthopaedic Hospital NHS Foundation Trust that a meeting of the Council of Governors will be held in the Board Room on Wednesday 14th October 2015 at 1500h to transact the business detailed on the attached agenda.

Members of the press and public are welcome to attend the public session which commences at 1600h.

Questions for the Council of Governors should be received by the PA to the Chairman and Associate Director of Governance & Company Secretary no later than 24hrs prior to the meeting by post or e-mail to: PA to the Chairman and Associate Director of Governance & Company Secretary, Jane Colley, Trust Headquarters or via email jane.colley1@nhs.net.

Dame Yve Buckland

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Council of Governors reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AGENDA

COUNCIL OF GOVERNORS

Venue Board Room, Trust Headquarters **Date** 14 October 2015: 1500h – 1645h

TIME	ITEM	TITLE	PAPER REF	LEAD
1500h	1	Exclusion of the press and public	Verbal	Chair
1502h	2	Trust Chairman's appraisal[#1]	Verbal	TP
1515h	3	Apologies and welcome	Verbal	Chair
1517h	4	Declarations of interest	Verbal	ALL
1520h	5	Minutes of previous meetings on 21 May 2015 and notes of workshop on 22 September 2015	ROHGO (5/15) 001 ROHGO (9/15) 001	Chair
1530h	6	Update on actions arising from previous meetings	ROHGO (10/15) 002	Chair
1535h	7	Non Executive appraisals	Verbal	Chair
1555h	8	Non Executive recruitment - skill set and search agent	Verbal	Chair
1600h	9[#2]	Clinical Governance Committee update	ROHGO (10/15) 003 ROHGO (10/15) 003 (a)	KS
1615h	10	Vanguard models of care	Presentation	JC
1630h	11	Governor updates	Verbal	ALL
1635h	12	For information: • Dates of forthcoming meetings • Annual Members Meeting • Staff Awards • Corporate Performance Report	ROHGO (10/15) 004 ROHGO (10/15) 005	Chair
1645h	**Date of next meeting: Wednesday 9 December 2015 @ 1300h – 1500h in Trust Headquarters**			

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 4 November 2015

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 4 November 2015 commencing at **1100h** in the Board Room at the Royal Orthopaedic Hospital NHS Foundation Trust Headquarters.

Members of the public and press are welcome to attend. The agenda for the public part of the meeting is available on the website.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Jane Colley at the Management Offices or via email jane.colley1@nhs.net.

Dame Yve Buckland

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Declaration to Monitor – Quarter 2**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Jo Chambers, Chief Executive & Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**4 November 2015**

EXECUTIVE SUMMARY:

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 (RAF). The Quarter 2 submission was due on the 30th October 2015.

The Trust's response to the statements are as follows:

For Finance statements that the Trust:
***cannot** confirm compliance with the following statements:*
The Board anticipates that the Trust will continue to maintain a Financial Sustainability risk rating of at least 3 over the next 12 months

***can** confirm compliance with the following statements:*
The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.

*For Governance that the Trust **cannot** confirm compliance with the following statement:*
The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards

REPORT RECOMMENDATION:

The Trust Board is asked to receive and note the declaration which was approved by a Committee of the Board comprising the Chair and Chief Executive as agreed at a prior meeting of the Board and submitted to Monitor on 30 October.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	X	Environmental		Communications & Media	
Business and market share		Legal & Policy	X	Patient Experience	X
Clinical	X	Equality and Diversity		Workforce	

Comments: [*elaborate on the impact suggested above*]
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Aligned to a number of key performance targets against which the Trust is monitored.
PREVIOUS CONSIDERATION:
Considered and approved by a Committee of the Board with delegated powers, comprising the Chair and Chief Executive.

FOR INFORMATION

ROHTB (11/15) HC1 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUARTER 2 MONITOR DECLARATION

Report to Trust Board on 4 November 2015

Background

1.0 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 (RAF). The Quarter 2 submission was due on the 30th October 2015.

1.1 Monitor initiated a process of consultation on the RAF which ended on 31st July 2015 and to which the Trust contributed. Monitor consulted on 3 main changes to the Risk Assessment Framework:

- The re-introduction of financial efficiency metrics to measure Foundation Trust deficits and their variance from plan.
- The introduction of a sustainability and financial performance financial risk rating to replace the current continuity of services risk rating.
- The introduction of measures relating to value for money in both the Monitor governance rating and the NHS Foundation Trust accounting officer memorandum.

1.2 All 3 main changes were introduced, with some minor changes to the proposed financial efficiency metrics.

Detail

2.0 The reporting requirements summarised above are addressed and evidenced as follows.

Financial information

2.1 Summary

2.1.1 Based on the supporting information in this section of the declaration, it is proposed that the following responses be made to the Monitor statements in respect of Finance:

For Finance statements that the Trust:
***cannot** confirm compliance with the following statements:*
The Board anticipates that the Trust will continue to maintain a Financial Sustainability risk rating of at least 3 over the next 12 months

***can** confirm compliance with the following statements:*

The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.

2.1.2 The evidence to assure the Board of the Trust's financial performance for the 3 months from the 1st July 2015 to 30th September 2015 is contained in the Trust's Corporate Performance Report.

2.1.3 The Trust's deficit stands at £2.445m at the end of Quarter 2, against a planned deficit of £0.952m. This has largely been driven by a significant underperformance on elective activity, which is 424 spells behind target in the year to date. This is partially offset by a year to date overperformance of 28 day cases and 52 non-elective cases, resulting in an overall admitted patient care underperformance of 343 cases. This, along with underperformance on outpatients, has driven the Trust to a shortfall of c.£3m on planned income during the year. Whilst there are some savings from underspends on pay and non-pay, this leaves an overall shortfall on the planned financial position.

2.1.4 The Trust had planned to deliver a Continuity of Services Risk Rating of 2 in Quarter 2 of 2015/16. As previously mentioned, changes to Monitor's risk assessment framework have result in the introduction of a different measure of financial risk. Under the new Financial Sustainability Risk Rating, the Trust has delivered a rating of 2, in line with our planned rating. This rating is underpinned by a strong liquidity position, with the other measures linked to Capital Service Cover and I&E performance being rated as a 1 (lowest score)

2.1.5 The quarterly governance declaration requires the Trust to declare that we will continue to achieve a Financial Sustainability Risk Rating of 3 for the next 12 months. Within the rules surrounding the new financial risk rating, there is an override trigger where by scoring a rating of 1 for any of the 4 elements of overall rating will result in the overall rating being capped at a 2. To avoid receiving a rating of 1 for our I&E margin, we would need to deliver a deficit of less than £800,000 for the full year. This is not currently deliverable, and as such, we are not in a position to declare that we are able to achieve a Financial Sustainability Risk Rating of 3 for the next 12 months

2.1.6 The Trust is required to submit monthly returns which include year-end forecasts of our I&E position and capital expenditure. The Board have already received a paper relating to our forecast I&E position, and there is a paper on the November Board regarding capital. We are required to declare that we anticipate that the Trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return. Whilst there is still some uncertainty in the timing of payments relating to the ePMA project, based on our current expectations it is recommended that we confirm this declaration.

3.0 Service Performance Targets

3.1 Summary

3.1.1 The table of Monitor requirements and evidence is attached as Appendix 1 of this report.

3.1.2 Based on the supporting information in this declaration, it is proposed that the following

response be made to the Monitor statements in respect of Governance:

*For Governance that the Trust **cannot** confirm compliance with the following statement:*
The Board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards

3.1.3 Further detail regarding the risk of any non-compliance (and any actions being taken to address this) is detailed in subsequent paragraphs.

3.2 Incomplete RTT

3.2.1 It was previously stated that the compound position of active waits has reported a healthy, albeit deteriorating position over the last 6 months. This has followed our modelling through Q1 and into Q2 which has previously been communicated to Monitor where we have indicated a continuing decline towards the 92% position.

3.2.2 Of the Trust's entire pathway of services, 46% of our current incomplete backlog above 18 weeks relates to spinal services, both general and deformity. As previously advised, the Trust was involved in detailed negotiation with NHS England over the summer months, culminating in a position just short of formal arbitration, directly around capacity constraints for spinal deformity services. With little alternative, the contract was signed to include some additional activity to reduce waits but this did not achieve everything the Trust required and a strategic solution to the capacity constraints has not yet been agreed with commissioners. The contract position means that the waiting list is not in equilibrium and spinal patients are a significant proportion of all over 18 week waits; this position will continue to deteriorate with an increasingly disproportionate impact on the incomplete pathway until the position is resolved with commissioners. A shortfall in spinal capacity remains to such a pronounced degree that all the Trust's data intelligence predicts a breach of the Trust level target during the latter part of this financial year. This breach can be directly attributable to Spinal Services and the longstanding challenges in this service. The Trust does not have the facility to safely manage complex cases onsite, therefore work is continuing to provide solutions to the capacity constraints both with commissioners and internally, including the active mitigation of the risks around this issue and the development of a robust recovery/outsourcing plans. For clinical safety reasons many of the long-waiting patients will require their surgery at Birmingham Children's Hospital, however there is insufficient capacity at BCH to meet this need, meaning that requests for access to additional capacity and Paediatric Intensive Care back up have not been met. The earliest that additional capacity could be made available is July 2017. From April 2016, it is hoped that one additional session every two weeks will be available from University Hospitals North Midlands. Commissioners are aware of both of these options and constraints but have been unable to assist in bringing forward timescales to address the current waits. There is therefore, still a significant possibility that the measures we are taking are able to control the continued reduction in performance in the short term, resulting in a risk to delivery of the Incomplete RTT standard, which, in the light of the contract settlement during Q2 is of more concern than at Q1.

3.2.3 The Board is satisfied that the capacity tools recently invested in by the Trust show a more accurate picture of the pressures faced over the coming year which will enable confidence in the picture to develop. Every effort is being made to optimise performance against the Incomplete target and the reduction of Trust backlogs. The Board remains committed to achieving a sustainable strategic solution for long waits with commissioners. The Board has considered and rejected temporarily suspending the list to new referrals but will keep this option under review.

3.3 Cancer 62 Day target

3.3.1 There have been no breaches of the cancer 62 day wait during Quarter 2.

3.3.2 In months where the Trust is treating low numbers of cancer patients or handling late referrals, there is a risk that breaches to the target may occur.

3.4 52 week RTT

3.4.1 The Trust has experienced several patient treatments' time breaches of the 52 week RTT standard during quarter 2 (note this is not a target included within Appendix A). All of the patients breaching the standard are children or young adults requiring complex Spinal Deformity surgery or Young Adult Hip surgery.

3.4.2 NHS England have been continuing to work with ROH to expand the service and provide reinvestment of penalties to support additional activity to be commissioned with independent sector providers.

3.4.3 We have worked with NHSE Specialist Commissioning to develop plans to treat an additional 35 of our complex patients in Q3 & Q4 using a mix of external capacity and internal temporary enhancements to our capability. Through this period we expect to continue to suffer 52 week breaches albeit at a reduced volume to the end of Q4.

3.4.4 The operational issues regarding the 52 Week RTT metrics have been highlighted to Monitor previously outside the quarterly reporting schedule.

4. Broader Governance

4.1 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 was selected to be part of one of 13 Vanguard models of care announced by the Chief Executive of the NHS England on 25 September. The National Orthopaedic Alliance will comprise the ROH, together with Robert Jones and Agnes Hunt Orthopaedic Hospital in Oswestry and Royal National Orthopaedic Hospital in Stanmore. This is an excellent opportunity for ROH to strengthen collaboration, support improved outcomes and spread good practice.
- The Trust held its Annual Members Meeting on 14 October, which was held in public and attracted c. 50 members, from public, stakeholder and staff constituencies.

- Plans to commence the recruitment of a Non Executive Director to fill the vacancy created by the departure of Elizabeth Chignell earlier in the year were approved by the Council of Governors at their meeting held on 14 October. The skill set for the individual is to be commercial acumen, experience of partnership working, supported by strengths around finance and risk.
- A substantive appointment to the post of Associate Director of Governance and Company Secretary commenced in post during August. The new post will take responsibility for strengthening the Trust's compliance, regulatory and governance framework.
- 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 (CGC) has met twice times during the quarter and reviewed the relevant assurances that risks to compliance are being managed. The workplan of the Committee has been refreshed to provide a more comprehensive span of assurance, including improved arrangements for trustwide governance committees to report upwards.
- The Audit Committee has met formally during the quarter and has also held a workshop, which focussed on potential improvements to the Trust's Board Assurance Framework and improving the effectiveness of the Audit Committee, including its relationship with the Clinical Governance Committee.
- On the 28th and 29th July 2015 there was a limited CQC re-inspection which followed the full CQC inspection during 2014. The draft report is awaited.
- The Trust is continuing to addressing a number of matters relating to clinical governance as summarised in the table below:

Issue	Actions taken	Work in progress
Serious Incidents Following review by the Clinical Governance Committee, additional assurances regarding the robustness of the processes by which serious incidents are reported and handled has been requested	The Serious Incident process is being redesigned to ensure that when actions have been taken to review the incident the action can be closed on the Ulysses system	The Clinical Governance Committee will continue to monitor the Serious Incident position as part of its monthly agenda. The refreshed, Executive-led Quality Committee is providing operational oversight of this work
Duty of Candour Processes by which incidents need to managed according to CQC Regulation 20 need to be systematised and strengthened	A database has been created to set out the 17 steps required to handle any case that falls within the remit of Regulation 20. New training material is being developed and delivered to raise awareness of the process and the Trust's obligations under this regulation	The position is reviewed on a weekly basis by the Executive Team and forms a part of the Patient Quality & Safety report presented monthly to the Clinical Governance Committee

Equipment A planned review by internal audit highlighted the need to improve equipment training, maintenance and documentation.	A Trust wide action plan responding to the review has been delivered, which has addressed the position.	The outputs from the action plan were reviewed by the Clinical Governance Committee in August and September.
Policies Policy governance within the organisation currently requires improvement, such that robust systems are in place to ensure that policies are reviewed in a timely way and are presented for approval in a systematic way	Work is underway to finalise the list of policies that are requiring a review. These will be prioritised for review and approval based on potential risk to the organisation and will be scheduled in for approval by the CEO on the advice of the Trust Management Committee. A refreshed Policy on Policies is being developed, which will provide a more effective framework for the development of policies going forward.	Work continues to improve policy governance. The Clinical Governance Committee is appraised of progress on a monthly basis.

4.2 The Audit Committee met in September and in respect to this declaration can offer the following assurance:

- The notable closer working links and communication between Audit Committee, Clinical Governance Committee and the auditors were welcomed. The enhanced reporting up to the Audit Committee by CGC was pleasing in particular.
- The outcome of the Capital CHKS 'Payment & Tariff Assurance Framework' audit presented the Trust in a positive light in respect of clinical coding and the Trust had been chosen by Monitor as 1 of 5 roadmap partners for costing.
- Much work was reported to have been undertaken by the Counterfraud team, which provided good assurance that fraud prevention and resolution was being handled well
- A large number of green audit recommendations within the internal audit recommendation action tracker was noted
- The levels of losses and compensations, when benchmarked, indicated a good level of control within the Trust
- The number of breaches of Standing Orders and Standing Financial Instructions was noted to be low
- Continued compliance with declarations of hospitality and interests was noted

The Committee challenged the following areas:

- It noted that there were a number of internal audit reports which had not received a management response. This matter was to be escalated to the Executive Team and relevant directors.
- Although good progress had been made with addressing open audit recommendations, it was reported that there remained pressure to close these (particularly the 'red' actions) in a timely manner
- The value and number of single tender forms had increased significantly. Further concerns were raised over the use of interim staff at a senior level from companies, where a tendering exercise had not been undertaken. This was being addressed with a plan to recruit substantive individuals into these positions by the end of the financial year, including within the governance team where there was currently a heavy reliance on interim staff.

The following actions arose from the Committee:

- A process for streamlining and simplifying the process for developing the annual report and accounts would be presented at the next meeting
- An enhanced report from Internal Audit would be created to provide additional details on the completed reports and show the process for signing off management responses
- Finance Director to review the Internal Audit plan with the Executive Team
- A review of the procurement exercise related to value for money from implants is to be undertaken
- Dates of CGC and Audit Committee are to be arranged so as to assist reporting arrangements

A workshop was held in October which focussed specifically on the current state of Board Assurance and the effectiveness of the Audit Committee. An action plan following feedback from Board members at this workshop is to be developed, which will be led by the Executive Team, with oversight on progress provided by the Audit Committee.

APPENDIX ONE

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.

A limited CQC re-inspection was carried out on July 28th and 29th 2015.

The Trust can confirm that there are no exception reports to be provided in Quarter 2 with regard to:

- Financial sustainability
- Financial Governance
- Governance

Targets and indicators with thresholds for 2015/16

Target or Indicator (per Risk Assessment Framework)	Threshold or target YTD	Scoring	Source	Comments
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
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0		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

*As stated in the last quarterly return, compliance actions were identified as part of the CQC review published on 17th October 2014. A plan is in place to deliver the actions. A follow-up visit by the CQC occurred in July 2015, but the findings are not yet available.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD

Venue Board Room, Trust Headquarters **Date** 4 November 2015: 1100h – 1300h

Members attending

Dame Yve Buckland	Trust Chair	(YB)
Mr Tim Pile	Vice Chair	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Prof Tauny Southwood	Non Executive Director	(TS)
Mr Rod Anthony	Non Executive Director	(RA)
HH Frances Kirkham	Non Executive Director	(FK)
Mrs Jo Chambers	Chief Executive	(JC)
Mr Jonathan Lofthouse	Chief Operating Officer	(JL)
Mr Andrew Pearson	Medical Director	(AP)
Mr Garry Marsh	Director of Nursing & Clinical Governance	(GM)
Mr Paul Athey	Finance Director	(PA)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(ACh)
Prof Phil Begg	Director of Strategy and Transformation	(PG)
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL) [Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies & welcomes	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	Patient Case – *not included this month to allow sufficient discussion for other quality matters*		
1107h	4	Minutes of Public Board Meeting held on the 2 September 2015 *for approval*	ROHTB (9/15) 001	Chair
1115h	5	Trust Board action points: *for assurance*	ROHTB (9/15) 001 (a)	Chair
1120h	6	Chairman & NED update: *for information*	Verbal	Chair & NEDs
1130h	7	Chief Executive's update: *for information and assurance*	ROHTB (11/15) 002 ROHTB (11/15) 002 (a)	JC
		STRATEGY & POLICY		
1150h	8	Paperless Board business case: *for information*	Verbal	Chair

CORPORATE PERFORMANCE & ASSURANCE				
1200h	9	Corporate Performance Report: *for assurance*	ROHTB (11/15) 003 ROHTB (11/15) 003 (a)	PA/JL/ GM
1215h	10	Nurse establishment review and safe staffing report: *for assurance*	ROHTB (11/15) 004 ROHTB (11/15) 004 (a)	GM
1225h	11	Nurse revalidation: *for information*	ROHTB (11/15) 005 ROHTB (11/15) 005 (a)	GM
1235h	12	Capital – Half yearly report 2015-16 *for approval*	ROHTB (11/15) 006 ROHTB (11/15) 006 (a)	PA
1245h	13	Monitor Quarterly Declaration – Quarter 2 *for information*	To follow	JC
ASSURANCE UPDATES FROM THE BOARD COMMITTEES				
1250h	14	Audit Committee	ROHTB (11/15) 007	RA
	15	Clinical Governance Committee	ROHTB (11/15) 008	KS
	16	Transformation Committee	ROHTB (11/15) 009	TP
	17	Charitable Funds Committee & minutes	ROHTB (11/15) 010 ROHTB (11/15) 010 (a)	FK
	18	Council of Governors & minutes	ROHTB (11/15) 011 ROHTB (11/15) 011 (a)	Chair
1255h	19	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 2nd December 2015 at 1100h, Board Room, Trust Headquarters				

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

MINUTES

Trust Board (Public Session) - DRAFT Version 0.4

Venue Boardroom, Trust Headquarters **Date** 2 September 2015: 1100h – 1500h

Members present

Dame Yve Buckland	Trust Chair	(YB)	[Chair]
Mr Tim Pile	Vice Chair	(TP)	
Mrs Kathryn Sallah	Non Executive Director	(KS)	
Mr Rod Anthony	Non Executive Director	(RA)	
HH Frances Kirkham	Non Executive Director	(FK)	
Mrs Jo Chambers	Chief Executive	(JC)	
Mr Jonathan Lofthouse	Chief Operating Officer	(JL)	
Mr Paul Athey	Director of Finance	(PA)	

In attendance

Ms Anne Crompton	Deputy Director of Nursing & Clinical Governance	(ACr)	
Ms Anne Cholmondeley	Director of Workforce & OD	(ACh)	
Mr Julian Denney	Interim Company Secretary	(JD)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]
Ms Sally Xerri-Brooks	Head of Communications	(SX-B)	

Apologies

Prof Tauny Southwood	Non Executive Director	(TS)
Mr Andy Pearson	Medical Director	(AP)
Mr Garry Marsh	Director of Nursing & Clinical Governance	(GM)
Prof Phil Begg	Director of Strategy & Transformation	(PB)

Minutes	Paper Reference
9/15/01 Apologies	**Verbal**
Apologies were received from Prof Southwood, Mr Pearson, Mr Marsh and Prof Begg. The Board welcomed Mr Maxell Tsopo, a member of the public.	

9/15/02	**Declarations of Interest**	**Verbal**
There were no declarations of interest to note.		
9/15/03	**Patient Case – an illustration of the work we do**	**Presentation**
Mr Chris Prothero joined the meeting to present an overview of the care of his father, a patient of the Trust, who had been treated on Ward 2 and Ward 12 primarily. The care was reported to have been exceptional and Mr Prothero praised a range of staff from both clinical and auxiliary groups. He suggested that imparting some of the custom and practice into other organisations would be beneficial. Mr Prothero was thanked for sharing his positive experience and was advised that it had been an honour to treat the patient's father. He was asked what additional measures would have made the experience even better and was advised that there was nothing additional that could be brought to mind. The Chair agreed to write to the relevant staff to thank them for the care of the patient and it was agreed that some of the feedback would be shared on the website. JC noted that it was pleasing to hear about the team effort that had been experienced and noted that the porters had recently been awarded a CEO award.		
ACTION:	**Chair to write to portering team, catering team and wards 2 & 12 to advise them of the positive patient experience heard by the Trust Board** **ACTION: SXB to arrange for the positive patient feedback to be used on the Trust website**	
9/15/04	**Minutes of the Public Board – 1 July 2015**	**Enclosure 1**
The minutes were approved as a true and accurate record of discussions held on 1 July.		
RESOLVED:	**The Board approved the minutes of the last meeting**	
9/15/05	**Trust Board action points**	**Enclosure 2**
It was noted that updates had been gained for the majority of actions, with a number being marked as resolved or suggested for closure. Overall, there had been no major delays with action progress. It was highlighted that a number of actions were marked as being due for completion in October and November and that it was the intention for the next meeting for the		

Board to be presented with a 'RAG' rated action list that shows progress, completion or items off track.	
9/15/06 Chairman & NED update	**Verbal**
The Chair provided an update on a number of matters, including: • Work underway to fill the outstanding Non Executive Director vacancy • Progress with NED appraisals, which was near completion • A proposal to remove Rod Anthony from the membership of the Clinical Governance Committee membership, with him being 'in attendance' instead in future. It was reported that this was seen as being necessary due to the potential conflicts of interest with his chair of Audit Committee role. The Board approved this proposal and agreed that the terms of reference of the CGC should be altered accordingly. It was agreed that the membership of CGC be reviewed later in the year • A reminder that a number of 'Paperless Board' solutions had been reviewed recently and that a short business case would be presented to the November meeting • The Annual Members Meeting & staff awards were reported to be scheduled for 14 October • The Board and Audit Committee workshops were planned for 7 October. Items for Board workshop included the GGI action plan, risk management and the commercial & estates strategies	
ACTION: SGL to undertake a review of the membership of the Clinical Governance Committee in November 2015 **AGREEMENT: The Board approved the removal of Rod Anthony from the membership of the Clinical Governance Committee and agreed that the terms of reference should be amended accordingly**	
9/15/07 Chief Executive's update	**Enclosure 3**
The Chief Executive's report was presented for acceptance, with a number of matters being drawn out for the Board. The Board was advised that the national context was extremely challenging around finances and all NHS organisations had been asked to consider whether the forecast positions could be improved. Modelling the new 2016/17 tariff was noted to be underway and the Director of Finance raised possible concerns about the possible	

financial implications on the Trust of the early proposals on the speciality tariff. It was noted that it would be harder to challenge the tariff in future. An update on the progress with the Vanguard bids was provided. The Board was reminded that the Trust had expressed an interest in being part of the Strategic Orthopaedic Alliance under this scheme and had been shortlisted for further evaluation. A series of bilateral meeting with CEOs and Chairs in the local system was underway to better position the Trust regionally. TP congratulated the team on the Health Service Journal Best Places to Work outcome and asked what the criteria were for this judgement. He was advised that a set of questions had been asked of staff which was a subset of all staff satisfaction questionnaire. It was noted that the Trust's position in terms of appraisal and learning & development had assisted the position and that the Trust was one of the few specialist organisations shortlisted. Staff joining the ceremony were reported to have been very honoured and felt valued at the Patient Safety Congress. Noting that the new divisional structure was now in effect, it was highlighted that the new staff would be engaged with the work and processes of the Clinical Governance Committee. It was noted that there was an ongoing work to develop the processes by which staff declared hospitality and interests. The Board offered their congratulations to Garry Marsh, Director of Nursing & Clinical Governance and Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary on their recent appointments.	
9/15/08 Communications and Engagement Strategic Framework initial report and quarterly report	**Enclosure 4**
SXB joined the meeting for this item. It was reported that the Communications and Engagement Strategic Framework was a significant piece of work and was supported by four key substrategies. The key points of discussion included: • The communications work to date had created a positive impact. • Press coverage had been good and positive overall. • The launch of the new website was planned, which included improved search	

functionality. • Effort should be given to measuring the penetration of messages that were issued corporately. • Presentationally, patients needed to be reflected more centrally within the diagram on page six of the strategy. • Brand 'personality' was suggested to need consideration and it was agreed that a progress update against would be included in the next quarterly report. • The work needed to bear in mind current financial limitations, although as it would centre on principally achieving a consistent style that reflected the Trust's value & heritage, it was noted that there were not significant financial implications at present. • A spike in referrals to the Functional Restoration Programme had been seen as a result of some media coverage in partnership with colleagues in physiotherapy and nursing. • The development of a set of indicators would be useful by which the Board could monitor progress and trends. • Birmingham Children's Hospital NHS FT should be added into the benchmark for mentions in print & online media. • A timeline for communications developments should be included within the next update. • The strengthened engagement with GPs was welcomed and it was noted that the Trust was getting stronger on Twitter.	
ACTION: **SXB to develop a suite of indicators & benchmarks to demonstrate the impact of the communications strategy** **ACTION:** **SXB to ensure that the following are included in the next quarterly report – progress against indicators, benchmark information against BCHNHSFT and a timeline for communications developments planned**	
9/15/09 **The Well Led Framework**	**Enclosure 5**
SG-L presented an overview of Monitor's Well Led Framework and the Trust's approach to the forthcoming review. The Well Led Framework was reported to have been published initially in May 2014 and	

republished in April 2015, bringing together the perspective of being well-led in the view of Monitor, Care Quality Commission and Trust Development Authority. The Well Led Framework links closely to the Risk Assessment Framework which sets out the expectation that Trust's will review their governance arrangements every three years, meaning that the latest that the Trust could undertake its assessment would be by May 2017. The background to the Well Led Framework was noted and the Board was guided through the assessment process. It was highlighted that the Well Led Framework replaced the Department of Health's Board Governance Assurance Framework (BGAF) and the Monitor Quality Governance Framework (QGF). The ten key questions which the Trust would be asked to answer were reviewed, which were noted to fall into four domains: strategy & planning; capability & culture; process & structures; and measurement. The opportunity to engage with the Trust's Council of Governors as part of the process was highlighted. In terms of financial implications, a desk top view and discussion with others who had organised their review was suggested to be £50k - £70k, mainly associated with the engagement of the independent reviewer. The timetable for the assessment was outlined, with a proposal that an early view of the Trust's position against the Well Led Framework be undertaken at the January Board workshop. It was suggested that the formal review is started in June 2016 and concluded by February 2017 to ensure that the arrangements currently being put into place to strengthen the Trust's governance framework are embedded sufficiently. It was highlighted that this was a transitional year for the Trust and as such, Monitor was comfortable with the plans and timetable proposed. The CQC report due for publication in October will also have some tools available to use to form some of the judgements in the Well Led Assessment. RA suggested that there was a link between the Well Led Framework and the work to redevelop the Board Assurance Framework.	
RESOLVED: **The Board approved the proposal to receive an early view assessment against the Well Led Framework at the workshop scheduled for January 2016**	
9/15/10 **Corporate Performance Report**	**Enclosure 6**
PA introduced the corporate performance report as a routine item.	

The financial position was noted to be challenging at present, with there being an underperformance on activity and income. It was reported that the current position was a deficit of £1.57m against a plan of £0.48m. Other pressures include the CIP plan, which was highlighted to be behind delivery by £290k, with a small number of significant schemes impacting significantly. Some of these will assist with delivery on income. There are a number of other schemes around digital dictation, repatriation that were reported to be off track at present. Additional pressures were reported to relate to pay spend and on theatre agency staffing due to high sickness absence rates. The private patient income position was noted to be positive at present.

It was suggested that some lead indicators needed to be identified to provide an early alert as to when activity was deviating from plan. It was reported that the next planning round with divisions would pick this up better and work more intelligently using job planning and performance monitoring. It was suggested that there needed to be better join up to ensure that there was consistent capacity and no areas where overstaffed or understaffed. The Director of Operations was asked to give further thought to developing the early warning indicators as suggested.

It was reported that admitted and non-admitted referral to treatment time standards would be breached in coming months as NHS England had removed sanctions on the admitted and non-admitted standards as they are to be abolished and all providers have been asked to focus on the incomplete standard instead.

To deliver the efficiencies required to recover the activity position, the processes related to Admission and Day Case Unit (ADCU) and Pre-operative Assessment Clinic (POAC) processes will be streamlined and performance will be optimised in September to give an indication of grip. In terms of assurance to the Board JL reported that the new divisional structure was in place, therefore medical secretaries would be managed differently and in due course bookings would be centralised. More mechanical restructuring was reported to be needed in ADCU to deliver improvements to ensure that patient scheduling is improved. It was highlighted that the Medical Staff Committee had raised the issue that ADCU was not open sufficiently early, however the matter had been rectified. Visibility of the September operating lists was reported to be good. There were plans to better flag systems issues in future and a comparison was being made between individual consultants to identify areas of poor performance. A map of theatre activity against job plans was an area of concern which would be addressed by the improvement clinician.

An update on performance against clinical indicators was presented. The Board was advised that two Serious Incidents had been reported in that last month, representing a decrease from the previous month. All seven falls reported have been reviewed, one of which was identified as being avoidable. Three pressure ulcers had been reported, one of which was a Grade 2 and one a Grade 3; two of the pressure ulcers were avoidable.

Some work was reported to be underway to look at devices in theatres and standardising these as a means of eliminating pressure ulcers and a tissue viability specialist from Lincoln was to be engaged to undertaken a systems review in the Trust. It was noted that the risk assessment for tissue damage that was in place was comparable to elsewhere. It was suggested that the use of pressure-alleviating mattresses needed to be considered, which was noted to be in hand. It was reported that the learning was discussed at the senior nurses forum and some work on sharing the stories at a ward level was planned. Seven complaints were reported to have been opened in July, all of which were being handled within the required timescale. All 2014/15 complaints have been dealt with. The Board agreed that this was pleasing and it was good to hear that the historical issues had been addressed. Average Length of Stay was noted to be rising at a time when activity was lower than expected which was queried. It was reported that a piece of transformation work was underway around discharge and the preoperative process for setting estimated date of discharge which would address this and linked to the CQUIN discharge. In terms of cancellations, current levels were circa ten per a week out of a caseload of 240, however once POAC work was completed there was an expectation that this would reduce significantly. Overrun and poor scheduling of theatre lists was a contributory factor. It was suggested that a patient quality dashboard was needed to be able to triangulate some of the key metrics. The Board was advised that a more integrated dashboard was planned and an executive summary of the dashboard would be developed. Work was being undertaken to differentiate the level of information received at board, committee and divisional level. It was highlighted that workforce was at 'green' status, which partly reflected that mandatory training issues had been addressed. Mr Pile left the meeting at this point.	
ACTION: **JL to consider and develop a set of metrics which would provide an early alert of deviation from planned activity** **ACTION:** **PA with SG-L to oversee the development of an integrated performance dashboard, including the provision of an executive summary**	
9/15/11 **Safe Staffing report**	**Enclosure 7**

The Board considered a report into nurse staffing levels for June and July. It was highlighted that staffing numbers had been sufficient to meet need during this period. The vacancy factor was reported to be low although agency usage remained static. The recent national guidance on setting an upper limit for use of agency staff was highlighted and would need to be borne in mind over the coming months. Implementation of the red flag shifts would be undertaken and developed shortly. It was suggested that there was further work to do to harmonise staffing levels between budgeted and recommended and that there was a lack of assurance available to indicate that the right skills were deployed in the most appropriate way. Some examples were given. It was noted that an establishment review was to be presented to the Board shortly and further detail of agency and sickness levels was to be built into the reports to show why temporary staffing was used and where. Further detail on the red flag shift work was requested. ACr reported that these were defined by NICE which includes the consequences of inadequate staffing levels. It was noted that in the majority of cases any incidents associated with staffing would be reported regardless. In response to questions about the robustness of the process for reporting Duty of Candour it was highlighted that the Ulysses system needed to be used more intelligently and proactively. It was suggested that this could be used as an early warning system. It was noted that a number of incidents needed to be recalibrated to provide consistency around staff in their training so that they are raising the alarm where needed but not unduly so. It was reported that as part of the recent meeting between the Chair & Chief Executive and Richard Burden MP, there had been discussions around the new restrictions around recruitment from abroad. ACh reported that an orientation plan was being developed for Philippine nurses including preceptorship and introduction into the local community. It was noted that the report's narrative needed to be changed to address the private suite references. In terms of bank and agency staff, it was suggested that an indication of what usage had been against planned levels would be useful.	
ACTION: **GM to present the nurse establishment review outcome to the Board** **ACTION:** **GM to amend the nurse staffing report to 1) incorporate nurse agency actual usage and expected usage in the next report 2) remove**	

	references to private suite	
9/15/12	**Self-assessment against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)**	**Enclosure 8**
JL presented the self-assessment against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) which the Board was asked to receive and accept. The Board was advised that the standards changed annually. Regarding the small number of areas of non-compliance, further development work is planned to address the position. Timescales agreed with local resilience forum will be achieved. The areas marked as being at amber status on the previous year's assessment were reported to have been responded to, apart from that relating to corporate manslaughter training for Executives.		
ACTION:	**SGL to organise training for the Board on corporate manslaughter**	
9/15/13	**Monitor Quarterly Declaration**	**Enclosure 9**
The latest quarterly declaration to Monitor was presented, which the Board was noted had been approved for submission by a Committee of the Chief Executive & Vice Chair. It was highlighted that compliance could not be declared in relation to meeting existing targets, given that the Trust was not achieving the non-admitted 18 weeks referral to treatment time target or the 62 day cancer waiting time target at present. The latter reflected the small number of patients being treated. Formal feedback from Monitor was awaited in this respect.		
9/15/14	**Annual Statement of Compliance – medical staff revalidation & appraisal**	**Enclosure 10**
The Board was presented with the summary compliance with medical staff revalidation & appraisal regulation. It was highlighted that compared to peer organisations, the Trust was an outlier in three areas and therefore an action plan had been developed to address the position. The Board agreed that the Chief Executive should sign the Statement of Compliance.		
RESOLVED:	**It was agreed that the Chief Executive should sign the annual Statement of Compliance relating to medical staff revalidation & appraisal**	

9/15/15	**Charitable Funds Committee, including any minutes of the Committee**	**Enclosure 11**
The Board was asked to note the minutes of the Charitable Funds Committee that had been held on 29 May 2015. It was reported that the Committee had not met since the last Board meeting, however it was scheduled to meet again in October. In the meantime, some further discussions had occurred regarding the Dubrowski legacy, which would be spent to conduct research and would be led by Professor Begg. It was highlighted that the take up of charitable funds was still slow. It was suggested that they might usefully be spent to support some of the issues raised on the safe staffing report, such as mattresses to prevent pressure ulcers. All full Board members were reminded that they were Trustees. In response to a query around the auditing of Charitable Funds, the Board was advised that the annual audit did not currently capture adherence to the terms of the spend. Further work was planned to understand the additional scrutiny as a result of the Dubrowski legacy but additional assurance may also be needed for trustees. It was suggested that an overview of the role of trustees was needed which PA agreed to provide. It was noted that the cost of a full audit could be expensive so a tailored approach could be valuable. It was suggested that donors should be asked to exclude certain areas for their donation to spent using standard documentation for donors to complete.		
ACTION:	**PA to prepare a briefing on the role of the charitable trustee** **ACTION: PA to review the audit requirements for Charitable Funds** **ACTION: PA to consider preparing standard documentation that prompted donors to define the purposes for which they did not wish their donation to be used**	
9/15/16	**Other Board Committees**	**Verbal**
The Board was advised that the Clinical Governance Committee was working to the new structure.		
9/15/17	**Council of Governors**	**Verbal**
The Chair reported that three new governors that had been elected to the Council of Governors (Alex Gilder, Carol Cullimore and Petro Nicolaides) and a further two had been re-elected (Marion Betteridge and Karen Hughes).		

It was highlighted that all Non Executive Directors were welcome and indeed encouraged to attend Council meetings.	
9/15/18 Any other business	**Verbal**
There was no any other business.	
Details of next meeting	**Verbal**
The next meeting is planned for 4 November 2015 at time to advised in the Boardroom, Trust HQ.	

PUBLIC SESSION

Next Meeting: 4 November 2015, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

2 September 2015, Boardroom @ Trust Headquarters

Members present: Yve Buckland (YB), Tim Pile (TP), Kathryn Sallah (KS), Rod Anthony (RJA), Frances Kirkham (FK), Jo Chambers (JC), Jonathan Lofthouse (JL), Paul Athey (PA)

In Attendance: Anne Crompton (ACr), Anne Cholmondeley (ACh), Julian Denney (JD), Sally Xerri-Brooks (SXB) [Part]

Apologies: Tauny Southwood, Andrew Pearson, Garry Marsh, Philip Begg

Secretariat: Simon Grainger-Lloyd (SGL)

Last Updated: 27 October 2015

Reference	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT. 008	Safe Staffing report	Enc 7	02/09/2015	Present the nurse establishment review outcome to the Board	GM	04-Nov-15	The process for nurse establishment review included in the public Trust Board paper on safe staffing; further detail to be provided at the December Board meeting	
ROHTBACT. 010	Charitable Funds Committee, including any minutes of the Committee	Enc 11	02/09/2015	Prepare a briefing on the role of the charitable trustee	PA	14-Oct-15	Discussed at the meeting of the Charitable Funds Committee held on 14 October and it was agreed to consider any training that may be available from Mills & Reeve LLP and Kathryn Sallah also offered to circulate some guidance that she had	
ROHTBACT. 011	Charitable Funds Committee, including any minutes of the Committee	Enc 11	02/09/2015	Review the audit requirements for Charitable Funds	PA	14-Oct-15	To be reported to the Charitable Funds committee in February 2016	

ROHTBACT. 012	Charitable Funds Committee, including any minutes of the Committee	Enc 11	02/09/2015	Consider preparing standard documentation that prompts donors to define the purposes for which they expressly do not wish their donation to be used	PA	14-Oct-15	To be reported to the Charitable Funds committee in February 2016	
ROHTBACT. 003	Chairman & NED update	Verbal	02/09/2015	Undertake a review of the membership of the Clinical Governance Committee in November 2015	SGL	13-Nov-15	Membership of Committee adjusted so that the Chair of Audit Committee is no longer a member, but can attend as an observer periodically. A discussion was also held at the Council of Governors meeting on 14 October, where it was agreed that a governor representative would be invited to join the committee as an observer. The membership will be reviewed further to determine the Non Executive director representation at the end of the calendar year.	
ROHTBACT. 004	Communications and Engagement Strategic Framework initial report and quarterly report	Enc 4	02/09/2015	Develop a suite of indicators & benchmarks to demonstrate the impact of the communications strategy	SXB	02-Dec-15	ACTION NOT YET DUE	
ROHTBACT. 005	Communications and Engagement Strategic Framework initial report and quarterly report	Enc 4	02/09/2015	Ensure that the following are included in the next quarterly report – progress against indicators, benchmark information against BCHNHSFT and a timeline for communications developments planned	SXB	02-Dec-15	ACTION NOT YET DUE	
ROHTBACT. 006	Corporate Performance Report	Enc 6	02/09/2015	Consider and develop a set of metrics which provide an early alert of deviation from planned activity	JL	04-Nov-15	Included within the private Trust Board paper scheduled for discussion on 4 November 2015	

ROHTBACT. 007	Corporate Performance Report	Enc 6	02/09/2015	With SG-L oversee the development of an integrated performance dashboard, including the provision of an executive summary	PA	04-Nov-15	Executive summary provided in the cover sheet; further work planned to improve the summary to pull out further deviations from plan or key trends at a glance	
ROHTBACT. 009	Safe Staffing report	Enc 7	02/09/2015	Amend the nurse staffing report to 1) incorporate nurse agency actual usage vs. expected usage in the next report 2) remove references to private suite	GM	04-Nov-15	Included within the public nurse staffing paper as requested	
ROHTBACT. 013	Self-assessment against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)	Enc 8	02/09/2015	Organise training for the Board on corporate manslaughter	SGL	28-Feb-16	ACTION NOT YET DUE	
ROHTBACT. 001	Patient Case	Presentation	02/09/2015	Write to portering team, catering team and wards 2 & 12 to advise them of the positive patient experience heard by the Trust Board	YB	30-Sep-15	Letter sent to staff congratulating them on the patient experience delivered	
ROHTBACT. 002	Patient Case	Presentation	02/09/2015	Arrange for the positive patient feedback to be used on the Trust website	SXB	30-Sep-15	Being retained in a central file of stories to use to promote patient experience when needed	

KEY:

	Major delay with completion of action or significant issues likely to prevent completion to time

	Some delay with completion of action or likelihood of issues that may prevent completion to time
	Action that is not yet due for completion and there are no foreseen issues that may prevent delivery to time
	Action that has been completed since the last meeting

Matters from previous meetings to be scheduled into future agendas:

Security of patient sensitive data	November 2015	Signed letters have been received from all bar one consultants regarding the security of patient sensitive data. This is due to be signed imminently.
Paperless Board business case	November 2015	Verbal update on the agenda
Visit to Nuffield Orthopaedic Centre, Oxford	November 2015	No further progress to report. Action superseded by other events.
SLA with St Mary's Hospice	December 2015	ACTION NOT YET DUE
Improvements in translation services	December 2015	ACTION NOT YET DUE

For remitting to other fora:

Declarations of interest	Audit Committee	September 2015	Discussed at Audit Committee on 17 September 2015
Cancelled operations	TMC	October 2015	To be raised as necessary as part of discussion of the CPR
Review of EOLC policy	TMC	October 2015	To be confirmed - revisit in December
Prebooking x-rays	Transformation Committee	October 2015	Discussed as part of Transformation Workstream 2
Spend of Dubrowski legacy	Charitable Funds Committee	October 2015	Discussed at CFC on 14 October 2015
Development of a park & ride solution	SMT and/TMC	October 2015	Discussion with BCC who are considering what support can be offered
Pre-operative fasting update	CGC	October 2015	Pre-operative fasting update presented to CGC in October
Patient story at a CoG meeting	CoG	December 2015	ACTION NOT YET DUE

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Jo Chambers, Chief Executive**
DATE OF MEETING:	**4 November 2015**

EXECUTIVE SUMMARY:

This report provides an update to board members on the national context and key local activities not covered elsewhere on the agenda.

There have been two significant national reports on finances and the 'state of care'. The sector is experiencing significant challenge.

There has been a change to the leadership of the Specialist Orthopaedic Alliance and the National Orthopaedic Vanguard proposal.

REPORT RECOMMENDATION:

To discuss the report and note the contents.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

None specifically

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

FOR DISCUSSION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 4 November 2015

1 EXECUTIVE SUMMARY

1.1 This report provides an update to board members on the national context and key local activities not covered elsewhere on the agenda.

