The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 3 February 2016

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 3 February 2016 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.

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** 3 February 2016: 1100h – 1300h

Members attending

Dame Yve Buckland	Chairman	(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	Director of Operations	(JL)
Mr Paul Athey	Finance Director	(PA)
Mr Andrew Pearson	Medical Director	(AP)
Mr Garry Marsh	Director of Nursing & Clinical Governance	(GM)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(AC)	
Prof Phil Begg	Director of Strategy and Transformation	(PB)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]
Ms Alicia Cartwright	Senior Physiotherapist	(AC)	

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies	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: *ROCs service*	ROHTB (2/16) 002 ROHTB (2/16) 002 (a)	SP
1115h	4	Minutes of Public Board Meeting held on the 2 December 2015 *for approval*	ROHTB (12/15) 001	Chair
1120h	5	Trust Board action points: *for assurance*	ROHTB (12/15) 001 (a)	Chair
	5.1	Paperless Board update	Verbal	SGL
1125h	6	Chief Executive's update: *for information and assurance*	ROHTB (2/16) 003 ROHTB (2/16) 003 (a)	JC
1135h	7	Strategic and environmental context report: *for information*	ROHTB (2/16) 015 ROHTB (2/16) 015 (a)	JC

MATTERS FOR APPROVAL				
1145h	8	Establishing a new Board Committee – Finance & Performance Assurance Committee	ROHTB (2/16) 004 ROHTB (2/16) 004 (a)	SGL
1150h	9	Policy for the Development, Approval and Management of Trustwide Policies	ROHTB (2/16) 005 ROHTB (2/16) 005 (a) ROHTB (2/16) 005 (b)	SGL
1155h	10	Major Incident – statement of readiness	ROHTB (2/16) 006 ROHTB (2/16) 006 (a)	JL
CORPORATE PERFORMANCE & ASSURANCE				
1200h	11	Activity rectification plan: *for assurance*	ROHTB (2/16) 012 ROHTB (2/16) 012 (a)	JL
1215h	12	Care Quality Commission – improvement plan: *for assurance*	ROHTB (2/16) 007 ROHTB (2/16) 007 (a)	GM
1225h	13	Corporate Performance Report: *for assurance*	ROHTB (2/16) 008 ROHTB (2/16) 008 (a)	PA/JL/ GM
1235h	14	Safe Staffing Report: *for assurance*	ROHTB (2/16) 009 ROHTB (2/16) 009 (a)	GM
1240h	15	Board Assurance Framework – Quarter 3 update: *for assurance*	ROHTB (2/16) 010 ROHTB (2/16) 010 (a)	SGL
1245h	16	Monitor declaration – Quarter 3: *for information*	ROHTB (2/16) 011 ROHTB (2/16) 011 (a)	JC
ASSURANCE UPDATES FROM THE BOARD COMMITTEES				
1250h	17	Transformation Committee	ROHTB (2/16) 013	TP
	18	Quality & Safety Committee to include update on pressure ulcers	ROHTB (2/16) 014	KS
	19	Council of Governors	Verbal	YB
1255h	20	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 2nd March 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.

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The Royal Orthopaedic Hospital NHS
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TRUST BOARD

DOCUMENT TITLE:	**Patient Story**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Executive Director of Nursing and Governance**
AUTHOR:	**Patient**
DATE OF MEETING:	**3 February 2016**

EXECUTIVE SUMMARY:

Patient Stories are brief descriptions of what people, particularly patients, say about our services.

REPORT RECOMMENDATION:

Trust Board is asked to receive and note this story and the actions taken to address the issues raised by the patient.

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:

Quality & Safety Committee on 27 January 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Patient Stories are brief descriptions of what people, particularly patients, say about our services.

Service

Large Joints

Patient Story title

Discharge from Hospital

Name of Presenter

Shelly Price - ROCS Manager

Background

Mr X attended ROH for a total hip replacement on 4 August 2015, from which he made a slow and complicated recovery. Immediately prior to his discharge he required support from the Critical Care Outreach team and was receiving help with mobilisation from physiotherapists. It was during one of these consultations that he was noted to have 'foot drop' which limited his mobility. Nonetheless, he made good progress and was considered fit for discharge on 22 August 2015.

Unfortunately when Mr X was discharged from hospital, a request for follow up from the ROCs team was not actioned and therefore MR X was left at home without support for a number of days. During this time his condition deteriorated, he was unable to effectively mobilise and was confined to an upstairs bedroom because he needed ready access to a bathroom. He was becoming increasingly distressed and was very worried about how he would manage in the future.

His daughter contacted the ROCs team at the end of August 2015 in order to seek help and advice. Following this contact a ROCs visit was arranged for 31 August 2015

What happened next?