1.2 There have been two significant national reports on finances and the 'state of care'. The sector is experiencing significant challenge.

1.3 There has been a change to the leadership of the Specialist Orthopaedic Alliance and the National Orthopaedic Vanguard proposal.

2 NATIONAL CONTEXT

2.1 The national picture continues to be a challenging one. In the last period, two important reports have been produced by Monitor and the Trust development Authority, one reflecting the Quarter 1 financial position for the NHS and the other, by the Care Quality Commission (CQC), setting out the key findings from over 5,000 registered providers.

The **Quarter 1 financial summary** reveals a rapidly deteriorating financial position for the provider sector overall, with a national deficit of £930m, and a forecast deficit of over £2bn. In the acute sector, 92% of all acute and specialist providers are in deficit, accounting for £923m of the overall deficit.

Trusts are spending around 59% more than planned on agency spend, averaging 6.9% of the total FT pay bill.

Cost improvement savings for the sector is lower than plan by 22% (£64m). Controllable operating costs have been reduced by 2.1% (£232m). The main reasons for under-achievement are activity, quality and safe staffing pressures.

Commentators predict that it will be difficult for the sector to improve on the current projected year end deficit and that there is more downside risk than upside opportunity at this point.

2.2 The **CQC State of Care 2014/15 report** provides a summary view of inspections undertaken during the last financial year. The key messages in the report are:

- The CQC recognised the complex and challenging environment in which the majority of services are operating.
- Services have responded well to changing care needs and extreme financial constraint.
- There is significant variation in the quality of care provided both within and between organisations, and for different groups of patients and service users.
- The factors impacting most on the safety of services include safe staffing numbers and skill mix, learning from incidents and errors, creating a culture of transparency and improvement, and staff feeling able to raise concerns.
- Strong leadership and collaboration are emerging as more crucial than ever to deliver good care.
- Safety remains the biggest concern across the health and care sector, with one in ten providers overall rated 'Inadequate' for safety. However, the report acknowledges it will be even more difficult to deliver safe care in the current challenging environment of increasing demand and flat funding.
- Of the acute providers inspected (including independent hospitals) two are outstanding, 51 are good, 85 require improvement and 12 were rated inadequate.
- Across the five domains, safety remains the biggest concern with 74% requiring improvement overall or rated inadequate.
- The report concludes by noting the significant challenges faced by the sectors regulated. It encourages organisations to build a collaborative culture with people who use services and engage with staff to ensure a shared vision and ownership of the quality of care delivered; to be open and transparent, learning from mistakes whilst using data to understand what works (and what doesn't); and ensuring that services have the right staff and skill mix in place to ensure that care is always safe.

3 QUARTER 1 MONITORING FEEDBACK

3.1 The Trust Board makes quarterly declarations to sector regulator Monitor, which are reviewed through discussion with members of the executive team. The Quarter 1 review took place in September, recognising the context set out in 2.1 above. Attached as Appendix 1 is a copy of the letter received from Monitor, which confirms the following ratings:

- Continuity of services risk rating 3
- Governance rating Green

3.2 From Quarter 2 a new set of risk rating indicators will be applied as previously advised.

4 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

4.1 Key stakeholder and partnership engagement activities over the period include:

- As Central Spoke Council Chair, I hosted an innovation workshop for the West Midlands Academic Health Sciences Network, attended the board meeting and the Health and Wealth Economic Summit

- I gave a keynote speech at the West Midlands Leaders' Summit
- Presented our 'learner achievement' awards and long service awards
- Met with the CEO of Birmingham City Council and Director of People
- Met with University Hospitals Birmingham NHS Foundation Trust, Heart of England NHS Foundation Trust, Birmingham Children's Hospital – all in relation to developing a collaborative approach within the Birmingham system, and Birmingham Cross City CCG in relation to developing our services to meet the needs of the population and engaging fully in the development of a system plan
- I have had a number of engagements with colleagues in the Specialist Orthopaedic Alliance. In accordance with the governance arrangements for the alliance I am now the lead CEO. It has also been agreed that I will lead the development of the national vanguard initiative, the National Orthopaedic Alliance. Initial discussions have taken place with the relevant CEOs and the lead Chair. There will now be a number of meetings and workshops with NHS England during November to enable the proposal to be further developed.

4.2 The Annual Members Meeting and Staff Awards were held on 14 October. The staff awards were a real success with much celebration amongst the winners and nominees. It is important that we continue to recognise and reward achievement, leadership and innovation and it was much appreciated by all concerned.

5 RECOMMENDATIONS

5.1 The Board is asked to discuss the contents of the report, and

5.2 Note the contents of the report.

Jo Chambers
Chief Executive

27 October 2015

15 September 2015

Ms Jo Chambers
Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham
B31 2AP

Monitor
Making the health sector work for patients

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: enquiries@monitor.gov.uk
W: www.gov.uk/ monitor

Dear Jo

Q1 2015/16 monitoring of NHS foundation trusts

Our analysis of your Q1 submissions is now complete. Based on this work, the trust's current ratings are:

- Continuity of services risk rating: 3
- Governance rating: Green

These ratings will be published on Monitor's website later in September.

The trust has been assigned a 'Green' governance rating.

We have noted that the trust's Q1 deficit if £0.9m adverse to plan due to an underperformance on elective income. We expect the trust to take action to improve its financial position over the coming quarter and will continue to monitor this issue closely.

A report on the FT sector aggregate performance from Q1 2015/16 will be available in due course on our website (in the News, events and publications section) which I hope you will find of interest.

For your information, we will be issuing a press release in due course setting out a summary of the key findings across the FT sector from the Q1 monitoring cycle.

Monitor is currently reviewing the responses of all NHS foundation trusts to David Bennett's letter dated 3 August 2015 as well as the outcome of the contract dispute resolution process. We will be writing to all NHS foundation trusts in due course to inform them of the outcome of our review. As a result, the content of this letter and our regulatory position only relates to our Q1 2015/16 monitoring process.

If you have any queries relating to the above, please contact me by telephone on 02037470617 or by email (Rebecca.Farmer@Monitor.gov.uk).

Yours sincerely

Rebecca Farmer
Senior Regional Manager

cc: Dame Yve Buckland, DBE,
Chair Mr Paul Athey, Finance
Director

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Corporate Performance report**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Director of Finance**
AUTHOR:	**Alex Gilder, Deputy Director of Finance**
DATE OF MEETING:	**4 November 2015**

EXECUTIVE SUMMARY:

The attached presents a summary of performance against key performance indicators and regulatory targets as at September 2015.

The key highlights to note are:

- Monitor Compliance Framework targets – Infection Control, Cancer waiting times and RTT for incomplete pathways were ACHIEVED

- Trust key targets - September saw the following targets not having been:
    - NOT ACHIEVED: Serious Incidents (11), unexpected hospital deaths (1), backlog patients (603), incomplete 14-18 week waits (565), admitted patient care patients vs. plan (92.8%), financial surplus (-£2,445k), CIP (£728k), agency spend (£439k) and locum doctor expenditure (£101k).

    - NO CHANGE against the CQUIN target at 90%. The following targets have been

    - ACHIEVED: complaints (4), unused theatre sessions (38) and sickness (3.7%)

Headlines:

- The financial deficit remains a significant concern, with the Trust incurring an underlying £614k deficit in September.

- The backlog has increased significantly in month, driven largely by the admitted backlog

- The incomplete RTT target has been met in month, although this shows a deterioration from prior months

REPORT RECOMMENDATION:

The Trust Board is asked to receive the report and note in particular the headlines and key risks associated with the achievement of key performance and financial targets

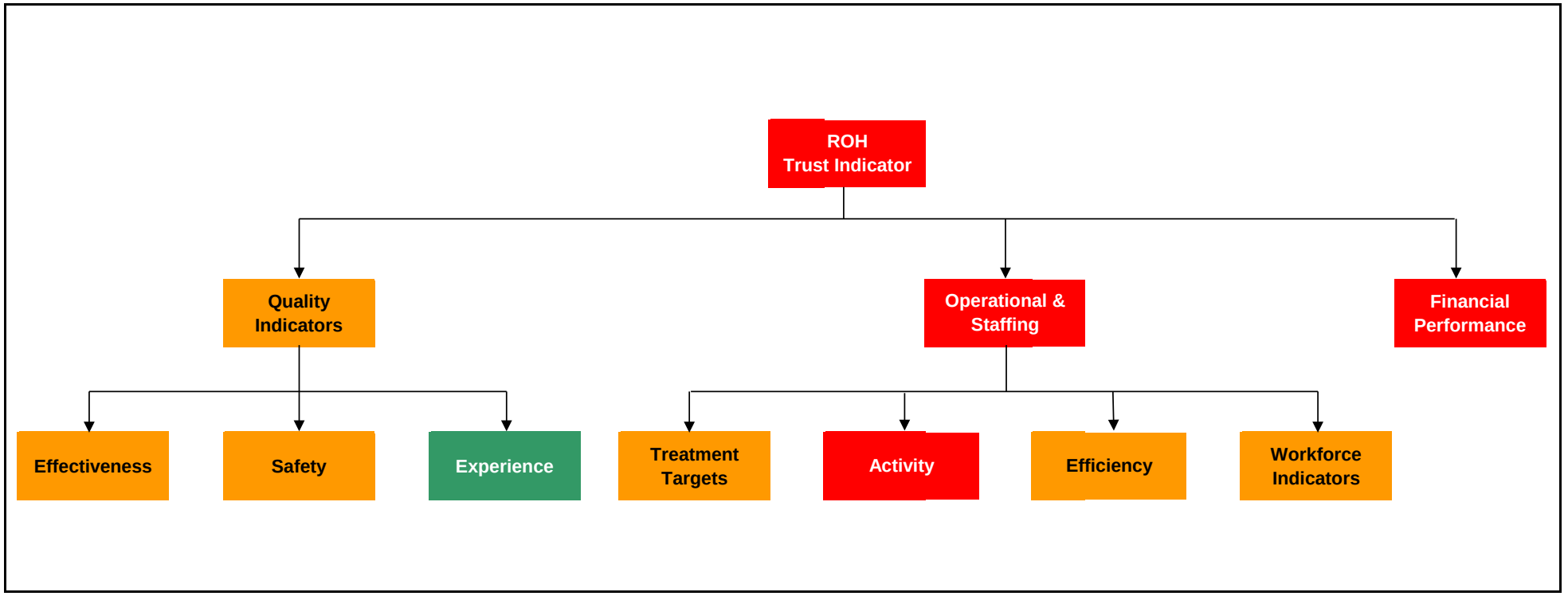
ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*: The receiving body is asked to receive, consider and:		
Note and accept	**Approve the recommendation**	**Discuss**
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***					
Financial	**X**	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	**X**
Comments: [*elaborate on the impact suggested above*]					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Aligned to the Trust's key targets, annual priorities and several entries within the trust risk registers

PREVIOUS CONSIDERATION:
An early version of the report was considered at October's Trust Management Committee.

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending September 2015



Quarterly Detailed Report
Executive Summary as at September 2015

Headlines

- The financial deficit remains a significant concern, with the Trust incurring an underlying £614,000 deficit in September
- Backlog has increased significantly in month, driven largely by the admitted backlog.
- The incomplete RTT target has been met in month, although it has declined.

Monitor Compliance Framework Targets	September 2015 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	93.80%	94.13%		
Referral to treatment time - Admitted %	90%	87.04%	88.08%		
Referral to treatment time - Incomplete Pathways %	92%	92.27%	93.05%	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%	97%	0	6
Cancer 2 week (all cancers)	93%	100%	99%	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	Amber
Indicative Monitor Financial Risk Rating	2

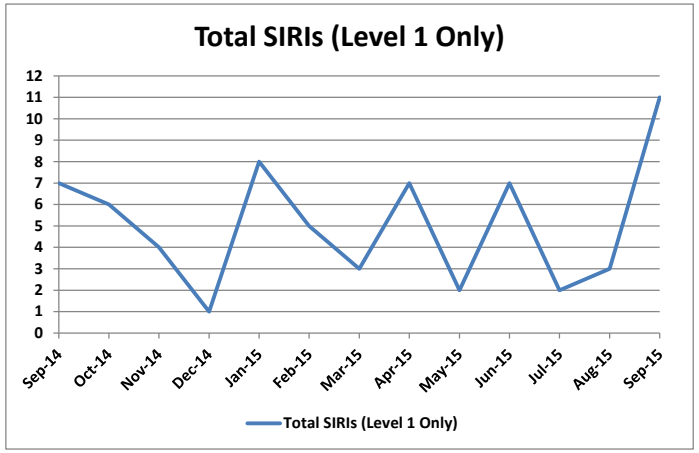
Key Trust Targets		September 2015 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	11		3
	Complaints	<=12	4		4
	CQUINS	100%	90%		11
	Total Unexpected Hospital Deaths	0	1		5
Efficiency & Workforce	Total Backlog Patients	<400	#REF!		
	Incomplete 14 - 18 Week Waiters	<450	#REF!		
	Total Admitted Patient Care Patients vs Plan	100%	92.8%		7
	Unused Theatre Sessions	<44	38		8
	Sickness	3.7%	3.7%		9
Financial	Surplus	(£952k)	(£2,445k)		10
	CIP	£1,135k	£728k		10
	Agency Expenditure	£295k	£439k		11
	Locum Doctor Expenditure	£145k	£101k		11

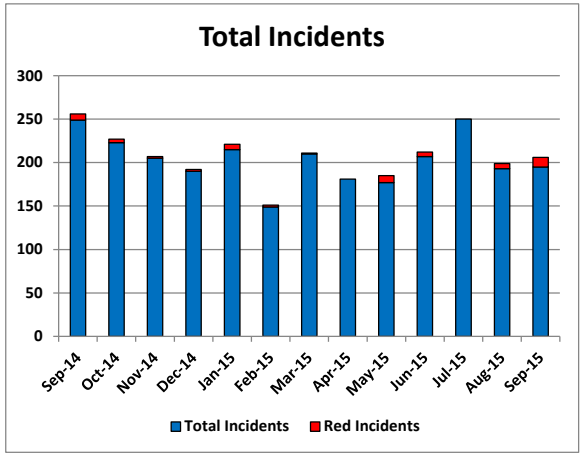
Quarterly Detailed Report
Safety Indicators as at September 2015

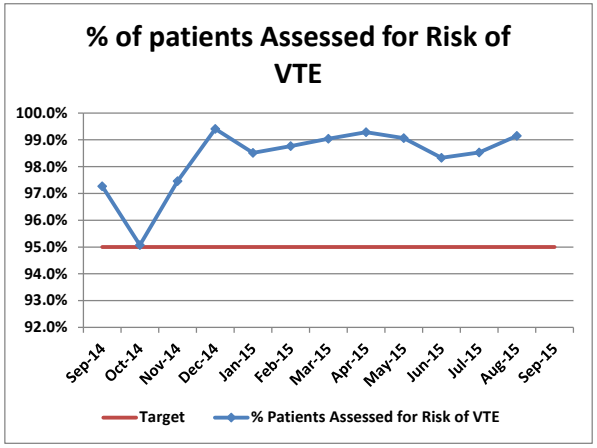
Headlines

- The number of medicines incidents reported in September was higher than August, but remains low. There were no medicine incidents with harm for the fifth successive month.
- There were 11 SIRIs in September, a significant increase on previous months. A report has been brought to TMC on VTEs and SIRIs.
- Patient falls increased in month, but there were no avoidable patient falls with harm.

	Monitor	National	CQC Standard		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	15/16 Full Year Position
Safety		N	4,16	Never Events	0	0	0	1	0	0	0	0	0	0	0	0	0	0
			4,16	Total SIRIs (Level 1 Only)	7	6	4	1	8	5	3	7	2	7	2	3	11	5
			4,16	SIRI per 1000 bed days	1.90	1.58	1.07	0.31	2.35	1.67	0.88	2.20	0.60	1.98	0.48	0.84	3.10	1.53
			4,16	Total Incidents	249	223	205	190	215	149	210	181	177	207	250	193	195	201
			4,16	Incidents per 1000 bed days	67.52	58.73	54.71	59.69	63.05	49.73	61.67	56.83	53.43	58.41	60.10	54.35	54.87	56.33
			4,16	Red Incidents	7	4	2	2	6	2	1	0	8	5	0	6	11	5
			9,16	Total Medicine Incidents Reported	12	16	16	20	15	18	30	24	13	26	39	11	19	22
			9,16	Medicine Incidents Reported per 1000 bed days	3.25	4.21	4.27	6.28	4.40	6.01	8.81	7.54	3.92	7.34	9.38	3.10	5.35	6.10
				Medicine Incidents with Harm	4	0	5	5	2	2	3	5	0	0	0	0	0	1
		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	97.27%	95.07%	97.46%	99.41%	98.51%	98.77%	99.04%	99.29%	99.06%	98.33%	98.53%	99.15%		98.86%
			9	Incidence of Hospital Related VTE	3	2	1	1	5	1	3	3	4	6	2	4	2	21
			4	Patient Falls - Inpatients	13	12	7	5	3	4	9	5	1	5	7	4	9	5
			4	Patient Falls per 1000 bed days	3.52	3.16	1.87	1.57	0.88	1.34	2.64	1.57	0.30	1.41	1.68	1.13	2.53	1.44
				Avoidable Patient Falls with Harm	2	0	0	0	0	1	2	1	0	0	1	1	0	1
			4,16	% Harm Free Care	98.04%	97.96%	94.50%	91.95%	97.89%	98.94%	97.14%	97.26%	98.02%	95.05%	95.24%	97.53%	99.04%	97.06%





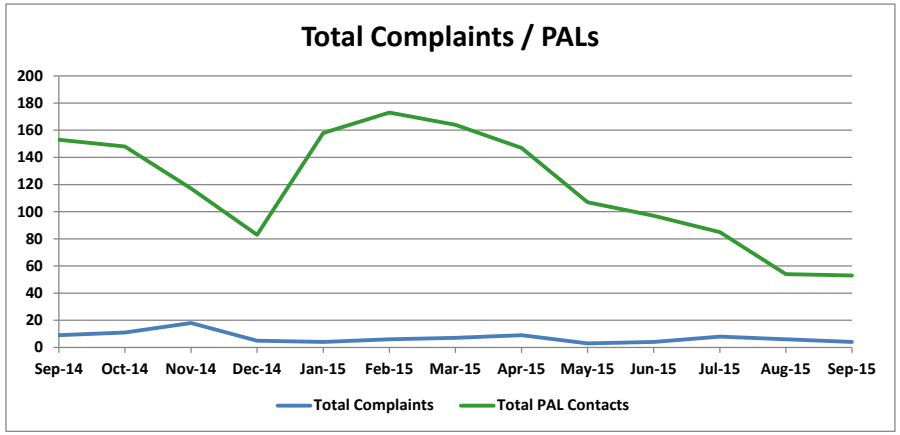


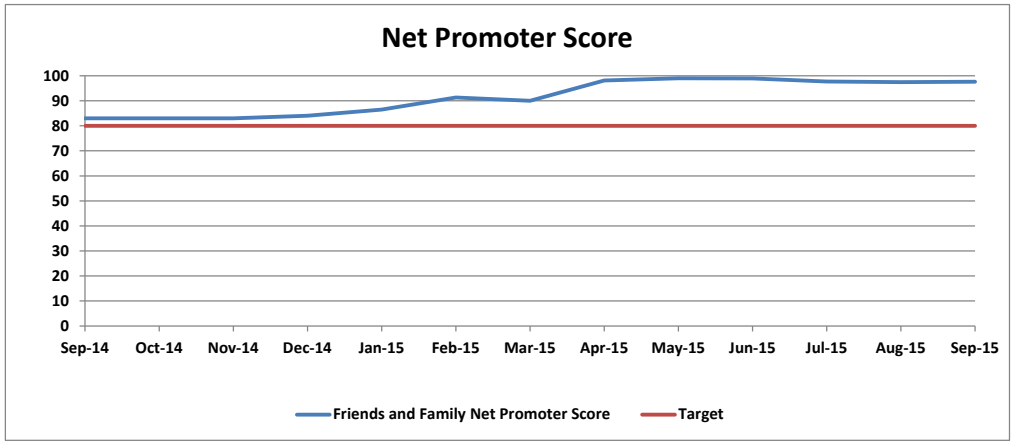
Quarterly Detailed Report
Experience Indicators as at September 2015

Headlines

- The level of complaints remained low at 4 in September
- PALs contact remained at green and dropped slightly from last month to 53. This remains a significant improvement on the rest of the year where the average is 91 contacts.
- Total compliments decreased but remained green rated, with a green rating having been maintained all year.

	Monitor	National	CQC Standard		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	15/16 Full Year Position
Experience			17	Complaints to Compliments Ratio	1:31	1:42	1:29	1:107	1:108	1:75	1:60	1:69	1:94	1:27	1:31	1:18	1:21	**1:43**
			17	Total Complaints	9	11	18	5	4	6	7	9	3	4	8	6	4	**6**
			17	Complaints reverted to informal <48 hrs	1	1	0	0	0	0	0	0	0	0	0	0	0	**0.0**
			17	Formal	8	10	18	5	4	6	7	9	3	4	8	6	4	**6**
			17	Complaints per 1000 bed days	2.44	2.90	4.80	1.57	1.17	2.00	2.06	2.83	0.91	1.13	1.92	1.69	1.13	**1.60**
				Complaints Response Time (Average No of Days)		109	67	69	24	27	39	35	48	83	77	133	50	**71**
			17	Total PAL Contacts	153	148	117	83	158	173	164	147	107	97	85	54	53	**91**
			17	PALS Contacts per 1000 bed days	41.49	38.98	31.22	26.08	46.33	57.74	48.16	46.15	32.30	27.37	20.43	15.21	14.91	**26.06**
				Total PALS Concerns	84	68	67	52	79	96	86	59	50	64	55	39	35	**50**
			17	Total Compliments	276	465	522	534	433	449	418	619	283	106	251	106	85	**242**
			17	Compliments per 1000 bed days	74.84	122.47	139.31	167.77	126.98	149.87	122.76	194.35	85.42	29.91	60.34	29.85	23.92	**70.63**
				Food - Real Time Patient Survey	95.5%	98.3%	96.8%	96.5%	96.4%	98.8%	94.7%	98.8%	98.8%	96.2%	98.8%		98.6%	**98.2%**
			17	Friends and Family Net Promoter Score	83	83	83	84	87	91	90	98	99	99	98	98	98	**98**
				Friends and Family Response Rate	46.5%	51.7%	58.0%	50.3%	61.0%	59.6%	52.0%	45.3%	48.0%		34.4%	37.0%	28.9%	**38.7%**



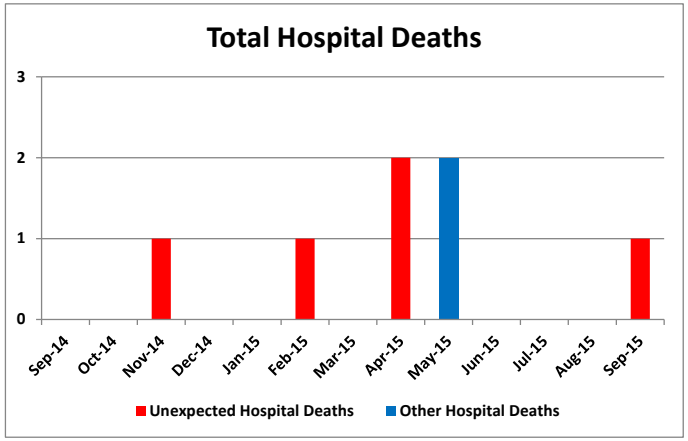


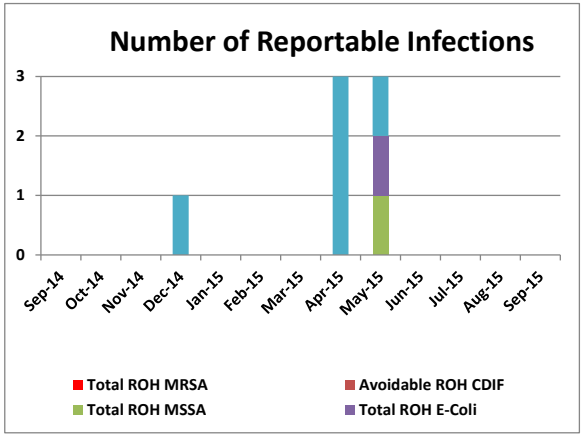
Quarterly Detailed Report
Effectiveness Indicators as at September 2015

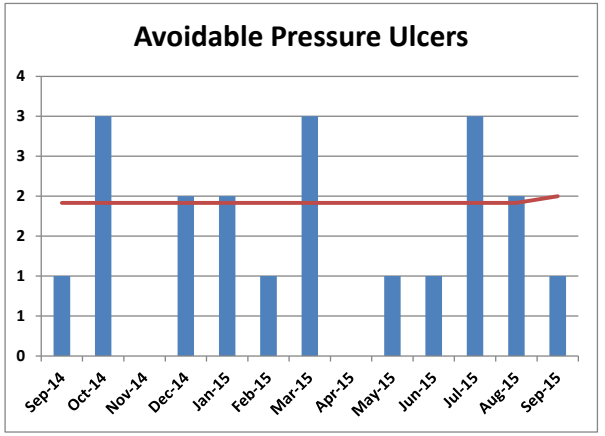
Headlines

- There were no hospital acquired infections in September.
- The completion of the WHO checklist remains above 99%
- There was an unexpected hospital death in month in relation to a patient who had undergone a THR. A SI is currently being completed on this case.

	Monitor	National	CQC Standard		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	15/16 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	0	1	0	0	1	0	2	2	0	0	0	1	0.8
			4,18	Hospital Deaths per 1000 bed days	0.00	0.00	0.27	0.00	0.00	0.33	0.00	0.63	0.60	0.00	0.00	0.00	0.28	0.25
			4,18	Unexpected Hospital Deaths	0	0	1	0	0	1	0	2	0	0	0	0	1	0.5
				Other Hospital Deaths	0	0	0	0	0	0	0	0	2	0	0	0	0	2
			8	MRSA % Screened	103.00%	124.90%	125.30%	111.00%	118.40%	121.80%	131.80%	175.00%	173.03%	169.60%	83.30%	96.30%	153.00%	175%
	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	0	0	0	0	0	0	0
				Unavoidable ROH CDIF	0	0	0	1	0	0	0	3	1	0	0	0	0	4
			8	Total ROH MSSA	0	0	0	0	0	0	0	0	1	0	0	0	0	1
			8	Total ROH E-Coli	0	0	0	0	0	0	0	0	1	0	0	0	0	1
			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	2	0	0	0	0	0	0	0	0	1	0	0	1
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	1	1	0	2	2	1	3	0	1	1	2	2	1	7
			4	Avoidable Pressure Ulcers per 1000 bed days	0.27	0.79	0.00	0.63	0.59	0.33	0.88	0.00	0.30	0.28	0.72	0.56	0.28	0.38
				% Completion of WHO Checklist	95.92%	97.96%	98.23%	97.81%	99.36%	98.90%	99.57%	99.64%	97.42%	99.12%	99.15%	99.07%	99.15%	98.93%





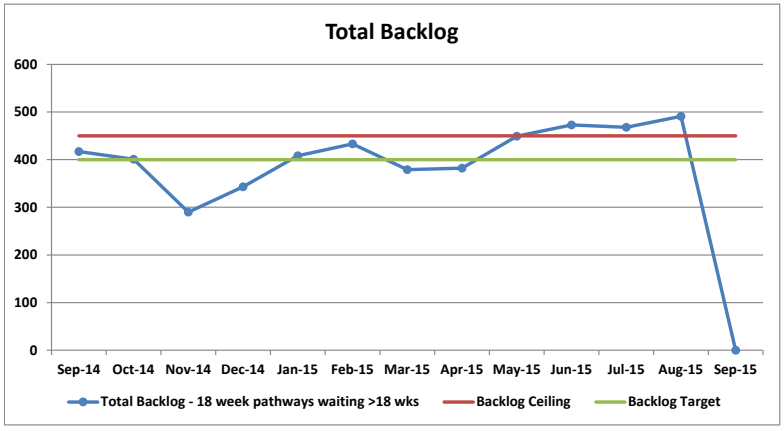


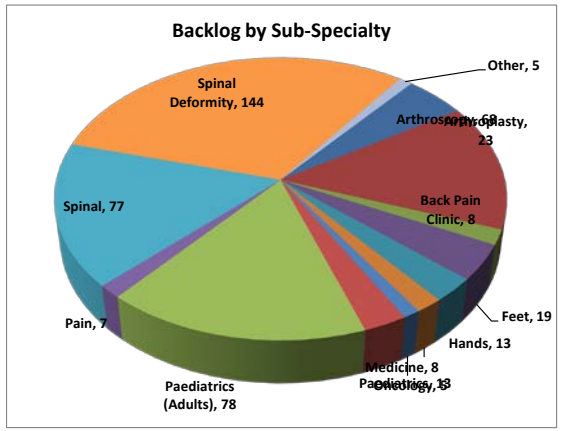
Quarterly Detailed Report
Treatment Targets as at September 2015

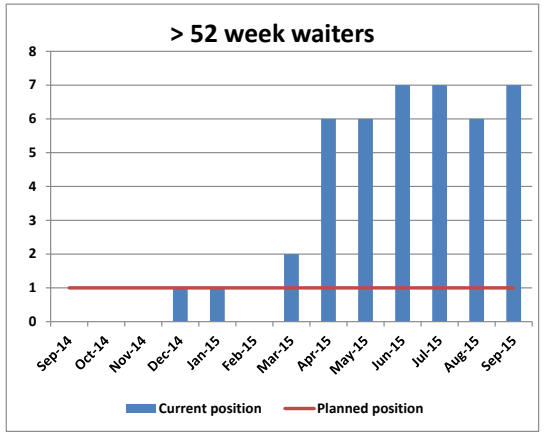
Headlines

- All cancer targets have been met for the quarter.
- Backlog has increased significantly in month, driven largely by the admitted backlog.
- The incomplete RTT target has been met in month, although it has declined.

	Monitor	National	CQC Standard		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	15/16 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks				1	1		2	6	6	7	7	6	7	7
				Referral to treatment waits over 45 weeks	8	11	6	12	13	11	10	11	22	16	19	30	36	36
	M	N	4	Referral to treatment time - Non Admitted %	95.05%	92.68%	92.65%	95.52%	95.58%	95.11%	95.07%	93.49%	96.12%	95.36%	93.91%	94.70%	93.80%	94.52%
	M	N	4	Referral to treatment time - Admitted %	91.96%	91.63%	86.32%	93.05%	92.17%	91.61%	90.17%	90.12%	91.47%	90.58%	89.48%	87.70%	87.04%	89.41%
	M	N	4	Referral to treatment time - Incomplete Pathways %	94.26%	94.67%	95.96%	95.20%	94.27%	93.94%	94.55%	94.38%	93.78%	93.69%	93.59%	93.28%	92.27%	93.48%
			4	Non admitted Backlog - Pathways waiting >18 wks	168	137	110	119	149	153	124	115	115	144	176	166	#REF!	173
			4	Admitted Backlog - Pathways waiting >18 wks	249	264	180	224	259	280	255	267	334	329	292	325	#REF!	430
			4	Total Backlog - 18 week pathways waiting >18 wks	417	401	290	343	408	433	379	382	449	473	468	491	#REF!	603
			4	Incomplete 14 -18 Week Waiters	594	531	438	520	581	540	522	396	466	461	421	482	#REF!	565
				Non Admitted Median Wait (Weeks)	9.00	8.92	8.10	8.45	9.21	9.07	7.72	8.59	8.64	8.43	8.22	8.09	8.26	8.26
				Admitted Median Wait (Weeks)	10.64	10.06	10.79	10.61	11.12	11.59	10.63	9.60	9.98	9.50	9.33	10.36	9.92	9.92
				Incomplete Median Wait (Weeks)	6.30	5.63	5.44	6.40	6.66	5.53	5.60	5.65	5.50	5.43	5.75	5.96	6.15	6.15
	M	N	4	Cancer 2 week (all cancers)	100.00%	100.00%	100.00%	97.30%	100.00%	100.00%	100.00%	100.00%	97.20%	100.00%	97.80%	100.00%	100.00%	99.21%
	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%*	100.00%	100%*	100.00%	100.00%	92.30%	100.00%	98.33%
	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%*	100.00%	100%*	100.00%	100.00%	100.00%	100.00%	100.00%
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	90.90%	75.00%	100.00%	83.33%	100.00%	100.00%	87.5%*	100.00%	66.70%	75.00%	100.00%	100.00%	100.00%	94.87%
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	99.06%	99.33%	99.25%	99.79%	99.49%	99.87%	99.68%	99.53%	99.47%	99.38%	99.57%	96.52%	99.52%	99.00%
		N	4	Cancelled Ops Not Admitted within 28 days	0	1	0	0	0	2	0	2	0	0	1	0	0	3
			1,21	Data Quality on Ethnic Group - Inpatients	96.74%	95.67%	94.19%	94.24%	97.56%	97.13%	95.80%	96.86%	97.90%	96.42%	96.80%	96.90%	95.37%	96.68%





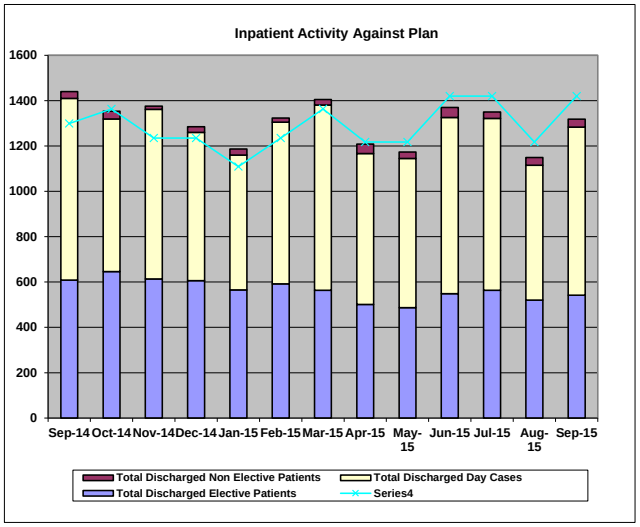


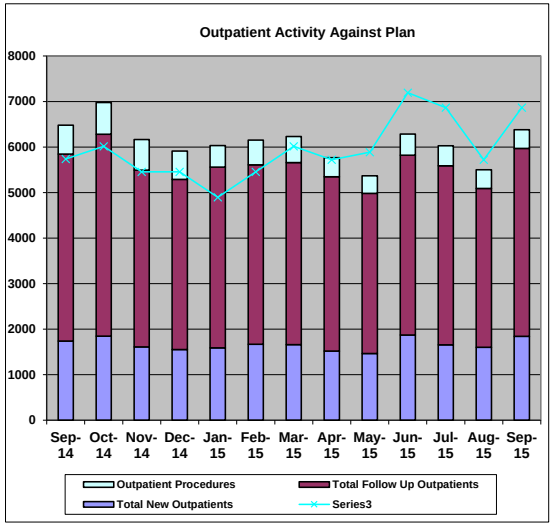
Activity Targets as at September 2015

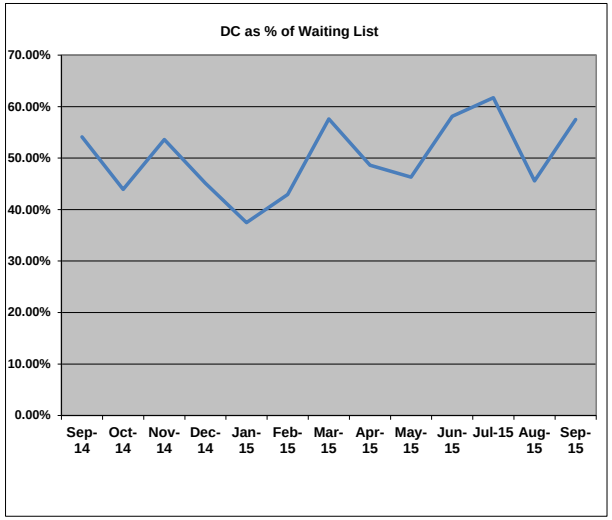
Headlines

- Elective activity underperformed by 101 cases in month, with day cases also underperforming by 7 cases.
- Non elective activity overperformed by 7 cases in month.
- Outpatient activity was also behind plan.

	Monitor	National	CQC Standard		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	15/16 Full Year Position
Activity			4	Total Discharged Elective Patients	609	646	614	606	565	592	564	501	487	549	564	520	542	3163
			4	Total Discharged Non Elective Patients	30	34	14	25	27	18	24	41	28	44	28	34	35	210
			4	Total Discharged Day Cases	801	673	748	654	595	713	817	666	658	777	758	595	741	4195
			4	Total New Outpatients	1740	1848	1611	1552	1591	1668	1658	1518	1466	1872	1656	1601	1844	9957
			4	Total Follow Up Outpatients	4107	4433	3882	3739	3968	3941	4000	3830	3516	3948	3930	3490	4126	22840
			4	Outpatient Procedures	634	697	671	621	471	543	573	420	386	467	442	411	412	2538
				DC as a % of WL	54.12%	43.93%	53.62%	45.13%	37.47%	42.93%	57.62%	48.61%	46.31%	58.12%	61.73%	45.56%	57.49%	44.20%
			4	Elective as % Against Plan	100.3%	101.4%	106.4%	105.0%	109.1%	102.6%	88.5%	90.8%	88.3%	85.3%	87.6%	94.2%	84.2%	88.2%
			4	Non Elective as % Against Plan	88.2%	94.4%	43.8%	78.1%	93.1%	56.3%	66.7%	169.0%	115.4%	155.5%	98.9%	140.2%	123.7%	133.2%
			4	Day Cases as % Against Plan	121.7%	97.5%	119.5%	104.5%	105.9%	113.9%	118.4%	103.9%	102.6%	103.9%	101.3%	92.8%	99.1%	100.7%
			4	% New Outpatients Against Plan	110.0%	111.4%	107.1%	103.1%	117.8%	110.8%	99.9%	96.5%	90.6%	94.7%	87.7%	101.8%	97.7%	94.7%
			4	% Follow Up Outpatients Against Plan	116.9%	120.3%	116.2%	111.9%	132.3%	117.9%	108.6%	106.4%	94.9%	87.2%	91.0%	96.9%	95.5%	94.9%
			4	% Outpatient Procedures Against Plan	99.0%	103.7%	110.1%	101.9%	86.1%	89.1%	85.3%	76.7%	68.5%	67.8%	67.2%	75.0%	62.7%	69.3%





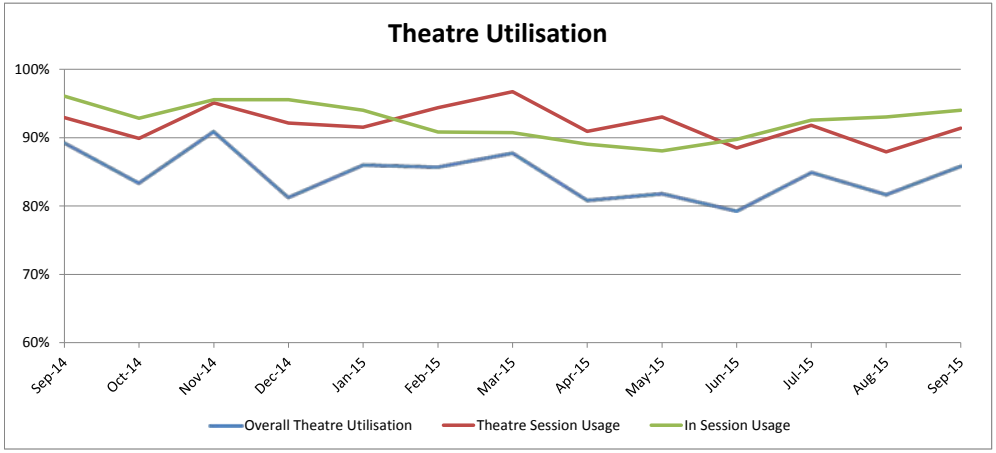


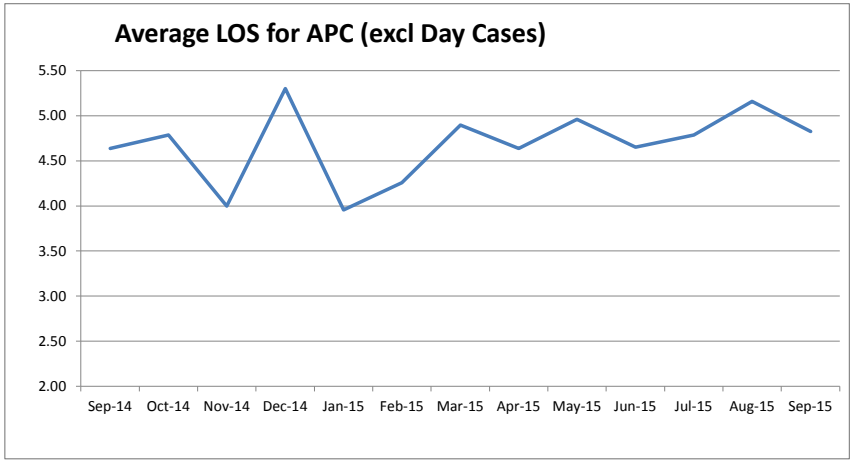
Quarterly Detailed Report
Efficiency Indicators as at September 2015

Headlines

- Cancellations remain high, although the hospital cancellations have all improved or remained
- New to review ratios remain high, which could result in the Trust being financially penalised
- AVLOS remains high, although it has improved slightly.

	Monitor	National	CQC Standard		Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	15/16 Full Year Position
Efficiency			4	Overall Theatre Utilisation	89.30%	83.47%	90.91%	81.38%	86.08%	85.77%	87.80%	80.97%	81.94%	79.42%	85.00%	81.81%	85.93%	**82.51%**
			4	Theatre Session Usage	92.94%	89.88%	95.12%	92.14%	91.54%	94.41%	96.74%	90.92%	93.04%	88.49%	91.82%	87.91%	91.38%	**90.59%**
			4	In Session Usage	96.09%	92.87%	95.58%	95.58%	94.04%	90.85%	90.76%	89.06%	88.06%	89.75%	92.56%	93.06%	94.04%	**91.09%**
			4	Unused Theatre Sessions	32	50	21	21	38	24	14	36	27	55	40	48	38	**41**
			4	Number of Cases per Theatre Session	3.27	2.88	3.20	2.97	2.72	3.07	3.20	3.09	3.12	3.08	2.85	3.37	3.09	**3.09**
			4	Total Cancelled Operations (On Day or Day Before)	39	54	74	88	53	60	62	46		79				**63**
			4	Total Cancelled Operations (On Day) - Avoidable	2	18	15	11	10	10	16	17	33	19				**23**
			4	Total Cancelled Operations (On Day) - Unavoidable	30	36	17	48	15	23	21	29	16	21				**22**
			4	Total Cancelled Operations by Hospital (On Day)	11	15	11	7	3		37	31	49	31				**37**
				Patient DNA											24	28	21	24
				Pat Cancelled on the day											19	12	20	17
				Pat Cancelled 1-3 days before											40	31	41	37
				Pat Cancelled 4-7 days before											25	23	33	27
				Hospital Cancelled on the day											10	10	8	9
				Hospital Cancelled 1-3 days before											36	42	42	40
				Hospital Cancelled 4-7 days before											46	32	27	35
			4	% Cancelled Operations by Hospital	0.80%	1.17%	0.84%	0.58%	0.27%		2.78%	2.77%	4.35%	2.40%	0.78%	0.85%	0.65%	**0.51%**
			4	Total T&O Review-To-New Ratio (including Spinal)	2.41	2.49	2.39	2.43	2.67	2.42	2.55	2.85	2.62	2.54	2.78	2.63	2.57	**2.66**
			4	Pain Review-To-New Ratio	3.55	3.36	2.85	3.69	2.71	2.69	3.85	3.45	3.23	2.65	2.46	2.31	3.03	**2.85**
			4	Outpatient DNAs	8.13%	8.23%	8.13%	9.21%	8.41%	7.82%	8.50%	10.07%	8.49%	8.42%	10.47%	12.05%	11.30%	**10.13%**
			4	Bed Occupancy - Adults	84.25%	83.17%	79.45%	69.20%	76.02%	79.93%	77.35%	67.10%	70.44%	78.83%	91.37%	84.76%	74.89%	**77.83%**
			4	Bed Occupancy - Paediatrics	50.00%	44.44%	60.74%	55.36%	55.36%	65.08%	74.91%	68.86%	66.67%	66.67%	88.42%	65.26%	80.95%	**72.82%**
			4	Bed Occupancy - HDU	73.39%	68.15%	70.46%	55.70%	67.42%	68.22%	75.56%	55.74%	58.74%	47.54%	62.99%	99.59%	58.85%	**64.13%**
			4	Bed Occupancy - Private Patients	82.86%	80.65%	84.33%	83.67%	84.29%	83.33%	54.25%	74.29%	76.96%	88.10%	82.03%	82.57%	86.19%	**81.67%**
			4	Admissions on the Day of Surgery	477	503	478	464	421	445	411	359	379	414	413	403	410	**2378**
			4	AVLOS for APC (excl day cases)	4.64	4.79	4.00	5.30	3.96	4.26	4.90	4.64	4.96	4.65	4.79	5.16	4.83	**4.84**



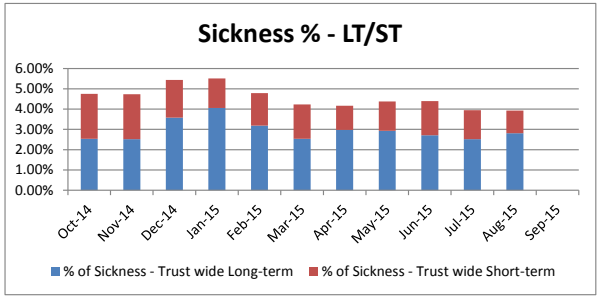


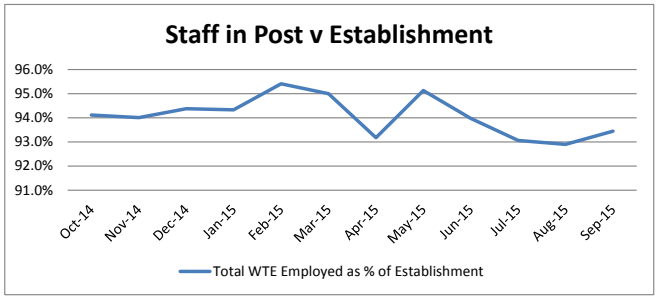
Monthly Report
Workforce Indicators as at September 15

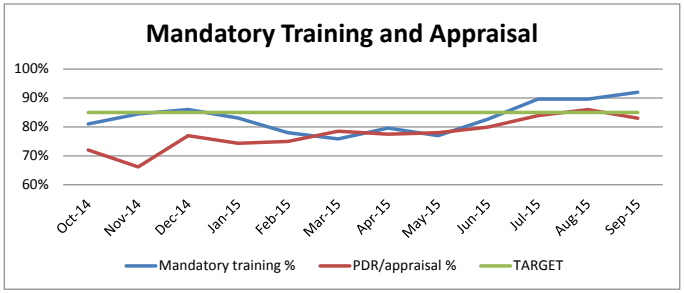
Headlines

- Sickness absence lowest rate since Sept 2014
- Mandatory Training highest rate since Apr 2013
- Sickness MAA is still showing as higher than desired, despite improved performance over 6 months

	Monitor	Contract	CQC Standard		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	15/16 Full Year Position
Workforce				Total WTE Employed as % of Establishment	94.1%	94.0%	94.4%	94.3%	95.4%	95.0%	93.2%	95.1%	94.0%	93.1%	92.9%	93.5%	93.6%
				Staff Turnover (%) - Unadjusted	11.4%	11.8%	1059.2%	10.3%	10.6%	11.1%	10.6%	10.9%	11.0%	11.4%	11.6%	12.5%	11.3%
				Staff Turnover (%) - Adjusted	8.9%	9.5%	926.9%	9.0%	8.9%	9.3%	8.6%	8.9%	7.9%	8.3%	8.3%	8.9%	8.5%
				% of Sickness - Trust wide	4.8%	4.7%	5.4%	5.5%	4.8%	4.2%	4.2%	4.4%	4.4%	4.0%	3.9%	3.7%	4.1%
				% Staff received mandatory training last 12 months	81%	84%	86%	83%	78%	76%	80%	77%	83%	90%	90%	92%	85%
				% Staff received formal PDR/appraisal last 12 months	72%	66%	77%	74%	75%	79%	77%	78%	80%	84%	86%	83%	81%







Workforce Commentary

Sickness absence fell again this month to its lowest level since September 2014: this indicator has been green for 3 consecutive months. Long Term sickness figure has also reduced this month to their lowest level since September 2013.

The vacancy position taken from the ledger has gone back to green this month.

The 12 month turnover figure for unadjusted (all leavers minus junior medical staff) is amber this month. This is because we had more leavers this month compared to September last year. This was expected and we are monitoring leaving reasons, and there is no underlying cause for concern - but monitoring continues. A more detailed piece of work will be undertaken in the event that this becomes concerning.

The mandatory training position has increased this month. There is a continual rise in the number of staff physically attending training and this indicator has now been green for 3 months.

The appraisal position has returned to amber for September. We will continue to contact managers regularly to ensure PDR's are carried out promptly and that the information is recorded in ESR in a timely manner.

Monthly Report

Finance Dashboard as at 30th September 2015

	Surplus £	Cash £	Capital spend £
Plan	(952k)	12,559k	3,692k
Actual	(2,445k)	14,112k	754k
Forecast for next month (YTD)	(2,309k)	12,416k	853k

Year to date			
	Actual	Plan	Risk Rating
Capital Servicing Capacity	-0.79	1.33	1
Liquidity Ratio	39.96	31.64	4
I&E Margin	-6.0%	-2.5%	1
I&E Margin Variance	-3.5%	-1.22%	1
Financial Sustainability Rating			2

Debtors are lower than expected. This is due to income being significantly lower than plan as a result of lower than expected activity.

The current Continuity of Services Risk Rating has been replaced with a Financial Sustainability rating (FSR), which includes 2 new metrics; I&E margin and I&E margin variance. As a result of the deficit, both planned, and the variance to plan, the Trust rates as a 1 for these new metrics. This therefore beings down our overall FSR rating to a 2.

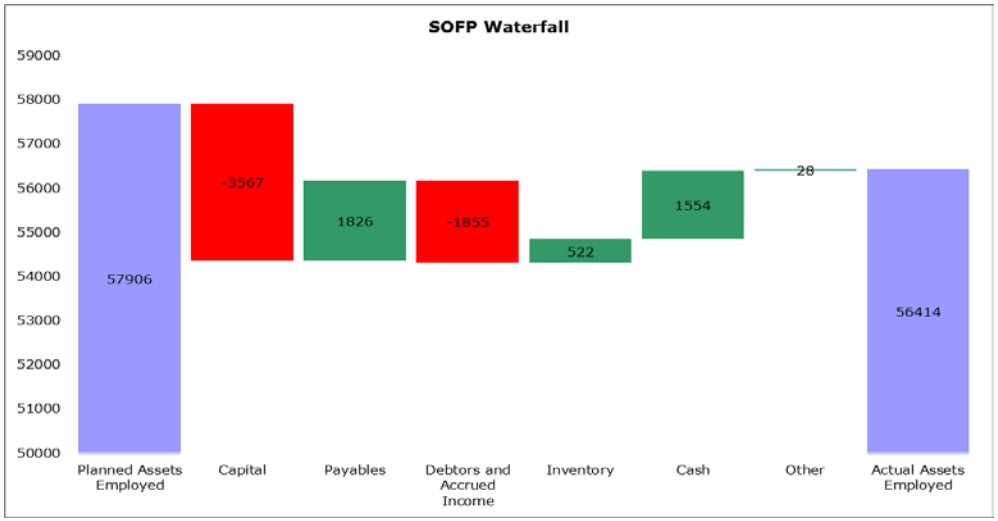
Despite a significant underperformance against plan in month financially, the true scale of the underperformance is being masked by net non recurrent financial benefits, such as a £180k payment received for the fire which occurred at the Trust in 2012, and £149k of prior year income overperformance agreed with our commissioners.

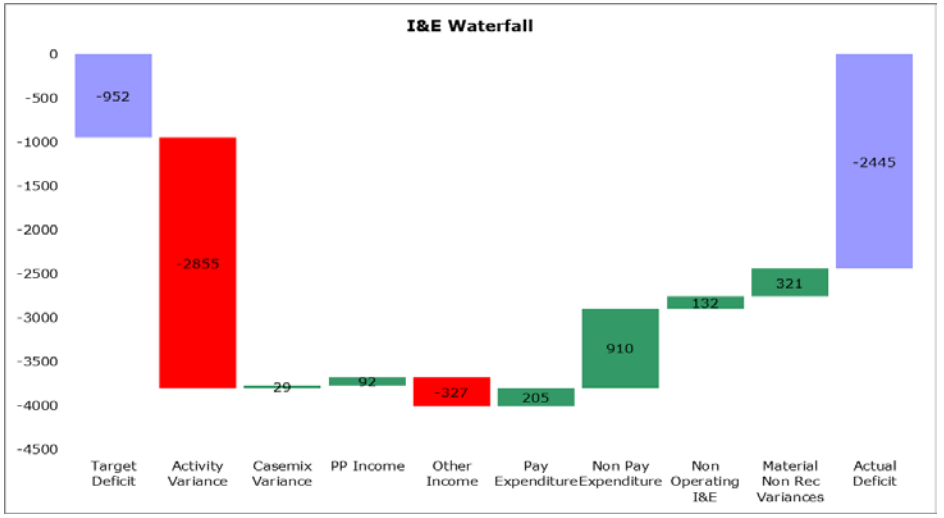
The underlying position would therefore have been a deficit of £2,766k, being an in-month loss of £614k.

This is being driven largely by elective activity levels continuing to underperform, with the Trust currently approximately 400 cases behind our elective target, but also by the Trust being less efficient than needed with regards to the use of agency staffing.

Casemix has also dropped in month, partly due to genuinely lower prices achieved, but also due to the signing of a revised specialist services contract, which results in a lower marginal adjustment than expected on the Trust's specialist underperformance.

As a result of the year to date underperformance against plan, the Board has agreed a revised deficit with Monitor of £2.75m from the original £2m. However, in order to achieve this, the Trust will need to deliver on the new activity rectification plan which is in place from the start of October, and all members of staff will need to focus on driving activity and being mindful of costs over the coming months.





Capital spend is lower than plan due largely to the theatre feasibility review not occurring at the timing expected and the fact that the first payments for ePMA were factored in to Q2 The variance on capital also drives payables being lower than planned as this relates to the expected capital creditor at the end of Q2.

Cash is higher than plan largely due to the capital spend being lower than expected and lower debtor levels

Pay expenditure is only slightly underspent at the end of September despite lower activity than planned over the first 6 months of the year. Spend in theatres and nursing areas is above the average spend in 2014/15, with vacancy and sickness pressures in theatres being a big driving factor.

Corporate spend has also increased over the last couple of months, with a significant cost pressure in the areas of Governance and operational management.

Non Pay continues to underspend at a level approximately equivalent to the marginal savings from the underperformance in activity.

Monthly Report
CIP Dashboard as at 30th September 2015

Plan for YTD	**£1135k**
Actual for YTD	**£728k**
Difference	**-£407k**

Top 5 savings to date

	£000s
Reduced Length of Stay / West Heath project	98
R&T Staffing Structure	83
Prosthesis	85
Digital dictation	54
Theatre consumables	44

CIP Scheme Delivery

A number of trustwide schemes have now been implemented and are starting to deliver savings. In addition to some of the schemes identified to the right, these include a Direct Engagement Model for medical locums and the managed print service.

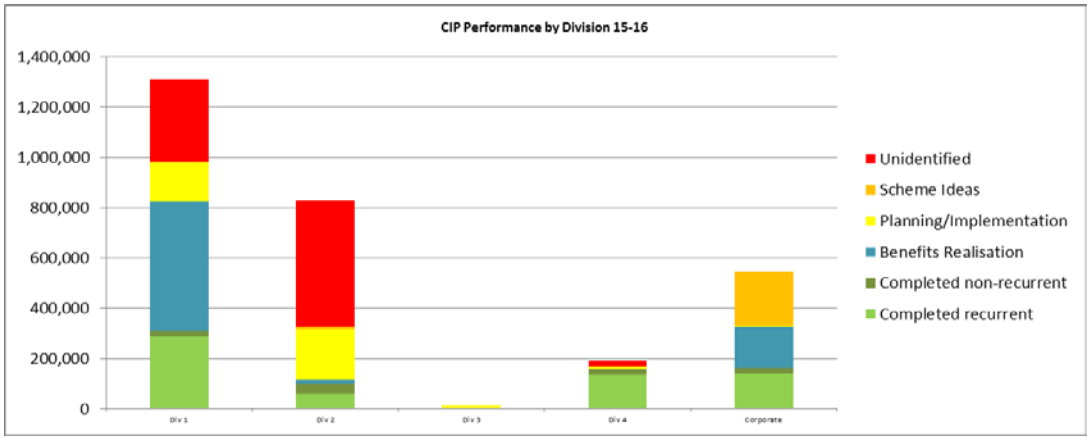
The majority of directorates are on course to deliver their local targets, with Theatres and Clinical Support still showing the largest gaps.

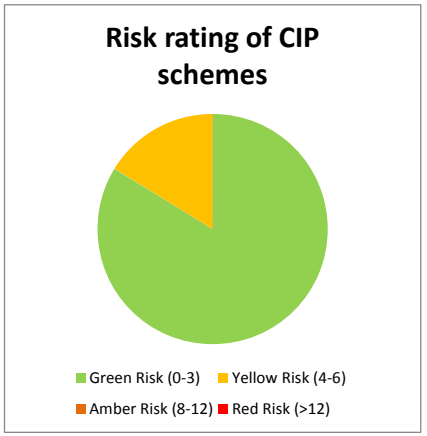
Quality Impact

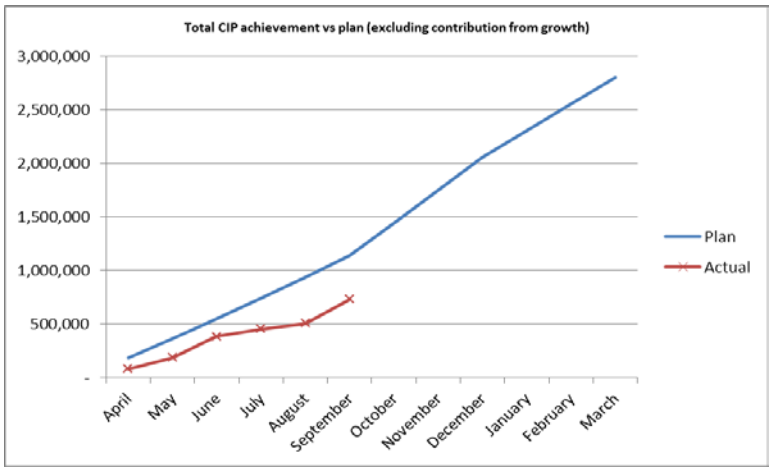
The are currently 4 schemes without a signed off QIA in place. All of these are newly identified schemes, and the process of approving the QIA is ongoing.

There are 3 schemes currently rated as an amber risk on their QIA (risk score 8-12), which are the introduction of an infection control database to market, the reduction in agency staffing in theatres and the introduction of tiger bags for clinical waste. None of the schemes has been implemented, however each have mitigations in place.

Going forward CIP Programme Board is being discontinued, and instead CIPs will be considered from a financial perspective at a new finance and activity committee, with quality risk being considered at another forum (to be decided).







Overall performance by category

	£'000
Completed recurrent	615
Completed non-recurrent	113
Benefits realisation	692
Planning/Implementation	388
Scheme Ideas	225
Unidentified	769
Total CIP target	**2802**

Forward Look

The overall Cost Improvement Programme has been reviewed, and schemes have been removed where this is a low likelihood of delivery this year. The main schemes to be removed relate to efficiency schemes that are ongoing, but that will be required to deliver baseline activity rather than additional activity or savings.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Nurse Staffing: Establishment Review**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Director of Nursing and Governance**
AUTHOR:	**Anne Crompton, Deputy Director of Nursing and Governance**
DATE OF MEETING:	**4 November 2015**

EXECUTIVE SUMMARY:

As per requirements for provider organisations following on from the Mid Staffordshire Foundation Trust public inquiry and Patients First and Foremost (DOH 2013), the Trust Board is committed to ensuring that the levels of nursing staff, are correct for the acuity and dependency needs of individual patient groups within in-patient wards.

This paper provides a six monthly appraisal of the Trust's current status for the provision of nurse staffing levels, and provides the Trust Board with assurance of the work in progress to monitor and manage safe levels of nursing staff in the Trust. It will provide an update on the requirements of the National Quality Board (NQB). The Trust Board is asked to note that the areas of non-compliance reported relate to the development of more robust systems and processes within the Trust and do not represent a concern for direct patient care.

Since April 2015 the Trust has made good progress against the following indicators:

- Compliance against the expectations set out by the NQB has improved with 8 out of 10 expectations being met in November 2015 compared to 5 in April 2015.
- Shift fill rates have remained consistently at 95% or above over the last six month period
- The NICE red flags have been added to the Trust Incident Reporting system (Ulysses) with a SOP and training plan developed in order to ensure that all staff are aware of the requirements.
- The first part of the planned establishment review is complete and a plan has been developed to move to three Registered Nurses on adult inpatient wards at night (4 on 10/12 due to ward layout).

In the next six month period the following actions will be completed:

- We will recruit to vacant and new posts in order to enable safe staffing on night shifts and eliminate the occurrence of red flag shifts during break times.
- The Deputy Director of Nursing and Governance will lead the development of guidance on the safe and appropriate use of additional staff to provide one to one support to patients
- A tool that accurately assesses acuity and dependency on paediatric wards will be sourced and used in order to accurately capture the staffing requirements for this patient group.
- A tool to map level of patient harm against shift fill rates is under development with completion expected by end November 2015.
- We will deliver compliance against the Nursing Standards for the Care of Critically ill Children published by the Paediatric Intensive Care Society (2010)

REPORT RECOMMENDATION:

The Trust Board is asked to note the contents of the report and to support the uplift of all adult in-patient ward areas from 2 to 3 registered nurses at night and from 3 to 4 registered nurses on ward 10/12.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	**X**

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

There is a risk of failure to maintain staffing levels that reflect the needs of patients and are sufficiently flexible to support variability in demand.

The provision of safe staffing levels aligns to Trust Strategic objectives to provide excellent patient experience every step of the way and to create a culture of excellence.

PREVIOUS CONSIDERATION:

The full report has not been considered at any other committee.

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Nurse Staffing & Establishment Review

Report to Trust Board on 4th November 2015

1.0 Introduction

1.1 This report is presented in two parts. The first presents the six monthly nurse staffing review (November 2015) mandated by NHS England and the Care Quality Commission (2014) joint guidance to Trusts on the delivery of the 'Hard Truths' commitments associated with publishing staffing data regarding nursing and care staff levels.

1.2 The second forms part of the organisation's commitment in providing open, honest and transparent nurse staffing information through the publication of this data both on the Trust and NHS Choices Websites. The data period presented in this part of the report is September 2015.

2.0 Part 1: Establishment Review

2.1 Background

2.1.1 The National Quality Board (NQB) expects that '*boards take full responsibility for the quality of care provided*'. This means ensuring that agreed staffing establishments are met on a shift by shift basis and decisions about setting this establishment must be evidence based and allow nursing and care staff sufficient time to undertake their caring duties.

2.1.2 Clinicians and managers must feel able to raise concerns about staffing and care providers must actively seek to recruit and retain staff to meet their requirements. Board accountability for safe staffing should be supported by '*monthly updates on workforce information and staffing capacity and capability and an at least six monthly discussion of the nursing and care establishment.*'

2.2 Progress against National Quality Board (NQB) Expectations- Organisational Context

2.2.1 Since the last nurse establishment report in April 2015, the following actions and changes have occurred. The Trust is now compliant with 8 of the 10 expectations against compliance with 5 of the 10 expectations reported in April 2015. Table 1 overleaf details evidence of compliance and highlights the actions that are in place to address outstanding areas of non-compliance.

Table 1: Compliance against NQB Expectations

NQB Expectations	Assessment of Compliance (April 2015)	Assessment of Compliance (November 2015)	Progress to date:	Action required
Expectation 1 Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staff capacity and capability	Compliant	Compliant	The Board and Executive Team have received monthly update reports detailing Nurse Staffing levels and compliance with the required standards within clinical environments. The Executive team has supported the usage of additional resource to deliver Safe Nurse Staffing levels whilst detailed work is undertaken.	No action required
Expectation 2 Process are in place to enable staffing establishments to be met on a shift-to-shift basis	Partially Compliant	Compliant	ROH has a system that documents both the number of staff and the skill of staff on duty within ward areas which is kept live throughout the day by the Duty Manager or Site Coordinators. Each area has described minimum safe levels. Clearly documented log sheets are available to demonstrate any measures taken to address maintain safer nurse staffing levels throughout the 24hour period. Duty rotas are stored at ward level for inspection.	In order to strengthen the process that enables safe staffing levels to be met, a daily staffing huddle will be introduced in November 2015 which will ensure that the conversations and decisions taken to support safe staffing have senior oversight.
Expectation 3 Evidence-based tools are	Partially	Partially	ROH utilises the Safer Nurse Staffing Tool to	A Trust wide review of the way the Safer

NQB Expectations	Assessment of Compliance (April 2015)	Assessment of Compliance (November 2015)	Progress to date:	Action required
used to inform nursing, midwifery and care staffing capacity and capability	Compliant	Compliant	assess the required vs actual number of staff on duty to meet the needs of our patients. The tool has been utilised daily since September 2014 and following training, consistency in application across clinical areas is now achieved. Scrutiny of the results occurs in a variety of forums but not at a forum with attendance by a representative cross section of nurses. There is no methodology to share the results with ward nursing teams	Nursing Care tool is underway. From December 2015, the tool will be used in line with recommendations of the Shelford Group. The findings of the Safer Nursing Care Tool will be included on the agenda of the ward sisters/ departmental leads meeting from November 2015 so that findings are shared widely. Methodology of sharing with wider ward teams to be designed.
<u>Expectation 4</u> Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feels able to raise concerns.	Compliant	Compliant	ROH has a whistleblowing policy and is a member of the Speak Out Safely Campaign. Reporting mechanisms are available to raise concerns and there is evidence of this system being utilised.	No action required
<u>Expectation 5</u> A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments	Partially Compliant	Compliant	The Director of Nursing leads the process and engagement with the wider team is achieved by Safe Nurse Staffing papers being discussed	A staffing escalation policy has been developed and will be shared with all ward sisters through November 2015.

NQB Expectations	Assessment of Compliance (April 2015)	Assessment of Compliance (November 2015)	Progress to date:	Action required
			and challenged at Trust Management Committee and Trust Board. The nursing management teams work closely with finance when agreeing the funded establishments.	This ensures engagement with all stakeholders in line with NQB requirements.
Expectation 6 Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties	Compliant	Compliant	Establishments contain funding (ringing) to allow leave and study. ROH invested in establishment to allow Senior Sisters weekly supervisory time and allow coverage for site management rota commitments.	No action required
Expectation 7 Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.	Partially Compliant	Compliant	Safe Nurse Staffing papers are submitted monthly to the Trust management Committee and Trust Board. Establishment Review papers have been submitted to Trust Board on a six monthly basis. .	No action required
Expectation 8 NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.	Partially Compliant	Partially Compliant	Board to display staffing information are in place outside each ward area. .	There is inconsistency of completion of staffing boards in ward areas. Although compliant with NQB requirements, the boards are difficult to access and are not clearly visible to the public. New staffing boards have

NQB Expectations	Assessment of Compliance (April 2015)	Assessment of Compliance (November 2015)	Progress to date:	Action required
				been sourced and will be in place by end December 2015. Monitoring against compliance of this requirement is undertaken on a daily basis by matrons and ward sisters. Confirmation of compliance will be part of the daily staffing huddle from December 2015.
Expectation 9 Providers of NHS services take an active role in securing staff in line with their workforce requirements	Compliant	Compliant	Evidence of workforce planning processes and sharing of plans with local LETB, CCG and NHS England exist at ROH.	No action required
Expectation 10 Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers whom they contract.	Compliant	Compliant	CCG receive copy of Trust Board Paper every 6 months	No action required

2.2.2 The actions outlined above will ensure that the Trust is fully compliant with all the requirements of the NQB by December 2015. The Trust Board is asked to note that the areas of non- compliance reported relate to the development of more robust systems and processes within the Trust and do not represent a concern for direct patient care.

2.3 Progress against NICE Safe Staffing Guideline and Reporting of Red Flag Shifts

2.3.1 The Trust Board report in April 2015 drew attention to the publication of NICE guidance that described Safe Nurse Staffing (2014) levels in adult inpatient wards in acute hospitals and introduced the concept of Red Flag shifts using the following indicators:

- Less than two registered nurses present on a ward during any shift.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift. If a shift requires 15 hours of registered nurse time, a red flag event would occur if 11 hours or less of registered nurse time is available for that shift.
- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan.

2.3.2 Since April 2015, a safe staffing questionnaire has been added to the incident reporting system at ROH (Ulysses). Incident reporters are being asked to complete the short questionnaire for every staffing incident to determine whether the NICE guidance on safe staffing has been breached and the shift in question constitutes a 'red flag shift'. A standard operating procedure is currently in development to support ward teams in completion of red flag shifts with training planned through November 2015. This will make analysis of the reported staffing incidents much more robust.

2.4 Assessing if nursing staff available on the day meet patients' nursing needs.

2.4.1 At ROH we currently use a staffing escalation flowchart to outline and describe the steps to take to ensure that nursing staff numbers meet patient needs on a daily basis. In order to strengthen this process further a Staffing Escalation Policy is in development, which details the steps that should be taken in response to staffing shortages. The purpose of this policy is to provide effective support to those staff that have responsibility for safe staff decision making on a shift by shift basis. It addresses the following questions:

- How do we know that there are enough staff deployed?
- What do we do when there are not enough staff?
- How and to whom is it escalated when there are concerns?

2.4.2 The person in charge of the relevant area is responsible for assessing that staffing numbers are as expected on the rota and that staffing numbers and skill mix are appropriate to patient acuity. The policy will be presented to Trust Management Committee in December 2015.

2.5 Peer Review

2.5.1 In July 2015 a benchmarking visit was undertaken with The Royal National Orthopaedic Hospital in Stanmore. Key findings from this review are:

- Adequate nursing numbers to provide safe patient care were noted in all ward areas
- The skill mix on adult in patient wards is lower than the recommended 65:35 RN: HCA ratio (RCN 201). Overall skill mix on adult in -patient wards is 60:40 with wards 10/12 having a skill mix closer to 50:50.
- The tool used to assess Safe Staffing within the Trust is a modified version of the Shelford tool. Whilst not of itself a concern, the team recommended review of the way the tool is used

across the Trust. This action is underway and progress against it will be monitored through the monthly ward sisters meeting led by the Director of Nursing.

2.6 Shift Fill Rates April to Sept 2015

2.6.1 Since June 2014 it has been mandatory for all trusts to publish shift fill rates of a monthly basis. Data collected via the UNIFY return provides evidence that safe staffing levels are consistently met on a daily and weekly basis. Table 2 below provides an overview of shift fill rates at ROH since April 2015.

Table 2: Shift Fill Rates 2015/16

Month 2015	Day	Day	Night	Night
	Av RN Fill rate %	Av HCA fill rate %	Av RN fill rate %	Av HCA fill rate %
April	95.7	94.8	99.8	95
May	96.2	95.1	100.8	97.0
June	96.6	96.9	100	101.8
July	98.6	95.8	101.0	97.8
August	98.1	97.0	100.6	103.3
September	97.1	97	99.9	96.1

2.6.2 Triangulation of data from the UNIFY return and from evidence collated from the staffing acuity tool confirms that all adult in-patient ward areas meet the NICE 2014 recommendation with a nurse to patient ratio of 1:6 for early shifts and 1: 8 for late shifts. In addition the Trust Board is asked to note the following:

- Where activity is maintained at expected levels, no wards are overstaffed.
- Temporary fluctuations in staffing requirements will be managed in a more visible way following the introduction of the daily staffing huddle in November 2015.
- Overnight our ward areas are predominantly 1:12 Registered Nurse ratio which means that only 2 RNs are on duty. When a registered nurse goes on break it leaves only one nurse on the ward which impacts on the ability of the nursing team to provide timely pain relief. Furthermore for two hours each night all wards at ROH are in breach of the NICE Red Flag 'less than two registered nurses present on a ward during any shift'.

2.7 Vacancy Rates

2.7.1 The overall vacancy rate for Registered Nurses at ROH is low when compared to the national picture where vacancy rates vary widely between provider Trusts. In September the vacancy factor across all in- patient wards was 9.03wte Registered Nurses which equates to a rate of 3.8%. It is anticipated that the majority of these posts will be filled by the end October 2015 with 5 new starters commencing. Recruitment is underway for the remaining posts.

2.8 Establishment Review

2.8.1 In April 2015 the Director of Nursing and Clinical Governance indicated his intention to work with the Director of Finance in order to understand how the movement of budgetary components, known as 'ringing' that are used to support bank and agency use can be

converted to permanent budget to allow permanent recruitment that will reduce our reliance on bank and agency staff.

2.8.2 Since April 2015 the Director of Nursing and Clinical Governance has met with ward managers, matrons and the Director and Deputy Director of Finance (DoF and DDoF) to review all in-patient ward establishments. The Director of Finance has in principle supported an establishment uplift for all adult in- patient ward areas to ensure that the Registered Nurse numbers at night increase to 3 in all in patient wards and 4 in ward 10/12 and it is likely that this will be delivered within current ward budgets by:

- Incorporating the existing 'ringing" funding into substantive ward budgets
- Reducing the number of Health care support workers on duty in each ward area overnight by 1.

This change will deliver the following benefits:

- An increase in the skill mix on night shifts to 70:30 RN to HCA
- Reduction in the use of temporary staff in line with recommendations from the Chief Nursing Officer England (June 2015) and Monitor (September 2015).
- A removal of the red flag shifts caused by having only 2 RNs on night duty in adult in patient wards.
- More timely response to patient requests for pain relief
- Enable patients to move back from theatre to ward areas in a more timely way during night shifts

2.9 Staffing Incidents: April to September 2015

2.9.1 Since April 2015 a total of 67 staffing incidents have been reported with the breakdown by ward detailed in Table 4 below:

Table 4: Incidents by Ward

	H D U	Ward 1	Ward 11	Ward 12 - Short Stay	Ward 2	Ward 3	Grand Total
Difficulty In Contacting Appropriate Staff			1	1	1		3
Lack Of Suitably Trained / Skilled Staff	11	6	1	5	6	2	31
Other Demands Affecting Quality Of Pt Care	1	1		1	1	1	5
Staff - Level Of Support To Pt	8	2		4	8		22
Staff Illness/ Absence Affecting Pt Care	1	1		2	1	1	6
Grand Total	**21**	**10**	**2**	**13**	**17**	**4**	**67**

2.9.2 Of these 67 reported incidents, 6 are NICE red flag shifts (only one RN on duty). All of these incidents occurred at night and were mitigated by the site co-ordinator basing herself/himself on the ward. A detailed escalation flowchart is in use to enable shift and unit co-ordinators to make risk based staffing decisions. Mitigations include:

- Moving staff between wards to ensure that skill mix and experience is appropriate
- Bleep holder takes responsibility for providing cover where only one RN on duty
- Escalation to matron

No patient harm has been recorded as a result of the staffing incidents reported.

2.10 The National Context

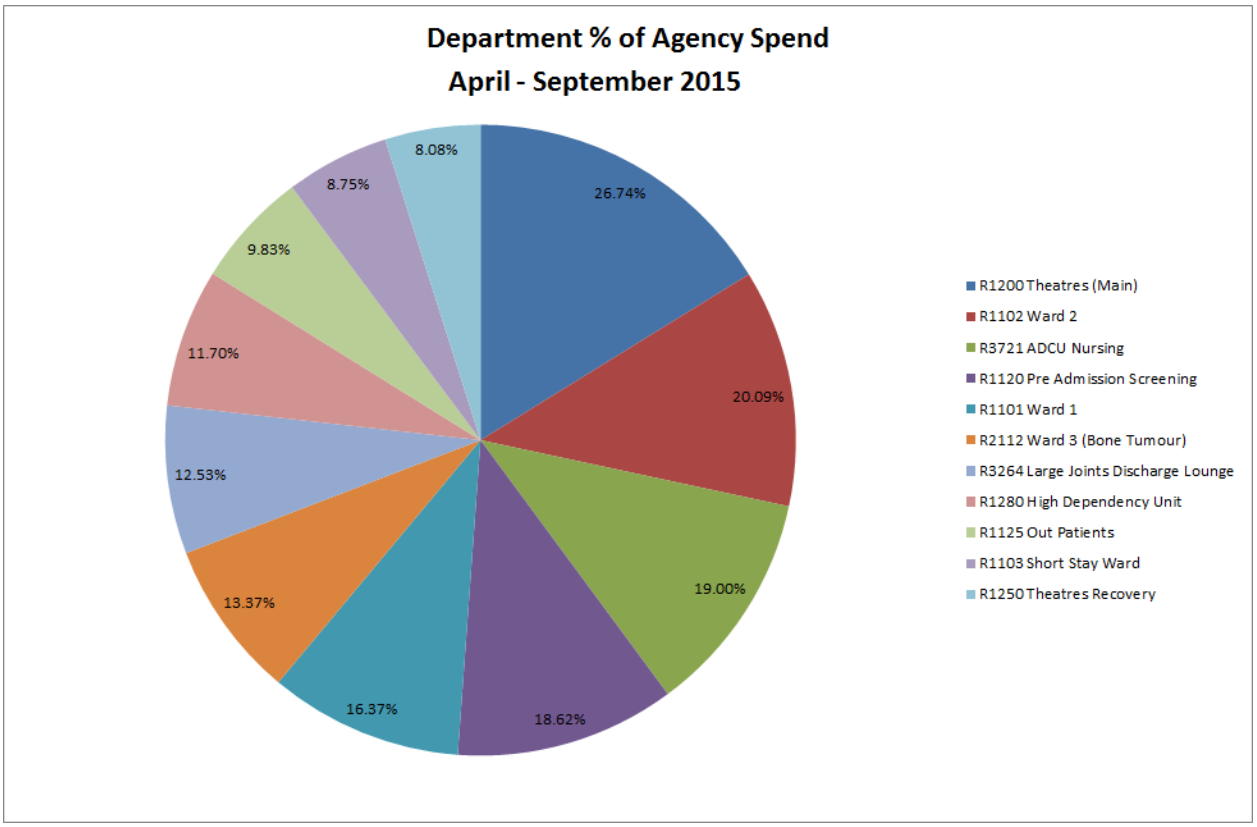
2.10.1 The national context is rapidly changing in response to concerns about high use of bank and agency staff in provider Trusts which is recognised to reduce quality of care and increase cost. In June 2015 the Chief Nurse for England set out five principles which will guide the nursing workforce strategy over the next five years. In summary these are:

- Reducing the use of bank and agency staff by moving a significant proportion of this spend into the employment of permanent staff.
- An increase in efficiency by improving rostering practice and ensuring the appropriate use of staff across the week when they are most needed.
- Better workforce planning supported by the creation of a Workforce Advisory Board chaired by Ian Cumming, CEO of Health Education England
- The development of a competency based career ladder for care assistants which will allow skill development and increase access to graduate nursing programmes.
- Recognition that safe staffing levels should be based on the needs of patients and staffing numbers should be defined through patient outcomes rather than by input numbers or ratios. The contribution of the MDT should be recognised.

2.10.2 In September 2015 Monitor and the TDA published clear intent to reduce nurse agency spend in NHS Trusts and set ceilings for each provider trust. A ceiling of 8% agency use by end October 2015 was initially suggested for ROH which was challenged by the Trust because of two particular concerns. Firstly the percentage of agency use for the period 2014/15 submitted via the Annual Plan was incorrect and adjusted, with agreement of Monitor relationship team to 11%. Secondly one third of this Trust's nurse agency expenditure is in Theatres, a known national shortage area. We are currently using agency Theatre Nurses with Spinal experience which are in particular short supply

2.10.2 ROH requested a revised trajectory of 12% by end October 2015 with a plan in place to reduce agency spend to 10% by year end. Monitor responded to this request by agreeing a modified trajectory and for the remaining financial year ROH is expected to meet and maintain agency use at 10% or below. Our current average use of agency is 15% and we are therefore required to reduce this 5% across the whole organisation. Table 5 below shows agency use by department/ area over the past six months.

Table 6: Agency spend by area (April to Sept 2015)



In order to respond to this requirement ROH has:

- Secured overseas recruits for Theatres with pre-employment clearance expected April 2016.
- Set up a working group, led by the Director of Workforce and Organisational Development to agree and implement actions required to reduce agency use and to develop effective monitoring strategies to ensure the reduction is maintained over time.
- Advertised for registered nurses to fill existing vacancies and to provide adequate numbers of nurses to ensure that additional staff are available for night duty as described earlier in this report.

2.11 Review of Registered Nurse staffing to provide Paediatric Cover in HDU.

2.11.1 During May 2015 the Director of Nursing began a piece of work to review the way children were nursed on HDU and in particular to review the provision of paediatric nurse cover on every shift. He identified that not all shifts had a Registered Children's Nurse on duty. The CQC also raised questions about paediatric nurse cover during their visit to the hospital in July 2015.

A gap analysis against the nurse quality standards developed by the Paediatric Intensive Care Society (June 2010) has subsequently been completed.

Table 7 below highlights the gaps identified and outlines that actions required to address them:

Table 7: Gap Analysis against Standard B3: Inpatient care of Children (including HDU)

Quality Standard	Gap identified (August 2015)	Actions required to address the gap	Progress
70: There should be a nominated nurse lead with responsibility for policies and procedures relating to high dependency care. This should be a senior children's nurse with competency and experience in providing high dependency care.	ROH has no identified nurse lead	The Deputy Director of Nursing has been tasked with developing links with Birmingham Children's Hospital in order to identify a clear process for the escalation of concerns and access to senior nursing support	Expected completion end December 2015.
71: There should be 24 hour access to a senior nurse with intensive care skills and training	This requirement is not met but all senior nurses who carry the bleep are trained in Advanced Life Support. A programme of development is in place to enable all Children's nurses on HDU to attend BCH for a skills update programme over a two week period. A detailed competency document for adult nurses has been developed in order to ensure that all nursing staff in HDU can respond appropriately to the sudden deterioration of a child.	The competency package needs to be completed by all Registered Nurses on HDU.	The update programme has commenced and three of the five permanent Children's nurses have spent time on HDU in BCH.
72: Children needing high dependency care should be cared for a by a Children's nurse with paediatric resuscitation training and competencies in providing	This requirement is not met within the existing workforce. The team are out to recruitment for additional children's nurses and have	Recruitment to vacant posts. Review of off duty management particularly	Expected to be complete by January 2016.

Quality Standard	Gap identified (August 2015)	Actions required to address the gap	Progress
high dependency care	reviewed rota management on the unit to ensure that existing paediatric staffs are used more effectively. Support from agency staff has been block booked in order to address the gap and a Children's nurse has been moved from Ward 11 to HDU	in respect of the bleep holding duties of paediatric trained staff.	
73: Nurse staffing for children needing high dependency care should be 0.5: 1 or 1:1 if nursed in a cubicle	All children cared for in HDU have access to one to one care. However not all nurses are Children trained and therefore this requirement is not fully met	Recruitment to vacant posts. Review of off duty management particularly in respect of the bleep holding duties of paediatric trained staff.	Expected to be complete by January 2016.

2.11.2 The gaps in provision of paediatric cover were noted by CQC during their recent visit to the Trust and the actions outlined above have been shared with them in order to address their immediate concerns. Trust Board is advised that the actions outlined in Table 7 above have enabled a Registered Children's Nurse to be on duty each shift on HDU during September for at least 80% of the time. When a paediatric nurse is not present, an adult nurse with experience of caring for children is always on shift. All nurses on HDU undergo Paediatric Immediate Life Support Training (PILS) on an annual basis.

2.11.3 Since August 2015 there have been no complaints or serious incidents recorded about the provision of paediatric care on HDU and one patient has been transferred to level 3 care. Incidents recorded on Ulysses are currently being analysed for emerging themes and trends.

2.12 Conclusion

2.12.1 Since April 2015 the Trust has made good progress against the following indicators:

- Compliance against the expectations set out by the NQB has improved with 8 out of 10 expectations being met in November 2015 compared to 5 in April 2015.
- Shift fill rates have remained consistently at 95% or above over the last six month period.
- The NICE red flags have been added to the Trust Incident Reporting system (Ulysses) with a SOP and training plan developed in order to ensure that all staff are aware of the requirements.

- The first part of the planned establishment review is complete and a plan has been developed to move to three RNs on adult in-patient wards at night (4 on 10/12 Due to environment).

2.12.2 In the next six month period the following actions will be completed:

- We will recruit to vacant and new posts in order to enable safe staffing on night shifts and eliminate the occurrence of red flag shifts during break times.
- The Deputy Director of Nursing and Governance will lead the development of guidance on the safe and appropriate use of additional staff to provide one to one support to patients.
- A tool that accurately assesses acuity and dependency on paediatric wards will be sourced and used in order to accurately capture the staffing requirements for this patient group.
- A tool to map level of patient harm against shift fill rates is under development with completion expected by end November 2015.
- A trajectory to meet the Monitor requirement to reduce agency spend to 10% through this financial year will have been agreed and actions to achieve the trajectory will have been implemented.

2.13 Recommendations.

2.13.1 The Trust Board is asked to note the contents of this report and to support the actions outlined within it. In particular the Trust Board is asked to support the move to increase funded ward establishment to enable 3 Registered Nurses on nights across all adult in-patient wards and 4 on Wards 10/12.

3.0 Part 2 - Safe Staffing in September 2015

3.1 Introduction

3.1.1 This report forms part of the Trusts commitment to the delivery of safe nursing care across all in-patient ward areas. The report provides details of shift fill rates, staffing incidents and agency use and shows harm measure against vacancy rates by ward. The data period covered is September 2015.

3.2 Shift fill Rates

3.2.1 The overall nurse staffing fill rate for September 2015 was 97 % for day shifts and 99.9 % for night shifts; this figure is inclusive of Registered Nurses and Health Care Assistants (HCA) during both day and night duty periods. Fill rates at ROH are consistently above 95%.The Unify Upload for September 2015 is provided in Appendix 1.

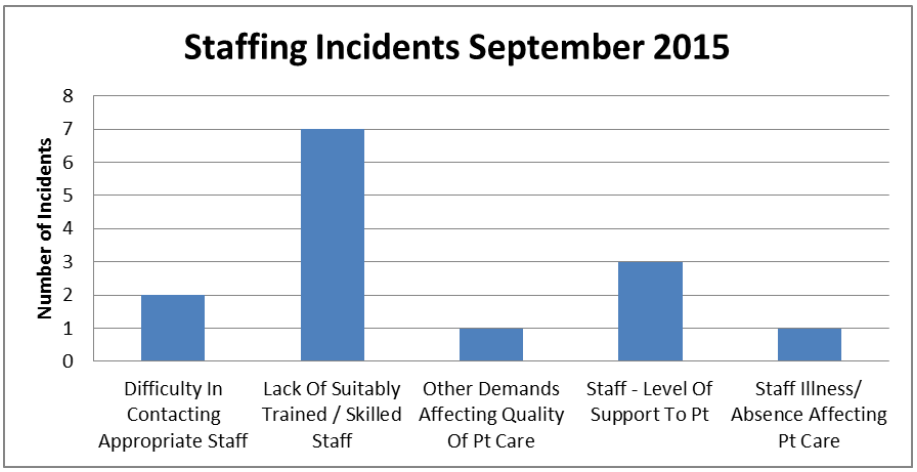
3.2.2 During September 2015 ward 1 recorded a day time registered nurse fill rate of less than 90%. There were no incidents of direct patient harm recorded as a result of staffing levels during September 2015.

3.3 Incident Reporting

3.3.1 An analysis and review of the 14 safe staffing incidents reported during the period of September 2015 has been undertaken and is represented in the graph below.