A visit from ROCs team took place on 31.August 2016. The physiotherapist who visited found Mr X to be able to only mobilise a few feet with his crutches. His foot drop was pronounced and he presented with only a limited range of movement in his right foot and ankle. It was noted that his lower limbs were weak and that he has lost muscle density from his left leg.

The physiotherapist commenced MR X on a series of movement and strengthening exercises and introduced a programme of gait re-education which included stair practice. These interventions are designed to improve mobility and enable Mr X to be able to become functional in his home environment.

Over the next few weeks and months MR X made steady progress and is now able to use the stairs independently and mobilise with one crutch. He has been referred for further physio assessment and for ongoing monitoring of his mobility.

What was good about the care received

Mr X is delighted with the aftercare received from ROCs. He also felt that his care as an in-patient was very good and that he received effective support from nursing and therapy staff.

Appropriate referral to other agencies has been made and Mr X is receiving the rehabilitation support required to enable him to improve his mobility.

What could have been done better?

Mr X feels that his discharge planning was poor. He feels that the nursing team 'rushed' him out of the building and did not pay enough attention to his needs. This saddens Mr X as up to that point he had felt very well cared for.

He considers that ROCs involvement should have been available to him immediately following discharge and he is angry that it was only made available once his daughter contacted the team.

Investigation of his concern confirms that discharge planning was poor. There is clear documentation within the patient record that he should be referred to RoCs on discharge and this did not take place.

What will we do to avoid a repeat of this event?

Mr X's story has been shared with all staff on Ward 12 so that the impact of the failure to refer to appropriate services is fully appreciated.

The story will be shared with all senior nurses as part of the ward sister/ charge nurse meeting and from there with all ward teams.

Much work is being completed at ROH to review the discharge pathway at the Trust and to ensure that an effective discharge plan is in place. This story will be shared with the team leading that work so that appropriate consideration is given to assessment of discharge planning as part of this project.

The RoCs team will undertake a review of the way they ensure that all patients who require their input are appropriately referred to them. It is expected that this review is complete by end March 2016.

Story provided by Alicia Cartwright, Senior Physiotherapist
06.10.2015

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 2 December 2015: 1100h – 1300h

Members present

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair	(TP)
HH Frances Kirkham	Non Executive Director	(FK)
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 Garry Marsh	Director of Nursing	(GM)

In attendance

Prof Phil Begg	Director of Strategy & Transformation	(PB)	
Ms Anne Cholmondeley	Director of Workforce & OD	(ACh)	
Mrs Jane Colley	PA to the Chairman and Company Secretary	(JCo)	[Secretariat]

	Paper Reference
1 Apologies	**Verbal**
Apologies were received from Andrew Pearson and Simon Grainger-Lloyd. The Chairman introduced Debby de Haes who was observing the Public Board. Following this year's NED appraisals she had been commissioned to explore the strengths and weaknesses of the Board and, in particular, how to get the best out of Board members to enable them to work more effectively as a unitary board. Debby de Haes would be talking with a subset of members ahead of the Board development session on 13 January.	
2 Declarations of Interest	**Verbal**
No Declarations of Interest had been received since the last meeting and no	

declarations had been made in connection with any item.	
3 Patient Case – an illustration of the work we do	**Verbal**
The Chairman had received a memo from a patient she had met during her stay at the ROH. Overall, this patient was delighted with the experience but had been asked by the Chairman to identify possible areas for improvement. This patient who had a hip replacement was cared for on Ward One and, in particular, had praised the cleanliness, kindness of the staff, good quality of vegetarian food and the ROCS service. The Director of Nursing went through the areas of concern and identified action that had been taken: a) The patient had observed apparent staffing issues on Ward 1, although there was not a shortage of nurses providing care on the ward. Certain behaviours had previously been considered at CGC (Clinical Governance Committee) and a Quality meeting was due to be held with the Ward Manager to address a number of issues on that ward, including pressure ulcers. b) Nil by Mouth. A number of conversations had been held at CGC about the time patients waited nil by mouth and agreement had been reached to reduce this. The Chairman of CGC expressed grave disappointment that agreed actions had still to be implemented and seemingly water was still not being made available to patients. c) The Privacy and Dignity Committee had looked at cleaning teeth in the evening and female patients being offered a bedpan by a male nurse. All staff should fully explore all other means of toileting before offering a bed pan. The bed pan in the toilet had been raised at the Ward meeting. d) Lack of a coeliac food option would be considered at the Nutrition Committee. This was disappointing as the ROH very much tailored its nutrition to its patients. Work was underway to look at protected mealtime policies as nursing oversight of breakfast was required. e) Efficiency improvements were being made to address discharge delays. These included implementation of planned discharge date; ensuring drugs to take home were no longer prescribed on the day of discharge and timely use of the discharge lounge. It was anticipated E prescribing should deliver significant improvements. Individual Ward Managers needed to take clear ownership of what occurred on their ward and separate Ward Manager meetings had now been established to share improvements and encourage cross learning. The Chairman of the CGC felt there needed to be zero tolerance of the very basic poor behaviours that had been identified.	