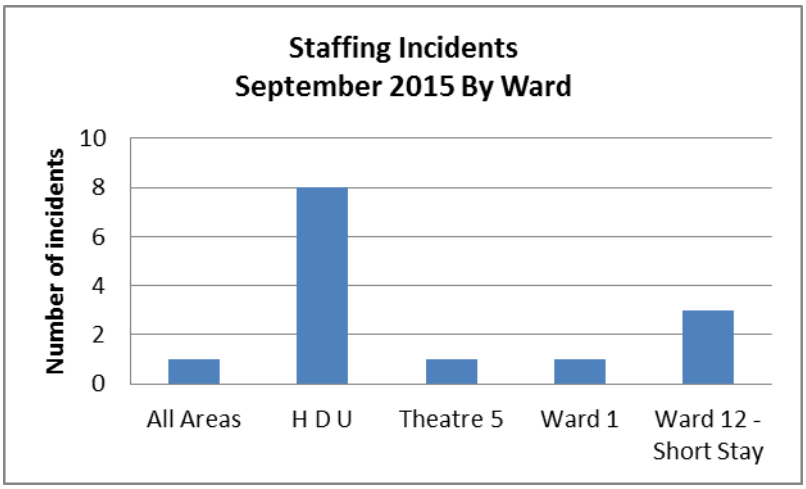
3.3.2 Incident Categories

Table 1: Staffing Incidents September 2015



3.3.3 Comparison with the 6-months from 1st April 2015 shows that lack of suitably skilled staff and level of support to patient are consistently the highest categories of concern. Incidents reported in these categories often relate to agency and bank staff not turning up for shifts.

Table 2: Incidents by ward/ area September 2015



3.3.4 The majority of staffing incidents relate to HDU, theatres, ward 2 and ward 12. On HDU the issues reported relate to the provision of paediatric nurse cover when a child is on the High Dependency Unit.

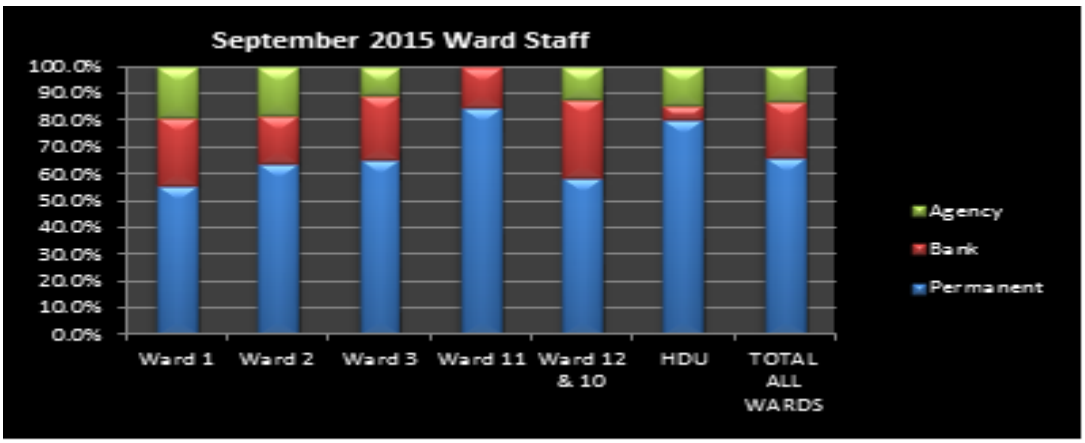
3.4 Level of harm

3.4.1 All incidents reported in September 2015 were graded 'no harm' with the exception of one HDU incident (graded 'moderate harm') that related to the care of a deteriorating paediatric patient; the care of this patient is currently the subject of an SI investigation.

3.5 Bank and Agency use

3.5.1 During September 2015 wards have continued to use bank and agency staff in order to meet patient care requirements. Table 3 below shows the ratio of bank and agency use by ward across the organisation through September 2015

Table 3: Ratio of bank and agency use by ward



3.5.2 Total agency use across all wards is recorded as 12.9% with highest usage in ward 1 and 2 at 19 and 18.2 % respectively. During September 2015 Monitor published new rules on the use on agency spend for all provider trusts which will introduce a mandatory ceiling for agency use. We await confirmation of our local ceiling but it is certain that we will be required to reduce usage during the remainder of 2015/16. The review of nurse establishment will suggest ways in which the high use of agency staff can be addressed. Moreover the development of a guideline on the provision of one to one care will be completed by November 2015 and will enable staff to ensure that appropriate nursing support is provided in all ward areas.

3.6 Vacancy rates against harm measures

3.6.1 The overall nurse vacancy rate at ROH remains low with 9.03 WTE with recruitment in place to address gaps and the vacancy factor is predicted to reduce further during October with circa 7 new starters joining the Trust. Table 4 below present harm and experience measures against ward vacancy rates. There is no evident correlation between experience of harm and vacancy absence rates on the basis of the evidence presented. The greatest numbers of staffing incident are reported on HDU. Almost all relate to the provision of paediatric nurse cover on shifts and none record evidence of direct patient harm. The Deputy Director of Nursing will develop this report over the next three months to also capture shift fill rates by ward.

Table 4: Vacancy/ absence rates against Harm/ Experience Measures by Ward

Measure	Ward 1	Ward 2	Ward 3	Ward 10/12	Ward11	HDU
Vacancy (WTE)	1.34	2.91	0	5.03	0	1.3
Number pressure ulcer	2	0	0	0	0	1
Number falls	0	1	1	2		
Number staffing incidents*	1	0	1	2	0	8
Complaints	0	0	0	0	0	0

- **Note only 12 of the 14 reported staffing incidents refer to in-patient areas.**

3.7 Conclusion

3.7.1 The Trust Board is asked to note that shifts at ROH are staffed to plan more than 95% of the time on both day and night shifts during September 2015

Whilst agency use remains high, shifts are being staffed at a level that supports safe patient care.

Garry Marsh
Director of Nursing & Clinical Governance

29 October 2015

Appendix 1: UNIFY upload September 2015

		Day				Night				Day		Night	
Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
110 - TRAUMA & ORTHOPAEDICS		1546.5	1388.5	914.5	915.5	660	660	638	648.5	89.8%	100.1%	100.0%	101.6%
110 - TRAUMA & ORTHOPAEDICS		1398	1340	953	911.5	660	660	660	583	95.9%	95.6%	100.0%	88.3%
800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1695	1610.5	1095	1012.5	600	600	600	590	95.0%	92.5%	100.0%	98.3%
110 - TRAUMA & ORTHOPAEDICS		1688	1702	1436	1441	990	990	990	946	100.8%	100.3%	100.0%	95.6%
110 - TRAUMA & ORTHOPAEDICS		1162.5	1163	274.5	270	660	660	154	154	100.0%	98.4%	100.0%	100.0%
110 - TRAUMA & ORTHOPAEDICS		1416.5	1446.5	240	217.5	1166	1163	11	11	102.1%	90.6%	99.7%	100.0%

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Nurse Revalidation at ROH**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Director of Nursing and Governance**
AUTHOR:	**Anne Crompton, Deputy Director of Nursing and Governance**
DATE OF MEETING:	**4 November 2015**

EXECUTIVE SUMMARY:

From April 2016 the Nursing and Midwifery Council (NMC) will be introducing revalidation. The purpose of revalidation is to improve public protection by making sure nurses and midwives continue to be fit to practise throughout their career. Without successful revalidation, nurses and midwives will no longer remain registered and therefore will no longer be able to legally practice.

This paper outlines the requirements of nurse revalidation, considers the implications for ROH and provides a summary of actions that are in place to support the implementation of successful revalidation across the Trust.

REPORT RECOMMENDATION:

Registration and Revalidation for nurses and midwives is intended to uphold public trust and confidence in the profession and provides opportunities to further enhance the delivery of high quality patient care. The Trust has a responsibility to ensure nurses and midwives employed by the Trust are registered and fulfil the requirement of the regulatory body to practice, to safeguard the public.

This paper was considered and approved by the Trust Management Committee on 21 October 2015 and the Trust Board is requested to note and accept the contents of this paper.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	**X**

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Risk that nurses and midwives are not aware of revalidation, or fail to take appropriate action themselves and are not prepared to meet new requirements, therefore cannot re-register with the NMC

when their renewal date is due and are unable to work as a registered nurse or midwife.

Potential risk of financial implications if additional time or resources required of managers to undertake the role of confirmer and the confirmation process.

PREVIOUS CONSIDERATION:

The report was considered at October's Trust Management Committee.

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Nurse Revalidation at ROH

Report to Trust Board on 4th November 2015

1. Introduction

From April 2016 the Nursing and Midwifery Council (NMC) are introducing revalidation. The purpose of revalidation is to improve public protection by making sure that nurses and midwives continue to be fit to practise throughout their career. Without successful revalidation, nurses and midwives will no longer remain registered and therefore will no longer be able to legally practice. This paper aims to provide the Trust Board with an overview of these new professional regulatory requirements. It will also provide Trust Board with an overview of work currently underway at ROH to prepare our nursing teams and develop local processes to support the implementation of a revalidation programme at the Trust.

2. Background to Revalidation

2.1 In September 2013, following the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Sir Robert Francis QC, the NMC committed to introducing an effective system of revalidation, in order to enhance public protection. A new process for revalidation should be implemented by the NMC from April 2016 and fully implemented by March 2019

2.2 Revalidation supports professionalism through a close alignment with the NMC Code for nurses and midwives which was published in March 2015. Revalidation is applicable to all nurses and midwives irrespective of their role and area of practice.

2.3 Revalidation is already common practice for medical staff and is not a new concept; however nursing and midwifery revalidation requires more confirmatory evidence to be provided by the registrants to meet the NMC requirements.

3. What is currently happening?

3.1 On 8th October 2015, the Nursing and Midwifery Council made the decision to introduce revalidation for nurses and midwives in the UK.

3.2 Nurses and midwives revalidating from April 2016 will be the first registrants required to meet the new requirements agreed for revalidation. Therefore those due to renew their registration will need to familiarise themselves with the revalidation requirements and start to develop their portfolio of evidence.

3.3 National and regional revalidation steering groups are now providing regular updates and guidance on the progress towards revalidation and supporting increased communication and raising awareness of these regulatory changes.

4. What is Required?

The NMC have confirmed that in order to revalidate the individual nurse/ midwife will have to:

4.1 Practice as a nurse/midwife for a minimum of 450 hours, this is typically met by working in a paid role that requires a nursing or midwifery registration. Those staff that have dual nursing and midwifery registration will need to achieve 450 hours of practice in each area.

4.2 Undertake Continuing Professional Development (CPD). This requires staff to undertake 40 hours of development relevant to a registrant's scope of practice. Of this development 20 hours must be what is termed participatory learning so gained through involvement in training activities.

4.3 Obtain five pieces of practice related feedback. This feedback can be from patients, carers, colleagues, students or through reviewing the outcome of complaints, serious incident reports or the Friends and Family test results for a clinical area.

4.4 Produce a minimum of 5 written reflections as evidence of the learning achieved from the practice, CPD and feedback gained over the previous 3 years. These reflections must link an aspect of CPD and/or feedback to the NMC Code of Practice known as The Code. These reflections must then be discussed with another NMC registrant (typically a line manager or professional lead) and the conversation confirmed through the completion of a specific form.

4.5 Provide a health and character declaration.

4.6 Declare professional indemnity arrangements are in place.

4.7 Demonstrate to a third party that they have met the Revalidation requirements and have their evidence confirmed.

5. Implications for the Royal Orthopaedic Hospital NHS Trust

5.1 Although individual staff have a responsibility for meeting their revalidation requirements the Trust will need to support staff by having robust systems and processes, capacity and resources to comply with revalidation to enable them to remain on the NMC register and continue to work as registered professionals within the Trust. In addition, there is a need to engage with patients and public to promote awareness and understanding of the revised NMC Code and revalidation process.

5.2. Our aim is to ensure that revalidation is not seen as a standalone additional requirement for nurses but is an integral part of everyday professional

practice aligned with the NMC Code and the trust values. Every nurse will require a robust appraisal that is of high quality and is linked to 'The Code' (NMC, 2015).

5.3 Guidance from the NMC identifies that registrants should obtain their confirmation during the final 12 months of the three year registration period to ensure that it is recent. They recommend the revalidation discussion and confirmation is undertaken during the annual appraisal. We are therefore planning to utilise staff's annual appraisal as a platform for revalidation. This approach is being adopted by most employers; line managers are best placed to undertake the professional development discussion / confirmation.

5.4 For this Trust, where a registrant's line manager is not an NMC registrant the professional development discussion/confirmation will be undertaken by the person who is identified as holding the professional line of accountability.

5.5 Escalation processes are being developed for individuals who do not or cannot complete the revalidation process at the identified time as they will not be able to work until compliant. Any issues with confirmation will be escalated through the professional lines of accountability to the Director of Nursing. It is anticipated that this would be a very small number once the system is embedded, as the existing oversight of practice, appraisal and personal development plans should highlight concerns early in the process and not at the point of revalidation.

5.6. There has been no additional funding identified to support the costs of implementation of revalidation. The costs of the process for revalidation are intended to be absorbed within the Trust's normal appraisal system and Continuing Professional Development programmes

6. Ongoing actions to assure readiness for Revalidation

6.1. The Trust has already made considerable progress in the implementation of revalidation.

6.2. A process has been established in association with Human Resources colleagues to identify nursing staff required to revalidate. This is held within the Electronic Staff Record.

6.3. Whilst revalidation is led by the NMC, and is being actively supported by other professional bodies, the details and consequences of failing to be able to revalidate are not universally understood by all nursing registrants. One of the key challenges for the Trust is to ensure that all nursing/midwifery staff are fully aware of what revalidation entails and what activities and evidence will be required. To meet this challenge the Trust has established a revalidation project plan to co-ordinate and take the work programme forward.

6.4 Awareness sessions have been delivered through September and October 2015 to a wide range of nursing staff and the Trust is hosting a ' ready for

revalidation date' on 20 October 2015 supported by colleagues from the Royal College of Nursing.

6.5. To underpin the process registered staff will include revalidation evidence within their annual appraisal. The PDR and professional registration policies are being updated to include the requirements of nurse revalidation to ensure that the role of the confirmer is clearly outlined.

6.4. Whilst registered staff are able to use the documentation of their choice to support their revalidation, the Trust will be providing NMC approved templates for staff to use in the form of a portfolio. This portfolio can be used as an electronic tool or paper based tool.

6.5 The Trust needs to ensure that appraisers are trained in their new role as confirmers and are competent to undertake the role of confirmer to the expected standard. For this reason, a series of 'confirmers' workshops are planned for November 2015.

6.6 Nurses who are required to revalidate from April 2016 will be contacted to commence the process from December 2015. Thereafter, Trust systems will commence to support registrants in the revalidation process as part of normal business.

7. Conclusion and Recommendations

7.1. Registration and Revalidation for nurses and midwives is intended to uphold public trust and confidence in the profession and provide opportunities to further enhance the delivery of high quality patient care. The Trust has a responsibility to ensure that nurses and midwives employed by the Trust are registered and fulfil the requirement of the regulatory body to practice, to safeguard the public.

7.2. There is an ongoing process in place to enable registered nurses to complete the revalidation process.

7.3 The Trust Board is requested to note the contents of this paper.

Garry Marsh
Director of Nursing and Clinical Governance

21st October 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Capital – Half yearly report 2015-16**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Director of Finance**
AUTHOR:	**Hannah Molloy, Head of Financial Accounting**
DATE OF MEETING:	**4th November 2015**

EXECUTIVE SUMMARY:

The Trust Board signed off the 2015-16 capital plan on 1st April 2015. This report outlines progress against these schemes during the first 6 months of the financial year.

Year to date spend of £754,000 has occurred against a full year plan of £8,059,000. Based on current projections, we anticipate a forecast outturn expenditure of £5,031,000. The main changes from the original plan are projected as follows:

- IM&T Schemes – Planned annual spend of £3,369,000, forecast outturn spend of £1,652,000
  - Linked to slippage on the profiled ePMA timescales, and re-prioritisation of other smaller IM&T schemes
- Theatre feasibility – Planned annual spend of £1,188,000, forecast outturn spend of £106,000
  - Only anticipated spend in 15/16 now relates to design fees in Q4

There are two schemes where the Executive are proposing varying the in-year capital programme to support additional expenditure. These relate to the purchase of server and storage capacity, and additional costs linked to the purchase of the InTouch Outpatient Management System. This paper outlines the rationale for these proposed changes.

REPORT RECOMMENDATION:

Trust Board are asked to note the progress on the 2015/16 capital programme and to approve the adjustment to the forecast outturn position, including the proposals around server and storage capacity, and the InTouch system.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*

Financial	X	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	X
Clinical	X	Equality and Diversity		Workforce	

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
A number of our capital schemes are directly related to transformation required as part of our strategic plan or to access risks highlighted through our risk assurance frameworks.
PREVIOUS CONSIDERATION:
The report, with additional details added around the two schemes requiring additional funding, was considered and noted at October's Trust Management Committee. The business cases for additional IT storage were also considered and supported.

FOR DECISION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CAPITAL – HALF YEARLY REPORT 2015-16

Report to Trust Board on 4th November 2015

1 EXECUTIVE SUMMARY

1.1 The Trust Board signed off the 2015-16 capital plan on 1st April 2015. This report outlines progress against these schemes during the first 6 months of the financial year.

1.2 Year to date spend of £754,000 has occurred against a full year plan of £8,059,000. Based on current projections, we anticipate a forecast outturn expenditure of £5,031,000. The main changes from the original plan are projected as follows:

- IM&T Schemes – Planned annual spend of £3,369,000, forecast outturn spend of £1,652,000
  - Linked to slippage on the profiled ePMA timescales, and re-prioritisation of other smaller IM&T schemes
- Theatre feasibility – Planned annual spend of £1,188,000, forecast outturn spend of £106,000
  - Only anticipated spend in 15/16 now relates to design fees in Q4

1.3 There are two schemes where the Executive are proposing varying the in-year capital programme to support additional expenditure. These relate to the purchase of server and storage capacity, and additional costs linked to the purchase of the InTouch Outpatient Management System. This paper outlines the rationale for these proposed changes.

2 2015-16 CAPITAL PROGRAMME

2.1 The Trust Board agreed a capital expenditure plan of £8,059k for 2015-16 which was made up of the following expenditure:

Scheme	£'000
Theatres redevelopment	1,538
Other Theatres estates schemes	500
Admin block refurbishment	200
Other estates schemes	670
EPMA	2,000
Electronic Patient records	400
In-touch kiosks	110
Mobile devices	100

Electronic Document Management	200
Referral management system	100
Other IM&T schemes	459
Radiology Equipment	1,180
Theatres Equipment	435
Other equipment replacement	167
TOTAL	**8,059**

3 YEAR TO DATE PERFORMANCE

3.1 To September 2015 the Trust has incurred £754k in relation to capital expenditure. Please see appendix A for a full breakdown of expenditure by scheme versus the planned expenditure. To September 2015 the expenditure is £3,693k behind the planned expenditure for the first six months of 2015/16. The table below highlights the schemes with the planned highest capital investments with details of their status:

Scheme detail	Plan £'000	Actual £'000	Var. £'000	Detail
Theatre redevelopment	1,188	9	1,179	This budget was incorrectly phased into the first half of the financial year. Plans to begin in Q4 which will mainly consist of professional fees with building works delayed until 2016/17.
Other theatres estates schemes	167	8	159	Works delayed due to the delay in the demolition of wards 5 & 7 which is now expected in December. This work is still expected to take place this financial year.
E-Prescribing/EPMA	1,000	0	1,000	The business case has now been approved, and work is ongoing to finalise a contract. It is now likely that only £584k of the planned £2,000k with be expended in 2015/16.
Radiology equipment	760	6	754	Relates to the purchase of DR plates and image intensifiers. The business cases have now been written and based on quotes received there will be an underspend of £200k for these two projects.
Theatres equipment	358	19	339	Originally planned to purchase £60k operating table and £90k anesthetic equipment which is no longer required for 2015/16 so the money is to be reinvested in replacing other theatres equipment. It was also planned that £90k would have been spend on the new stock management system, this is still going through the business case approval process.
TOTAL	**3,473**	**42**	**3,431**	

4 FORECAST OUTTURN

4.1 Based on the current information from the project managers the capital expenditure for 2015/16 is forecast to be £5,031k which is a reduction of £3,029k when compared to the original plan. The table below shows the revised forecast in summary form, please see appendix B for the full forecast.

Scheme	Plan £'000	Forecast £'000	Var. £'000	Detail
Theatre redevelopment	1188	106	1,082	Anticipating £106k of expenditure in relation to feasibility and architectural fees.
Other estates schemes	1720	1750	(30)	While there are year to date delays in expenditure it is expected that there will be a £30k over spend by the year-end mainly in relation to the admin block refurbishment.
IM&T Schemes	3369	1652	1,717	Mainly due to slippage in the ePMA project. £1m of hardware costs will now be incurred in 2016/17 as well as c£0.5m of software costs relating to this project.
Radiology DR Plates	800	600	200	Based on quotes received for the business case resulting in lower costs than planned.
Radiology image intensifiers	360	300	60	Based on quotes received for the business case resulting in lower costs than planned.
Operating tables	60	89	(29)	Based on quotes received. Whilst the cost is higher than planned the use of the same supplier means that the theatre staff will not need additional training to use the tables and means that they are safer to purchase.
Anaesthetic equipment	90	0	90	Original plan was to purchase 2 in 2014/15 and 2 in 2015/16. All 4 were purchased in 2014/15 in order to achieve a discounted price.
Theatre stock system	90	147	(57)	Based on quotes received as part of business case development. This project is still going through the business case approval.
Other equipment replacement	382	387	(4)	Increase mainly relates to the under spends on theatre equipment being transferred to the other equipment line.
TOTAL	**8059**	**5031**	**3029**	

5 PROPOSED VARIATIONS TO ORIGINAL CAPITAL PLAN

5.1 There are two material variations to the original capital plan where the Executive would like formal approval from Trust Board. These relate to the purchase of additional server and storage capacity to support future IM&T developments, and additional costs related to the implementation of the InTouch Outpatient Management System.

5.2 The Trust approved the implementation of a new IT infrastructure in December 2013 which included new storage, servers, virtual desktops and off-site backups. All equipment came with a 5 year warranty. Although a 500% allowance was given for expansion, the current infrastructure is almost full and further expansion is required to host future clinical systems developments. Appendix 3 shows the massive increase in IT requirements since the IM&T Strategy was approved in early 2014.

5.3 Trust Board have already approved the business case for ePMA, which included provision for additional storage and server capacity, and Trust Management Committee has approved a business case for the use of the existing capital resources for IT replacement to support the virtualisation of the image storage from our PACs radiology system.

5.4 Whilst service and storage capacity can be bought on an ad-hoc basis as each clinical system development is supported, it is far more economic and operationally effective to purchase this capacity in greater volumes. The Executive team are therefore requesting support to purchase an additional £225,000 of server and storage capacity to provide for future clinical system developments in a way that maximises value for money.

5.5 This level of funding will allow the purchase of 47TB of fast disk and slow disk storage, and 1,152GB of memory.

5.6 There is slippage on a number of the IT capital budgets that could be utilised to provide this funding, however a number of these schemes are being slipped rather than removed (ePMA, Portal, Electronic Document Management) so it is suggested that these budgets are protected and rolled forward.

5.7 There are a few schemes (Referral Management, Mobile Devices, Clinical Outcomes) that may underspend their planned budgets and provide some support to this funding request. It is proposed that any residual funding is brought forward from the £400,000 allocated in the 2016/17 capital programme for IT replacement.

5.8 Following the appointment of the preferred contractor, a range of complex ICT architecture issues have been identified that if left unaddressed will result in only circa 70% of the system functionality being utilised. The architecture issues relate to system interfaces with our PAS and Radiology system suppliers. These issues will equally impact upon the functionality of other linked systems within the agreed ICT

Strategy such as Amplitude Outcomes, Electronic Document Transfer and the Ormis replacement. This is not a shortcoming of the In Touch Partner more a significant factor of some of our outdated partnerships. As it is clear additional coding and linkages will be required to support future systems as well as the InTouch solution the Board is asked to agree release of an additional £90k to cover the totality of this issue.

6 RECOMMENDATION(S)

6.1 Trust Board is asked to note the progress on the 2015/16 capital programme and to approve the adjustment to the forecast outturn position, including the proposals around server and storage capacity, and the InTouch system.

Paul Athey, Jonathan Lofthouse, Hannah Molloy
Director of Finance, Director of Operations, Head of Financial Accounting

22nd October 2015

APPENDICES:

Appendix 1 – Year to date capital expenditure

Scheme detail	Plan	Actual	Variance
- Fire & DDA	15,000	12,920	2,080
- Hospital Signage	4,500	5,819	(1,319)
- Replacement Windows	21,500	14,685	6,815
- Enabling Works Gas	40,000	(24,402)	64,402
- Enabling Works Electricity	40,000	0	40,000
- Legionella Works	11,000	5,950	5,050
- Estates Rationalisation	20,000	137,833	(117,833)
- Asbestos Removal	27,000	2,524	24,476
- Road works	25,000	6,500	18,500
- Cadbury House Refurbishment	100,000	138,068	(38,068)
- Demolition of Wards 5 & 7 / Theatre Pad	50,000	2,798	47,202
- Improvement works in theatres	166,667	8,202	158,465
- Feasability review of theatre & overall site development	1,188,000	8,576	1,179,424
- Servers / Disaster Recovery / VDIs - Other	49,000	36,599	12,401
- Ongoing replacement / maintenance	142,500	153,708	(11,208)
- Pharmacy / E-Prescribing	1,000,000	0	1,000,000
- Clinical Outcomes	50,000	0	50,000
- Referral management system	100,000	0	100,000
- InTouch Kiosks	110,000	151,066	(41,066)
- Mobile Devices	50,000	1,270	48,730
- Digital Dictation	26,000	30,423	(4,423)
- Image intensifiers	400,000	0	400,000
- DR Plates	360,000	5,569	354,431
- Other	10,000	0	10,000
- Operating Tables	60,000	0	60,000
- Anaesthetic Equipment	90,000	0	90,000
- Theatre lights	40,000	18,625	21,375
- Other	77,500	103	77,397
- Stock System	90,000	0	90,000
- Rolling Replacement Programme	25,000	0	25,000
- Emergency Equipment replacement	58,500	46,177	12,323
Prior year VAT adjustment	0	(8,830)	8,830
TOTAL	**4,447,167**	**754,184**	**3,692,983**

Appendix 2 – 2015-16 Forecast outturn on capital expenditure

Scheme detail	Plan	Forecast	Variance
Fire & DDA	30	30	0
Hospital Signage	9	9	0
Replacement Windows	43	43	0
Enabling Works Gas	65	65	0
Enabling Works Electricity	65	65	0
Legionella Works	22	22	0
Estates Rationalisation	43	263	(220)
Lifts	65	145	(80)
Asbestos Removal	43	23	20
Road works	85	85	0
Admin block refurbishment	200	200	0
Demolition of wards 5 & 7 / Theatre Pad	350	300	50
Theatres Environmental improvements	200	200	0
Move Plater room	150	150	0
Theatres Storage Extention and Units	150	150	0
Estates contingency	200	0	200
Feasibility review of Theatre & overall site development	1,188	106	1,082
Servers / Disaster Recovery / VDIs - Other	98	98	0
Ongoing replacement / maintenance	285	510	(225)
Pharmacy / E-Prescribing - Hardware	1,000	0	1,000
Pharmacy / E-Prescribing	1,000	584	416
Portal to support Electronic Patient Records	200	0	200
New clinical systems / Electronic Patient Record	200	100	100
Referal management system	100	0	100
Electronic document management	200	0	200
InTouch Kiosks	110	180	(70)
Mobile Devices	100	100	0
Digital Dictation	26	30	(4)
Clinical Outcomes	50	50	0
DR Room 1&2 - Plates	800	600	200
Image intensifiers	360	300	60
Ultrasound Refurbishment	20	0	20
Operating Tables	60	89	(29)
Anaesthetic Equipment	90	0	90
Theatre lights	40	39	1
Stock System - Hardware	60	74	(14)
Stock System - Software	30	73	(43)
Other	155	189	(34)
Rolling Replacement Programme	50	50	0
Emergency Equipment replacement	117	117	0
Prior Yr VAT Adj	0	(9)	9
TOTAL	**8,059**	**5,031**	**3,029**

Appendix 3 – IT infrastructure capacity and growth

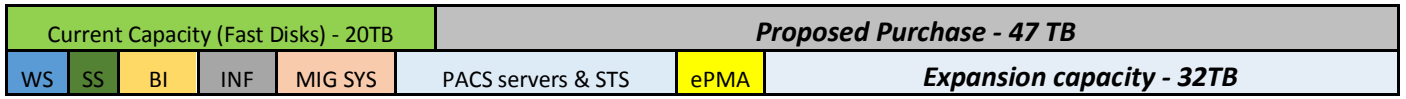
STORAGE

Old Infrastructure Capacity — Fast disks | Slow disks — *10TB*

Old Infrastructure storage used (April 2014) — servers | Files — *10TB*

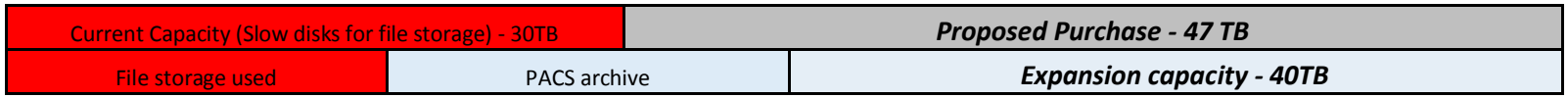
New Infrastructure Capacity - servers

New infrastructure used (Aug 2015)



New Infrastructure Capacity - files

New infrastructure used (Aug 2015)

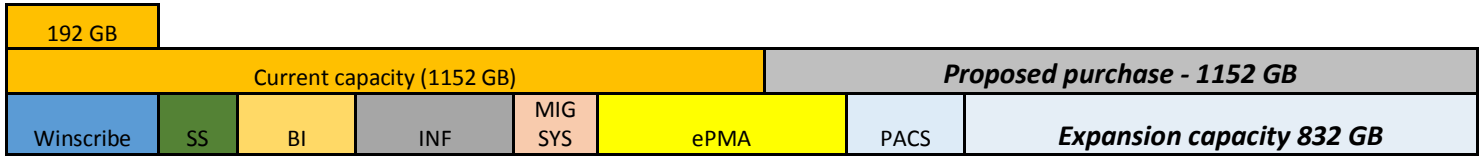


MEMORY

Old Infrastructure Capacity — 192 GB

New Infrastructure Capacity

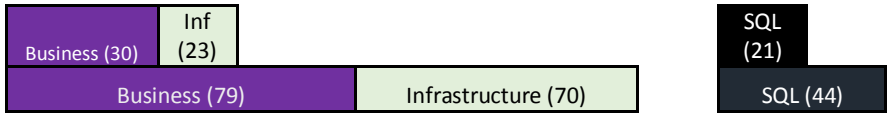
New infrastructure used (Aug 2015)



VIRTUAL SERVERS

Old Infrastructure

New infrastructure



KEY

WS = Winscribe

SS = Small systems

BI = Business Intelligence

INF = Infrastructure related

MIG SYS = Migrated systems

Small systems include:

Medicus

Blood results

EDT

Oncology*

Tiara*

*growing fast

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	17 September 2015 7 October 2015 (workshop)
Guests	Audit teams from Baker-Tilly (Internal Audit) and Deloitte (External Audit) were in attendance at the meetings
Presentations received	Board Assurance – Baker-Tilly
Major agenda items discussed	• External Audit progress report • Internal Audit progress report • Capita CHKS report • Counterfraud update • Recommendation tracker • Losses and compensation register • Breaches and Waivers of SFIs • Hospitality register • Declarations of interest • Audit Committee annual report • Audit Committee workplan • Board Assurance Framework • Assurance report from CGC • Board Assurance & Audit Committee effectiveness (workshop)
Matters presented for information or noting	• Nothing additional
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• It was reported that the Trust was currently operating with a level of agency spend over and above the cap set by Monitor • The Committee noted that there were a number of internal audit reports which had not received a management response. This matter was to be escalated to the Executive Group and relevant directors. • It was suggested that in respect of the 'Equipment Training – High risk Medical Devices', the Executive Lead should attend the next meeting • Although good progress had been made with addressing open audit recommendations, it was reported that there remained pressure to close these (particularly the 'red' actions) in a timely manner • The Committee noted that the value and number of single tender forms had increased significantly. Concern was raised that this position may not ensure that best value for

	money was being gained in all cases. Further concerns were raised over the use of interim staff at a senior level from companies, where a tendering exercise had not been undertaken. This is being addressed with a plan to recruit substantive individuals into these positions shortly.
Positive assurances and highlights of note for the Board	• The closer working links and communication between Audit Committee, Clinical Governance Committee and the auditors were welcomed. The enhanced reporting up to the Audit Committee by CGC was pleasing in particular. • The outcome of the Capital CHKS 'Payment & Tariff Assurance Framework' work presented the Trust in a positive light in respect of clinical coding, with the Trust having been chosen by Monitor as one of five roadmap partners for costing • A positive report was presented by the Counterfraud team, which provided good assurance that fraud prevention and resolution was being handled well • A large number of green audit recommendations within the action tracker was noted • The levels of losses and compensations, when benchmarked, indicated a good level of control within the Trust • The number of breaches of Standing Orders and Standing Financial Instructions was noted to be low • Continued compliance with declarations of hospitality and interests was noted
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A process for streamlining and simplifying the process for developing the annual report and accounts would be presented at the next meeting • An enhanced report from Internal Audit would be created to provide additional details on the completed reports and show the process for signing off management responses • Finance Director to review the Internal Audit plan with n the Executive Team • A review of the procurement exercise related to value for money from implants is to be undertaken • Dates of CGC and Audit Committee are to be arranged so as to assist reporting arrangements • An action plans following feedback from Board members on the effectiveness of current Board Assurance arrangements and the operation of the Audit Committee is to be developed, following the workshop on 7 October
Decisions made	• None specifically

Rod Anthony

NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Trust Board scheduled for 4 November 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CLINICAL QUALITY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	11 September 2015 14 October 2015
Guests	Sarah Mimmack, Nurse Lead for Infection Prevention and Control Evelyn O'Kane, Matron & Lead for Safeguarding Dr Bill Rae, Chair of Drugs & Therapeutics Committee Ms Gillian Davidson, Nurse Lead for Falls Dr Egidio da Silva, Clinical Services Leads for Anaesthetics
Presentations received and discussed	Falls update Pre-operative fasting & water prescriptions
Major agenda items discussed	• Annual Infection Prevention & Control report • Safeguarding annual report • Complaints summary • Falls prevention summary • Medical equipment update • Policy governance update • Quality & Patient Safety report • Duty of Candour operational process • Litigation position statement • Directorate clinical quality framework • Report back from the Quality Committee • Report back from the Drugs & Therapeutics Advisory Group • Quality improvement priority quarterly report • Results of national inpatient survey • CGC risk register
Matters presented for information or noting	• Quality heat maps • Never Events assurance report • CGC workplan
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• Compliance with bare below the elbow infection control best practice was highlighted to be below acceptable compliance and the Medical Director is developing strategies to improve compliance amongst medical staff • There remain two complaints outstanding from 2014/15 that remain to be closed. • At present there is little evidence of lessons learned from complaints, incidents and litigation activity, therefore further work is being undertaken to identify this, build it into the formative Quality & Patient Safety report and communicate it through routes such as the Trust wide

	learning day • There remain a significant number of policies in existence which have passed their review date; much work is being undertaken to develop a revised process and format for policies and a system for ensuring that those policies which are out of date are reviewed on a priority basis • The falls presentation highlighted that further work may be required pre-operatively, involving therapy staff, to prepare patients for the post-operative experience, which had the potential to reduce falls • The update on progress with delivering the Quality improvements set out in the Trust's Quality Account, reported that the position concerning patients having sufficient help to eat and that concerning pain management had deteriorated. This is being investigated and will be addressed by the Deputy Director of Nursing & Clinical Governance. • The national inpatient survey reported that there had been deterioration in the length of time patients needed to wait for beds. Other areas of concern were reported to relate to noise at night, cleanliness and delayed discharges. Action plans are in place to address the majority of the issues raised. • Although good progress had been made, the pre-operative fasting update highlighted that the Trust was not meeting the national guidance of ensuring that patients could take fluids up until two hours before surgery. It was reported that a 'lock down' of theatre lists was a key enabler to this, as was a multi-disciplinary signing up to a set of professional standards that ensured that the Trust as a whole embraced the national guidance. A target of ensuring that patients are taking fluids until three hours before surgery was noted to be a more realistic aim at present. Nurse and Medical Directors have been charged with implementing fully by January 2016
Positive assurances and highlights of note for the Board	• The annual Infection prevention & Control update reported that there had been a low level of infections during the year; performance against the Surgical Site Infection rate target was reported to be pleasing. A reduction in the number of Grade 2 pressure ulcers was reported to have been seen. • Pleasing work to ensure that the Trust met its obligations under Safeguarding and Deprivation of Liberties legislation was noted • Good work was reported to have been undertaken to deliver the medical equipment action plan, including addressing completion of training records and maintenance requirements

	• A systematised way of handling serious incidents that needed to be managed under CQC Regulation 20, Duty of Candour is being developed • Work continues to be underway to implement the new governance requirements into the new divisional structure and create a link through to Clinical Governance Committee • The improved effectiveness of the Quality Committee was noted, including better representation from a range of disciplines and the intention to strengthen its role in escalating matters of concern through to CGC • It was noted that the separation of responsibilities around medicines management and the strengthened arrangements for managing Controlled Drugs was pleasing • The Committee was appraised of the innovations developed in response to lessons learned from falls, including the 'hoverjack' • The Committee noted the improved oversight of delivery of the quality improvements • The summary of the results from the latest national inpatient survey was reported to be overall satisfying • The improved quality of reports and updates from the trustwide governance committees was noted
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Plans to increase awareness of bare below the elbow practice • Update on the work of the bone infection unit • Process to be developed for capturing and reporting lessons learned • Undertake a mapping exercise between staffing levels and harm • Further develop processes to better improve policy governance • Develop processes to provide upward assurance on quality & safety from the divisions to CGC • Realign meeting dates to be better aligned to Trust Board and Audit Committee • Arrange for the most positive aspects raised in the national inpatient survey to be communicated • Consider most appropriate reporting route for medical devices in terms of training and maintenance • Further refine the Quality & Patient Safety report • Develop professional standards concerning pre-operative fasting and fluid in take • Organise a project around addressing some aspects of basic care
Decisions made	• The revised, more comprehensive Committee workplan was supported

	• A suggestion that the Committee's name should change to be 'Quality & safety Committee' was made, which would need to be formally approved by Trust Board & Council of Governors via an amendment to the Trust's constitution

Kathryn Sallah
NON EXECUTIVE DIRECTOR AND CHAIR OF THE CLINICAL QUALITY COMMITTEE

For the meeting of the Trust Board scheduled for 4 November 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRANSFORMATION COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	22 September 2015
Guests	None
Presentations received	Detailed update on Workstream 1- Culture of Excellence, Innovation and Service
Major agenda items discussed	• Highlight report including new KPIs • Workstreams 1 – 7 updates
Matters presented for information or noting	• Nothing additional
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• On the basis that the IM & T projects appeared to be congested, it was suggested that a deep dive into the IM & T programme should be considered at the next workshop • Within Worksteam 3, Safe & effective care, the enhanced recovery work was reported to be at RED status, which reflected an issue concerning data quality. A relaunch around data collection was planned which would address this position. • Within Workstream 7, it was highlighted that the number of individuals participating in clinical trials had deteriorated, which had a potential to impact on research funding. The work to relauch the Knowledge Hub would address this.
Positive assurances and highlights of note for the Board	• Pleasing progress was noted across all workstreams overall. • A suggestion as to how progress with the workstreams could be communicated was presented which was discussed at length and a range of alternative models were proposed which would be developed jointly between the Communications Team and Transformation Team. • Workstream 1: The developing 'People and OD' strategy was discussed, which provided input from the New Beginnings sessions. • Workstream 2: 'In Touch' had been procured and would go live by the end of the calendar year. Work was underway to standardise patient letters. • Workstream 3: Digital dictation had been well received by the majority of clinicians. A higher degree of compliance with analgesia protocols was reported, which was noted to be a significant achievement.

	• Workstream 4: The positive impact of the Communications Strategy on press and social media was noted. • Workstream 5: Work continued to progress to develop the plans for the estate over the next five years • Workstream 6: the use of a web-based system for finance was highlighted as a particular success. Service Line Reporting was being implemented well. • Workstream 7: The research strategy was reported to be under development and the implementation of Amplitude was underway.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A workshop is to be arranged to consider the IM & T Programme and potential networking/collaboration projects • A means of communicating progress with the Transformation Programme workstreams is to be developed • Consideration to be given to developing a ten year organisation plan • Workstream 4 to be rescoped • Presentation of the plans to launch the Knowledge Hub at the next meeting • Review recruitment practice , particularly around attracting consultants • Present the deliverables of the People & OD strategy at the next meeting
Decisions made	• None specifically

Tim Pile
VICE CHAIR AND CHAIR OF THE TRANSFORMATION COMMITTEE

For the meeting of the Trust Board scheduled for 4 November 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	14th October 2015
Guests	• Mrs Jo Chambers, Chief Executive Officer • Mr Paul Athey, Director of Finance (Chair for this meeting) • Ms Stella Noon, Patient Representative • Mr Tim Pile, Non-Executive Director • Mr Rod Anthony, Non-Executive Director (Part) • Mrs Kathryn Sallah, Non-Executive Director • Mr Mohammed Qasim, Assistant Financial Accountant • Mrs Hannah Molloy, Head of Financial Accounting and minute taker • Dr C Blunt, Consultant Anaesthetist (shadowing J Chambers) • Mr Andrew Pearson, Medical Director • Mr Garry Marsh, Director of Nursing and Governance (Part) • Dame Yve Buckland, Chairman
Presentations received	None received
Major agenda items discussed	• Actions from the previous meeting • Final Annual Report and Accounts 2014/15 • Review of financial position to 31st August 2015 • Cazenove market update and review of investments • Update in relation to the Mr Dubrowsky legacy • Draft Fundraising policy • Draft Risk register • Bids for funding • Six month updates in relation to previously approved bids
Matters presented for information or noting	• Review of financial position to 31st August 2015 • Cazenove market update and review of investments
Matters of concern, gaps in assurance or key risks to escalate to the Committee	None specifically
Positive assurances and highlights of note for the Board	• The committee was advised that the final annual report and accounts presented had been independently examined by the external auditors Deloitte LLP and only minor changes were identified in relation to rounding's and consistency of wording. • The auditors have provided a clean audit report and

	confirmed that the charity accounts provided a true and fair view. • The committee agreed the risk register. • The Learning and development project was noted that clearly had been a successful project.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Legacy funds to be invested with Cazenove to ensure receiving returns. • To confirm with L Jeys that existing charities have been contacted/considered in relation to business plans for the use of the Mr Dubrowsky legacy funds. • To review the fundraising. • Committee terms of reference to be reviewed to assess who has the responsibility for agreeing fundraising activities • To discuss structure of fundraising activities with BCH to ensure ROH policy is robust. • Strengthen wording in relation to one of the risks on the risk register. Add charity risk register to main Trust register. • To confirm maintenance/service costs in relation to the ward 11 beds bid for funds. To be included in revenue budgets. • Request for new fund which was not reviewed at the meeting on the 14th October 2015 to be circulated to the committee for approval via email.
Decisions made	The following bid for funds were approved by the committee: • Beds for Ward 11, £19,720.10 + VAT • Support for overseas nurses, £15,950 • Mindfulness Training, £7,100 The following bid was agreed in principal but subject to a more detailed business case being presented and approved by the Director of Operations: • Wheelchairs, £20,000 The committee approved the 2014/15 Annual Report and Accounts to be signed by Paul Athey on behalf of the Trustees following the independent examination and for this to be submitted to the Charities Commission. The committee agreed that the £1.2m received in relation to the Mr Dubrowsky legacy should be invested to ensure receiving returns on this income. The committee approved the draft risk register and for it to be included with the main Trust register for monitoring.