The Chairman would feedback to the patient the learning that had arisen from her case.	
ACTION: **The Chairman to feedback to the patient the learning that had arisen from her case.**	
4 Minutes of the Public Board – 4 November 2015	**ROHTB (11/15) 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 (11/15) 001(a)**
As Corporate Manslaughter training had to be completed by the executive team as part of emergency care requirements it had been felt this should be offered to the wider Board. The NEDs were also required to undertake safeguarding training.	
6 Chief Executive's update	**ROHTB (12/15) 002** **ROHTB (12/15) 002(a)**
The Chief Executive would circulate a presentation on the Comprehensive Spending Review to members of the Board. The recent Downing Street reception had confirmed vanguard members as the architects of change in delivering healthcare. The Chief Executive would circulate a presentation on the National Orthopaedic Alliance. The Trust's work on vanguards linked in with the Monitor Optimum model of elective care and potentially the Trust might be able to act as the lead vanguard partner in this area. Vanguards should be included on the February Trust Board agenda. A memorandum of understanding had been agreed with Aston University to work in partnership in research and teaching as that University built up its new medical school. This was a commitment to collaborate and it was recognised this was the right time to cement this relationship. The Chief Executive and Chairman had also met with senior representatives from Birmingham University to encourage greater collaboration between the Trust and University and to confirm that the Trust was keen to support the development of Birmingham Health Partners. The Chairman was delighted to report that the previous week 5 consultants had been recruited, 3 in oncology and 2 anaesthetists.	
ACTION: **The Chief Executive would circulate the Comprehensive Spending review presentation to Board members together the presentation**	

on the National Orthopaedic Alliance. **SGL to include Vanguards on the Agenda for the February Trust Board meeting.**	
7 Therapy Services	**Verbal**
NM, Head of Therapies and members of her team provided an overview of Therapy services, including key offerings, risks and future developments. The team highlighted numerous areas of good practice together commercial opportunities which could make the hospital more efficient: a) The team was keen to introduce Physio follow ups on the ward for all patients to help identify early signs of wound problems etc. Ideally the team would like to see all patients 2-3 weeks post operatively. NM hoped to put forward a business plan to determine what could be funded; b) There were space issues and, although a Saturday clinic could be held in OP, the OP staff were already providing support to the Inpatient weekend service; c) There were already a large number of self-referrals to the physio service. This needed to be promoted in the public domain and the model explored with commissioners; d) At present Physios did not work with Chiropractors/Osteopaths; e) The Paediatric Physio service had good links with both the Children's Hospital and the community; f) The therapy service could be used to help move patients more rapidly through the hospital, for example pre-operative preparation and working more smartly with patients before admission; g) There were social care package issues and on average patient discharge was being delayed by about one to two days with Birmingham patients assessed more rapidly than those out of area. It could take up to one to two weeks for some packages to be arranged; h) To ensure provision of a respiratory service on HDU therapists needed to maintain competence. This was a challenge and training was in place for Physios on the on call rota. Staff who came from district general hospitals had far superior competency. Gaps were being identified and training was being provided; i) There was optimism that the new GPs who had joined the muscoskeletal service would use their network to improve GP communication and educate the community. There was a demand issue and waits were about 8 weeks; j) The service recognised the need to promote its successful functional restoration programme which helped GPs recognise that 90% of the time patients did not need surgery. k) The use of Community clinics needed to be explored;	

l) The functional restoration programme provided a huge opportunity to change the patient's mindset, improve their wellbeing by becoming, not only an expert in their own care, but also an expert patient able to help other patients;
m) More could be done to work with colleagues in primary care to educate and develop the service's relationship with GPs;
n) The commissioners were reforming their locality groups. The Trust needed to provide confidence to the commissioners of the financial benefits. For example patients on the functional restoration programme coming off long term medication delivered not only financial savings, but the healthy patient returned back to work. Patients developed new strategies to manage their symptoms and should go less to their GP practice.
o) Orthotics for Podiatry was being provided by Blatchfords and the Trust was able to recharge the CCG for appliances. Spinal brace scanning was now being done which helped reduce waiting times;
p) A shock wave podiatry service was now being delivered. At present this was commissioned for heel pain only. The ROH was the only NHS trust in the Midlands providing this service the results of which were fabulous;
q) The pain management service received very positive feedback. The main clinician was due to retire and this could provide a real opportunity to totally review the service. This would be a major and challenging review but potentially could be very profitable;
r) The service was involved in a large amount of research;
s) There was growing demand from POAC and it was difficult recruiting rotational physios, but there were plans to develop Band 5 training posts;
t) The service suffered from lack of space and as part of service expansion needed to look at purpose build facilities, for example a centre for musco-skeletal service. The service was encouraged to make use of Charitable Funds for such schemes.

The Trust was working with and maintaining an interest in the Bournville Village Trust project. However the Trust need to gain sufficient support from the commissioners for such growth and clarity would be required before the Trust could commit to a lease. The Board supported this approach. With the project two years from completion, NM confirmed the service was exploring other lower risk options for running clinics. The Chief Executive agreed that taking rooms in GP practices would provide more services in the Birmingham area and could be a good, lower risk, model in the short-term pending commissioner support for the BVT development.

The Chairman believed Therapy Services was providing models which could be put on a more commercial footing as some of the population would be prepared to pay

rather than wait and were currently going elsewhere. The team were thanked for the comprehensive overview of their services. This was an area the Trust was keen to see developed given the opportunities for service development and revenue generation.	
8 Update on the delivery of the Communications & Engagement Strategy	
SXB, Head of Communications, provided an update on the delivery of the Communications and Engagement strategy: a) The 75th anniversary film of the ROH bombing, which also celebrated nursing today, received wide media coverage and reached many thousands; b) SXB was leading on communications for the Vanguard National Orthopaedic Alliance; c) The team had supported the national staff survey with the ROH achieving 52% participation, compared to 37% nationally; d) The launch of the new website was eagerly anticipated and there was confidence this would deliver a good service for patients; e) The production of a patient handbook to replace leaflets was being worked on; f) In terms of branding use of the historic ROH Crest was being promoted with a particular focus on courage and compassion. This was being combined with a focus on the NHS brand and its values; g) All written communications should be simple and clear. The Chairman thanked SXB for this very useful and positive report and noted she had received much positive feedback on this area of work. This report should be considered at the next Council of Governors meeting as an example of how non-clinical expenditure helped and provided support to the Trust.	
ACTION: The Communications & Engagement Strategy Update to be presented by SXB at the Council of Governors meeting on 9 December 2015.	
9 Corporate Performance Report	**ROHTB (12/15) 005** **ROHTB (12/15) 005(a)**
The Trust was currently struggling to deliver its forecast outturn financial position and activity. The financial deficit continued to be a major concern and that morning the Private Board had considered the areas where the Trust was off track on performance and had agreed further action. Monitor Risk Rating and Feedback from Q2 submission - The Trust had a risk rating of 2 but, based on its October run rate, under the old rating this would have been amber. Formal communication had been received that the Trust's financial	

sustainability was under review and Monitor would require further information on expenditure, agency spend and fines.

RTT - For October RTT compliance had been 92.07% but for November elements of the target had been breached. There was a large backlog and rectification of the position was not expected in the short term. 28 patients had waited over 52 weeks and the longest wait was a child who had waited 74 weeks. Reasons for this have been discussed by the Trust Board at previous meetings and actions suggested to try to improve the situation. Legal advice had been taken about options for managing the spinal list because there was a lack of capacity and a shortage of specialist skills for the most complex surgery. Some work was being done through Ramsay and the Cromwell. Ramsay were now running a clinic on a fortnightly basis for general spinal degenerative adult cases. To date 34 patients had been referred and it was expected this would reach 200 patients by the end of financial year. Cromwell had taken 30 patients but this would only have a marginal effect on the waiting list. The position was complex and further activity was being sought.

SIs – During October there had been four SIs all of which were classified as avoidable. There had been particular concern surrounding pressure ulcer SIs. The commissioners had targeted the Trust with zero G3 and G4 pressure ulcers for the financial year and the penalty for these breaches was not yet known. There would be an in depth discussion on pressure ulcers, including staff training and infrastructure, at next week's CGC. CGC would be requested to provide a report back to Board.

The Chairman of CGC was particularly concerned by the effect the G4 pressure ulcer would have on that patient's quality of life. The message had to go out that this was very serious and ward staff must understand how this had happened in order that it did not occur again.

Investigation of SIs was slow. The Trust had a low number of staff who had been trained in root cause analysis and a wider pool of trained staff was required.

During the year a common theme of SIs had been VTE. In future there would be a VTE slot at Clinical Audit. The Governance team was now stable and with a wider pool of trained staff in root cause analysis, a slot at TBALD to share learning with clinicians, the ability to share learning would be enhanced. There had been a lot of input into SIs, and the need for a good level of challenge was recognised together with how learning should be fed back and shared.