Paul Athey, on behalf of Frances Kirkham
CHAIR OF THE CHARITABLE FUNDS COMMITTEE

For the meeting of the Trust Board scheduled for 4 November 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Enclosure 1

Minutes of the Charitable Funds Sub-Committee Meeting
Held on 29 May 2015
Board Room

Present:

Frances Kirkham (FK)	Non-Executive Director (Chair)
Jo Chambers (JC)	Chief Executive
Paul Athey (PA)	Director of Finance
Jonathan Lofthouse (JL)	Director of Operations
Stella Noon (SN)	Patient Representative
Yvonne Scott (YS)	Patient Representative
Lin Russell (LR)	Consultant Nurse
Rod Anthony (RA)	Non-Executive Director
Claire Kettle (CK)	PA – Minute Taker

Agenda Item No.		Action
1.0	**Apologies** Garry Marsh – Director of Nursing & Governance Hannah Molloy – Head of Financial Accounting	
2.0	**Minutes from the Meeting of 26 January 2015**	
	The Minutes were agreed as true record of the meeting.	
3.0	**Actions from the Meeting of 26 January 2015**	
	Members of the Charitable Funds discussed, updated and agreed the action points on Enclosure 2.	
4.0	**Annual Report & Accounts 2014-15**	
	PA referred to Enclosure 3 entitled "Charitable Funds Trustees' Annual Report & Accounts for the year Ended 31 March 2015" and explained to the Committee that they were reviewing the accounts at an earlier stage this year as the numbers form part of the Trust's overall Consolidated Accounts.	
	PA highlighted the Review of the Financial Performance & Achievements on Page 4 and explained to the Committee how	

Agenda Item No.		Action
	the fund balances has decreased in the year by £37,000.	
	PA commented that Page 9 onwards of this enclosure detailed the financial figures and gave a brief overview.	
	PA concluded by commenting that this enclosure will be brought back to a future meeting with Audit's opinion.	
	No further questions were raised in respect of the Annual Report & Accounts.	
5.0	**Review of Financial Position to 31 March 2015**	
	PA presented Enclosure 4 and updated members of the committee on the financial position as at 31 March 2015.	
	PA highlighted on Page 1 the closing balance of £873,000.	
	PA went through the income donations on Page 3 and commented that the total donations received was £27,000.	
	The process of checking expenditure was discussed, with regards to whether appropriate challenge was in place to ensure that all use of funds was in line with the terms of the fund. PA stated that this was the responsibility of the trust fund signatories to check, and to challenge where appropriate. He also stated that finance staff supported signatories in this matter on an ad-hoc basis. FK asked about the audit process and PA responded that the Charitable Funds Accounts are audited by Deloitte. He stated that this audit reviews the accuracy of the figures and information within the accounts, but would not generally cover whether money had been spent in line with the terms of particular trust funds. FK raised concerns around how assurance could be provided that donations were being used for the purpose that they were intended. RA noted that there was no independent audit into this factor. PA commented that there is a record of the income received and that the expenditure was being spent appropriately. PA suggested to pull this together and have a rolling review and incorporate a workplan within this Committee.	**PA**
	YS asked if the Trust goes back to the donor to say how the money has been spent. It was discussed that information could be put into a Newsletter and PA agreed to speak to Sally Xerri-Brooks, Head of Communications.	
	FK asked if the £27,000 were all new donations and PA confirmed that they were. FK also asked if these are all documented and the purposes are recorded. PA responded that where the donor is specific on the purpose of the	

Agenda Item No.		Action
	donation, then this is added to an appropriate trust fund. Where the donor does not specific a purpose, the money is allocated to the general fund. He stated that letters go out to the donors to acknowledge receipt and to confirm a high level purpose for who the money will be spent.	
	PA went through the Expenditure on Page 4. PA explained the money returned to the funds related to an accrual for additional functionality in the Clarity outpatients system that the supplier was unable to provide.	
	PA stated that the Investments Portfolio ended in a value of £735,354, an increase of 7.6%.	
	PA went through the Future Plans section on Page 5 and highlighted the comparison to the 5 year plan sent to Monitor, in Quarter 4 of 2014/15 there has been a major underspend of £125,000. FK said that she had written out to fund holders asking for their responses by 12 June 2015. Her letter had stated that if fund holders were not able to provide clarity on how the money would be spent, then the committee would consider whether their funding should be transferred into the general fund.	
	No further questions were raised in respect of this report.	
6.0	**Cazenove Market Update & Review of Investments**	
	PA referred to Enclosure 5 entitled "Charity Multi-Asset - Quarterly Report" and commented that this provides a review of the investments.	
	FK asked if we have reviewed this to obtain better investments. PA confirmed that we had and that, while there were a handful of other competitors in the market, there review had highlighted no major differences between the offerings. The Charitable Funds sub-committee had therefore decided to stay with Cazenove.	
	PA commented that the requirements for reporting and audit will be greater once the expected legacy has been received. There would also be a requirement to report on our approach to ethical investments within our annual report. It was suggested that Cazenove speak to Committee Members with regard to this.	**PA**
	FK asked about the timing of the legacy. PA responded that the original expectation was that the first payment was due in June/July time. HM to follow up.	**HM**
7.0	**Administration Fee 2015/16**	
	PA presented Enclosure 6 entitled "Review of Charitable Funds Administrative Fee". PA commented that the committee has approved a new methodology for 2014/15, and that this	

Agenda Item No.		Action
	methodology has been rolled forward for 15/16.	
	PA asked Members of the Charitable Funds Committee to approve the admin fee of £13,134 and this was approved.	
8.0	**2015/16 Plan**	
	PA presented Enclosure 7 with regard to the proposed charitable funds activity plan for 2015/16 and explained that this was for discussion and approval in line with the Monitor Plan requirements for the Main Trust.	
	PA commented that most of the larger funds have plans in place but there was scope for a wider discussion with regard to General Funds.	
	PA highlighted the expected legacy of £1.6 million in 2015/16 and stated that no assumptions have been made around this this large legacy other than the initial bid approved for an on-site lab.	
	It was discussed that Philip Begg and Andrew Pearson should view any proposal from a clinical/requirement point of view.	
	SN asked about revenue costs for the proposed on-site lab. JC responded that the previously approved bid had some initial running costs that may need prime-pumping but that it would be expected to become self-sufficient within a certain time. JC agreed to put a meeting group together to include JL, PA, FK and report back to Members of this Committee.	**JC**
	It was agreed to add a standing agenda item entitled "Legacy".	**HM**
	JL asked how broad the uses of the Chapel trust fund was. PA responded that this was very broad and needed to meet the needs of multi-faith offering.	
	A discussion took place around the Multi-Faith room and JL suggested to attract a change in balance around patient population and introduce something more than we are currently offering. It was questioned if the Chaplains are asking, do we have the needs to do this. PA agreed to look into the purpose of this fund.	**PA**
9.0	**Governance Arrangements**	
	PA presented Enclosure 8 with regard to the governance arrangements. PA advised the committee of changes in relation to the governance of NHS Charities and advised that this paper was just for information at this stage.	
	Members of the Charitable Funds Committee were in agreement that changing the organisational form of the charity would have no benefits to the Trust at this moment in time. Members of the Charitable Funds Committee thanked HM for a helpful paper.	

Agenda Item No.		Action
10.0	**Bids for Funding**	
a)	Dementia Event	
	LR presented Enclosure 9 and explained that this bid came in from the Matron of Large Joints and the purpose was to raise the profile and awareness of dementia across the organisation.	
	JC commented that she would be happy to raise and support awareness and stated that this should be a piece of work the Trust should be carrying out. It was however discussed that the Committee would like to see more information to justify the request, with particular regard to as to what and who will be involved. LR further commented that it was hoped that the funding would be spent on advertising. LR agreed to ask Stacey Keegan to update this request and HM to recirculate it to the Members of this Group.	**LR/HM**
	Following discussion, the Charitable Funds Committee were in agreement to support this request following receipt further detailed information.	
	JL commented that the Estates Department are working on dementia adaptions and he anticipates a further bid coming to this Committee to fund the work. SN asked if future bids could be screened for more information before being presented at this group. FK asked if this could come out any specific funds.	
b)	Mindfulness Training	
	LR presented Enclosure 10 and explained that this was a bid from the Pre-Operative Assessment Ward to support a Mindfulness Training Programme around the clinical supervision for staff.	
	JC stated as a general comment, mindfulness is a technique and asked what extent does this link to HR. PA had spoken to AC who felt that the committee should consider a) if mindfulness had benefits for the staff and if so, b) whether this should be available more generally. SN commented that it would be more effective if more areas were targeted. JL commented that the beneficial impact should be able to be measured. JL further commented that the concept might be worth testing out. JL mentioned the future portfolio of stress awareness and context from HR jointly on where this fits. JL stated that it would be difficult to approve this in isolation but it could be looked at with a few other things on the back of it.	
	SN asked if there was evidence of a department that was in need of this. YS asked does this monitor if sickness rates go down with this in place.	
	Following discussion, it was agreed that a conversation would take place with Anne Cholmondeley to see how it fits in with other schemes and how it's set up in the appropriate way. It	

Agenda Item No.		Action
	was agreed to invite Anne Cholmondeley and Connie Blunt to the next Charitable Funds Meeting. FK to write to Dr Blunt. AC & Dr Blunt to meet before the next meeting.	**FK**
11.0	**Items Approved Outside of the Committee for Minuting**	
a)	Changes to SORP & Accounting Standards	
	PA presented Enclosure 11 in relation to the Standing Operational Reporting Practices (SORP's) and explained the changes to the accounting standards for charitable funds.	
	PA commented that the Trust will have a choice for how we account for our charities going forward.	
	PA highlighted the changes to the Trustee's Annual Report under Section 2.01 on Page 2 and flagged the number of new additional requirements that will require discussion with the Trustee's.	
	The Members of the Charitable Funds agreed to recommend to the Board that we approve the recommendations in this paper.	
12.0	**New Fund Request**	
	PA referred to Enclosure 12 and explained that the purpose of this paper was to seek Committee Members approval to set up a new fund based on funding received from UHB.	
	PA explained the transfer from UHB to our funds and the request was to transfer this sum from the general funds to a new descriptive fund.	
	FK asked if there is a specific fund that this could be transferred to and PA responded that there are none that are that specific as this is for orthopaedic teaching.	
	SN asked if there is a separate R&T charity. PA confirmed that there was a separate charity, but that this request related to our own ROH Trust funds. PA highlighted what the department wished to spend the money on and suggested they put some bids together for the Charitable Funds Committee to consider.	
	A discussion took place if Members should refuse this request and leave these funds in the general fund and have a strategy in place and for this Committee to monitor this particular fund. Following this discussion RA highlighted that the paperwork has a restriction on it which specifies the funds are allocated to a specific purpose.	
	Following the above conversation, a decision was taken to agree to the request to set up a separate fund to deliver teaching and general development and training. It was requested that appropriate fund holders be in place and Khalid Baloch and the new Associate Medical Director for education were suggested. It was questioned how much this fund would be set up with and a request was for them to demonstrate how	**PA**

Agenda Item No.		Action
	much funding they have. PA to action this.	
13.0	**Date of Future Meetings** 14 October 2015, 1:00 pm, Board Room 14 December 2015, 1:30 pm, Board Room	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS UPDATE	
Date of meetings since last Board meeting	22 September 2015 (workshop) 14 October 2015
Guests	Faheem Uddin, Lead Governor from Birmingham and Solihull Mental Health NHS Trust presented an overview of his experience as a governor from a local Foundation Trust
Presentations received	Training session for governors held at the workshop on 22 September around holding Non Executives to Account
Major agenda items discussed	• Chairman's and NED appraisals • Non Executive Director recruitment • Update from the Clinical Governance Committee • Vanguard models of care • Governor updates
Matters presented for information or noting	• Corporate performance report
Matters of concern, gaps in assurance or key risks to escalate to the Board	• The Council sought assurances on the use of agency staffing and the impact that this would have on quality and finances; it was noted that there had been specific pressure in the governance team and in theatres, however there were plans underway to recruit into these positions substantively
Highlights of note for the Board	• It was reported that plans were underway to recruit into the vacant Non Executive director post, which had been created by the departure of Elizabeth Chignell earlier in the year
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	Workshop: • Ensure that cover sheets for reports to CoG identify why the report is being presented and what the CoG is expected to do with it • Provide a 'Who's Who' guide within the induction material • Re-invite the NEDs to the CoG meetings and devise a schedule of which NEDs are to present formally to the CoG on their area of speciality • Add as routine agenda items to the CoG meetings a copy of the corporate performance report, quarterly complaints report and risk registers • Investigate the use of governors within Trust induction

	• Resend dates of Trust Board meetings to CoG • Develop a Governor and Membership Involvement strategy • Consider the proposal to invite a governor to the Clinical Governance Committee in an observer capacity • Add an update on Vanguards to the agenda of the next CoG
Decisions made	• The Council requested a note on the activity position to be circulated

Dame Yve Buckland
CHAIR OF THE COUNCIL OF GOVERNORS

For the meeting of the Trust Board scheduled for 4 November 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Council of Governors meeting held on Thursday 21 May 2015 in the Seminar Room in the Research & Teaching Centre

Present:
Yve Buckland, (Chairman)
Alan Last, Public Governor
Stella Noon, Public Governor
Marion Betteridge, Public Governor
Yvonne Scott, Public Governor
Karen Hughes, Staff Governor
Sue Arnott, Public Governor
Andy Clark, Appointed Governor
Rob Talboys, Public Governor
Ronan Treacy, Staff Governor
Sue Loccoco, Staff Governor
Paul Sabapathy, Appointed Governor
Jean Rookes, Public Governor

In attendance:
Jo Chambers, Chief Executive
Julian Denney, Interim Company Secretary
Paul Athey, Director of Finance
Tauny Southwood, Non-Executive Director
Kathryn Sallah, Non-Executive Director
Anne Cholmondeley, Director of Workforce and Organisational Development (part)
Garry Marsh, interim Director of Nursing and Governance (part)
Lisa Kealey Public and Patient Services Manager
Sally Xerri-Brooks – Communications Manager

Apologies:
Dia Martin, Public Governor
Marion Thompson, Appointed Governor
Anthony Thomas, Public Governor
Richard Burden, Appointed Governor
Alison Braham, Staff Governor

Agenda No.	Agenda Item	ACTION
1	**Apologies** There were apologies from Dia Martin, Marion Thompson, Anthony Thomas, Richard Burden, and Alison Braham	

<table>
<tr><td>2</td><td><u>Welcome and Introductions and Declarations of interest</u>

The Chairman welcomed all to the meeting. She suggested that the formal items were dealt with first in the interests of managing the time for what was a full agenda.

She welcomed Mr Maxwell, a member of the public, to the meeting. He had previously attended a Board meeting of the Trust.

There were no new declarations of interest</td><td></td></tr>
<tr><td>3</td><td><u>Minutes of the meetings held on Wednesday 4th February 2015 and Tuesday 24th March 2015 and Matters arising</u>

Resolved:

1. That the minutes of the meeting of Wednesday 4th February 2015 be and are hereby approved as a true record
2. That the minutes of the meeting of Tuesday 24th March 2015 be and are hereby approved as a true record</td><td></td></tr>
<tr><td>4</td><td><u>Action Log</u>

The action log was updated (see separate sheet):

<table>
<tr><th>Action</th><th>Response</th></tr>
<tr><td>The governors wanted a higher degree of interaction with the NEDs – this was not always easy to do in the middle of a formal meeting with only a limited number of NEDs present. Governors wished to meet the NEDs on their own. The Chair agreed that we should explore NED / Governor joint meetings – perhaps twice a year.</td><td>On agenda NEDs/ Governors meetings suggested for July and November at lunch on the days of the Public Board meetings – take off action notes</td></tr>
<tr><td>Members requested a written version of the CEO’s brief</td><td>Done – take off action notes The CEO explained that the brief was based on her verbal briefing to the Board in May.</td></tr>
<tr><td>Regarding the recent increase in Trust activity, work is being done to assess whether there is a relationship with recent costs increases – however it is believed that the increased was not a primary driver of increased agency</td><td>Reworded in the minutes – take off action notes</td></tr>
</table>
</td><td></td></tr>
</table>

	costs and PA agreed to look at the wording in the minute to ensure this was clear.		
	It was agreed that there should be a learning and refection session for Council members regarding the controlled drugs matters as part of a wider learning journey for the Trust, probably for 2-3 months' time.	The Chair said this action was timely; in addition it could be an opportunity to bring new governors into the Council and also to learn from some of the good practice guides (covered later on this agenda). The Chair said that to date there had been many improvements in process but she felt there was now an opportunity to consider the focus of the Council to ensure it addressed the most important matters and really added value. She felt that in recent meetings there had been an undue focus on operational matters and an externally facilitated meeting in July could be very beneficial. She invited suggestions as to potential facilitators.	
	PA agreed to check the functionality of standing scans in relation to radiology capital programme	PA reported that the Trust uses the MRI facilities at Edgbaston for standing scans, and will continue to do so in future for the handful of patients requiring this service. The ability to provide standing x-rays is already provided on the ROH site, and the ongoing replacement of all of the radiology equipment at the ROH will continue to deliver improvements in efficiency and quality in this area. Action now closed	
	Council members wanted to	Done within action log	

have greater details on timings for actions in relation to the progress report re governance at the Council of Governors and JD agreed to do this and to update the action log	
Full implementation of the communications plan – update	See Minutes below – action now complete – take off action list
Create individual governor training plans and create training opportunities for specified need	On agenda – LK to feedback. Take off action list
The Council noted the guidance to help governors represent the interests of NHS foundation trusts members and the public and it was agreed that it should be passed onto SXB regarding a possible case study for next year and whether there were any ideas that could be incorporated into the Governor Communication programme	Done – take off the action list

Communications Strategy

Sally Xerri-Brooks (SXB) provided an update on the Communications Strategy highlighting the following :

- She explained that she would be meeting each member of the Council to create an internally facing website page to increase the profile of Governors among staff.
- A much more substantial overhaul of the website was planned in the future which would further enhance the Governors' pages.
- It is planned to use the screens in outpatients over the next few months to highlight how Governors are making a difference.
- Communications with GPs are being reviewed; the involvement of Governors is being considered.

Points made in discussion

- Sue Arnottt said she had received additional recognition by staff feedback as a result of the publicity in ROH Live

	• Members of the public wishing to contact Governors currently do so via Lisa K. NHS Net addresses for Governors have been set up and members of the public will be able to contact them directly in due course. • Other ideas for Governor contact included a Governors' post box. The Chairman said the Trust might need to consider other approaches – such as topic based sessions to which the public are invited and which the Governors would front.	
5	**<u>Governor feedback and issues to raise with the Board (Standing Item)</u>** ***Trust Offices refurbishment*** • The Chair introduced the discussion by referring to the paper which provided detailed information regarding costs and reason why the refurbishment was necessary. She added that the refurbishment was intended to benefit everyone working in HQ not just senior people • The Lead Governor said that this matter had been discussed with the Governors in their private meeting and they felt that it had now been given sufficient coverage. ***Appointments – recent advertisements on NHS Jobs*** Karen Hughes said that the issues and queries raised by staff specifically related to new and interim posts that do not replace existing posts. Examples given were- Associate CEO and advertised deputy communications officer posts. She also added that the fact that a number of new jobs had been advertised prior to the proposed structure being disseminated to staff may have been a contributory factor in relation to concerns, queries and uncertainty. The CEO explained the position as follows: • It was important to understand the context behind the creation of the new posts. They arose following a process of internal change which sought to bring together and consolidate the seven directorates and refocus the management resource. In addition the Board had reviewed Monitor's guidance regarding recommended capabilities with senior teams – this was the motivation for creating the Director of Strategy and Transformation post. The Board considered that there was a need to strengthen communications in the Trust -including the appointment of a Head of Communications • There had been some interim appointments in the recent past - this was intentional because of the importance of agreeing the structure before making permanent appointments and to cover for vacancies in the short-term to reduce the risk of any permanent staff being displaced. • The controlled drugs issue also created some delay in filling	

	the interim roles with permanent staff because of the need to focus management attention on improving medicines management. • There were a very small number of staff who are expected to have a substantial change to their job and they are currently in discussion with their respective staff side representatives, around four staff who are undergoing some reconfiguration of their roles between each other and two staff who will be having a change in line management • Management and administration costs as a proportion are the same year on year. Investment/ additional costs since last year are c £1M Nursing , £1M Medical and £0.33M Other (this includes management and administration and some support costs e.g. portering) • A number of interim management posts have been recruited on a part time basis because of the extra cost of interims/ agency staff; these will generally be replaced by full time posts when the new structure is implemented. • While it is important to contain management costs, if management resources are inadequate clinicians may have to use their time in bridging the gap and doing more administrative work. • A number of 'non-clinical' roles, such as IT project managers, are in face supporting key clinical development such as electronic prescribing and digital dictation, all of which will enhance patient services and reduce the burden on clinical staff. The Chair reminded the Council that their role was to hold the Board to account and that it should avoid being drawn into staff negotiation issues more appropriately addressed through the recognised staff negotiation processes.	
6	**<u>Update by CEO</u>** Jo Chambers introduced her report highlighting the following points: ***Staff communications / New beginnings – general*** • The CEO agreed with earlier comments that communications had improved substantially with SXB's appointment • Staff engagement events are in progress and are very well supported. • There are c988 people working at the Trust – of these c140 have staff responsibilities. There has been some feedback from front line staff that they are not receiving adequate communication from their line manager. This means that senior management need to be wary of assuming that the cascade process always works effectively • There has been some really positive feedback from staff –	

	especially were staff can see progress via the Transformation Programme in tackling long standing problems • Other staff are more sceptical – based on experience of previous improvement initiatives ***Raising Concerns*** • Some staff continue to express concerns about raising concerns. • The CEO reiterated that staff were free to raise concerns; as an example she had recently received a patient safety concern raised by a member of staff because referring consultants were not filling in documentation covering contraindications to MRI treatment. She had held a very positive meeting with clinical colleagues which provided assurance that patent safety was being safeguarded, and which identified changes to the processes, communication and documentation in MRI to address the concerns raised by the member of staff. • This situation reinforced a wider concern, where, in the past, there had been issues regarding compliance with clinical procedures designed to ensure safety and legal requirements. • Even if there are other patient safety safeguards, if the MRI form is important it should be filled in. • Regarding the MRI cancellation there was a lack of clarity regarding where the information is captured and reported. Garry Marsh, Director of Nursing and Governance is investigating this • From the patient's perspective being sent home because of failure to check suitability for a MRI scan is highly frustrating. • The WHO checklist issue, controlled drugs problem and this recent MRI form issue were all matters of documentation and compliance with Trust policy. There may be other similar issues in other areas and the CEO is keen for all areas of the Trust to consider potential weak spots which should be examined. • The CEO said a key learning point was the need to inject pace into addressing possible patient safety concerns. • The Chairman agreed and said learning from Manchester emphasised the importance of a bottom up culture in driving improvement • There would be feedback to the Governors after the New Beginnings session had been completed ***Election and Longer term outlook*** Positive comments have been received from Monitor regarding the	**AC**

	Trust's five year strategic plan The £8Bn promised in the run up to the election has to be offset against new commitments for the NHS and the financial outlook is likely to remain very challenging. Despite the challenging financial position, the ROH has one of the lowest CIP targets (by %) in England which suggests a higher degree of achievability than is the case for most providers. Over 51% of Trusts rejected the original tariff at Christmas time. On 18th February 2015, Monitor and NHS England wrote to all Trusts with a third option, a "voluntary tariff" that addressed some of the concerns that led to the initial dispute. This voluntary tariff, termed the "Enhanced Tariff Option" (ETO) was offered to Trusts to sign up to by 4th March 2015. Any Trust not signing up by this point would have automatically defaulted to the 2014/15 "Default Tariff Rollover" (DTR) until such point that a formal tariff is agreed for 2015/16, at which point these Trusts would automatically move over to the new tariff. NHS England also announced that, in order to balance their books, they would not be paying any CQUIN payments to Trusts sticking with the DTR. This equates to a loss of income of 2.5%. The ROH signed up to the enhanced tariff option; this created a £1.5M loss for 2015/2016 compared with the 2014/2015 tariff and is a substantial contributor to the planned deficit of £2.8M ***Collaboration*** The national research project (Monitor collaboration) is a good opportunity to explore new levels of good practice elsewhere. The Trust is the only specialist hospital in the group of five. The Trust was experimenting locally through its partnership with Walsall. The five year forward view reinforces the importance of collaboration. ***Improvement and celebrating success*** The CEO said that while the driver for improvement within the Trust is the need to do the right things for patients it also provides a good basis for the CQC re inspection. There have been real successes recently e.g. the peer review initiated by the HDU matron and all of the controlled drugs improvements. The CEO had been delighted to recognise the achievement of Nia Reeves by presenting her with the patient safety award; the patient experience award recipient was still a secret. The Trust also has the opportunity to take part in a "Best places to work award event" and	

	in the Patient Safety Congress The Chair said she was now getting feedback from patients and staff re possible award winners. Consideration should also be given to potential national honours; the West Midlands is underrepresented.	
7	**Patient and Carer's Council – Feedback and other updates by Jean Rookes, Dia Martin and Stella** Stella Noon introduced her report highlighting the following points: • The group has reviewed and fed back comments on a large number of patient information leaflets • There has been a productive visit to the OT room and a successful meeting with student OTs • Liz Towell has presented an update to the group regarding the Outpatients review • The group has met the Transformation team • Dia Martin will join the Nutrition Group • Yvonne Scott will join the Outpatients review group • A new site map has been received and it will be circulated to Governors when it is finished. It will be important to check the way in which it is being provided to those wishing to come to the Trust e.g. if it is included as part of a letter it will probably be too small • Two volunteers have participated in PLACE assessment • The group has been very well supported by LK with good management of actions It was noted by the Council that the Patient and Carer's Council has made a number of key interventions in the Trust that will now benefit patients.	**LK**
8	**Safe Nurse Staffing Report ;** **Quality Governance – involvement of Governors (GM 1 year operational plan** Garry Marsh introduced the discussion making the following points • The purpose of this item was to show Governors an example of what the Board receives including mandatory requirements (e.g. the acuity tool) and discretionary items - e.g. nurse vacancy data and recruitment work • Work is being done to try to attract staff to theatres – there have been successes in appointing at Sister level. Two people in leadership roles have been appointed to theatre roles – one from London and one returning from overseas. • Staff nurse recruitment in theatres is more challenging – Anne	

	Cholmondeley is working to support an overseas recruitment campaign • Bank and agency nurse levels have been a cause of concern – work is being done with finance to explore how these levels can be reduced • Safe staffing incidents are reported - NICE guidance refers to a 1:8 staffing ratio as a minimum. There are very few such incidents: an analysis is carried out after each incident to understand the underlying reasons. In many cases failure of agency nurses to arrive is an issue. ***Discussion points/ questions*** • There is high reliance on bank and agency staff within Ward 10/12 that has increased since the previous month and this is related to a number of vacancies • There are also planning and scheduling issues relating to HDU • The template in the document has some issues given that it uses a national model hence it includes categories such as trauma and orthopaedics The Council of Governors were assured that the Trust is acting to meet national standards and noted the knock on impact this has had in the use of Bank and agency staff.	
9	**Chair's Items** :***Resignation of Ms Elizabeth Chignell from the Trust*** The Chairman reported that at the May Trust Board meeting Ms Elizabeth Chignell had stated that she felt that she needed to resign from the Trust Board, the Chairmanship of the Remuneration Committee and the membership of the Nominations and Clinical Governance Committees with immediate effect for personal reasons; she had previously indicated her intention to resign to the Chair in April. The Chair said that she was very sorry to lose Elizabeth Chignell's experience and wise advice but she understood and respected her decision. Elizabeth had been a very supportive and helpful NED and in particular helped both the CEO and the Chair address some very complex issues early on. The Board had offered its thanks to Elizabeth Chignell; the Council of Governors wished that their own thanks and best wishes be also recorded. The Board had also agreed that Tim Pile had proposed and it had been agreed by all present that Dame Yve Buckland would be appointed to be Chairman of the Remuneration Committee. The Council of Governors were advised that they needed to consider the appointment of a NED to replace Elizabeth Chignell. The Chair	

	recommended that possible candidates be sourced from the Trust's own network. After a short discussion the Council resolved that the following would be appointed to the Nominations and Remuneration Committee for the purposes of supporting the recruitment of the replacement of Elizabeth Chignell on behalf of the Council replacing the exiting membership: • Alan Last • Stella Noon • Karen Hughes • Marion Thompson • Andy Clark ***Governor policy board election results*** The Chairman explained that the biographies provided were those of the successful candidates. ***Governor focus conference notes*** The Chairman explained that the notes were provided for information • They could form a valuable input to the proposed Council workshop • The Trust would support attendance at the governor focus conference in the future • Some governors said that some of the conferences in the past had been poor and complimented the Trust on its in house training. **Action** • find out when the regional and national events for Governors are • Arrange a workshop to review the operation of the Council ***Forthcoming Governor elections (LK)*** LK explained that : • UK Engage had won the tender – this was a change from the previous provider but they had been the lowest cost • The election date is the 22nd of July 2015 • Yvonne Scott is about to complete her third and therefore final term (Constitution Annex 6 para 4)– the Council expressed the hope that she could be brought back to the Trust to support it in an different capacity	**JD**

	• Marion Betteridge , Karen Hughes and Dia Martin finish their term of office on the 22nd of July 2015 and are eligible to stand again • Alison Braham has resigned – and thus has created a vacancy • Lisa Kealey is working with Sally Xerri – Brooks to provide publicity for the elections ***Non-audit services provided by the external auditor – Briefing (PA)*** Paul Athey explained that recent Monitor guidance requires that : • The audit committee should review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements. • The audit committee should also develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm. • The council of governors should receive a report at least annually of non-audit services that have been approved for the auditors to provide under the policy (on the basis of services approved, regardless of whether they have started or finished) and the expected fee for each service. In relation to the Trust's auditors: • There were no new orders placed this year for non-audit services but there had been £29k spent with Deloitte to support the development of the five year strategy. This related to a contract which began in the previous year.	
10	**Briefing on the annual report and accounts (n.b. private until laid before Parliament on June 25 2015) (copy of Board paper and latest version of annual report and accounts)** **Resolved :** "That representatives of the press and other members of the public be excluded from this part 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".	
11	**Monitor year end declarations (copy of Board paper)**	

	The Board of Directors of the Trust is required to make annual declarations to Monitor, having regard to the views of Governors. This paper and its appendices provide the supporting evidence for the 2014/15 declarations together with the draft templates to be submitted to Monitor. In each case a confirmed response has been included for every element of the declarations. **The Council hereby:** Notes the Monitor year end declarations	
12	**NED attendance at Council meeting** • Tauny Southwood • Kathryn Sallah The Chairman welcomed Tauny Southwood and Kathryn Sallah to the meeting and said that it was Kathryn's first Council meeting. Kathryn explained her background starting as a cadet nurse, followed by nursing and midwifery training. She had worked in Germany, in the army, been a Head of Midwifery and served as Midwifery Advisor to the DH. She had held the post of Nurse Director in Walsall, Birmingham Women's Hospital and Birmingham and Black Country SHA. Her commitment was to always focus on what is best for patients and how we can improve their care and experience. Tauny Southwood (TS) explained his role as Chair of the CGC as follows: : • This was his first formal attendance at the Council • He has been involved with the ROH as a NED for four and half years. He chairs the Clinical Governance Committee. He believes that the current leadership of the Trust Board and Executive is the strongest he has experienced. • This period has been a very turbulent time – and many major issues have come to the CGC • Some are easier to understand e.g. the need to interrogate information provided to CGC • Others are much harder – e.g. knowing how to deal with missing information • The third area is clinical engagement – TS is looking at the review by Manjit Obhrai which covers this matter • TS said that the systems for identification of incidents need to be improved as well changing the culture to remove any barriers to reporting incidents • He has found the demands on his time as a NED and Chair of the CGC sometimes difficult to manage alongside his other commitments.	

	Questions/ responses • Regarding the learning from the controlled drugs scenario systems and controls are now much more robust. However it will not be possible to say such matters will never arise again. There are other potential improvements relating to non-controlled drugs which are now being considered • Clinical engagement remains an issue for example attendance at CGC meetings by some invitees needs to be more consistent • Regarding avoiding rogue members of staff – this is very difficult to control – the revalidation provides some assurance but this is limited. • Regarding staff raising concerns there are policies in place to protect staff who come forward. However there are difficult cultural issues to ensure that staff who raise concerns feel protected. Recent data shows a reduced level of incident reporting which may be indicative of barriers to raising concerns. • The CEO said she would follow up with the member of staff who raised the MRI documentation issue to check that he had not experienced any negative impact because of his action • AC said that some of the staff sessions were designed to facilitate staff discussing any issues regarding their ability to feedback concerns. Staff had wanted to know that their concerns were being acted on and had questioned the quality of the reporting forms. • TS said he thought the biggest risks related to missing information and his biggest frustration related to clinician engagement in governance matters; he felt that this engagement should be part and parcel of life for every clinician from day 1 • The Chair said that at Manchester all of their new consultants devoted one SPA for a year to learn more about the hospital, clinical governance and how to exercise their clinical leadership role. • Historically the focus at the ROH has been on activity rather than on these wider matters • In the past governance has not been a focus of medical training. The Council thanked TS for his contribution at the CGC and for his insights shared with the Council.	**JC**
13	**<u>Calendar and indicative Work plan for 2015/2016</u>** Julian Denney said that the paper summarised the planned meetings of the Council for the rest of the year, Trust Board meetings to which Members of the Council are invited and the indicative work plan for Council meetings.	

	The meetings included the NEDs' only lunch meetings with Members of the Council which the Governors had requested. **The Council hereby:** Notes the Calendar and indicative Work plan for 2015/2016	
14	**Governors' Award** Anne Cholmondeley explained that the report proposed that the Council of Governors sponsor one of the award categories for the 2015 Staff Awards. The report outlined proposals for the governors to judge nominations and present the award at the ceremony itself. She asked the Members of the Council to: • Consider and support a new category of ' The Governors Unsung Hero Award' • Nominate up to three governors to judge the nominations alongside members of the Executive Team and the Chair of Staff-side, and also present the award at the Ceremony in October which would be at the same time as he AGM **The Council hereby:** 1. Agrees the proposals for a new category of ' The Governors Unsung Hero Award' 2. Nominates Marion Betteridge , Sue Arnott , Stella Noon , and Jean Rookes to judge the nominations alongside members of the Executive Team and the Chair of Staff-side, and also to present the award at the Ceremony in October.	
15	**Any Other Business** • Regarding staff suspensions there were only two: a consultant and a nurse – both of these are now back at work with supervision. There is a pharmacist whose case is currently undergoing investigation • The Chair said that she was looking forward to having the opportunity to say goodbye to Yvonne Scott on July 1st and to thank her for her contribution.	
16	**Date and Time of Next Meeting** Provisionally Wednesday 14 Oct 2015 – time tba	

APPROVAL

Signed: _____

Print: _____

Date: _____

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 2 December 2015

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 2 December 2015 commencing at **1100h** in the Board Room at the Royal Orthopaedic Hospital NHS Foundation Trust Headquarters.

Members of the public and press are welcome to attend. The agenda for the public part of the meeting is available on the website.

Questions for the Board should be received by the Trust Board Administrator no later than 24hrs prior to the meeting by post or e-mail to: Trust Board Administrator, Jane Colley at the Management Offices or via email jane.colley1@nhs.net.

Dame Yve Buckland

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PUBLIC TRUST BOARD

Venue Board Room, Trust Headquarters **Date** 2 December 2015: 1100h – 1300h

Members attending

Mr Tim Pile	Vice Chair	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Prof Tauny Southwood	Non Executive Director	(TS)
Mr Rod Anthony	Non Executive Director	(RA)
HH Frances Kirkham	Non Executive Director	(FK)
Mrs Jo Chambers	Chief Executive	(JC)
Mr Jonathan Lofthouse	Chief Operating Officer	(JL)
Mr Paul Athey	Finance Director	(PA)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(ACh)	
Prof Phil Begg	Director of Strategy and Transformation	(PG)	
Ms Anne Crompton	Deputy Director of Nursing & Clinical Governance	(ACr)	
Mrs Jane Colley	PA to the Chairman & Company Secretary	(JCo)	[Secretariat]
Ms Nikki Mason	Head of Therapy Services	(NM)	[Item 7]
Mrs Sally Xerri-Brooks	Head of Communications	(SXB)	[Item 8]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies – Yve Buckland, Garry Marsh, Andy Pearson, Simon Grainger-Lloyd	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	Patient Case – an illustration of the work we do: *for assurance*	ROHTB (12/15) 003 ROHTB (12/15) 003 (a)	ACr
1115h	4	Minutes of Public Board Meeting held on the 4 November 2015 *for approval*	ROHTB (11/15) 001	Chair
1120h	5	Trust Board action points: *for assurance*	ROHTB (11/15) 001 (a)	Chair
1125h	6	Chief Executive's update: *for information and assurance*	ROHTB (12/15) 002 ROHTB (12/15) 002 (a)	JC
SERVICE PRESENTATION				
1140h	7	Therapy services: *for assurance*	Presentation	NM

STRATEGY & POLICY				
1155h	8	Update on the delivery of the Communications & Engagement strategy	ROHTB (12/15) 004 ROHTB (12/15) 004 (a)	SXB
CORPORATE PERFORMANCE & ASSURANCE				
1205h	9	Corporate Performance Report: *for assurance*	ROHTB (12/15) 005 ROHTB (12/15) 005 (a)	PA/JL/ ACr
1215h	10	Nurse establishment review: *for assurance*	ROHTB (12/15) 006 ROHTB (12/15) 006 (a)	ACr
1225h	11	Safe Staffing Report: *for assurance*	ROHTB (12/15) 007 ROHTB (12/15) 007 (a)	ACr
1235h	12	Board Assurance Framework – Quarter 2 update: *for information*	ROHTB (12/15) 008 ROHTB (12/15) 008 (a)	ACr
ASSURANCE UPDATES FROM THE BOARD COMMITTEES				
1240h	13	Audit Committee report	ROHTB (12/15) 009 ROHTB (12/15) 009 (a)	RA
1245h	14	Clinical Governance Committee & terms of reference	ROHTB (12/15) 010 ROHTB (12/15) 010 (a) ROHTB (12/15) 010 (b)	KS
1250h	15	Transformation Committee & terms of reference	ROHTB (12/15) 011 ROHTB (12/15) 011 (a) ROHTB (12/15) 011 (b)	TP
1255h	16	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 13th January 2016 at 0900h, Board Room, Trust Headquarters, which will be a Board workshop to be held in private

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

TRUST BOARD

DOCUMENT TITLE:	**Patient Story**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Director of Nursing & Jonathan Lofthouse, Director of Operations**
AUTHOR:	**Patient**
DATE OF MEETING:	**2 December 2015**

EXECUTIVE SUMMARY:

The attached presents a letter received from a patient treated by the Trust on Ward 1.

An update will be provided at the meeting on the measures taken to address the issues raised in the feedback.

REPORT RECOMMENDATION:

Trust Board is asked to receive the letter and receive and update on any corrective action taken as a result of the feedback.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
		X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	**X**
Business and market share		Legal & Policy		Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	**X**

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Excellence in patient care

PREVIOUS CONSIDERATION:

Clinical Governance Committee on 13 November 2015.

LETTER RECEIVED BY THE OFFICE OF THE CHAIRMAN – 28 OCTOBER 2015

Good morning Yve,

We met when I was recovering from a hip replacement on ward 1, bed 10a.

We chatted and I made some points which you asked me to email you about.

As far as the patient journey is concerned, I will give you all of the positive points first.

Without exception, all of the staff I personally had dealings with were kind and considerate. The ward cleanliness was very good and I observed staff changing aprons and cleansing hands in between every patient contact. When a patient in our ward developed diarrhoea she was immediately isolated and her bed space area thoroughly cleaned.

The food I was given was always warm and there was a good variety as I am a vegetarian. I reluctantly had to leave some meals but that was due to feeling unwell rather than the quality of the food.

I had the support of the ROCS nurses at home and this was very reassuring and useful. The nurse who came to me was wonderful.

Now for the negative points. I arrived at the hospital at 7am on my day of admission to be told there was an administration error, and my surgery would be early afternoon. I ended up sitting in the waiting room until 3pm feeling faint due to hunger and only sips of water until 1pm. I actually developed a migraine to go into surgery with. Thankfully I was not sick after my surgery as promised by my anaesthetist and was back on the ward quickly. The only criticism here is that my belongings were just left in a bag and were inaccessible to me until my visitors arrived the next morning. This will be I know, due to staff shortages but it did make things very difficult.

As I was bed bound for a couple of days I was unable to clean my teeth in the evening as you aren't given the option of a wash etc., as you are in the morning. I was having to use a bed pan and obviously it is very difficult to remain covered and I found this extremely embarrassing when a man did the bed pan. Again I know this will be due to staffing but it is about dignity.

When I was using the zimmer to go to the toilet I was never sure that it had been wiped after other patients and on one occasion there was a used bedpan sitting on the toilet and the brakes were off the seat so I had to move it alone. Again I am sure this would have been due to staffing as my observations were that the staff never stopped.

A patient came onto the ward post back surgery and I could hear her asking from behind the curtain for fruit at breakfast as she was gluten intolerant. She was told that there wasn't any fruit so I offered my own grapes so that she could have something to eat. She was extremely grateful but what did surprise me was that she would have been left without a breakfast.

On my day of discharge I was told at 11am that I would be going home that day. I was informed at lunchtime that I was being moved to the discharge lounge. I suggested that I would get my daughter to drive over from Tamworth to free up my bed and avoid the discharge lounge. I was told that would be fine and so I rang my daughter. She arrived at 1. I constantly asked for my medication etc to be sorted out and then I waited an eternity for a porter. I eventually left at 4.45pm and had an unpleasant journey back to Tamworth due to traffic which could have been avoided. I was also obviously still occupying the bed.

It was sad that the beginning and end of my journey it was marred by what I feel were administration problems rather than nursing issues.

I hope that this helps and that you see it in the spirit in which it was written.

Kind regards

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.5

Venue Boardroom, Trust Headquarters **Date** 4 November 2015: 1100h – 1300h

Members present

Dame Yve Buckland	Trust Chair	(YB)	[Chair]
Mr Tim Pile	Vice Chair	(TP)	
Mrs Kathryn Sallah	Non Executive Director	(KS)	
Mr Rod Anthony	Non Executive Director	(RA)	
Prof Tauny Southwood	Non Executive Director	(TS)	
Mrs Jo Chambers	Chief Executive	(JC)	
Mr Jonathan Lofthouse	Chief Operating Officer	(JL)	
Mr Paul Athey	Director of Finance	(PA)	
Mr Andy Pearson	Medical Director	(AP)	
Mr Garry Marsh	Director of Nursing & Clinical Governance	(GM)	

In attendance

Prof Phil Begg	Director of Strategy & Transformation	(PB)	
Ms Anne Cholmondeley	Director of Workforce & OD	(ACh)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	Paper Reference
1 Apologies	**Verbal**
Apologies were received from Frances Kirkham.	
2 Declarations of Interest	**Verbal**
There were none received by the Company Secretary since the last meeting and there were no declarations made in connection with any item.	
3 Patient Case – an illustration of the work we do	**Verbal**
It was noted that there would not be a patient story this month, to allow sufficient space for other items of significance to be discussed. A month by month plan of patient	

stories is to be developed by the Director of Nursing & Clinical Governance, however.	
ACTION: A month by month plan of patient stores to be developed by GM	
4 Minutes of the Public Board – 2 September 2015	**ROHTB (9/15) 001**
The minutes of the public meeting were accepted as a true and accurate record of discussions held.	
AGREEMENT: The minutes of the previous meeting were approved	
5 Trust Board action points	**ROHTB (9/15) 001 (a)**
It was noted that the majority of actions were on track to be delivered as planned. A small number of actions were flagged as being at amber status, due to some slippage with delivery, however there was confidence that those in relation to Charitable Trustee training and the completion of the nurse establishment review would be delivered shortly. It was reported that Mrs Sallah had provided information that would assist with the provision of training for Charity Trustees.	
6 Chairman & NED update	**Verbal**
Chairman reported that the annual general meeting had been held since the last meeting, as had the staff awards, which had been well received. It was noted that it was pleasing that some of the teams that would not normally have a significant profile had won an award, including the catering department. The Board was advised that a dedication event to Max Harrison, a former consultant, had occurred, which had been a particularly positive experience for the Trust.	
7 Chief Executive's update	**ROHTB (9/15) 002** **ROHTB (9/15) 002 (a)**
The CEO provided some information on local and national developments and context. It was reported that in Quarter 2, the new Risk Assessment Framework had been introduced, which impacted on the quarterly declarations that could be made to the Monitor, a matter to report later on the agenda. The significance of the leadership changes at Heart of England NHS FT and University Hospitals Birmingham NHS FT was noted, creating one of the biggest NHS conglomerations in the United Kingdom. It was reported that Mrs Chambers had been formally appointed as the lead CEO for the Specialist Orthopaedic Alliance and the associated Vanguard nationally. The CEOs for the partner organisations were reported to have met and the first of the national	

workshops had been organised for the specialist Vanguards on 5 November.	
8 Paperless Board business case	**Verbal**
The development of the proposal for the use of paperless board technology was reported to be continuing. The technical functionality was being considered and further cost effective solutions were also being considered and the outcome would be reported back at the next meeting.	
ACTION: SGL to arrange for a further update on the plans to introduce a paperless board solution at a future meeting	
9 Corporate Performance Report	**ROHTB (9/15) 003** **ROHTB (9/15) 003 (a)**
It was highlighted that an Executive summary had been added for ease and reference. The areas at red status were noted to concern finance and activity performance. The financial deficit was reported to stand at £2.445m, the position including an £180k insurance payment for the fire on Ward 12 some time ago. Shortfalls on activity and CIPs were noted and staffing vacancies in some areas were reported to be being filled by agency staff. Locum spend was reported to have reduced. It was noted that the position on activity and finances were being discussed further in the private session of the Board. The Board was advised that eleven Serious Incidents (SIs) had been reported in September. An inpatient death was also reported to have occurred, which related to a deteriorating patient and would form a coroner's case in the future. Nine falls were noted to have been reported, relating to seven patients, one of which resulted in a potential head injury. A number of falls occurred at night. The Friends and Family Test (FFT) response rates were reported to have deteriorated and therefore there was further work underway to investigate the reasons behind this. It was reported that the position in terms of pressure ulcers was to be discussed at the forthcoming meeting of the Clinical Governance Committee and a nurse consultant from United Hospitals Lincoln NHS Trust had started a peer review. It was noted that there had been a spike in deterioration against some key targets in September, however the Board was advised that the position appeared to have improved in October. The patient death was noted to have occurred at the weekend. Although medical care of the patient had been good, the case would be reviewed to clarify what decisions had been made in relation to acting on deterioration. The patient was reported to have had an abdominal issue and it appeared that access to general surgeon had not been sufficiently rapid. It was reported that there had been a breach of the 62 day cancer standard during the month and the breach had been levied at the ROH as the contract of the primary organisation that had treated the patient did not accept shared breaches.	

The Board was advised that there was a gradual deterioration towards the 92% incomplete 18 weeks referral to treatment time standard, a matter that had been discussed in some detail as part of the private session of the Trust Board meeting. In terms of workforce, it was reported that additional focus would be placed on appraisal and mandatory training. An improvement in cancelled operations was noted to be anticipated as a consequence of more effective pre-operative assessment processes. Bed occupancy was noted to be variable and over a few days there had been a shortage in the number of beds, although overall there was sufficient capacity in the system. A 90% occupancy rate was expected and pressure on discharge would assist.	
10 Nurse establishment and Safe Staffing report	**ROHTB (9/15) 004** **ROHTB (9/15) 004 (a)**
The Board was informed that in April, compliance had improved against the National Quality Board standards. The area of non-compliance was reported to relate to the need to use the national care tool, which would occur from December 2015 and the requirement to maintain a 'live' display of staffing levels outside each ward, a matter which would be addressed by December 2015. The list of red flag events, as defined by NICE were reviewed and these were reported to have been added to the Ulysses reporting system. Responding to staffing is defined by a manual algorithm, however this is to be systematised in future through the use of a Standard Operating Procedure. A peer review by the Royal National Orthopaedic NHS Trust suggested that the staffing levels were adequate however skill mix at night needed to be considered in the context of quality & safety. Each individual area was reported to have been approached to establish the position against statutory requirements and there is consistency between the wards other than Ward 10/12 and HDU. It was reported that the change in the skill mix could be addressed within current budgets providing that there was a reduction in the reliance on agency staff. The fill rates were reported to have been c. 95% during the period. It was reported that there were currently none whole time equivalent vacancies and applicants for positions were in excess of vacancies, which it was noted was a positive position. It was suggested that over recruitment could be beneficial for filling vacancies that were created more speedily and it was confirmed that this was the case where there was a sufficient calibre of candidates. It was reported that a predicted pattern of bank and agency staff usage was now in place and there would, in turn, be a reduction	

in the reliance on agency staff. Considering the national focus on agency staff, it was suggested that levels of vacancies and additional detail on agency staff usage needed to be reflected in the Corporate Performance Report. A working group around control of agency staff would also be established. The Board supported the planned measures to address the skill mix.	
ACTION: **PA to work with GM to include further detail on nurse staffing vacancies and the use of agency staff within the Corporate Performance Report** **AGREEMENT: The Board approved the proposed actions to address nursing skill mix at night**	
11 Nurse revalidation	**ROHTB (9/15) 005** **ROHTB (9/15) 005 (a)**
It was reported that from April 2016 nurses would be required to undergo a revalidation process in accordance with the recommendations of Robert Francis QC. The Board was advised that this requirement built on the existing systems, given that a process was in place jointly with HR and the Electronic Staff Record system could be used to assist with the delivery of the process. A series of awareness sessions for staff was reported to have been undertaken. It was highlighted that this requirement was a personal professional responsibility and this had been made clear to staff, therefore if the nurses do not revalidate then measures were in place to suspend them from active duty. It was reported that revalidation was undertaken on a three yearly cycle from the point at which they had been registered. Evidence was reported to be required to support the revalidation. The administrative implications were highlighted.	
12 Capital – half-yearly report 2015/16	**ROHTB (9/15) 006** **ROHTB (9/15) 006 (a)**
Year to date capital spend was reported to be £754k, a position significantly behind plan. The areas of shortfall were highlighted and it was noted that the phasing initially set was not viewed as being realistic. Spend on the ePMA was reported to be an area of shortfall, with substantive spend being more likely to start in Quarter 4. Additionally, radiology equipment purchase was less than expected in the plan. A slippage of c. £3m against plan overall was noted, therefore the purchase of additional server storage and capacity was requested to address the requirements of the new clinical systems both now and in the future. Authorisation for the additional costs of implementing the new outpatients system was also requested which would be paid out of IT budgets. Assurance was sought that the requested additional storage capacity was sufficient. It	

was noted that there was no definite guarantee, however there was an expectation that several additional clinical systems that could be introduced on the back of this new capacity. The position would be monitored and the use of a Cloud-based system would be investigated in the future if appropriate and timely. On the basis that there was further work to do to verify the storage requirements, the additional spend was agreed in principle, however the position would be reviewed with IT and then a committee of the Chairman and CEO could approve the final proposal.	
AGREEMENT: The variation to the capital plan was approved, subject to verification of the future IT storage requirements	
13 Monitor Quarterly Declaration – Quarter 2	**Hard copy paper**
It was reported that the Board had previously delegated approval to a committee of the Chairman and CEO to approve the declaration to Monitor. The responses to the Monitor statements were reported to be as follows: *For Finance statements that the Trust:* ***cannot** confirm compliance with the following statements:* **The Board anticipates that the Trust will continue to maintain a Financial Sustainability risk rating of at least 3 over the next 12 months** ***can** confirm compliance with the following statements:* **The Board anticipates that the trust's capital expenditure for the remainder of the financial year will not materially differ from the amended forecast in this financial return.** *For Governance that the Trust **cannot** confirm compliance with the following statement:* **The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards** It was noted that the paper contained the detail as to the reasons for non-compliance where necessary. The declaration was received and noted.	
14 Audit Committee assurance report	**ROHTB (9/15) 007**
The update was received and noted.	

15 Clinical Governance Committee assurance report	**ROHTB (9/15) 008**
The update was received and noted.	
16 Transformation Committee	**ROHTB (9/15) 009**
The update was received and noted.	
17 Charitable Funds Committee assurance report and minutes	**ROHTB (9/15) 010** **ROHTB (9/15) 010 (a)**
It was noted that the proposed investment in learning had been deferred pending clarification of other Charitable Funds commitments.	
18 Council of Governors update and minutes	**ROHTB (9/15) 011** **ROHTB (9/15) 011 (a)**
The update was received and noted. The focus on holding the NEDs to account was highlighted to have been the subject of the Council of Governors workshop in September.	
19 Any other business	**Verbal**
There was none.	
Details of next meeting	**Verbal**
The next meeting is planned for 2 December 2015 at 1100h in the Boardroom, Trust HQ.	

PUBLIC SESSION

Next Meeting: 3 February 2016 , Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

4 November 2015, Boardroom @ Trust Headquarters

Members present: Yve Buckland (YB), Tim Pile (TP), Kathryn Sallah (KS), Rod Anthony (RJA), Tauny Southwood (TS), Jo Chambers (JC), Jonathan Lofthouse (JL), Paul Athey (PA), Andy Pearson (AP), Garry Marsh (GM)

In Attendance: Phil Begg (PB), Anne Cholmondeley (ACh)

Apologies: Frances Kirkham (FK)

Secretariat: Simon Grainger-Lloyd (SGL)

ite+A1

Reference	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
ROHTBACT. 008	Safe Staffing report	Enc 7	02/09/2015	Present the nurse establishment review outcome to the Board	GM	04-Nov-15	The process for nurse establishment review included in the public Trust Board paper on safe staffing; further detail to be provided at the December Board meeting	
ROHTBACT. 010	Charitable Funds Committee, including any minutes of the Committee	Enc 11	02/09/2015	Prepare a briefing on the role of the charitable trustee	PA	~~14/10/2015~~ 26/02/2016	Discussed at the meeting of the Charitable Funds Committee held on 14 October and it was agreed to consider any training that may be available from Mills & Reeve LLP and Kathryn Sallah also offered to circulate some guidance that she had UPDATE: Details of training courses sourced and will be discussed at the meeting of the CFC in February 2016	
ROHTBACT. 011	Charitable Funds Committee, including any minutes of the Committee	Enc 11	02/09/2015	Review the audit requirements for Charitable Funds	PA	~~14/10/2015~~ 26/02/2016	To be reported to the Charitable Funds committee in February 2016	

ROHTBACT. 012	Charitable Funds Committee, including any minutes of the Committee	Enc 11	02/09/2015	Consider preparing standard documentation that prompts donors to define the purposes for which they expressly do not wish their donation to be used	PA	~~14/10/2015~~ 26/02/2016	To be reported to the Charitable Funds committee in February 2016	
ROHTBACT. 007	Corporate Performance Report	Enc 6	02/09/2015	With SG-L oversee the development of an integrated performance dashboard, including the provision of an executive summary	PA	~~04/11/2015~~ 03/02/2016	Executive summary provided in the cover sheet; further work planned to improve the summary to pull out further deviations from plan or key trends at a glance	
ROHTBACT. 003	Chairman & NED update	Verbal	02/09/2015	Undertake a review of the membership of the Clinical Governance Committee in November 2015	SGL	13-Nov-15	Membership of Committee adjusted so that the Chair of Audit Committee is no longer a member, but can attend as an observer periodically. A discussion was also held at the Council of Governors meeting on 14 October, where it was agreed that a governor representative would be invited to join the committee as an observer. The membership will be reviewed further to determine the Non Executive director representation at the end of the calendar year. UPDATE: Revised terms of reference presented for approval at the December meeting suggest a revision of the NED membership of the Committee	
ROHTBACT. 004	Communications and Engagement Strategic Framework initial report and quarterly report	Enc 4	02/09/2015	Develop a suite of indicators & benchmarks to demonstrate the impact of the communications strategy	SXB	02-Dec-15	Included in paper to the Board in December 2016	

ROHTBACT. 005	Communications and Engagement Strategic Framework initial report and quarterly report	Enc 4	02/09/2015	Ensure that the following are included in the next quarterly report – progress against indicators, benchmark information against BCHNHSFT and a timeline for communications developments planned	SXB	02-Dec-15	Included in paper to the Board in December 2016	
ROHTBACT. 013	against the NHS England Core Standards for Emergency Preparedness,	Enc 8	02/09/2015	Organise training for the Board on corporate manslaughter	SGL	28-Feb-16	ACTION NOT YET DUE	
ROHTBACT. 001	Patient Case - an illustration of the work we do	Verbal	04/11/2015	A month by month plan of patient stories to be developed by the Director of Nursing & Clinical Governance	GM	31-Jan-16	To be presented to CGC in January 2016.	
ROHTBACT. 002	Paperless Board Business Case	Verbal	04/11/2015	SGL to arrange for a further update on the plans to introduce a paperless board solution at a future meeting	SGL	03-Feb-16	A number of systems have been assessed for compatibility with the Trust's VDI environment and a trial for a small number of users will occur shortly. An assessment of cost vs. benefit will be presented at the February meeting	
ROHTBACT. 003	Corporate Performance Report	Enc 9	04/11/2015	PA to work with GM to include further detail on nurse staffing vacancies and the use of agency staff within the Corporate Performance Report	PA/GM	03-Feb-16	ACTION NOT YET DUE	
ROHTBACT. 006	Corporate Performance Report	Enc 6	02/09/2015	Consider and develop a set of metrics which provide an early alert of deviation from planned activity	JL	04-Nov-15	Included within the private Trust Board paper scheduled for discussion on 4 November 2015	

ROHTBACT. 009	Safe Staffing report	Enc 7	02/09/2015	Amend the nurse staffing report to 1) incorporate nurse agency actual usage vs. expected usage in the next report 2) remove references to private suite	GM	04-Nov-15	Included within the public nurse staffing paper as requested	

KEY:

	Major delay with completion of action or significant issues likely to prevent completion to time
	Some delay with completion of action or likelihood of issues that may prevent completion to time
	Action that is not yet due for completion and there are no foreseen issues that may prevent delivery to time
	Action that has been completed since the last meeting

Matters from previous meetings to be scheduled into future agendas:

Security of patient sensitive data	November 2015	Signed letters have been received from all bar one consultants regarding the security of patient sensitive data. This is due to be signed imminently.
Paperless Board business case	November 2015	Verbal update on the agenda
Visit to Nuffield Orthopaedic Centre, Oxford	November 2015	No further progress to report. Action superseded by other events.
SLA with St Mary's Hospice	~~December 2015~~ February 2016	Still in the process of securing the SLA with St Mary's
Improvements in translation services	~~December 2015~~ February 2016	Update deferred to February 2016

For remitting to other fora:

Declarations of interest	Audit Committee	September 2015	Discussed at Audit Committee on 17 September 2015
Cancelled operations	TMC	October 2015	To be raised as necessary as part of discussion of the CPR
Review of EOLC policy	TMC	October 2015	To be confirmed - revisit in December
Prebooking x-rays	Transformation Committee	October 2015	Discussed as part of Transformation Workstream 2
Spend of Dubrowski legacy	Charitable Funds Committee	October 2015	Discussed at CFC on 14 October 2015
Development of a park & ride solution	SMT and/TMC	October 2015	Discussion with BCC who are considering what support can be offered
Pre-operative fasting update	CGC	October 2015	Pre-operative fasting update presented to CGC in October
Patient story at a CoG meeting	CoG	December 2015	ACTION NOT YET DUE

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Jo Chambers, Chief Executive**
DATE OF MEETING:	**2 December 2015**

EXECUTIVE SUMMARY:

This report provides an update to board members on the national context and key local activities not covered elsewhere on the agenda.

REPORT RECOMMENDATION:

To discuss the report and note the contents.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	x	Environmental	x	Communications & Media	x
Business and market share	x	Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity		Workforce	x

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

None specifically

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 2 December 2015

1 EXECUTIVE SUMMARY

1.1 This paper sets out the national position of the NHS at a high-level and also some of the key local priorities for the Trust.

2 NATIONAL CONTEXT

2.1 The national picture continues to be a challenging one. The **Quarter 2 financial summary** produced by Monitor and the TDA reveals a significantly worse position than Quarter 1 with an overall NHS deficit of £1.6bn and a forecast deficit of £2.2bn. Trusts are being asked to do all they can to reduce the deficit.

The agency spend cap and management consultant controls have now come into force and it is anticipated this will assist in reducing the rate of deficit over the second half of the year. Providers have also been asked to reduce capital spending plans.

A reduction in the specialist 'top up' allowances will add to financial pressures next year for the Trust. This will need to be assessed more fully when the overall tariff is released. The Board will recall that the tariff objection mechanism has recently been changed to require 66% of the system to object; providers make up approximately 62% of the system.

3 QUARTER 2 MONITORING FEEDBACK

3.1 The Trust Board makes quarterly declarations to sector regulator Monitor, which are reviewed through discussion with members of the executive team. The Quarter 2 review took place in November recognising the context set out in 2.1 above. As expected, the Trust has been impacted by the introduction of the new ratings system, which has triggered a financial risk rating of 2. This is a trigger for Monitor to review financial performance and the Trust has provided additional information and assurance regarding the controls in place. The Trust has previously decided to introduce all recommended controls on a voluntary basis.

3.2 We are awaiting further feedback from our Senior Relationship Manager.

4 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

4.1 Key stakeholder and partnership engagement activities over the period include:

- Attended a Parliamentary Reception with the Specialist Orthopaedic Alliance to raise the profile of our work in orthopaedics and some of the challenges and opportunities.
- Various launch events for the National Orthopaedic Alliance vanguard as part of the national cohort involved in this developmental work.
- Attended the NHS Providers Annual Conference
- Met with Gisela Stuart MP, with the Chairman
- Attended a reception at Downing Street where the Prime Minister, Secretary of State and CEO of NHS England set out their ambitions for the NHS and expectations from the comprehensive spending review, identifying the vanguards as the 'NHS pioneers' who would lead the transformation of health services.
- With the Chairman, met with Professor David Adams, Pro-Vice Chancellor, Head of College of Medical & Dental Sciences and Dean of Medicine, University of Birmingham, and Professor Paul Moss, Director of Research, University of Birmingham to encourage greater collaboration between the Trust and University.
- Birmingham, Sandwell and Solihull Unit of Planning Chief Officers Meeting
- West Midlands Academic Health Science Network Board

5 RECOMMENDATION(S)

5.1 The Board is asked to discuss the contents of the report, and

5.2 Note the contents of the report.

Jo Chambers
Chief Executive
25 November 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	Quarterly progress in communications with a focus on branding
SPONSOR (EXECUTIVE DIRECTOR):	Jo Chambers, Chief Executive
AUTHOR:	Sally Xerri-Brooks, Head of Communications
DATE OF MEETING:	2 December 2015

EXECUTIVE SUMMARY:

This paper summarises the Trust's approach to branding, consistent with the Communications and Engagement Strategic Framework. This is following a specific request at the September Board meeting. In addition, this paper highlights key actions and performance measures for the past quarter.

This paper highlights both the levels of communications activity currently being undertaken, and some of the value it is already beginning to deliver. This is integral to the five year strategy for the Trust, and corresponds with one of the Transformation workstreams.

REPORT RECOMMENDATION:

It is recommended that the Board notes this paper.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X	X	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	
Clinical		Equality and Diversity		Workforce	

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

An engaged, effective organisation.

PREVIOUS CONSIDERATION:

Last update to the Board in September.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Quarterly Progress in Communications with a Focus on Branding

Report to Trust Board on 2nd December 2015

1 Introduction

1.1 This report summarises the key activities and achievements of the Communications Team in the last quarter, looking at:

- Voice – who we are engaging with and where
- Support – assistance for specific projects led by other teams
- Outcomes – the results of some of the key areas of the team's work
- Future plans – what you can expect in the next few months.

1.2 In addition, there is a section focusing on the Trust's approach to branding consistent with the Communications and Engagement Strategic Framework.

2 Quarterly update

Voice | Who we are engaging with and where

33,017 visitors to the ROH website, with the most popular pages being 'how to get to ROH', surgeon bios and the 'work with us' section.	33k website visitors
Social media followers on Twitter, Facebook and LinkedIn have increased by 7%, with a total direct reach of 3,009 followers, and a viral reach of 34,200.	34k social media reach
21 media mentions, 90% of which were either positive or neutral, in publications such as the Birmingham Mail, Digital Health, the Telegraph and the HSJ.	90% positive or neutral media mentions
143 internal views of the Staff Survey film produced by the Communications Team – 10% of all ROH staff viewed the film within 90 minutes of it being released.	10% staff watched survey film in 90 minutes
80% of staff now regularly receive Team Brief, with 69% scoring it between 7 and 10 out of 10 for usefulness – a 17% increase in the last nine months.	4 out of 5 staff receive Team Brief
266 GPs across Birmingham and Sandwell emailed an electronic briefing about Musculoskeletal Ultrasound as a pilot to inform future communications with this group.	266 GPs briefed on Musculoskeletal Ultrasound
Well attended workshop for patients, staff and stakeholders looking at the new website and ensuring it is fit for purpose.	Engagement with patients to shape the website
The anniversary of the 75th anniversary of the bombing of the ROH and the short film made by the Communications Team sparked coverage on BBC Midlands Today, BBC Radio WM and the Birmingham Mail, along with a reach of several thousand people on social media.	75th anniversary of the bombing of ROH received positive coverage

Support | Assistance for specific projects led by other teams

Filming, editing and production of the film for the Staff Recognition Awards, alongside design and print of programmes and certificates as well as photography support on the night. This was in support of Workforce and Organisational Development.	Film, programme and certificate development
Promotion of Osteoporosis Awareness Day to staff and patients in partnership with Extended Scope Practitioners, including intranet pages, surveys, posters and support for the roadshow.	Osteoporosis awareness work
Promotion and support of Nurse Revalidation, with posters, leaflets and a dedicated intranet page created.	Promotion of Nurse Revalidation
Design, print and general support for the redesign of the ROH bed flow system which is now in operation.	Bed flow redesign materials
Promotion of inclusion training, values based recruitment and values based appraisals alongside Learning and Development, through intranet and E-bulletin comms.	ROH Values promotion
Communications lead for the new National Orthopaedic Alliance Vanguard, co-ordinating communications between RNOH, ROH and RJAH.	Vanguard communications and engagement support
Presentation design and on the day support for the Annual Members Meeting.	Presentation design

Outcomes | The results of some of the team's key areas of work

60% of those who receive team brief have good retention of key corporate messages. This compares with 40% across the staff team as a whole.	60% retention of core messages
17% of all staff booked onto Christmas celebration sessions within 48 hours of the related E-bulletin going out.	17% staff response in 48 hours
With support from Communications, the National Staff Survey response rate stood at 48% as of 23rd November 2015, with four days remaining before the survey closes, against 35% nationally.	Staff survey completion rate 48%
38.5% of staff have already received their flu jab as of 23rd November, against a total of 39.7% at the end of the winter season in 2014/15, with support from the Communications Team's #immuniseyourselfie campaign.	38.5% staff have had flu jab
Launch of a new and simplified first appointment letter for patients, which means that each patient now receives just a simple one-sided letter with a map on the reverse, rather than the old style letter with a long information leaflet. This has already saved on printing costs and should support better understanding for patients.	New appointment letter for patients

Future plans | What you can expect to hear about in the next few months

The launch of the new ROH website is due to take place in December 2015. Feedback will be sought in the early weeks after its launch to get a sense of its success and where future developments need to be focused.	New website launch
The launch of the new patient handbook, which will replace around 10 existing patient leaflets. It will sit in a newly designed folder, which will then be able to house additional bespoke information.	Patient handbook launch
The review of all patient letters to simplify them and improve understanding for patients, as well as bringing branding and appearance in line with a consistent standard.	Roll out of improved patient letters
Planning and delivery of a GP engagement event to start to build relationships with this key group.	GP engagement event
Development of an electronic newsletter specially designed for Members of ROH.	Electronic newsletter for members

3 Branding the Royal Orthopaedic Hospital

3.1 Dictionary definition of brand: A particular product or a characteristic that serves to identify a particular product, a trade name or trademark, a particular type of something or way of doing something.

3.2 So branding is about far more than a logo or a set of colours. It is about what an organisation does, how the organisation does it and how all of that is communicated.

3.3 The historic brand of ROH

The words, the 'Royal Orthopaedic Hospital' confer a variety of meanings ,including a sense of heritage, specialism, healthcare and respect. These words are underlined by the ROH crest.

The cross of the crest was designed to represent courage, and the laurel leaves, compassion. Members of the public respond to the name and the crest of the hospital very warmly, and talk fondly of past experiences there.

3.4 The NHS brand as part of the ROH

While the NHS lozenge and brand is shared by all NHS organisations, it is highly valuable – one of the most recognisable logos in the country. It confers respectability, familiarity and safety, but also bureaucracy and predictability.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

3.5 The values of the ROH

The relaunched values of the Royal Orthopaedic Hospital give us a unique opportunity to update the brand of the organisation – building on the strength that is already there, but refocusing on the future, innovation, development and modern medicine. There is imagery alongside the values, but more important are the words that underpin them.

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

- 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.

3.6 The future of branding at the Royal Orthopaedic Hospital

Branding the ROH is about bringing together the heritage and history of the organisation, with its safety, respectability and trustworthiness with a focus on innovation and the future, and core values which permeate through.

4.0 What does this mean in reality?

It means that in staff behaviour, in written communication and in visual products, there is consistency.

The values are now part of the appraisal and recruitment process, so they are becoming core to the way staff are both managed and recruited. This will have an impact on behaviour.

In terms of written communications, the principles that are carried through from those values are:

- Simplicity of language – don't use jargon or confusing terminology when you can describe something in simple words, especially when communicating with patients
- Be compassionate in language used – while this is our working environment, information about surgery for patients needs to not only be honest and informative, it also needs to be sympathetic and sensitive.
- Openness and honesty – not hiding difficult subjects in complex wording or technical language. For example, the difference between talking about 'looking into what went wrong' and 'carrying out a root cause analysis'. They mean the same, but one is far easier to understand than the other.
- Using words that demonstrate our values – writing about courage, compassion, honesty, respect, excellence and innovation.

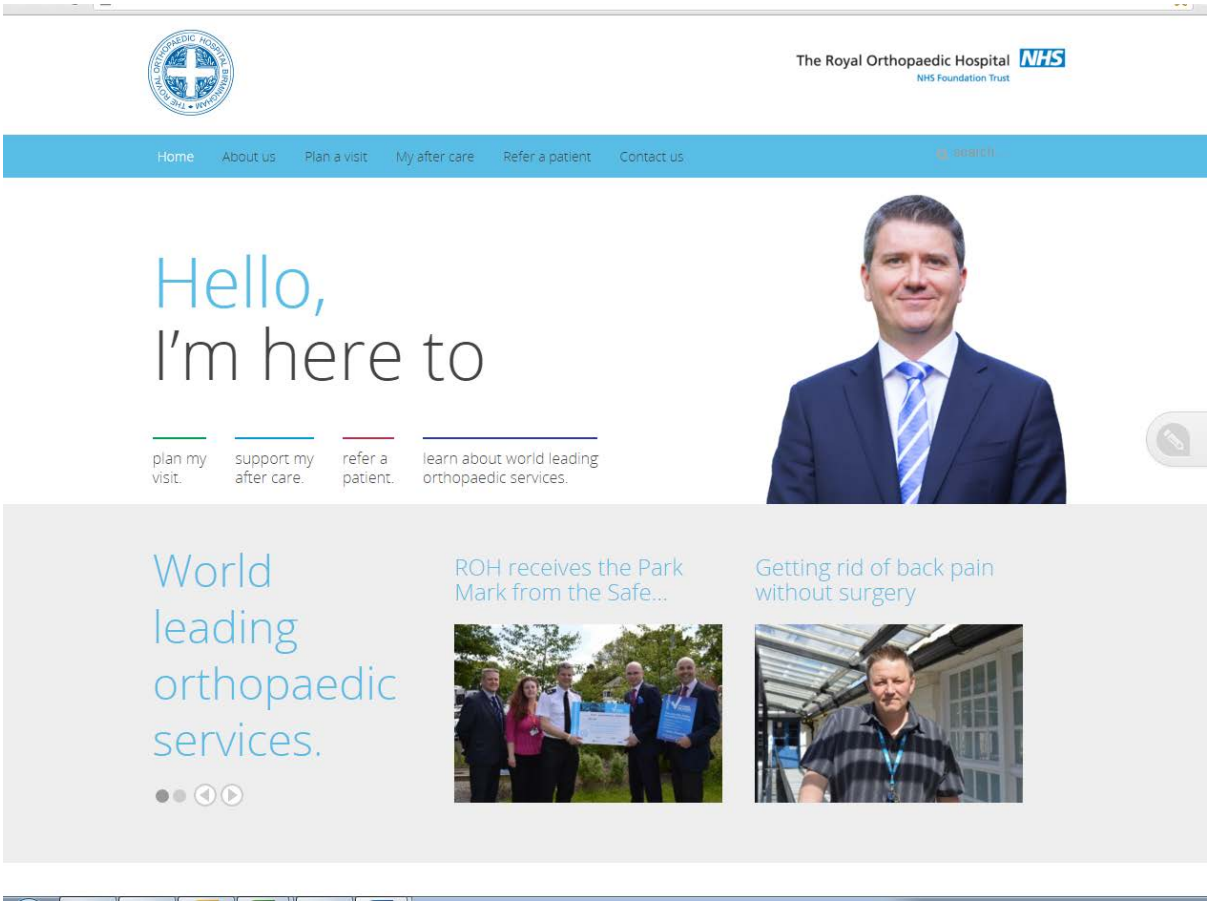
An example of this is in the update of patient letters inviting patients to their first appointment in Outpatients. Historically, patients were sent a two-sided letter which seemed to be written mostly with the needs of the hospital as the first priority, and the patient as secondary. In addition, four pages of additional notes were sent to patients as guidance. This has now been completely changed, with patients simply receiving a one sided letter with a clear map on the reverse. The language has been amended to be far less complex and a lot more friendly, without losing the

professionalism that patients expect from a hospital. It contains clear advice which is simply explained, along with signposts for further information should it be needed. So far patients have responded positively to the change, which will be rolled out to all patient letters in the coming months.

In terms of visual communications, a clean, clear, professional approach is being taken, drawing together the imagery of the three logos detailed above. The guiding principles of the visual identity are that all visual communication, such as films, websites, posters, banners and more should be:

- Clean and without clutter
- Easy to read and access
- Be distinctly 'ROH' in appearance, by using the colour palette used in the Values imagery and the crest, alongside the NHS logo
- Professional
- Friendly.

The most recent example of using this approach can be seen in the new website, which is due for launch in December 2015.



This was developed as a result of patient, public and staff feedback and has tested positively with patients and staff, with particular praise for its simplicity and 'clean' appearance.

6 Conclusion

This report sets out to highlight the key achievements of the previous quarter, which demonstrate progress against the Communications and Engagement Strategic Framework. In addition, a focus on branding offers a clear idea of how the organisation needs to look and feel in its communication, building on input from patients and staff.

7 Recommendation

7.1 Trust Board notes the Quarterly progress report in communications with a focus on Branding

Sally Xerri-Brooks
Head of Communications

25 November 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Corporate Performance report**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Director of Finance**
AUTHOR:	**Alex Gilder, Deputy Director of Finance**
DATE OF MEETING:	**2 December 2015**

EXECUTIVE SUMMARY:

The attached presents a summary of performance against key performance indicators and regulatory targets as at October 2015.

The key highlights to note are:

- Monitor Compliance Framework targets – Infection Control, Cancer waiting times and RTT for incomplete pathways ACHIEVED.

- Trust key targets - September saw the following targets not having been NOT ACHIEVED: Serious Incidents (4), backlog patients (622), incomplete 14-18 week waits (554), admitted patient care patients vs. plan (95.6%), financial deficit (£2,792k), CIP (£969k), agency spend (£446k) and locum doctor expenditure (£109k). The following targets have been ACHIEVED: complaints (8), unexpected hospital deaths (0), unused theatre sessions (36) and sickness (3.9%).

Headlines:

- The financial deficit remains a significant concern, with the Trust having a year to date deficit of £2,792k against a plan of £815k.

- The backlog has increased in month, driven largely by both the admitted and non-admitted backlog.

- The incomplete RTT target has been met in month, but is now very close to the required target.

REPORT RECOMMENDATION:

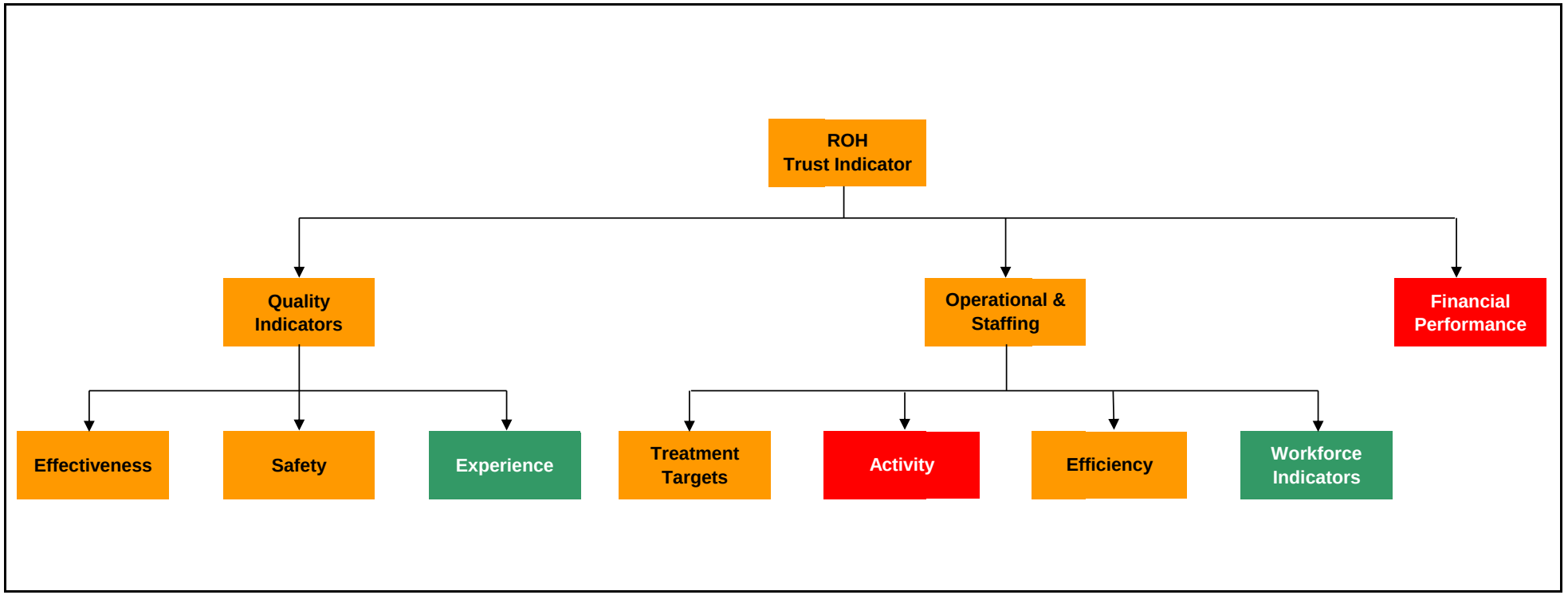
The Trust Board is asked to receive the report and note in particular the headlines and key risks associated with the achievement of key performance and financial targets

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***					
Financial	**X**	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	**X**
Clinical	**X**	Equality and Diversity		Workforce	**X**
Comments: [*elaborate on the impact suggested above*]					
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
Aligned to the Trust's key targets, annual priorities and several entries within the trust risk registers					
PREVIOUS CONSIDERATION:					
An early version of the report was considered at November's Trust Management Committee.					

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending October 2015



Quarterly Detailed Report
Executive Summary as at October 15

Headlines

- The financial deficit remains a significant concern, with a year to date deficit of £2,445k.
- Backlog has worsened in month. RTT incomplete was met in month, but by a small margin.

Monitor Compliance Framework Targets	Oct-15 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	91.60%	91.60%	0	6
Referral to treatment time - Admitted %	90%	86.18%	86.18%	0	6
Referral to treatment time - Incomplete Pathways %	92%	92.07%	92.07%	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
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	Amber
Indicative Monitor Financial Risk Rating	2

Key Trust Targets		Oct-15 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	4		3
	Complaints	<=12	8		4
	CQUINS	100%	90%		11
	Total Unexpected Hospital Deaths	0	0		5
Efficiency & Workforce	Total Backlog Patients	<400	622		6
	Incomplete 14 - 18 Week Waiters	<450	554		6
	Total Admitted Patient Care Patients vs Plan	100%	95.6%		6
	Unused Theatre Sessions	<44	36		8
	Sickness	3.7%	3.9%		9
Financial	Surplus	(£815k)	£2,792k		10
	CIP	£1,442k	£969k		10
	Agency Expenditure	£295k	£446k		11
	Locum Doctor Expenditure	£145k	£109k		11

Quarterly Detailed Report
Safety Indicators as at October 2015

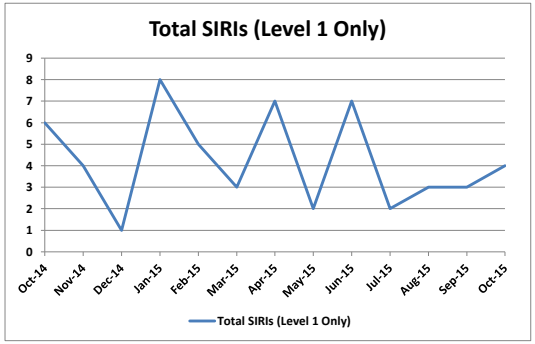
Headlines

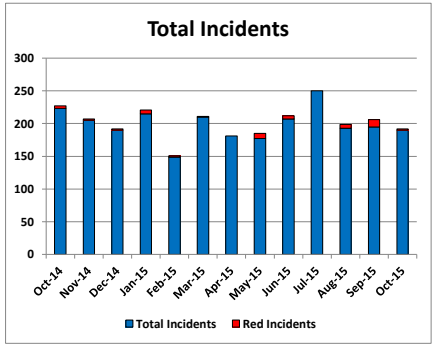
The number of medicines incidents reported in September reduced from 19 to 16. There were no medicine incidents with harm for the 6th successive month.

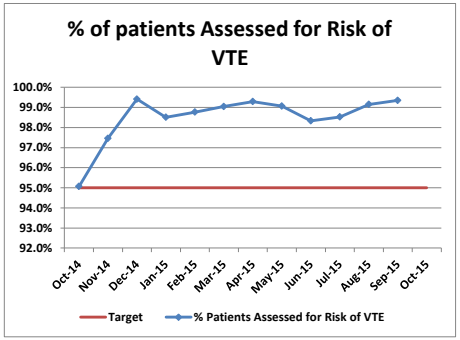
There were 4 SIRIs in October, 1 higher than September.

Patient falls remained static in month, and there were no avoidable patient falls with harm.

	Monitor	National	CQC Standard		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	15/16 Full Year Position
Safety		N	4,16	Never Events	0	0	1	0	0	0	0	0	0	0	0	0	0	0
			4,16	Total SIRIs (Level 1 Only)	6	4	1	8	5	3	7	2	7	2	3	3	4	4
			4,16	SIRI per 1000 bed days	1.58	1.07	0.31	2.35	1.67	0.88	2.20	0.60	1.98	0.48	0.84	0.84	0.99	1.13
			4,16	Total Incidents	223	205	190	215	149	210	181	177	207	250	193	195	190	199
			4,16	Incidents per 1000 bed days	58.73	54.71	59.69	63.05	49.73	61.67	56.83	53.43	58.41	60.10	54.35	54.87	47.18	55.02
			4,16	Red Incidents	4	2	2	6	2	1	0	8	5	0	6	11	2	5
			9,16	Total Medicine Incidents Reported	16	16	20	15	18	30	24	13	26	39	11	19	16	21
			9,16	Medicine Incidents Reported per 1000 bed days	4.21	4.27	6.28	4.40	6.01	8.81	7.54	3.92	7.34	9.38	3.10	5.35	3.97	5.80
				Medicine Incidents with Harm	0	5	5	2	2	3	5	0	0	0	0	0	0	1
		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	95.07%	97.46%	99.41%	98.51%	98.77%	99.04%	99.29%	99.06%	98.33%	98.53%	99.15%	99.34%		98.94%
			9	Incidence of Hospital Related VTE	2	1	1	5	1	3	3	4	6	2	4	2	2	23
			4	Patient Falls - Inpatients	12	7	5	3	4	9	5	1	5	7	4	9	9	6
			4	Patient Falls per 1000 bed days	3.16	1.87	1.57	0.88	1.34	2.64	1.57	0.30	1.41	1.68	1.13	2.53	2.23	1.55
				Avoidable Patient Falls with Harm	0	0	0	0	1	2	1	0	0	1	1	0	0	0
			4,16	% Harm Free Care	97.96%	94.50%	91.95%	97.89%	98.94%	97.14%	97.26%	98.02%	95.05%	95.24%	97.53%	99.04%	97.83%	97.17%







Quarterly Detailed Report
Experience Indicators as at October 2015

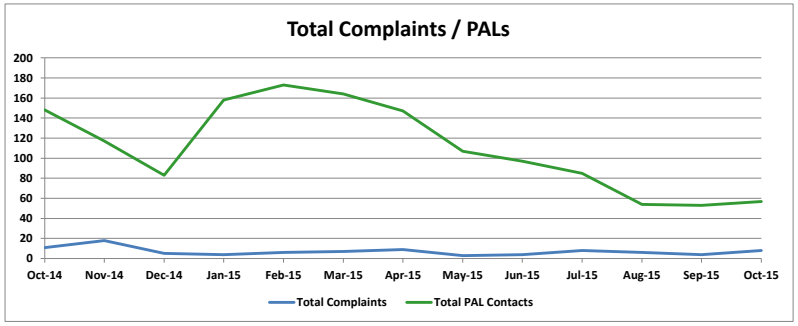
Headlines

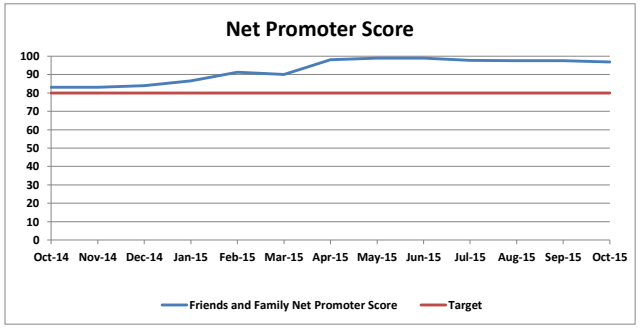
The level of complaints increased from 4 to 8, but this remains a green rating.

PALs contact remained at green, and compliments increased significantly on prior month from 85 to 159.

The Friends and Family test appears to have declined over the past few months, but this is due to ADCU now being included which has a low response rate (10%). This is currently being reviewed to see if a higher rate can be achieved.

	Monitor	National	CQC Standard		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	15/16 Full Year Position
Experience			17	Complaints to Compliments Ratio	1:42	1:29	1:107	1:108	1:75	1:60	1:69	1:94	1:27	1:31	1:18	1:21	1:20	**1:38**
			17	Total Complaints	11	18	5	4	6	7	9	3	4	8	6	4	8	**6**
			17	Complaints reverted to informal <48 hrs	1	0	0	0	0	0	0	0	0	0	0	0	0	**0.0**
			17	Formal	10	18	5	4	6	7	9	3	4	8	6	4	8	**6**
			17	Complaints per 1000 bed days	2.90	4.80	1.57	1.17	2.00	2.06	2.83	0.91	1.13	1.92	1.69	1.13	1.99	**1.65**
				Complaints Response Time (Average No of Days)	109	67	69	24	27	39	35	48	83	77	133	50	64	**70**
			17	Total PAL Contacts	148	117	83	158	173	164	147	107	97	85	54	53	57	**86**
			17	PALS Contacts per 1000 bed days	38.98	31.22	26.08	46.33	57.74	48.16	46.15	32.30	27.37	20.43	15.21	14.91	14.15	**24.36**
				Total PALS Concerns	68	67	52	79	96	86	59	50	64	55	39	35	33	**48**
			17	Total Compliments	465	522	534	433	449	418	619	283	106	251	106	85	159	**230**
			17	Compliments per 1000 bed days	122.47	139.31	167.77	126.98	149.87	122.76	194.35	85.42	29.91	60.34	29.85	23.92	39.48	**48.28**
				Food - Real Time Patient Survey	98.3%	96.8%	96.5%	96.4%	98.8%	94.7%	98.8%	98.8%	96.2%	98.8%		98.6%	99.5%	**98.5%**
			17	Friends and Family Net Promoter Score	83	83	84	87	91	90	98	99	99	98	98	98	97	**98**
				Friends and Family Response Rate	51.7%	58.0%	50.3%	61.0%	59.6%	52.0%	45.3%	48.0%		34.4%	37.0%	28.9%	26.4%	**36.7%**





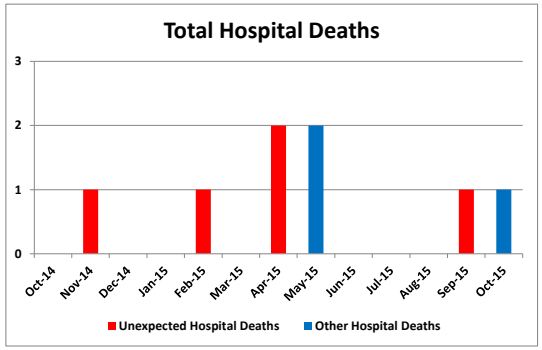
Quarterly Detailed Report
Experience Indicators as at October 2015

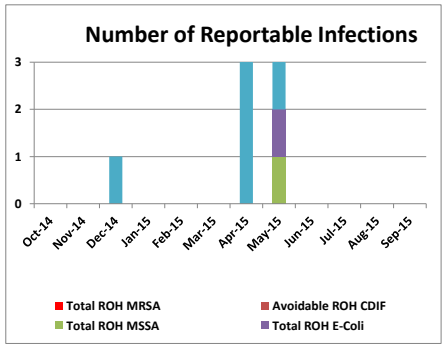
Quarterly Detailed Report
Effectiveness Indicators as at October 2015

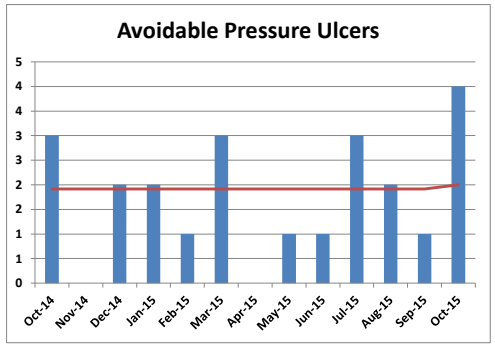
Headlines

- The percentage completion of the WHO chcklist remained high.
- There were 2 instances of grade 3 or 4 pressure ulcers in month, taking our full year total to 3.
- There was a case of E. coli in month, the first since May 15.