The Chairman reiterated the Board's serious concerns about activity and that it was

imperative for this to be kept under careful review and the Board must be kept informed of what the team was doing to address this. At present 38.9% of staff had been immunised against flu and consultant uptake was low. AC would include the immunisation breakdown in the workforce indicators.	
ACTION: **The CGC Committee to provide a report on the discussion on pressure ulcers to the Board** **AC to include the percentage immunisation breakdown in the workforce indicators**	
10 Nurse establishment review	**ROHTB (12/15) 006** **ROHTB (12/15) 006(a)**
The Trust Board was asked to fully support the immediate uplift of all ward establishments on adult wards: 1,2 and 3 by 1 registered nurse to ensure national standards were met and patient safety and experience was enhanced. The Trust Board was also asked to support an incremental approach to uplift the 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. Recruitment would need to be made to staffing gaps and agency staff would have to be taken out to ensure this was cost efficient and did not become a cost pressure. Reduction in the use of agency staff should result in improved quality and it would be important for the improvements to be quantified. It should be possible to measure the impact on shift fill rates. The Trust Board agreed to approve the uplift in establishment in both areas but the cost benefits but spend would need to be closely monitored	
AGREEMENT: The Trust Board approved the immediate uplift of all ward establishments on adult wards: 1,2 and 3 by 1 registered nurse to ensure national standards were met and patient safety and experience was enhanced. **The Trust Board approved an incremental approach to uplift the 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.**	
11 Safe Staffing Report	**ROHTB (12/15) 007**

	ROHTB (12/15) 007(a)
This report detailed the Trust's current status of nurse staffing levels and provided assurance to the Trust Board of work being undertaken to monitor and manage safe levels of nursing staff in the Trust. Agreed staffing establishments needed to be met on a shift by shift basis and at present shifts at the ROH were staffed to plan more than 95% of the time on both day and night shifts. A new Safe Staffing Escalation policy had been developed which included a daily staffing huddle to review staffing against plan for the next 24 hours. Total agency across all in patient wards had been 15.8% but, as new establishment nurses started, there should be a decrease in the utilisation of agency	
12 Board Assurance Framework	**ROHTB (12/15) 008** **ROHTB (12/15) 008(a)**
The revised BAF was work in progress. Further development was required which included translating major issues faced by the Trust being included on the BAF. This would provide assurance that actions were being tracked. A more formal version of the BAF would be presented to the February meeting of the Trust Board.	
ACTION: SGL to include the BAF on the February Trust Board Agenda	
13 Audit Committee assurance report	**ROHTB (12/15) 009** **ROHTB (12/15) 009(a)**
This update summarising key matters from the 24 November Audit Committee was received and noted.	
14 Clinical Governance Committee assurance report	**ROHTB (12/15) 010** **ROHTB (12/15) 010** **ROHTB (12/15) 010**
This update summarising key matters from the 13 November Clinical Governance Committee was received and noted. The Trust Board approved the change in the Terms of Reference of the Committee and that the Clinical Governance Committee be renamed the Quality and Safety Committee.	
AGREEMENT: The Trust Board agreed the change in the Terms of Reference of the Committee and that the Clinical Governance Committee be renamed the Quality and Safety Committee	
15 Transformation Committee	**ROHTB (12/15) 011** **ROHTB (12/15) 011**
The update was received and noted.	
16 Any other business	**Verbal**

The Chairman passed on the Trust Board's best wishes to Alex Gilder, Deputy Director of Finance and Staff Governor, on the imminent birth of her child.	
Details of next meeting	**Verbal**
A Board Workshop would be held on 13 January 2016 and the next formal meeting of the Trust Board would be on 3 February 2016.	

PUBLIC SESSION

Next Meeting: 3 February 2016 , Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Meeting: 2 December 2015, Boardroom @ Trust Headquarters

Members present: Yve Buckland (YB), Tim Pile (TP), Kathryn Sallah (KS), Rod Anthony (RJA), Tauny Southwood (TS), Frances Kirkham (FK), Jo Chambers (JC), Jonathan Lofthouse (JL), Paul Athey (PA), Garry Marsh (GM)

In Attendance: Phil Begg (PB), Anne Cholmondeley (ACh), Sally Xerri-Brooks (SX), Nicky Mason (NM)

Apologies: Andy Pearson (AP), Simon Grainger-Lloyd (SGL)

Secretariat: Simon Grainger-Lloyd (SGL)

Last Updated: 29 January 2016

Reference	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
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~~ ~~03-Feb-16~~ 06-Apr-16	Further work planned to improve the summary to pull out further deviations from plan or key trends at a glance	
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	To be scheduled into either March Workshop event or April Board Day	

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 6-Apr-16	Further work to do to refine nurse staffing indicators	
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~~ 26-Feb-16	~~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	
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~~ 26-Feb-16	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~~ 26-Feb-16	To be reported to the Charitable Funds committee in February 2016	

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	Forward schedule developed	
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. UPDATE: Verbal item on agenda for February	
ROHTBACT.001	Patient Story	Verbal	02/12/2015	The Chairman to feedback to the patient the learning that had arisen from her case.	YB	02-Feb-16	An extract from the Minutes of the meeting relating to the patient story has been sent to the patient	
ROHBACT.002	Chief Executive's Update	Enc 6	02/12/2015	The Chief Executive would circulate the Comprenshive Spending review presentation to Board members together with the presentation on the National Orthopaedic Alliance. SGL to include Vanguards on the Agenda for the February Trust Board meeting	JC/SGL	02-Feb-16	Presentations were circulated to Board members. Vanguards on Agenda as part of CEO's Strategy Update for the February meeting	
ROHBACT.003	Update on the delivery of the Communications & Engagement Strategy	Enc 8	02/12/2015	The Communications & Engagement Strategy Update to be presented by SXB at the Council of Governors meeting on 9 December 2015	SXB	09-Dec-15	SXB presented the Communications & Engagement Strategy Update to the Council of Governors meeting on 9 December 2015	
ROHBACT.004	Corporate Performance Report	Enc 9	02/12/2015	The QSC Committee to provide a report on the discussion on pressure ulcers to the Board.	GM	06-Apr-16	Verbal update on pressure ulcers as part of QSC Chair's report. Further written report to be provided at April meeting	

	Corporate Performance Report	Enc 9	02/12/2015	AC to include the percentage immunisation breakdown in the workforce indicators	AC	02-Feb-16	Verbal update at meeting.	
ROHBACT.005	Board Assurance Framework	Enc 8	02/12/2015	Further development was required which included traqnslating major issues faced by the Trust being included on the BAF. This would provide assurance that actions were being tracked. A more formal version of the BAF would be presented to the February meeting of the Trust Board.	SGL	02-Feb-16	On Agenda for February meeting	
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. 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	
ROHTBACT. 004	Communications and Engagement Strategic Framework initial	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	

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:

Paperless Board business case	~~November 2015~~ February 2016	Verbal update on the agenda
SLA with St Mary's Hospice	~~December 2015~~ ~~February 2016~~ April 2016	Still in process of securing the SLA with St Mary's. Update at April meeting
Improvements in translation services	~~December 2015~~ ~~February 2016~~ April 2016	Update deferred to April 2016

For remitting to other fora:

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

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:	**3 February 2016**

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

FOR DISCUSSION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 3 February 2016

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 NHS continues to identify significant pressures operationally and financially during 2015/16. A number of centrally managed initiatives are seeking to address the rising in-year deficit. The agency and price cap is one mechanism seeking to manage the market and a change in the contract fines levers are being suspended for quarter 4. The contract variation in relation to fining mechanisms may bring some benefit to the Trust's forecast outturn and this will be assessed by the Director of Finance. The Trust will continue to exceed its agency cap pending the conclusion of the recruitment processes for key clinical areas such as theatres, which is dependent upon Home Office clearance procedures. In the meantime, the Trust will continue to use agency at a level necessary to maintain safe services. This approach has been fully discussed with Monitor and a forward look trajectory is being developed to enable appropriate monitoring of the anticipated decrease in agency use.

3 LOCAL CONTEXT

3.1 Guidance has now been received for the 2016/17 planning round and the Board will spend time considering its response to the initial requirement of the plan during private session. At this point in time, the Trust is being asked to sign up to an agreed control total in return for a share of the Sustainability and Transformation Fund (based on our emergency activity only), and commit to working with partners on a local health system plan. There are also a number of other conditions relating to performance targets. Trusts have also been warned to limit capital expenditure and to differentiate between essential and strategic development spend projects in

anticipation of restrictions on autonomous decisions to invest accumulated surpluses.

3.2 At this stage the Trust has not yet received offers from commissioners and therefore the risk of signing up to a control total will need to be carefully considered by the board and various scenarios used to undertake a sensitivity analysis. The Director of Finance is separately preparing a detailed recommendation.

3.3 All organisations are being asked to agree a Sustainability and Transformation Plan (STP) 'footprint' of organisations grouped together for planning purposes. Over recent years, the ROH has been within a 'Unit of Planning' covering Birmingham, Sandwell and Solihull. Under the current proposals from the four local Clinical Commissioning Groups (CCGs) Sandwell and West Birmingham CCG and Sandwell and West Birmingham Hospitals NHS Trust would become part of a Black Country STP and the ROH would be part of a Birmingham and Solihull STP. I have written to confirm our agreement to participate and have committed to work together on developing a shared vision for Birmingham and Solihull.