	Monitor	National	CQC Standard		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	15/16 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	1	0	0	1	0	2	2	0	0	0	1	1	0.9
			4,18	Hospital Deaths per 1000 bed days	0.00	0.27	0.00	0.00	0.33	0.00	0.63	0.60	0.00	0.00	0.00	0.28	0.25	0.25
			4,18	Unexpected Hospital Deaths	0	1	0	0	1	0	2	0	0	0	0	1	0	0.4
				Other Hospital Deaths	0	0	0	0	0	0	0	2	0	0	0	0	1	3
			8	MRSA % Screened	124.90%	125.30%	111.00%	118.40%	121.80%	131.80%	175.00%	173.03%	169.60%	83.30%	96.30%	153.00%	150.00%	167%
	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	0	0	0	0	0	0	0
				Unavoidable ROH CDIF	0	0	1	0	0	0	3	1	0	0	0	0	0	4
			8	Total ROH MSSA	0	0	0	0	0	0	0	1	0	0	0	0	0	1
			8	Total ROH E-Coli	0	0	0	0	0	0	0	1	0	0	0	0	1	2
			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)	2	0	0	0	0	0	0	0	0	1	0	0	2	3
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	1	0	2	2	1	3	0	1	1	2	2	1	2	9
			4	Avoidable Pressure Ulcers per 1000 bed days	0.79	0.00	0.63	0.59	0.33	0.88	0.00	0.30	0.28	0.72	0.56	0.28	0.99	0.45
				% Completion of WHO Checklist	97.96%	98.23%	97.81%	99.36%	98.90%	99.57%	99.64%	97.42%	99.12%	99.15%	99.07%	99.15%	99.86%	99.06%







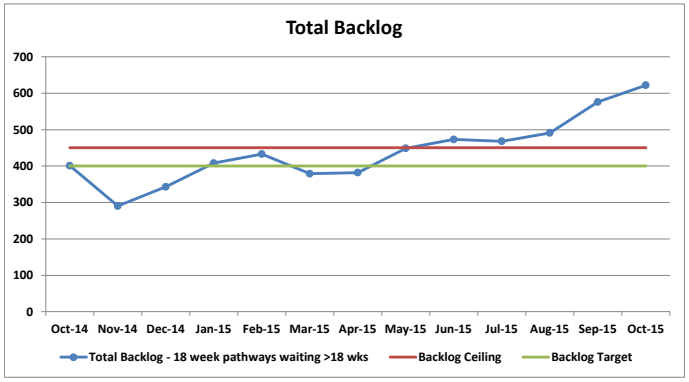
Quarterly Detailed Report
Treatment Targets as at October 2015

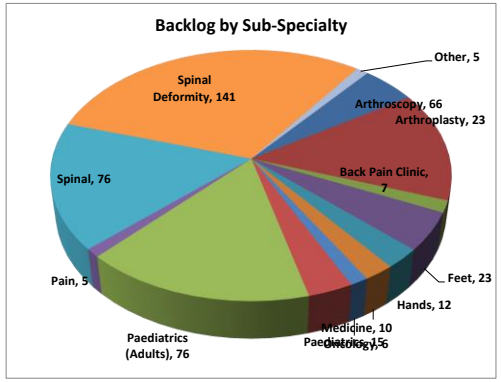
Headlines

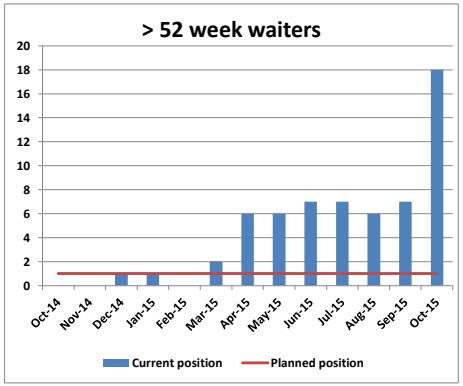
All cancer targets have been met for the month.

Backlog has worsened in month. RTT incomplete was met in month, but by a small margin.

	Monitor	National	CQC Standard		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	15/16 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks			1	1		2	6	6	7	7	6	7	18	**18**
				Referral to treatment waits over 45 weeks	11	6	12	13	11	10	11	22	16	19	30	36	47	**47**
	M	N	4	Referral to treatment time - Non Admitted %	92.68%	92.65%	95.52%	95.58%	95.11%	95.07%	93.49%	96.12%	95.36%	93.91%	94.70%	93.80%	91.60%	**94.12%**
	M	N	4	Referral to treatment time - Admitted %	91.63%	86.32%	93.05%	92.17%	91.61%	90.17%	90.12%	91.47%	90.58%	89.48%	87.70%	87.04%	86.18%	**88.93%**
	M	N	4	Referral to treatment time - Incomplete Pathways %	94.67%	95.96%	95.20%	94.27%	93.94%	94.55%	94.38%	93.78%	93.69%	93.59%	93.28%	92.27%	92.07%	**93.27%**
			4	Non admitted Backlog - Pathways waiting >18 wks	137	110	119	149	153	124	115	115	144	176	166	163	196	**196**
			4	Admitted Backlog - Pathways waiting >18 wks	264	180	224	259	280	255	267	334	329	292	325	413	426	**426**
			4	Total Backlog - 18 week pathways waiting >18 wks	401	290	343	408	433	379	382	449	473	468	491	576	622	**622**
			4	Incomplete 14 -18 Week Waiters	531	438	520	581	540	522	396	466	461	421	482	565	554	**554**
				Non Admitted Median Wait (Weeks)	8.92	8.10	8.45	9.21	9.07	7.72	8.59	8.64	8.43	8.22	8.09	8.26	8.41	**8.41**
				Admitted Median Wait (Weeks)	10.06	10.79	10.61	11.12	11.59	10.63	9.60	9.98	9.50	9.33	10.36	9.92	9.66	**9.66**
				Incomplete Median Wait (Weeks)	5.63	5.44	6.40	6.66	5.53	5.60	5.65	5.50	5.43	5.75	5.96	6.15	5.83	**5.83**
	M	N	4	Cancer 2 week (all cancers)	100.00%	100.00%	97.30%	100.00%	100.00%	100.00%	100.00%	97.20%	100.00%	97.8%*	100.00%	100.00%	100.00%	**99.31%**
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100%*	100.00%	100%*	92.30%	100.00%	100.00%	**98.63%**
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.00%	100.00%	100.00%	100.00%	100.00%	100%*	100.00%	100%*	100.00%	100%*	100.00%	100.00%	100.00%	**100.00%**
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	75.00%	100.00%	83.33%	100.00%	100.00%	87.5%*	100.00%	66.70%	75.00%	100%*	100.00%	100.00%	100.00%	**95.83%**
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	99.33%	99.25%	99.79%	99.49%	99.87%	99.68%	99.53%	99.47%	99.38%	99.57%	96.52%	99.52%	99.72%	**99.08%**
		N	4	Cancelled Ops Not Admitted within 28 days	1	0	0	0	2	0	2	0	0	1	0	0	0	**3**
			1,21	Data Quality on Ethnic Group - Inpatients	95.67%	94.19%	94.24%	97.56%	97.13%	95.80%	96.86%	97.90%	96.42%	96.80%	96.90%	95.37%	95.47%	**96.51%**





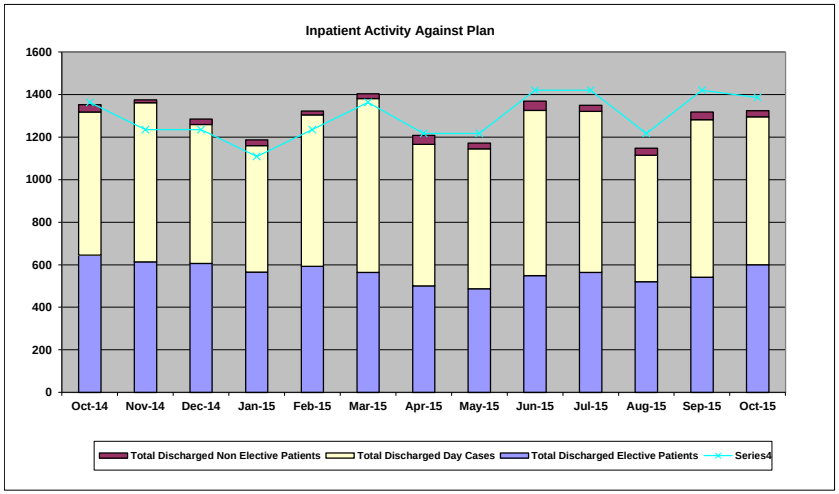


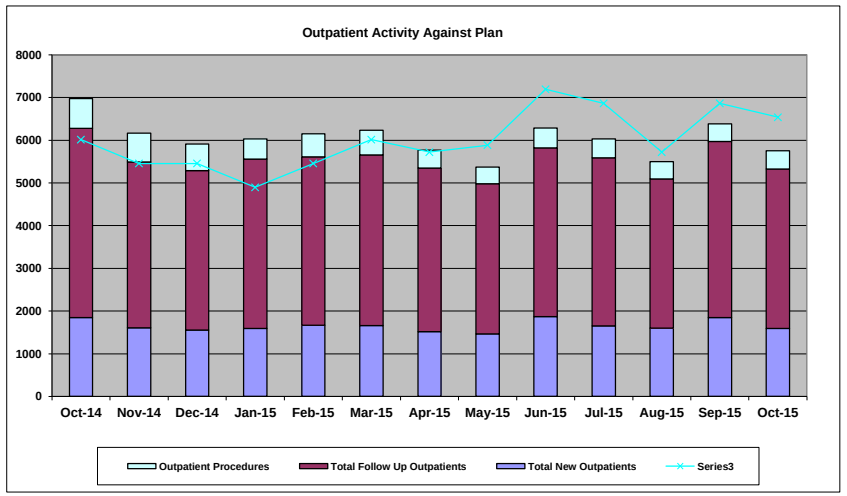
Quarterly Detailed Report
Activity Targets as at October 2015

Headlines

- Elective activity was the highest it has been this month, but still underperformed by 28 cases against plan, and was 46 cases behind October last year. A revised rectification plan has been agreed at Board level for all APC.
- Day case activity also underperformed, being 34 cases behind plan, although this is 23 cases ahead of last year's October.
- All outpatient activity was behind plan.

	Monitor	National	CQC Standard		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	15/16 Full Year Position
Activity			4	Total Discharged Elective Patients	646	614	606	565	592	564	501	487	549	564	520	542	600	3763
			4	Total Discharged Non Elective Patients	34	14	25	27	18	24	41	28	44	28	34	35	29	239
			4	Total Discharged Day Cases	673	748	654	595	713	817	666	658	777	758	595	741	696	4891
			4	Total New Outpatients	1848	1611	1552	1591	1668	1658	1518	1466	1872	1656	1601	1844	1590	11547
			4	Total Follow Up Outpatients	4433	3882	3739	3968	3941	4000	3830	3516	3948	3930	3490	4126	3737	26577
			4	Outpatient Procedures	697	671	621	471	543	573	420	386	467	442	411	412	430	2968
			4	Elective as % Against Plan	101.4%	106.4%	105.0%	109.1%	102.6%	88.5%	90.8%	88.3%	85.3%	87.6%	94.2%	84.2%	95.5%	89.3%
			4	Non Elective as % Against Plan	94.4%	43.8%	78.1%	93.1%	56.3%	66.7%	169.0%	115.4%	155.5%	98.9%	140.2%	123.7%	105.0%	129.0%
			4	Day Cases as % Against Plan	97.5%	119.5%	104.5%	105.9%	113.9%	118.4%	103.9%	102.6%	103.9%	101.3%	92.8%	99.1%	95.3%	99.9%
			4	% New Outpatients Against Plan	111.4%	107.1%	103.1%	117.8%	110.8%	99.9%	96.5%	90.6%	94.7%	87.7%	101.8%	97.7%	88.5%	93.8%
			4	% Follow Up Outpatients Against Plan	120.3%	116.2%	111.9%	132.3%	117.9%	108.6%	106.4%	94.9%	87.2%	91.0%	96.9%	95.5%	90.8%	94.3%
			4	% Outpatient Procedures Against Plan	103.7%	110.1%	101.9%	86.1%	89.1%	85.3%	76.7%	68.5%	67.8%	67.2%	75.0%	62.7%	68.7%	69.2%



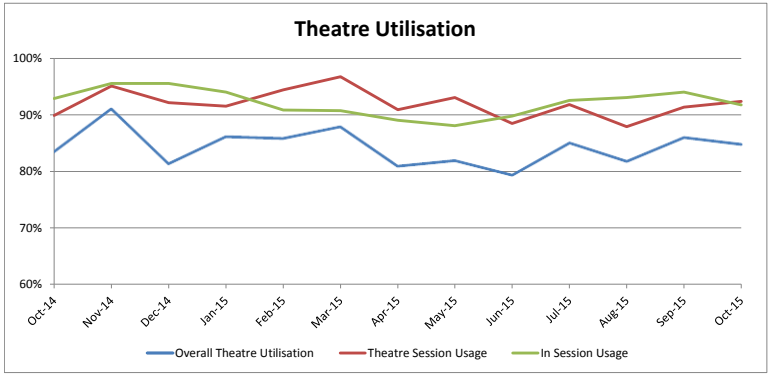


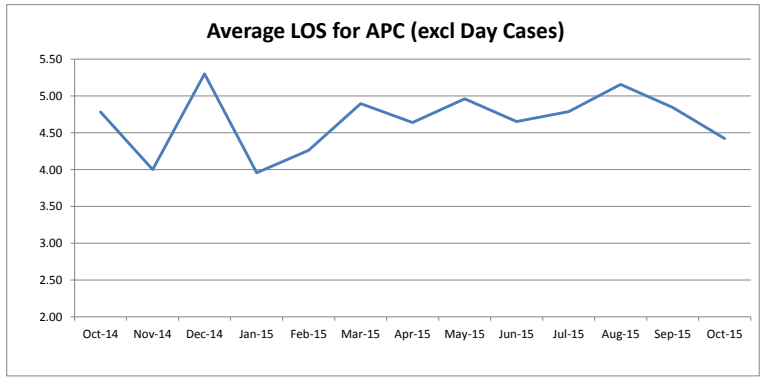
Quarterly Detailed Report
Efficiency Indicators as at October 2015

Headlines

- Cancellations remain high, with hospital cancellations having increased.
- New to review ratios remain high, which could result in the Trust being financially penalised
- AVLOS has improved and is now amber rated instead of red.

	Monitor	National	CQC Standard		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	15/16 Full Year Position
Efficiency			4	Overall Theatre Utilisation	83.47%	90.91%	81.38%	86.08%	85.77%	87.80%	80.97%	81.94%	79.42%	85.00%	81.81%	85.93%	84.76%	**82.83%**
			4	Theatre Session Usage	89.88%	95.12%	92.14%	91.54%	94.41%	96.74%	90.92%	93.04%	88.49%	91.82%	87.91%	91.38%	92.36%	**90.85%**
			4	In Session Usage	92.87%	95.58%	95.58%	94.04%	90.85%	90.76%	89.06%	88.06%	89.75%	92.56%	93.06%	94.04%	91.77%	**91.19%**
			4	Unused Theatre Sessions	50	21	21	38	24	14	36	27	55	40	48	38	36	**40**
			4	Number of Cases per Theatre Session	2.88	3.20	2.97	2.72	3.07	3.20	3.09	3.12	3.08	2.85	3.37	3.20	2.84	**3.06**
			4	Total Cancelled Operations (On Day or Day Before)	54	74	88	53	60	62	46		79					**63**
			4	Total Cancelled Operations (On Day) - Avoidable	18	15	11	10	10	16	17	33	19					**23**
			4	Total Cancelled Operations (On Day) - Unavoidable	36	17	48	15	23	21	29	16	21					**22**
			4	Total Cancelled Operations by Hospital (On Day)	15	11	7	3		37	31	49	31					**37**
				Patient DNA										24	28	21	26	**25**
				Pat Cancelled on the day										19	12	20	22	**18**
				Pat Cancelled 1-3 days before										40	31	41	46	**40**
				Pat Cancelled 4-7 days before										25	23	33	20	**25**
				Hospital Cancelled on the day										10	10	8	7	**9**
				Hospital Cancelled 1-3 days before										36	42	42	54	**44**
				Hospital Cancelled 4-7 days before										46	32	27	32	**34**
			4	% Cancelled Operations by Hospital	1.17%	0.84%	0.58%	0.27%		2.78%	2.77%	4.35%	2.40%	0.78%	0.85%	0.63%	0.57%	**0.43%**
			4	Total T&O Review-To-New Ratio (including Spinal)	2.49	2.39	2.43	2.67	2.42	2.55	2.85	2.62	2.54	2.79	2.63	2.58	2.68	**2.67**
			4	Pain Review-To-New Ratio	3.36	2.85	3.69	2.71	2.69	3.85	3.45	3.23	2.65	2.49	2.31	3.03	2.64	**2.83**
			4	Outpatient DNAs	8.23%	8.13%	9.21%	8.41%	7.82%	8.50%	10.07%	8.49%	8.42%	10.47%	12.05%	11.23%	10.07%	**10.11%**
			4	Bed Occupancy - Adults	83.17%	79.45%	69.20%	76.02%	79.93%	77.35%	67.10%	70.44%	78.83%	91.37%	84.76%	74.89%	89.73%	**79.59%**
			4	Bed Occupancy - Paediatrics	44.44%	60.74%	55.36%	55.36%	65.08%	74.91%	68.86%	66.67%	66.67%	88.42%	65.26%	80.95%	56.14%	**70.39%**
			4	Bed Occupancy - HDU	68.15%	70.46%	55.70%	67.42%	68.22%	75.56%	55.74%	58.74%	47.54%	62.99%	99.59%	58.85%	67.72%	**64.55%**
			4	Bed Occupancy - Private Patients	80.65%	84.33%	83.67%	84.29%	83.33%	54.25%	74.29%	76.96%	88.10%	82.03%	82.57%	86.19%	88.48%	**82.66%**
			4	Admissions on the Day of Surgery	503	478	464	421	445	411	359	379	414	413	403	416	454	**2838**
			4	AVLOS for APC (excl day cases)	4.79	4.00	5.30	3.96	4.26	4.90	4.64	4.96	4.65	4.79	5.16	4.85	4.42	**4.78**



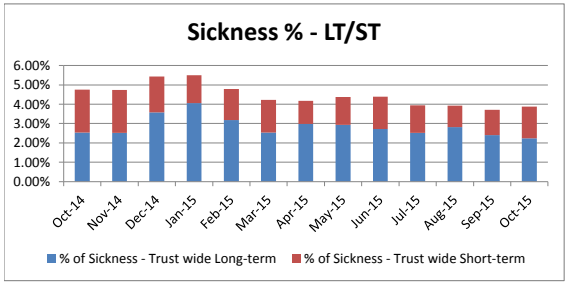


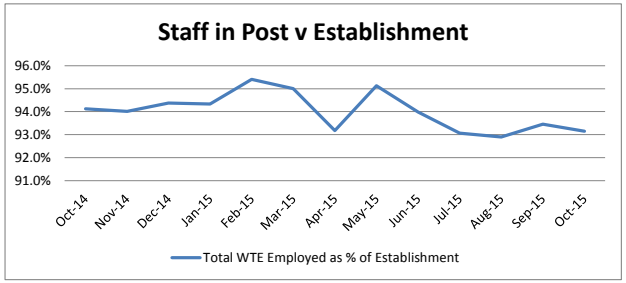
Monthly Report
Workforce Indicators as at October 15

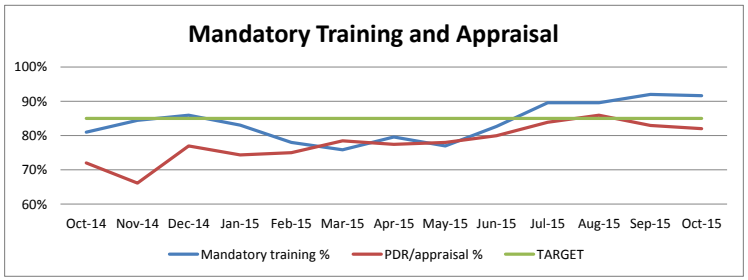
Headlines

- Long Term Sickness continued with lowest rate since Sep 2013
- Staff Turnover (all staff exc. Jr Doctors and employees who have retired and returned) on target for four consecutive months
- Appraisals are continuing to decrease slightly

	Monitor	Contract	CQC Standard		Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	15/16 Full Year Position
Workforce				Total WTE Employed as % of Establishment	94.1%	94.0%	94.4%	94.3%	95.4%	95.0%	93.2%	95.1%	94.0%	93.1%	92.9%	93.5%	93.1%	93.5%
				Staff Turnover (%) - Unadjusted	11.4%	11.8%	1059.2%	10.3%	10.6%	11.1%	10.6%	10.9%	11.0%	11.4%	11.6%	12.5%	11.0%	11.3%
				Staff Turnover (%) - Adjusted	8.9%	9.5%	926.9%	9.0%	8.9%	9.3%	8.6%	8.9%	7.9%	8.3%	8.3%	8.9%	8.0%	8.4%
				% of Sickness - Trust wide	4.8%	4.7%	5.4%	5.5%	4.8%	4.2%	4.2%	4.4%	4.4%	4.0%	3.9%	3.7%	3.9%	4.1%
				% Staff received mandatory training last 12 months	81%	84%	86%	83%	78%	76%	80%	77%	83%	90%	90%	92%	92%	86%
				% Staff received formal PDR/appraisal last 12 months	72%	66%	77%	74%	75%	79%	77%	78%	80%	84%	86%	83%	82%	81%







Workforce Commentary

Sickness absence has increased marginally this month but is still green at under 4%. Our moving annual average (the underlying 12 month figure) has returned to amber this month, and continues its downward trend. We are monitoring the timeliness of information inputting and will be pursuing managers whose data is not timely.

The vacancy position taken from the ledger has retained its green status.

The turnover figure for unadjusted (all leavers minus junior medical staff and excluding employees who retire and return to work) has returned to green this month. We will exclude "retire and return" staff from turnover figures moving forwards.

The mandatory training position is still green at over 90%: we will continue to remind managers to ensure their staff attend the training session.

The appraisal position is still amber and has decreased by 1% despite our efforts of contacting managers to ensure PDR's are carried out promptly and that the information is recorded in ESR in a timely manner.

Monthly Report

Finance Dashboard as at 31st October 2015

	Surplus £	Cash £	Capital spend £
Plan	(815k)	10,735	4,580
Actual	(2,792k)	14,300	860
Forecast for next month (YTD)	(2,380k)	12,261	1,691

Year to date			
	Actual	Plan	Risk Rating
Capital Servicing Capacity	-0.70	1.69	1
Liquidity Ratio	38.62	32.83	4
I&E Margin	-6.3%	-1.7%	1
I&E Margin Variance	-4.6%	-1.22%	1
Financial Sustainability Rating			2

Despite activity being higher than last month, there has been a significant in month deficit of £347k.

Activity was behind plan for the month, with elective activity now being 452 cases behind the original plan year to date. OP activity was also significantly behind plan.

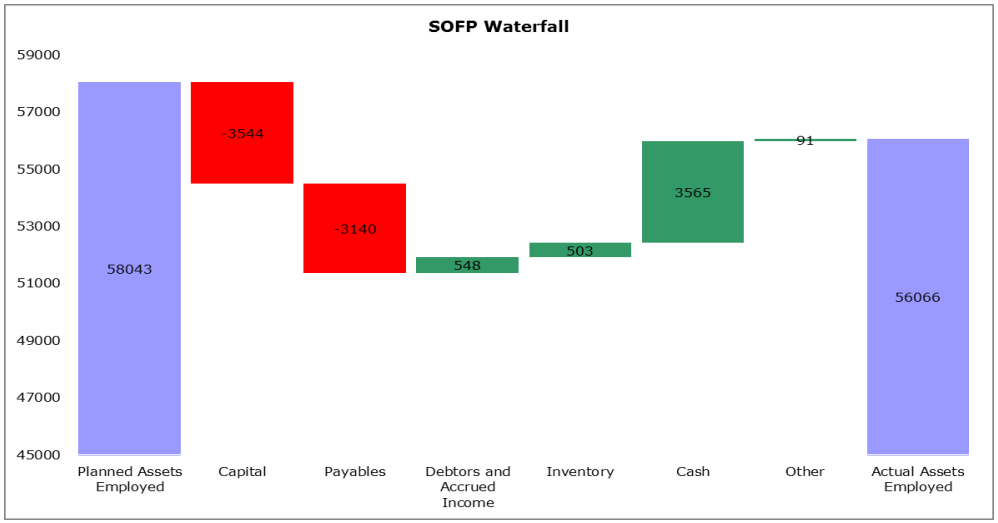
A rectification plan has been agreed which requires activity to be delivered of 363 admitted patient care cases in a normal week.

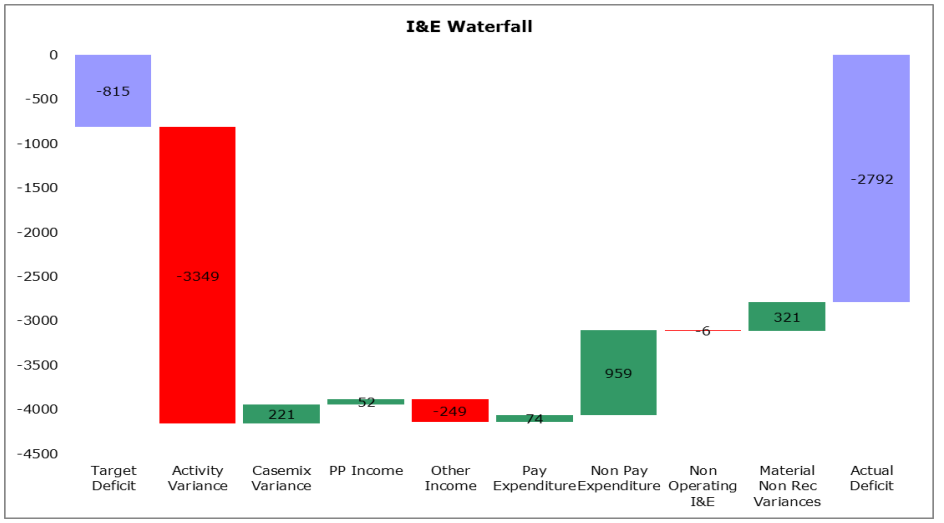
The deficit in month is being driven by this lower than expected activity in addition to the Trust being less efficient than needed in the use of agency workers. A weekly task and finish group has been set up with the Director of Workforce and OD reviewing nurse agency spend and ways to lower this as described below.

Operations and finance have also been working together this month to perform a full review of ongoing CIPs, with a revised CIP plan having now been developed by the Director of Finance. This is on the agenda for discussion at this meeting.

Creditors (payables) have increased in October, however approximately £1.3m of this relates to SLA's with local trusts where invoices have been paid since month end. A further £0.4m relates to invoices on hold with J&J due to ongoing pricing disputes.

As a result of the deficit, both planned, and the variance to plan, the Trust rates as a 1 for the capital servicing capacity, and the two I&E margin ratios. This therefore beings down our overall FSR rating to a 2, despite our strong liquidity.





Capital spend is lower than plan due largely to the theatre feasibility review not occurring at the timing expected and the fact that the first payments for ePMA were

Cash is higher than plan largely due to the capital spend being lower than expected.

Pay expenditure is only slightly underspent at the end of October despite lower activity than planned over the first 7 months of the year. Spend in theatres and nursing areas is above the average spend in 2014/15, with vacancy and sickness pressures in theatres being a big driving factor.

Corporate spend has also increased over the last couple of months, with a significant cost pressure in the areas of Governanc e and operational management. Governance spend has been reducing since October with a significant reduction in the use of agency individuals. There now remain three agency team members, which will further decrea se in January. The operational management cost pressures are partly due to the double running during the handover period to the new divisional structure.

Significant work is currently taking place into reducing agency spend, with actions being taken such as;
- A tightening of the rules and questions asked on the Single Tender Action form for agency spend, and a requirement for all a gency spend to be on framework.
- A weekly nurse agency spend task and finish group, which is implementing actions such as enhancing management information aro und the reasons for agency usage on the wards and in theatres and developing a business case for e-rostering.
- A review of bank rates is currently underway to ensure that they are market competitive and that the Trust are therefore enco uraging the optimum use of bank over agency staff.
- A watching brief and ongoing consultation with agencies around the potential Monitor agency rate caps.
- A review of nurse establishment on the wards and the potential to manipulate budgets to allow more flexibility to recruit to posts rather than holding them as bank

ROHTB (12/15) 006 (a)

TRUST BOARD

DOCUMENT TITLE:	**Nurse Staffing Establishment Review**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Executive Director of Nursing and Governance**
AUTHOR:	**Ms Anne Crompton, Deputy Director of Nursing and Governance**
DATE OF MEETING:	**2 December 2015**

EXECUTIVE SUMMARY:

In November 2015 a proposal was presented to Trust Board to uplift the number of registered nurses on duty at night by 1, in order to increase the skill mix of staff available on night duty. This proposal was accepted in principle subject to the submission of detailed costings.

This brief report provides details of the costings associated with that proposal. It provides details of the agency cost by in patient ward in order to demonstrate the potential to off- set costs by reducing reliance on agency staff.

REPORT RECOMMENDATION:

1. Trust Board is asked to fully support the immediate uplift all ward establishments on adult wards 1,2 and 3 by 1 registered nurse in order to ensure that national standards are met and patient safety and experience is enhanced.
2. Trust Board is asked to support an incremental approach to uplift in paediatric nurse establishment, moving to an immediate uplift of 1 registered nurse per night shift and to a further uplift of 1 registered nurse on shifts with higher acuity from April 2016.

ACTION REQUIRED (Indicate with 'x' the purpose that applies):
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	x	

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*

Financial	**x**	Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	x
Clinical	**x**	Equality and Diversity		Workforce	x

Comments: [*elaborate on the impact suggested abo*

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

PREVIOUS CONSIDERATION:

In November 2015 the proposal to uplift the skill mix on all in- patient wards was accepted in principle by Trust Board.

ROHTB (12/15) 006 (a)

Nurse Staffing Establishment Review

REPORT TO TRUST BOARD – 2 DECEMBER 2015

1.0 Introduction

This brief report provides details of the costings associated with the proposal presented to Trust Board in November 2015 to uplift the number of registered nurses on duty at night in order to increase the skill mix of staff available on night duty. It provides details of the agency cost by in patient ward in order to demonstrate the potential to off- set costs by reducing reliance on agency staff.

2.0 Background to proposal

In April 2015 the Director of Nursing and Governance indicated his intention to work with the Director of Finance in order to understand how the movement of budgetary components, known as 'ring in' that are used to support bank and agency use can be converted to substantive budget to allow permanent recruitment that will reduce our reliance on bank and agency staff.

Since then the Director of Nursing and Governance has met with ward managers, matrons and the Director and Deputy Director of Finance (DoF and DDoF) to review all in-patient ward establishments. In order to ensure the accuracy of ward establishment a detailed ward by ward review was completed in the six months between April and November 2015 which took account of patient acuity and ward environment.

In November 2015 a proposal was presented to Trust Board to uplift the establishment on all in-patient areas by one on each night shift on wards 1,2 and 3. This proposal was accepted in principle subject to the submission of detailed costings.

This change will deliver the following benefits:

- An increase in the skill mix on night shifts to at least 70:30 RN to HCA in wards 1, 2 and 3.
- Reduction in the use of temporary staff in line with recommendations from the Chief Nursing Officer England (June 2015) and Monitor (September 2015).
- A removal of the red flag shifts caused by having only 2 Registered Nurses on night duty in all in-patient wards which results in red flag shifts occurring at meal break times.
- More timely response to patient requests for pain relief, particularly increasing timely access to Controlled Drugs.
- Enable patients to move back from theatre to ward areas in a more timely way during night shifts. Night shifts commence at 19.30 hours, a time when patients are still returning from theatre.

- Improve the nursing teams' capacity to respond quickly to a deteriorating patient.
- Enhance the quality of nursing documentation and patient records.

3.0 Cost of proposal

The cost pressure created by this change in budgets is anticipated to be partially off-set by:

- Incorporating the existing 'ring in' funding into substantive ward budgets
- Reducing the number of Health Care Assistants on duty in each ward area overnight by 1 in adult in-patient areas.

3.1 Adult in- Patient wards

Table 1 below outlines the cost of the proposal for adult in patient wards and provides details of the potential savings from agency costs. The costs are based on uplift in all adult areas by 1 registered nurse on every night shift supported by 1 HCA which meets the standards outlined by the National Quality Board (2014)

Table 1: Costs for Adult in-patient wards

Ward	Current Night Ratios	Move to	Investment Required	Total Agency Opportunity for B5
1	2:2	3:1	32,379	51,479
2	2:2 plus twilight trained	3:1	5,457	57,414
3	2:2	3:1	32,379	45,881
10/12	4:2	4:2	0	35,496
Total			70,216	190,270

The above table shows the investment which would be required to ensure that there are no red flag incidents on the wards overnight. In addition, the table shows the saving which could be made if the current forecast B5 annual agency usage for the wards could be replaced with the use of substantive members of staff on agency for change rates. It can be noted that for adult in-patient wards those potential savings are higher than the investment required.

3.2 Paediatric in-patient ward

Best Practice for staffing paediatric wards is outlined by the Royal College of Nursing (RCN) in ' Defining Staffing levels for Children and Young People' (2012) which outlines the expectation that for bedside nursing care the following ratios should be applied. The ratio required is that for Children > 2 years of age there should be 1:4 registered nurse: child, day and night.

The maximum number of children cared for at night on Tuesday, Wednesday and Thursday is sufficient to warrant an uplift to 4 registered nurses on duty; further work is needed however to understand whether there is a need for this to be on a permanent arrangement (as per the costing model below) or could be met by the periodic use of temporary staffing to cope with peaks in demand.

For the remainder of the week the average number of children cared for of a lower level and requires 3 registered nurses to be on duty.

Table 2 below presents the costs of two options, the first line of the table brings the Trust in line with the RCN guidance, and the second means that the Trust will be partially compliant with these guidelines.

Table 2: Costs for paediatric ward

Ward	Current Night Ratios	Move to	Investment Required	Total Agency Opportunity for B5
11 (fully compliant)	2:0, with 2:1 for Tues-Thurs	4.0, Tuesday to Thurday 3:0 , Friday to Monday	109,507	1,252
11 (partially compliant)	2:0, with 2:1 for Tues-Thurs	3:0	69,124	1,252

Ward 11 could only release savings of c.£1-1.5k through agency to substantive transition and it can be seen that the investment required by both options is substantially greater than the savings which can be released. The total costs of investment across both paediatric and adult wards associated with this proposal are detailed in Table 3 and 4 below:

Table 3 Total cost of Investment (Partial Compliance with RCN Guidance)

Wards	% of total investment	Cost of uplift	Total agency opportunity for B5
Adult Wards	50%	70,216	190,270
Paediatric Ward	50%	69,124	1,252
All	100%	139,340	191,522

Table 4 Total cost of Investment (Full Compliance with RCN Guidance)

Wards	% of total investment	Cost of uplift	Total agency opportunity for B5
Adult Wards	39%	70,216	190,270
Paediatric Ward	61%	109,507	1,252
All	100%	179,723	191,522

It can be seen that the total cost of investment in both options is exceeded by the agency opportunity for savings.

4.0 Conclusion

This brief paper provides a detailed breakdown of the cost pressures by ward to enable the uplift of night ward teams by 1 registered nurse on every night shift on adult wards 1,2 and 3 and paediatric ward 11. The costs presented include a planned reduction in the number of HCA staff on duty at night. The reduction in the use of bank and agency use of nursing staff could off-set the cost of the establishment increase.

5.0 Recommendations

5.1 Trust Board is asked to:

- fully support the immediate uplift all adult ward establishments by 1 registered nurse on Wards 1,2, and 3 in order to ensure that national standards are met and patient safety and experience is enhanced.
- support an incremental approach to uplift in paediatric nurse establishment, moving to an immediate uplift of 1 registered nurse per night shift and to a further uplift of 1 registered nurse on shifts with higher acuity (3 nights per week) from April 2016.

Garry Marsh
Director of Nursing & Clinical Governance

27 November 2015

ROHTB (12/15) 007 (a)

TRUST BOARD

DOCUMENT TITLE:	**Safe Staffing Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Nursing and Governance**
AUTHOR:	**Ms Anne Crompton, Deputy Director of Nursing and Governance**
DATE OF MEETING:	**2 December 2015**

EXECUTIVE SUMMARY:

The report forms part of the organisation's commitment in providing open, honest and transparent nurse staffing information through the publication of this data both on the Trust and NHS Choices Websites. The data period presented in this report is October 2015.

REPORT RECOMMENDATION:

The Trust Board is asked to note that shifts at ROH are staffed to plan more than 95% of the time on both day and night shifts.

The Trust Board is asked to note the contents of this report and support the plans outlined to improve monitoring of shift fill rates through the implementation of the daily staffing huddle.

ACTION REQUIRED (Indicate with 'x' the purpose that applies):
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	
Clinical	**x**	Equality and Diversity		Workforce	x

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

The provision of safe staffing levels aligns to Trust Strategic objectives to provide excellent patient experience every step of the way and to create a culture of excellence.

PREVIOUS CONSIDERATION:

This report was presented to Trust Management Committee on 18.11.2015

ROHTB (12/15) 007 (a)

Nurse Staffing Report

REPORT TO TRUST BOARD – 2 DECEMBER 2015

1.0 Introduction

The National Quality Board (NQB) expects that '*boards take full responsibility for the quality of care provided'*. This means ensuring that agreed staffing establishments are met on a shift by shift basis and decisions about setting this establishment must be evidence based and allow nursing and care staff sufficient time to undertake their caring duties.

This report forms part of the organisation's commitment in providing open, honest and transparent nurse staffing information through the publication of this data both on the Trust and NHS Choices Websites. The data period presented in this report is October 2015.

1.1 Progress against NICE Safe Staffing Guideline

In July 2014 NICE published guidance that described Safe Nurse Staffing levels in adult inpatient wards in acute hospitals. The guideline identifies a series of organisational and managerial factors that are required to support safe staffing for nursing, and indictors that should be used to provide information on whether safe nursing care is being provided in adult inpatient wards in acute hospitals.

Work across ROH has been undertaken to fulfil the recommendations of the guideline demonstrated by enhanced nursing numbers on duty within clinical areas, acuity studies and the evidence of reporting of staffing incidents and their assessment against Safe Nurse Staffing levels.

A new Safe Staffing Escalation Policy has been developed which includes the introduction of a daily staffing huddle on 30.11.2015. The purpose of the huddle is to review staffing against plan for the next 24 hours, make a professional assessment of risk and take action as appropriate. Actions taken from the huddle will be recorded.

It is evident from the data submitted for the Unify return (Appendix 1) that the described minimum Registered Nurse staffing of a 1:8 ratio is being met within clinical areas on day shifts, with incident reporting occurring when this is not happening and reporting within the monthly staffing reports. Table 1 below presents a summary of the staffing hours used at ROH during October 2015.

Table 1: Hours used October 2015

	Totals - All Staff		Summary Data			
			Qualified		Unqualified	
	Qualified Hours Used	Un-Qualified Hours Used	Bank	Agency	Bank	Agency
Ward 1	2268.0	1716.5	320.5	451.5	521.5	228.0
Ward 2	2080.0	1859.5	256.5	598.0	319.5	281.5
Ward 3	2229.5	1734.5	297.5	369.5	558.5	180.0
Ward 11	1855.0	370.5	331.0	141.0	50.0	0.0
Ward 12 & 10	2779.0	2454.5	222.0	346.5	1306.5	276.0
HDU	3155.0	223.0	77.5	708.0	0.0	0.0
TOTAL ALL WARDS	14366.5	8358.5	1505.0	2614.5	2756.0	965.5

2.0 Trust overview of planned versus actual Nursing hours

The overall nurse staffing fill rate for October 2015 is shown in table 1 below; this figure is inclusive of Registered Nurses and Health Care Assistants (HCA) during both day and night duty periods. Table 2 provides further detail regarding nurse staffing fill rates by month since April 2015. It can be seen that average fill rates are consistently above 95%.The Unify Upload for October 2015 is provided in Appendix 1.

Table 2: Fill rates by month 2015/16

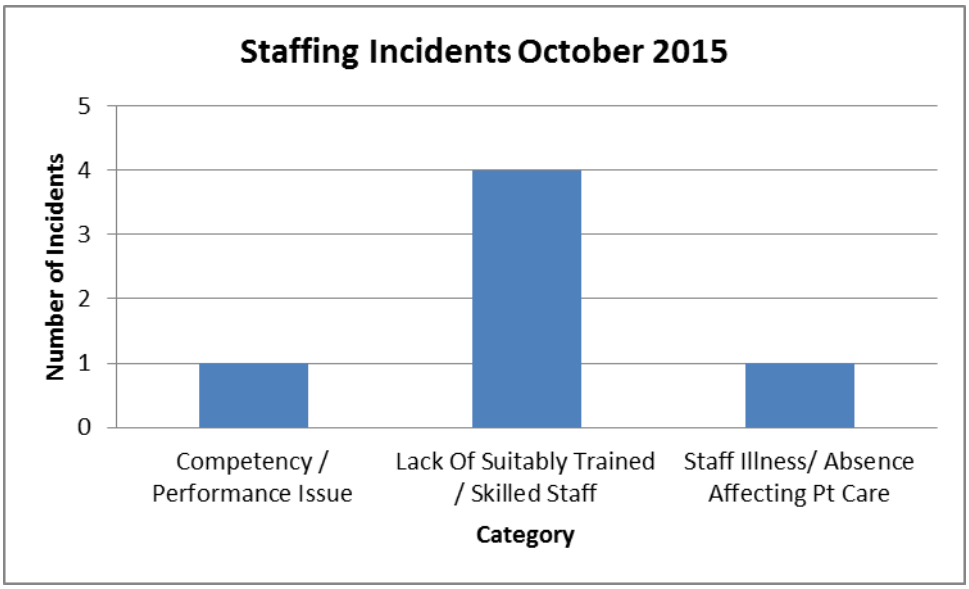
Month 2015	Day	Day	Night	Night
	Av Fill rate %	Av fill rate %	Av fill rate %	Av fill rate %
October	96.8	99.5	100.1	100.8
September	97.1	97.0	99.9	96.1
August	98.1	97.0	100.6	103.3
July	98.6	95.8	101.0	97.8
June	96.6	96.9	100.0	101.8
May	96.2	95.1	100.8	97.0
April	95.7	94.8	99.8	95

During October 2015, Ward 3 recorded the lowest fill rate for registered nurses on day shifts at 89% against planned hours. However the reduction in fill rate was commensurate with planned reduction in weekend activity and therefore did not impact on the delivery of patient care. There are no recorded incidents of patient harm attributed to a deficit in staffing numbers on ward 3.