4 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

4.1 In addition to routine partnership meetings, key stakeholder and partnership engagement activities over the period include:

- Attended a national NHS Leaders briefing on the Comprehensive Spending Review and implications for health budgets from 2016/17 onwards.
- Attended various Vanguard related meetings and a workshop to develop the proposition.
- Chaired the AHSN Central Spoke
- Attended the West Midlands Provider CEO Network*
- Contributed to an NHS Improvement engagement event designed to help the establishment and operating model of the proposed new body, which will replace Monitor and the Trust Development Authority on 1 April 2016.
- Attended a roundtable discussion with a selection of Chairs and CEOs to debate the big strategic issues facing the health and social care system, led by the Stephen Dorrell, former Secretary of State for Health and Chair of the Health Select Committee, who was recently appointed as Chair of the NHS Confederation and is leading the call for a cross-party review of health and social care strategy.
- Met with Jack Dromey MP, with the Chairman.
- Attended the West Midlands AHSN Board.
- Met with the acting CEO of Birmingham Children's and Women's Hospitals to discuss opportunities for closer collaboration and improved joint management of our clinical network for complex children's orthopaedic surgery.

* Further discussions took place regarding the Emergency Planning Team and arrangement Birmingham, which we will continue to support to ensure resilience and compliance with our Civil Contingency Act responsibilities. An action arising from the meeting is the development of a revised fee structure proposal to reflect the different size and requirements of organisations.

5 TRUST MANAGEMENT COMMITTEE

The new divisional management structure is now in place and the senior management team meet with executives on a monthly basis to oversee the management of the hospital. The Trust Management Committee (TMC) also includes the operational Associate Medical Directors and other specialist 'Heads of Service' to ensure that strategy is understood and cascaded consistently throughout the Trust, activity, quality and financial performance is collectively reviewed and business cases can be considered.

The Director of Finance and Director of Operations have established a divisional performance review structure which enable greater scrutiny of individual operational areas, and divisional boards have been established to bring together senior managerial and clinical leads to focus on all aspects of quality, performance and governance at a divisional level.

The following matters were considered agreed as items to bring to the Board's attention:

16th December 2015 meeting

- Activity recovery plan and CIP performance – which is being scrutinised through the NED Steering Group (prior to formal establishment of the Finance & Performance Assurance Committee).
- CQC action plan – which has been circulated as part of the Board workshop in January 2016, and formally received at the public Board meeting in February 2016.
- Business cases
    - Pharmacy IT system- ***TMC recommended that this business case be approved by Chief Executive or Director of Finance which will secure the negotiated discount***

27th January 2016 meeting

- New or increasing risks, including activity, HDU staffing, informatics and data quality – these will be reflected in the risk register and BAF.
- CIP progress - Divisional General Managers expressed confidence that the £2.5m revised full year target for 2015/16 would be achieved although currently behind schedule. A number of schemes are expected to come to fruition during February and March. A 'bridging analysis' has been requested to identify which schemes, what value and expected delivery date to provide more assurance. The Finance and Performance Assurance Committee will also be looking for the detailed working behind this confidence. Work is underway on 2016/17 cost improvement plans.
- RTT deterioration – primarily as a result of longstanding challenges over capacity for spinal deformity operating sessions at Birmingham Children's Hospital (BCH), which is the subject of ongoing discussion with BCH and commissioners to identify

alternatives. In the meantime, other services will be monitored separately to ensure that performance is optimised.

- As part of our ongoing efforts to bring all Trust policies up to date, to reflect all current guidance, a number of policies were approved by the CEO on the advice of TMC and expert members. The need to ensure communication and training for staff on changes made was emphasised.
- Business cases-
    - 7 day Critical Care Outreach Team and Acute Pain service - ***In principle, TMC members supported the business case subject to information being provided to demonstrate the current costs, the added value from the service and any residual funding gap, which will need to be covered in the 2016/17 budget setting process. This is a quality improvement initiative and subject to additional information can be approved by the CEO or Director of Finance.***

    - Relocation of the Discharge Lounge- ***In principle, TMC members supported the proposal to relocate the discharge lounge from Ward 2. However, further work will be undertaken around the configuration of the discharge lounge and its optimum location. Further consultation will also be undertaken with staff who would be affected by the relocation of the discharge lounge, and patients likely to use it. A revised plan will be brought to the next TMC meeting which will include the SOP for the discharge lounge, criteria for use of it, clinical requirements arising from the criteria agreed, patient supervision requirements, the anticipated benefits for patient flow linked to activity and cancellations, staffing implications and the options for the use of the vacated space on ward 2.***

6 RECOMMENDATION(S)

6.1 The Board is asked to DISCUSS and NOTE the contents of the report, and

6.2 Note the contents of the report.

Jo Chambers
Chief Executive
27 January 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Strategic and environmental context**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Jo Chambers, Chief Executive**
DATE OF MEETING:	**3 February 2016**

EXECUTIVE SUMMARY:

This report provides an update to Board members on a number of key strategic changes in development in the local system. The report will be accompanied by a presentation, which will bring Board members up to date on these changes and prompt consideration of any impact on the Trust as it refreshes its strategic plan.