3.0 Incident Reporting

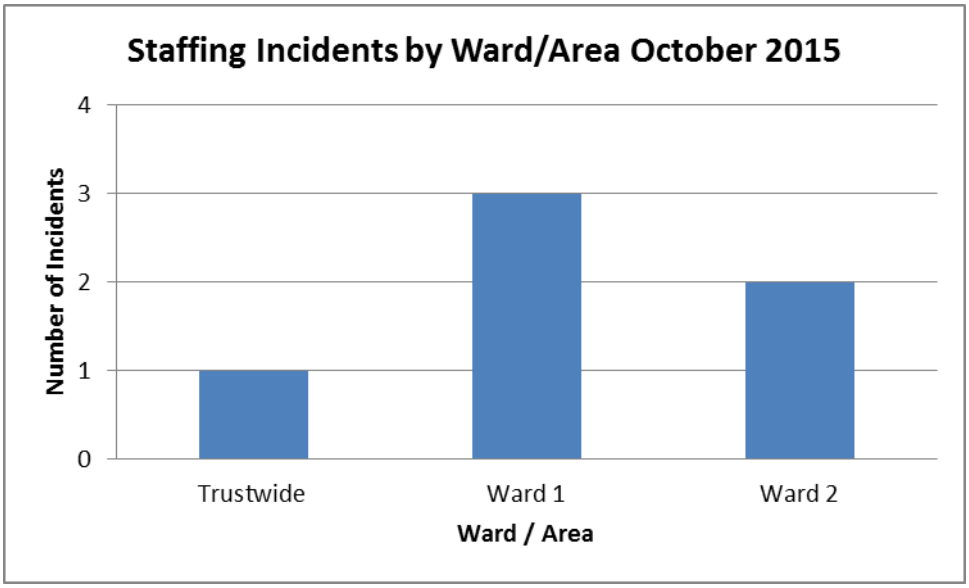
An analysis and review of the 6 safe staffing incidents reported during the period of October 2015 has been undertaken and is represented in the graph below. The number of incidents reported in October shows a significant drop since last month when 14 incidents were reported.

3.1 Table 2 Incident Categories



Comparison with the 7-months from 1st April 2015 shows that lack of suitably skilled staff and level of support to patient are consistently the highest categories of concern. Incidents reported in these categories often relate to agency and bank staff not turning up for shifts. The newly established Task and Finish group led by the Director Of Workforce and OD is undertaking a review of the processes by which bank and agency staff to ensure that incidence of DNA is captured and monitored more effectively.

3.2 Table 3 Incidents by area/ward:



3.3 Level of harm

All incidents were graded low harm or near miss. There were no incidents of harm attributed to staffing deficits in October 2015.

3.4 Red Flag Shifts Questionnaire

A safe staffing questionnaire has been added to the incident reporting system (Ulysses). Incident reporters are being asked to complete the short questionnaire for every staffing incident to determine whether the NICE guidance on safe staffing has been breached and the shift in question constitutes a 'red flag shift'.

Of the six incidents reported, one red flag shift has been identified as follows:

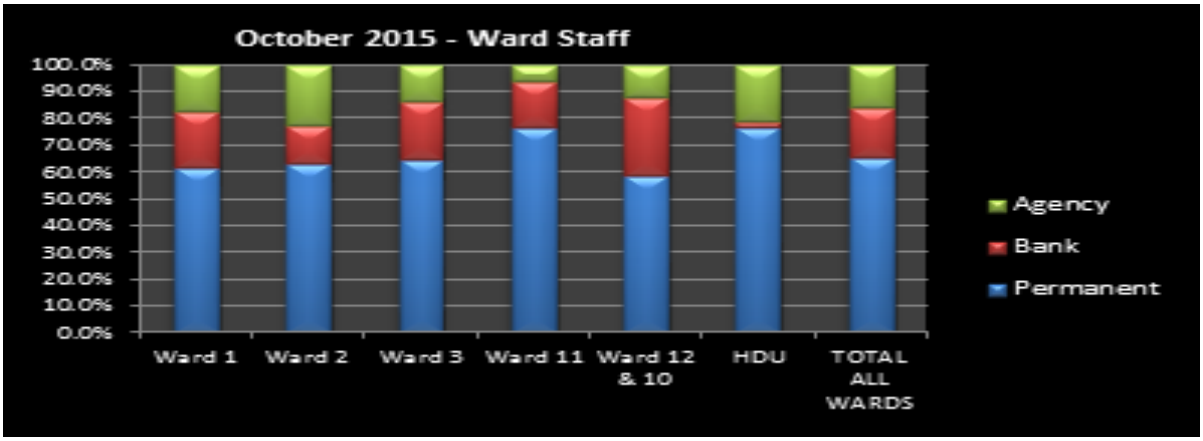
- 16436 (ward 1) – lack of registered staff, impact 1. The patient's pain relief was delayed 2. Post- operative observations were not completed as often as required. 3. Some written communication was not able to be completed as thoroughly as might be required.

Two other incidents (16281 and 16388) did not trigger a 'red flag' and 3 other incidents (16381, 16326 and 16383) are awaiting full completion of the red flag shift questionnaire. The recording of red flag shifts is still inconsistent across the Trust. A standard operating procedure has been developed to support ward teams in completion of red flag shifts with training planned through November and December 2015. Red flag shifts will be discussed and recorded daily through the staffing huddle. This will increase the accuracy of reporting and ensure that all harm events are correctly identified and managed.

4.0 Bank and Agency use

During October 2015 wards have continued to use bank and agency staff in order to meet patient care requirements. Table 4 below shows the ratio of bank and agency use by ward across the organisation through October 2015.

Table 4: Ratio of bank and agency use by ward



Total agency use across all in-patient wards is 15.8% with the highest usage in Wards 1 and 2 and HDU at 17.1%, 22.3% and 21% respectively. This is higher than the usage recorded in September 2015 when total agency use across all wards was recorded as 12.9% , however highest usage is consistent across ward 1 and 2 .In September 2015 Monitor published new rules on the use on agency spend for all provider trusts which introduced a mandatory ceiling for agency use. We had confirmation of the ROH cap in October 2015 which stands at 10%. A Task and Finish group to review and implement improved approaches to the planning, deployment and management of substantive, bank and agency registered nurses to reduce reliance and expenditure on commercial agency staff has been establish led by Director of Workforce and Organisation a Development.

6.0 Fill rates against harm measures

The overall nurse vacancy rate at ROH remains low with 6 WTE. Plans are in place to recruit to vacant posts. If the establishment review presented to Trust Board today receives approval to progress to recruitment, the vacancy rate at ROH will rise and therefore future reports are likely to show a higher vacancy factor.

Table 6 below present harm and experience measures against shift fill and sickness rates. There is no evident correlation between experience of harm and shift fill rates on the basis of the evidence presented.

Table 6 Shift Fill Rates against Harm/ Experience Measures by Ward

Measure	Ward 1	Ward 2	Ward 3	Ward 10/12	Ward11	HDU
Fill Rate (day)	95.3%	99	88.3	99	101.7	99.9
Number pressure ulcer	0	2	0	2	0	0
Number falls	4	1	3	0	1	0
Number staffing incidents*	0	2	3	0	0	0
Complaints	0	1	1	0	0	0

7.0 Conclusion and Recommendations.

7.1 The Trust Board is asked to note that shifts at ROH are staffed to plan more than 95% of the time on both day and night shifts with the exception of ward 3 which recorded 89% fill rate during October 2015.

7.2 Whilst agency use remains high, shifts are being staffed at a level that supports safe patient care. The Trust has received its agency use ceiling imposed by Monitor, which is 10%.

7.3 A comprehensive nurse establishment review was presented to Trust Board in November 2015 which supported the move from 'ring-in' ward budgets to substantive posts in order to reduce reliance on bank and agency staff.

Mr Garry Marsh
Executive Director of Nursing
26 November 2015

7.0 Appendix 1: UNIFY upload October 2015

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

Comments

http://www.roh.nhs.uk/services/safe-staffing-national-reporting

Only complete sites your organisation is accountable for					Day				Night				Day		Night	
Hospital Site Details		Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours				
RRJ05	ROYAL ORTHOPAEDIC HOSPITAL - RRJ	Ward 1	110 - TRAUMA & ORTHOPAEDICS		1684.5	1586	997	1011.5	682	682	682	705	95.3%	101.5%	100.0%	103.4%
RRJ05	ROYAL ORTHOPAEDIC HOSPITAL - RRJ	Ward 2	110 - TRAUMA & ORTHOPAEDICS		1412.5	1398	976.5	1078.5	682	682	682	781	99.0%	110.4%	100.0%	114.5%
RRJ05	ROYAL ORTHOPAEDIC HOSPITAL - RRJ	Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1622.2	1609.5	1185	1084.5	640	620	640	650	98.3%	91.5%	96.9%	101.6%
RRJ05	ROYAL ORTHOPAEDIC HOSPITAL - RRJ	Ward 10 & 12	110 - TRAUMA & ORTHOPAEDICS		1763.5	1745	1491	1477.45	1023	1034	1022	977	99.0%	99.1%	101.1%	95.6%
RRJ05	ROYAL ORTHOPAEDIC HOSPITAL - RRJ	Ward 11	110 - TRAUMA & ORTHOPAEDICS		1163.5	1173	271.5	271.5	682	682	99	99	101.7%	100.0%	100.0%	100.0%
RRJ05	ROYAL ORTHOPAEDIC HOSPITAL - RRJ	HDU	110 - TRAUMA & ORTHOPAEDICS		1670	1668	253	223	1474	1487	30	0	99.9%	88.1%	100.9%	0.0%

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**2nd December 2015**

EXECUTIVE SUMMARY:

The Audit Committee workshop on 7 October produced a number of suggestions as to how the Board Assurance Framework might be reformatted and used to better provide a more useful tool for the Board & its Committees.

The attached presents a working draft of a revised Board Assurance Framework which is a working draft but contains all risks deemed to be of sufficient gravity as to appear on the BAF.

The key changes are:

- Removal of the risk 'themes'
- Grouping of the risks under the relevant strategic objectives
- A requirement for additional detail around the primary assurance committee for each risk, together with more detailed articulation as to the sources of assurance that the risk is being mitigated

These changes are designed to bring the Trust's Board Assurance Framework more into line with models of best practice elsewhere, including that of NHS England.

It is acknowledged that further work is required to populate the BAF more comprehensively, therefore the Board can expect a more acceptable update at its February meeting.

REPORT RECOMMENDATION:

The Board is asked to note the working draft of the revised Board Assurance Framework.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
X		

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial	X	Environmental		Communications & Media	
Business and market share	X	Legal & Policy		Patient Experience	X
Clinical	X	Equality and Diversity		Workforce	X
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Covers all risks to the delivery of the Trust's strategic objectives.
PREVIOUS CONSIDERATION:
Considered by the Executive Team and an early version was presented to the Audit Committee at its last meeting.

RISK ASSESSMENT MATRIX

1. LIKELIHOOD: What is the likelihood of the harm/damage/loss occurring?

LEVEL	DESCRIPTOR	DESCRIPTION
1	Rare	The event may only occur in exceptional circumstances
2	Unlikely	The event is unlikely to occur (remote chance)
3	Possible	The event may occur occasionally (25-50% likelihood)
4	Likely	The event is likely to occur (above 50% likelihood)
5	Almost Certain	The event will happen (and frequently)

2. SEVERITY: What is the highest potential consequence of this risk? (If there is more than one level, choose the highest)

Descriptor	Potential Impact on Individual(s)	Potential Impact on Organisation	Financial Impact	Number of people affected	The Potential for complaint / litigation
Insignificant	No / superficial harm	No impact	No litigation, Less than £100 to reduce risk, Financial risk less than £50K	Only 1 person	Unlikely to cause complaint / litigation
Minor	SHORT TERM INJURY / DAMAGE e.g. injury that is likely to be resolved within one month, Increased level of care 1-7 days	Minimal risk to organisation	Litigation between £100-£25k, £100-£10K to reduce risk, Financial risk £51K - £500K	Greater than 1 but less than 5	Complaint possible, Litigation unlikely
Moderate	SEMI-PERMANENT INJURY/DAMAGE, e.g. injury that may take up to 1 year to resolve, Increased level of care 8-15 days	Some disruption in service with unacceptable impact on patient, Short term sickness	Litigation between £25k-£250k, £10k-£50K to reduce risk, Financial risk £501K - £2M	Greater than 5 but less than 50	High potential for complaint Litigation possible but not certain.
Major	PERMANENT INJURY, Loss of body part(s), Increased level of care over 15 days, Loss of sight	Long term sickness, Service closure, Service/dept external accreditation at risk	Litigation between £250k-£1m, £50k-£250K to reduce risk, Financial risk £2M - £4M	Greater than 50 but less than 200	Litigation expected /certain, Multiple justified complaints
Catastrophic	DEATH, Suspected Homicide, Suicide	National adverse publicity, External enforcement body investigation, Trust external accreditation at risk	4 Litigation greater than £1m, Greater than £250k to reduce risk, Financial risk greater than £4M	Greater than 200	Multiple claims or a single major claim

3. RISK RATING: Use the matrix below to rate the risk *(e.g. 2 x 4 = 8 = Yellow, 5 x 5 = 25 = Red)*

Element of Risk	SEVERITY				
LIKELIHOOD	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
1 Rare	1	2	3	4	5
2 Unlikely	2	4	6	8	10
3 Possible	3	6	9	12	15
4 Likely	4	8	12	16	20
5 Almost Certain	5	10	15	20	25

Green = LOW risk **Yellow = MODERATE risk** **Amber = MEDIUM risk** **Red = HIGH risk**

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DNG	178	standards of care	There is a risk that patient safety may be compromised owing to lack of evidence that the WHO safety checklist is being completed as per statutory guidance.	CGC			16	Working partly in place, reviewing whole process. Daily WHO Audits undertaken and published. Poor Practice highlighted Weekly audit completed by Theatre Manager Theatre teams managed by Band 7 team Band 7 team address at local level staff training and competence Band 7 team address compliance Clinical Directors to ensure medical teams understand and are compliant Clinical leads for Surgery and Anaesthetics to endorse and support	Sept 2015 Update August compliance = 03.08.15 – 97.86% 10.08.15 – 99.32% 17.08.15 – 99.18% (remaining data not yet available) July compliance = 99.15% Audits identify 'non-compliance' as a box being not ticked on the checklist not the whole checklist not being completed. Other Trusts only report on completion of the whole checklist (not individual boxes as at ROH). Data collection methods will be changing very shortly which should enable us to attain the 99% -100% as requested by the CCG.			12						6
DNG	275	standards of care	There is a risk that safe practices and patient care are compromised owing to a lack of robust internal processes for 1) disseminating learning from serious events/claims/complaints and 2) providing assurance that learning is embedded within the organization.	CGC			16	EMT and Board Patient Quality Report presented monthly to Directorate teams Clinical Audit monthly presentation Directorate Governance Meetings Clinical Governance Committee overview	Patient Quality Report presented monthly to EMT and Board Clinical Audit meeting shared events/claims/SIRIs/Incidents Directorate Governance meetings			12		additional training to be rolled out to new directorate leads once new directorate structure in place. Governance to send monthly reports of outstanding RCA actions				4
MD	414	standards of care	There is a risk that the Trust may suffer reputational damage owing to its low position for health improvement as measured by PROMs on national Information Centre figures. Reputational damage, for example, if Trust deemed to be an outlier.				16					12		Sept 2015: update on PROMS to be presented to CGC in October or November 2015. Latest PROMS figures have been published and are undergoing analysis.				4

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DNG	796	standards of care	The Board and organisation loses its focus on patient care so the ROH is no longer a patient centric organisation				5	Patient Quality Report reviewed by the Board in public sessions.CoG review of Corporate Performance Report. Patient stories shared at Board. Director team approach to joint planning of service delivery. Strengthened links between Patient and Carer Council to Quality Committee/EMT. Board members visiting wards and departments speaking directly to patients and staff.	Patient Quality Report; CPR; Patient & Carer Council; Quality Meeting; Patient Harm Reviews; FFT feedback; Complaints & PALS review; Patient Stories.			5						5
Fin	804	standards of care	Information is insufficient in quantity, usefulness or reliability to run the organization, improve service and provide evidence of effectiveness and assurance to the Board				12	September 2015: Business case approved to develop in-house reporting suite. Project underway with early focus on the data warehouse architecture and source data requirements. In Q4, this will develop into the front-end, reporting package element of the project. It is at this point that elements that effect the scoring of this risk will begin to be addressed. IM&T Strategy developed and being implemented; Informatics strategy to be developed; Upgrade of Informatics infrastructure to SQL 2012 to provide platform for future Informatics developments; Refocus of Informatics team to prioritise business intelligence. Develop culture of good data quality at all levels of the organization; Transformation project to identify, collect and report on a new set of KPIs aligned with Trusts strategic objectives	CPR; Internal Audit reports; Benchmarking; Transformation Board Reports; CQC report; Data Quality Committee Papers; IM&T Programme Board			12	12					4

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DNG	30	CQC registration	There is a risk that the Trust is non-compliant with the CQC safety domain - management of medicines				6	Action plans for all areas have been issued and any concerns identified addressed with department management. Completion of documentation correctly remains a concern particularly in theatres and this is being addressed by theatres management and the Chief Pharmacist who will look into each individual non compliance regarding CD destruction.				9	9	Quarterly medicines management audit is due December to cover the period Sept Oct Nov.				8
CEO	801	CQC registration	Trust is adversely affected by the regulatory environment by diverting energy from the strategy, creating a focus on suboptimal targets or creating exposure to policy shifts such as reducing support for single specialty hospitals.				12	Engage in the wider NHS nationally and locally to stay on top of changing context and regulatory requirements. Ensure the organization is set up to deliver key requirements of the regulator and commissioner, supported by internal performance management systems to ensure 'business as usual' operational delivery. Strengthen internal operational capability to ensure key requirements are delivered to negate need for regulatory intervention	Regular engagement in national and local policy and planning events and meetings to maintain and develop an informed understanding of the changing policy context to support ROH response and strategy development: Monitor briefings; FTN Networks; CEO events; SOA; Tripartite events; Unit of Planning processes; NHS Confederation; Kings Fund papers. Evidence through CEO and other Director reports to the Board. Evidence of managing operational delivery through CPR to Board.			12	12	Controls are being put in place and will be further developed through the appointments to the new organizational structure and further development of the governance system which provides assurance to the Board. The Trust will not be able to mitigate against changes in national policy or new target introduced in response to areas of political interest, but must be able to adapt in these circumstances				6

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
OPS	7	Business Continuity	Long waiting times for spinal deformity. Impact of BCH capacity on ROH's waiting list potentially causing delays.				20	The Trust is currently in active pre-arbitration discussions with NHS England regarding the current contract and ongoing capacity constraints, and have an agreed Remedial action plan which is expected to provide only limited improvement in capacity in the short term. A proposal has been submitted to NHSE regarding developing the existing on-site ROH service from January 15 (Vanguard model), and/or use of BMi Cromwell to treat a further 30 patients (subject to funding) before March 2016.	Appointment of 2 additional spinal deformity consultants Active management of waiting list Sourcing additional capacity as required			16	16	Finalising plans to use Cromwell hospital from Jan 16 to treat 30 patients and 5 extra patients to be treated at ROH. 6 patients have been waiting currently over 52 weeks with a further 9 patients between 48 and 50 weeks				9
	27	Business Continuity	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.				20	Director of Operations approves request for locum doctor appointment				16	16	5 physicians associates have now been offered employment. Amendment to remuneration for discussion at Board on 1 September. Working group now formed to develop working practices of PAs/ANPs/junior doctors; output expected by end September. Implementation of model now expected to be Q4 – Q1. Risk score from 20 to 16 as offers made and working group in place but the risk remains red pending a				6

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
	269	Business Continuity	Activity Targets: There is a risk that the Trust may fail to deliver activity targets				12	The rectification plan is in place and is being managed through twice weekly activity "Huddles" to match activity to the planned volumes and identifying gaps/actions. The weekly theatre list review meeting is also working to ensure high levels of utilisation backed up by the appointment of a theatre utilisation lead to support the theatre manager in ensuring productivity. The work being received from external organisations remains a point of significant concern. Walsall Healthcare had previously committed to 40-50 table operations per month across the financial year lists however we have only received activity leading to 15-20 operations per month with a view that this will decrease further in coming months. Whilst there are ongoing conversations with other providers (Coventry & Heart of England) these are at an early stage and may not provide a direct replacement for the planned Walsall activity				16		Following discussion with the board a final rectification plan has been agreed between operations & finance. In close discussion with the clinicians several schemes have been agreed to deliver. These include: Additional bookings for large joints within their in week theatre lists ;Sunday operating for large joints; Additional Saturday lists where possible; Productivity payment scheme for weekend working ; Additional activity for Spinal degenerative cases at Oxford Ramsay; Cromwell activity for Spinal Deformity; In addition to the above there continues to be a focus on utilization Mon-Fri with the weekly activity huddles and the 6-4-2 theatre planning meeting.				4
Ops	666	Business Continuity	There is a risk that the 18 week monitoring of patient cannot happen so effectively if information is not up to date				12	Formation of a Data Quality Group underway comprising a Stakeholder panel to review & escalate data issues and a technical panel charged with the rectification of data quality issues				12		With the new CSM team working with the clinicians on their waiting lists further requirements to ensure the data is relevant and usable have been identified and will be developed along with the fixes to the existing data that is required. With 18/52 performance deteriorating within the Incomplete measure the accuracy of the data remains a concern.				4

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
Ops	669	Business Continuity	Assurance that point of care testing (POCT) equipment is fit for purpose and compliant with regulations.				16	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				12		ADCU are reassessing the need for POCT. ROCS are nearly ready to start validation procedure against laboratory standard through the pre-operative assessment service but it is considered that a patient information leaflet needs to be available. Patient information leaflet has been prepared and will go to POCT team before the patient and carers forum. Once this has happened it is proposed that the leaflet is sent to the medical director for final approval before validation commences.				4
Ops	770	Business Continuity	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure,				15	Continue with annual rolling theatre maintenance programme. Introduction of temporary theatre would be limited to single replacement theatre due to limited on-site space available, and is dependent on demolition of decommissioned ward block in 2015				12		Requires review of Trust wide Estates Strategy at EMT, and previous investment decision into proposed new Theatre block				4
Csec/DNG	800	staff engagement	Governance structure and processes are poorly understood with a result that they become a barrier rather than a tool for delivery				9	Ensure structure and processes are designed to provide assurance and are easily understood by all groups. Launch and regular reinforcement of the developed structure and processes to raise awareness and develop practical understanding and application by all participants. Be considerate of neither over simplifying or overly complicating the developments whilst being mindful of the need for robust assurance. Work with teams to ensure they understand the role of governance, have work plans that are aligned to reporting dates to overseeing Committees (e.g. CGC) and ensure that those designated as Chairs understand their role , the link to patient benefit and can commit to fulfilling the role	Structure chart; TOR; Awareness, understanding application of organizational structure and processes at sub Board level; effectiveness of the new structure; Quality Governance Framework sections 3 & 4 improvements to scoring.			9						4

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
ops	832	staff engagement	The Trust is unable to respond rapidly enough to changes in market demand, new offers from competitors or more compelling brands thus losing competitive position				6	Membership of unit of planning meetings; Membership of SOA; Membership of academic health science network; Membership of regional chief operating officers group	Transformation Committee meetings and regular reports to board; Quarterly Commissioner review meetings; Activity Review Group; Business Planning Group			3						1
WFOD	582	staff engagement	Risk of non-delivery of strategic objectives associated with leaders' ability to lead change, including cultural change.				16	Kings Fund reported to Board on 3rd June and due to go to medical workforce at end of June. This has now happened although a presentation was received not the full report Next steps to be taken include design of medical leadership roles, functional responsibilities and leadership strategy				12		Areas for action have been identified and will be discussed with a small group of consultants later in September. The leadership strategy is also in development and the aim will be to take to the Board in November				4
WFOD	797	organizational leadership	The Board and organization is unable to achieve the necessary culture change quickly enough to embed an improvement and learning culture to deliver better quality of care for less money				12	Action on-going to improve engagement – improved communication, embedding values, management of sub-optimal performance, staff involvement in improvement activity and increased learning opportunities for whole workforce; New Beginnings events. Engagement scores reviewed by Board quarterly (FFT) and annually (survey) Work with Kings Fund on medical leadership	Staff Survey results; FFT for staff; Incident numbers;% staff participation in improvement activity; Improvements in high priority patient areas – outpatients + ADCU			12						2
WFOD	798	organizational leadership	The Board and organization does not have adequate capacity or capability to change or does not organize its resources to change effectively				15	Investment in transformation capacity; recruitment of Transformation team and other senior managers to lead change in operational areas complete and due to start in post in Q2; existing work on staff communication and engagement via New Beginnings sessions. Work with the Kings Fund on medical leadership; restructure of the operational directorates and some corporate services effective from September 2015	Recruitment decisions; New Beginnings outputs; medical staff engagement event on 29th June 2015; plans for corporate departments.			12						6

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
Strat	799	organizational leadership	The Board is unable to create the common beliefs , sense of purpose and ambition across the organisation among clinicians and other staff to deliver the strategy and avoid the diversion of energy into individual agendas				12	Transformation Committee; Clear work programmes, with Executive leads and a clear reporting structure; Establishment of the RoH Improvement Hub; Evidence of clinical engagement across the Trust; Clear evidence of changing practice and processes, across the Trust	Transformation Committee meetings and regular reports to Trust Board; Staff satisfaction; Patient satisfaction; Clinical engagement			12						6
FIN	270	Long-term viability	Tariff: national tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist				10	The Trust is working with NHS England to ensure contractual baseline is adequate to deliver required level of care to our specialised patients. As part of the Strategic Orthopaedic Alliance, work with Monitor on the long term plans for the funding of specialist orthopaedic care.	Completion of reference costs and development of PLICS to ensure specialist costs are understood at a national level. Director of Finance sits on national PbR techinical working group to influence tariff development			15		Monitor have recently published their response to the consultation on the changes to the tariff objection methodology. The revised methodology has gone unchanged despite significant objection by providers, and as a result going forwards even if every relevant NHS trust and foundation trust, who make up 62% of relevant providers, objected to the proposals, this would not trigger the mechanism to stop the tariff (66% threshold is required). This is obviously very concerning				5
CEO	802	Long-term viability	The Trust is too small to be viable in the longer term				12		Viable business plan. Key milestones met – growth, expenditure, CIPs, transformation initiatives. Evidence of alignment with commissioner intentions.			12		Continue to develop the growth strategy and seek multiple opportunities. Ensure robust CIP plans are in place to keep costs within the tariff. Delivery of transformation programme to ensure the most efficient use of resources in meeting the needs of patients. Form strategic alliances to support either cost control and/ or growth strategy. Controls will require further development and will be strengthened through improved governance and by appointment to the new organizational structure to bring new skills into the Trust.				6

Executive Lead	Risk Ref	Annual Priority	Risk Statement	Primary Assurance Committee	Initial risk score			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled residual risk score			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Tolerable risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
Fin	803		Risk to financial viability through the inability to manage internal costs, deliver key programmes or respond to tariff deductions				20	Formal programme structure for transformation Detailed financial plan agreed and monitored Involvement in national policy direction (i.e. PbR, Specialist services) Check and challenge of financial performance at all levels of the Trust	CPR; Monthly Performance Reviews; Transformation Board Reports; Audit Committee – Review of contract risk; CIP Board reports			20		September 2015 – The Trust continues to overspend, with the deficit standing at £2.15m against a plan of £1m at the end of Month 5. Monthly finance and activity performance meetings have been introduced to endure that the new divisional management teams are sufficiently focussed on the financial risk. Recovery plans will be developed for each of the key areas of overspend, with greater transparency sought around future financial projections. An action plan has been developed to ensure a reduction in the reliance on agency nursing in line with new Monitor guidelines				8
MD	805	Long-term viability	The Trust is unable to maintain its reputation for excellent work (or has an unwarranted view of its own reputation) with the result that referred work declines				12	Continue to engage constructively with commissioners. Clear and accurate reporting collaboration with stakeholders	Patient Quality Report. PROMS, Registries. Quality Meeting. Patient Harm Reviews. FFT feedback. Staffing skills. Complaints & PALS review			12						8
MD	806	Long-term viability	The Trust is unable to anticipate or respond to disruptive technology which creates a paradigm shift putting the ROH out of business				8	Transformation Committee; R+D and Innovation	Transformation Committee meetings ; Quality meeting			8						4

KEY

strategic risk

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	24 November 2015
Guests	Audit teams from Baker-Tilly (Internal Audit) and Deloitte (External Audit) were in attendance at the meeting. Presentations were received from the following executives: Garry Marsh (Director of Nursing and Governance) and Steve Harnett (Head of Estates).
Presentations received	Board Assurance – Baker-Tilly
Major agenda items discussed	• External Audit progress report • Internal Audit progress report • Changes to the Internal Audit plan • Counterfraud update • Recommendation tracker update • Losses and compensation register • Review of accounting policies • Annual report structure and content • Annual reporting and accounting timetables • Contract risk review • Audit Committee terms of reference • Board Assurance Framework • Assurance report from CGC
Matters presented for information or noting	• Nothing additional
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The external audit progress report identified a number of risks that would impact their year-end audit planning, including that relating to the financial sustainability of the Trust given the deterioration of the financial position & the challenges with delivering the CIP requirement. Other risks identified related to recognition of NHS revenue in relation to the PbR regime; slippage of the capital spend programme & the judgemental valuation of the Trust's property assets; and the inherent risk that management may be able to override controls to prevent inaccurate or fraudulent financial reports. Audit work wold be planned around these. • The impact of the changes to the Risk Assessment Framework and the tightened control of agency spend were noted to be significant challenges to the Trust in terms of scrutiny

	• The Committee received updates from the Director of Nursing & Clinical Governance and the Head of Facilities in respect of the unsatisfactory assurance provided by a number of internal audit reviews. Progress with the recommendations raised was reported to be good and the Committee was able to gain some positive assurance that adequate controls were in place around equipment training and local income collection in particular. Some follow up work around identified weaknesses relating to patient consent issues was agreed and was remitted to the Clinical Governance Committee for monitoring. • Some changes to the internal audit programme (including work identified to potentially take place early in 2016/17) were considered and, subject to an assurance from Internal Audit that the revised plan would be sufficient to support their Annual Opinion, were approved. • A report relating to contract risk was presented. It was noted that the Trust was underperforming against contract income plans by c. 4%. The Trust has developed a rectification plan to address the most significant issue that will as a minimum deliver the activity and commensurate income to meet the contracted levels by the end of the financial year. The detail of contract performance notices received by the Trust was discussed.
Positive assurances and highlights of note for the Board	• The notes from the Audit Committee workshop were noted to contain some useful suggestions for improving the effectiveness of the Committee and to the Board Assurance Framework • It was reported that good progress had been made with the delivery of the internal audit plan, which since the last meeting and audits around some core financial systems and electronic staff records systems had taken place. Internal Audit team provided assurance that the remaining agreed plan would be delivered by the end of the year. • The improvements to the Trust's overall governance arrangements, such that reporting between Committees and upwards from clinical governance committees, was now more effective were noted to be pleasing • There was noted to have been good progress with the counterfraud workplan, including participation in Fraud Awareness Month in November • Positive and improved progress had been made with delivery of actions arising from more recent internal audit report recommendations, with few now being overdue or in progress • The Committee was advised that the number of losses and compensation payments made since the last meeting was low, including only one salary overpayment which was

	being recovered • The work to prepare for the revisions to the Annual Reporting Manual was reported to be underway and the timetable for the preparation of the annual report & accounts was discussed. No issues were raised. • Good work was reported to be underway to reformat the Board Assurance Framework to make it simpler and in line with other best practice examples
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Progress with implementing the actions arising from the Board workshop would be presented at the next meeting • It was agreed that in response to the risks outlined by external audit (and already identified by the Board), the annual paper to support the 'Going Concern' status of the Trust needed to be presented and considered at the next meeting. It is likely that the Chair and CEO would be required to attend for this discussion. • The Committee remitted discussion of patient consent, particularly the actions to reduce consent on the day of surgery, to the Clinical Governance Committee. It was also suggested that Clinical Governance Committee should maintain a 'watching brief' over the assurances relating to Controlled Drugs. • The ongoing risk relating to stock control in theatres was identified. This will remain a risk until the new system is established. • Further update on the development of the Board Assurance Framework is to be presented at the next meeting • The suggested amendments to the Committee's terms of reference (identified mainly during the workshop) are to be presented and considered by the Committee at its February meeting
Decisions made	• None specifically

Rod Anthony
NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Trust Board scheduled for 2 December 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CLINICAL QUALITY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	13 November 2015
Guests	Kevin Dunn, Head of Knowledge Management Anne-Marie Williams, Divisional General Manager (Division 1)
Presentations received and discussed	Clinical Audit & Outcomes
Major agenda items discussed	• Report back from the Quality Committee • Quality & Patient Safety report • Duty of Candour process • Never Events Assurance report • Inpatient survey action plan • CGC risk register • Policy governance update & improvement plan • Update on the operation of the new divisional structure • CGC terms of reference
Matters presented for information or noting	• Corporate performance report • Patient story for the Board
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• As part of the report back from the Quality Committee, the Committee was made aware of non-compliance with national guidance to take two 'group and save' samples prior to blood transfusion; mitigations are being developed to address this. • There is potential non-conformity with the duties and responsibilities over the management of blood fridges, although this was being managed operationally via the Blood Transfusion Group. • 11 Serious Incidents had been reported in month. The high number of VTE incidents was noted; the CCG are to undertake a themes review and there is further work to do internally to understand the reasons for this. A Grade 3 pressure ulcer was reported to have occurred on Ward 1; much work is underway to educate and prevent further occurrences. • A contract performance notice has been received in respect of central venous catheter observations • It was noted that there are currently a high level of cancelled operations on the day of surgery, a number of which are the fault of the Trust • Delivery of the Never Events assurance plan was reported

	to be behind schedule at present and did not provide the Committee with the assurances it needed; further work will be done to improve the position in readiness for the next meeting • The CGC risk register was discussed; new risks around medical devices servicing and training were discussed, although the mitigations were noted to be robust and good progress was being made to address the position • The Committee received an update on the development of the new divisional structure. There was some concern that there was some delay in fully embedding the new structure and some key roles were yet to be appointed into; a means of measuring the benefits of the structure is to be agreed
Positive assurances and highlights of note for the Board	• The process for shadowing patients (one of the CQUINs) was reported to be in place and was working well • Good progress is being made to develop the infrastructure to deliver clinical audit and some helpful local connections have been made to share best practice; a clinical lead has been appointed for clinical audit • Work is underway to develop a process for assessing and embedding new NICE guidance into the organisation; a link with the work planned by internal audit to assess this process is planned • The new process for handling Duty of Candour incidents was presented and would be embedded into the organisation to ensure compliance with CQC Regulation 20 • Good progress is being made to deliver the actions arising to address the areas of concern raised in the national inpatient survey • The Committee received a plan designed to deliver an improvement in policy governance; a new Policy on the Development, Approval and Management of Policies is being developed
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Creation of means by which any clinically-related decisions or feedback are cascaded to relevant staff in the organisation • Arrange for litigation information to be presented to the Trust Board • Include reasons for cancelled operations to be included in future versions of the Quality & Patient Safety report • Organise for a paper on the divisional structure to be presented at the next meeting
Decisions made	• The Committee agreed with some suggested amendments to its terms of reference, including to change its name to 'Quality & Safety Committee', a reduction in the NED membership and the decision to remove policy approval from the list of the Committee's authorities

Kathryn Sallah
NON EXECUTIVE DIRECTOR AND CHAIR OF THE CLINICAL QUALITY COMMITTEE

For the meeting of the Trust Board scheduled for 2 December 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Proposed revisions to the terms of reference of the Clinical Governance Committee**
SPONSOR:	**Kathryn Sallah, Chair of the CGC & Non Executive Director**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**2 December 2015**

EXECUTIVE SUMMARY:

The attached presents a suggested revision to the terms of reference of the Clinical Governance Committee.

In summary, the changes proposed are:

- A change in name from 'Clinical Governance Committee' to 'Quality & Safety Committee'
- Removal of the authority of the Committee to approve policies (so that all policies are routed through Trust Management Committee) as per the agreement at the CGC meeting in July
- Adjustment to the NED membership to reflect that from the new calendar year, NED membership is to be reduced to three (the quorum requires that two out of three NEDs be present)
- The addition of a member of the Council of Governors to the list of those invited to attend – this will be in a non-participative, observatory capacity

Should the changes be accepted, the Scheme of Delegation and Trust Constitution will also need to be amended, the changes to which will be proposed to the Trust Board and Council of Governors subsequently.

REPORT RECOMMENDATION:

Trust Board is asked to consider and approve the proposed revisions to the terms of reference.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:

The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy	X	Patient Experience	
Clinical	X	Equality and Diversity		Workforce	

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

None specifically

PREVIOUS CONSIDERATION:
Clinical Governance Committee on 13 November 2015, where the changes were supported.

~~ROHCG (11/15) 015 (a)~~

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
~~Clinical Governance~~Quality & Safety Committee
Terms of reference
Revised December~~July~~ 2015

1 Constitution

The Constitution of the Trust provides that the committees and sub-committees established by the Board of Directors are:

(i) Remuneration Committee;
(ii) Nominations Committee;
(iiii) ~~Clinical Governance~~Quality & Safety Committee; and
(iv) Audit Committee

The Constitution states that "~~Clinical Governance~~Quality & Safety 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.

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; this includes the authority to approve any Trust policy (including any revision to a Trust Policy) relating to a clinical matter except for policies which the Chief Executive considered, acting on appropriate clinical advice, needed to be approved more quickly than the Clinical Governance Committee could accommodate~~

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 establish Advisory Groups including forums. The Committee shall determine the membership and terms of reference of those Advisory Groups including forums.

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, clinical policies 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 The committee will oversee, by appropriate monitoring of actions taken by responsible officers the provision of evidence of trust performance in line with contractual requirements commissioners.

6.2 **Leadership for quality**
6.2.1 Provide oversight to maintain a focus on quality by the Trust's leadership provide assurance to the Board regarding the adequacy of 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

~~6.2.3 The committee will review and approve the Trusts' clinical policies subject to the exclusion explained in paragraph 2.1.2~~

Formatted: Font: +Body (Calibri), Font color: Red, Strikethrough

6.3 **Regulatory Assurance** – Monitor and CQC (review of guidance, CQC outcome assurance report, quarterly governance declaration)
6.3.1 The committee will oversee, by appropriate monitoring of actions taken by responsible officers, 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~~Quality & Safety 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 groups
6.8 The committee will consider feedback from the Trust's patient groups and from peer reviews.
6.9 The committee will receive reports on cases which are dealt with by the NHSLA or any successor body and will seek to monitor lessons learnt.

7 Permanency

The Committee is permanent

8 Membership

The Committee membership will comprise no fewer than three Non Executive Directors and the Chair of the Committee will be a non Executive holding a clinical background.
The Vice Chair of the Committee will be a Non Executive with a clinical background and will take on the Chair's duties in their capacity as chairman of the Quality & Safety Committee if the Chair is absent for any reason.

Formatted: Font: Bold

~~A non-executive Director with a clinical background.~~

~~**Vice Chair**~~
~~A non-executive Director with a clinical background.~~
~~The Vice Chair will take on the Chair's duties in their capacity as chairman of the~~

~~Clinical Governance Committee if the Chair is absent for any reason.~~

~~**Other members**~~ **Executive members**
~~All other NEDs~~
Medical Director
Chief Executive
Director of Nursing and Clinical Governance
Director of Operations

9 Quorum

At least 2 NEDs and one from Medical Director or Director of Nursing and Clinical Governance

10 Secretariat
Associate Director of Governance & Company Secretary

11 In attendance, by invitation

Deputy Director of Nursing & Clinical Governance
Others relevant to the agenda of the meeting such as chairs of advisory groups and Clinical Directors and successor roles
A representative from the Council of Governors may attend in a non-participative, observatory capacity

12 Internal Executive Lead
Director of Nursing and Clinical 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 **1 January ~~July 1st~~ 2016~~5~~**
Date of review **January~~uly~~ 2017~~6~~**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRANSFORMATION COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	17 November 2015
Guests	None
Presentations received	None
Major agenda items discussed	• Highlight report including new KPIs • Workstreams 1 – 7 updates
Matters presented for information or noting	• Nothing additional
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The meeting was not quorate as there were insufficient numbers of Executive Directors present; the terms of reference for the Committee are to be refined to ensure that the quorum is more appropriate • The status of the overall workplan was reported to be 'amber', which reflected that some workstreams were behind plan • In Workstream 3, it was reported that there was a risk of delay with the seven day reporting work; the clinical standards project was reported to be being rescoped • A more comprehensive update on Workstream 5 was requested for the next meeting
Positive assurances and highlights of note for the Board	• Pleasing progress was noted across most workstreams overall. • Discussions had been held at a workshop earlier in the month to assess and prioritise the delivery of the IT projects within Workstream 6 • Good links have been made with the Royal National Orthopaedic Hospital NHS Trust transformation team, to share best practice and understand different ways of working • The concept of a 'Perfect Day' is being developed, which draws on a set of tools to ensure that productivity is as high as it can be; the Trust is being supported by Monitor on this • Workstream 1: good progress is being made to separate clinical and corporate governance responsibilities; Physician Associates are on track to join the organisation in early 2016 • Workstream 2: 'In Touch' had been procured and would be implemented as planned; the use of an electronic

	whiteboard to assist with bed management is being investigated. The benefits of the approach are being discussed with Sandwell & West Birmingham Hospitals NHS Trust where these are in place • Workstream 3: Preparation for phase 2 of digital dictation is underway • Workstream 4: The positive progress with a number of projects within this workstream were noted, including the continued development of the relationship with the press and media and the creation of a new patient handbook • Workstream 6: e-procurement is to be the subject of a workshop in future • Workstream 7: The research and academic strategies were reported to be under development. The plans for the launch of the Knowledge Hub are to be finalised in January 2016. Progress with the implementation of Amplitude is good.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Further development of the relationship with RNOH NHS Trust for collaboration and benchmarking purposes • Consideration of the introduction of Transformation Champions and an associated recognition scheme • Refinement of the inpatient handbook • Amendment of the terms of reference and presentation to the Trust Board
Decisions made	• None, as the meeting was not quorate.

Tim Pile
VICE CHAIR AND CHAIR OF THE TRANSFORMATION COMMITTEE

For the meeting of the Trust Board scheduled for 2 December 2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Proposed revisions to the terms of reference of the Transformation Committee**
SPONSOR:	**Tim Pile, Chair of the Transformation Committee & Vice Chair**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**2 December 2015**

EXECUTIVE SUMMARY:

The attached presents a suggested revision to the terms of reference of the Transformation Committee.

In summary, the changes proposed are:

- Adjustment to the membership to reflect that from the new calendar year, NED membership is to be reduced to no fewer than two, with the remainder of the membership being the Executive workstream leads
- The quorum requires that three member be present, one of which is to be a Non Executive Director and another to be an Executive Director
- On the basis that the Transformation Programme is to be ongoing, the Committee is confirmed to be permanent

REPORT RECOMMENDATION:

Trust Board is asked to consider and approve the proposed revisions to the terms of reference.

ACTION REQUIRED *(Indicate with 'x' the purpose that applies)*:
The receiving body is asked to receive, consider and:

Note and accept	Approve the recommendation	Discuss
	X	

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy	**X**	Patient Experience	
Clinical	**X**	Equality and Diversity		Workforce	

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

None specifically

PREVIOUS CONSIDERATION:

Transformation Committee on 17 November 2015, where the changes were discussed.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Transformation Committee
Terms of Reference
~~July~~December 2015

1 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 Trust's 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 who shall be agreed by the Trust Chairman.

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 and other groups 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

6.11 To oversee the work of the Innovation review panel (IRP) and to provide assurance to the Board regarding its operation and decisions in accordance with the Trust's Intellectual Property Policy and any other relevant decisions of the Trust Board

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

No fewer than two Non Executive Directors, one of which shall be the Chair
~~**Chair**~~

16 Date of review

~~July 2016~~December 2016