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:

Aligns closely with the aims of the Trust's strategic plan and ambitions.

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

FOR DISCUSSION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

STRATEGIC AND ENVIRONMENTAL CONTEXT

Report to the Board on 3 February 2016

1 EXECUTIVE SUMMARY

1.1 There are a number of key strategic changes going on in the local system that this report, and accompanying presentation, will bring Board members up to date on and consider any impact on the Trust as it refreshes its strategic plan.

2 THE DEVOLUTION AGENDA

2.1 Following the 'Devo Manc' proposition, local authorities in the West Midlands have been working on a potential combination of authorities coming together to create a larger footprint and critical mass from which to make long term plans. Accordingly, the local authorities of Birmingham, Coventry, Solihull, Sandwell, Walsall, Dudley and Wolverhampton have formed the 'Combined Authority' and have established a programme board to review opportunities for closer working. At this stage, unlike Manchester, health is not included other than a Mental Health Commission to review local provision.

2.2 A Public Service Board (PSB) has been established to oversee the programme of work and develop thinking. I will be the provider representative on the PSB and will therefore have an early opportunity to understand the potential and ambition of the Combined Authority.

3 CLINICAL COMMISSIONING GROUPS

3.1 Birmingham Cross City Clinical Commissioning Group (CCG) is the Trust's 'host' commissioner and we enjoy a constructive relationship with the team there. As part of the 'Unit of Planning', the CCG works closely with CCGs in Birmingham South Central, Solihull and Sandwell & West Birmingham CCGs. Going forward, it is proposed that Sandwell and West Birmingham CCG join the new Sustainability and Transformation Plan (STP) footprint, effectively becoming part of the Black Country. As a result, the current Unit of Planning will reduce in size and cover Birmingham and Solihull, with the 'west Birmingham' part of Sandwell and West Birmingham CCG becoming an associate to support the development of a vision and plan for Birmingham.

3.2 The CCGs have given a clear commitment to early engagement with providers and the local authority, and an early piece of work will be to develop a combined clinical strategy across the health economy.

3.3 In support of shaping a place-based plan, the CEO of Birmingham City Council is hosting a meeting on 1 February to enable further consideration of the strategic planning required for Birmingham, which I have committed to attend as part of our system leadership responsibilities.

3.3 By June 2016, the new STPs are required to develop a five year strategic plan which achieves a new sustainable model of health and social care in each geographical patch.

3.4 The ROH has formally agreed to participate in the Birmingham and Solihull STP footprint.

4 PROVIDERS

4.1 There has been a significant development in the local provider landscape with the Chair and CEO of University Hospitals Birmingham taking over leadership responsibilities at Heart of England Foundation Trust.

4.2 Birmingham Children's Hospital and Birmingham Women's Hospital have indicated an intention to come together into a single organisation subject to appropriate due diligence.

4.3 As a consequence of the STP footprint decisions in section 3, Sandwell and West Birmingham Hospitals NHS Trust are proposed to become part of the Sandwell and Black Country STP, and an associate in the Birmingham and Solihull STP. This in part reflects where the new Midland Metropolitan Hospital will be based.

4.4 Two GP Federations of substantial size are emerging in Birmingham to create primary care organisations covering a large proportion of the Birmingham and Sandwell population.

4.5 The ROH continues to collaborate on a national footprint with other specialist orthopaedic providers as part of the National Orthopaedic Alliance (Acute Care Collaboration vanguard), which I am currently leading on behalf of the Specialist Orthopaedic Alliance. The development of the value proposition is being finalised for submission on 8 February and an update will be provided to board members in private session pending formal agreement of partners to the submission document. However, this provides an opportunity for the ROH to provide local system leadership in the provision of quality assured orthopaedic care built on a set of evidence based quality standards.

Local commissioners are indicating interest in working with ROH as the project develops.

5 STRATEGIC CHANGES

As the commissioning and provider landscape changes it offers both opportunities and potential threats which board members will want to be aware of and take into consideration as the strategic plan refresh is completed. A presentation will be given to stimulate discussion and enable the context to be considered collectively to inform strategic thinking.

6 RECOMMENDATION(S)

6.1 The Board is asked to discuss the contents of the report and presentation, and

6.2 Note the contents of the report.

Jo Chambers
Chief Executive
27 January 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Establishment of a Finance & Performance Board Committee**
SPONSOR:	**Yve Buckland, Trust Chairman**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**3rd February 2016**

EXECUTIVE SUMMARY:

The Trust's constitution makes provision for the Trust Board to establish committees of Directors to assist it to discharge the Trust's responsibilities (Section 4).

At present, the following Board Committees exist:

- Audit Committee
- Quality & Safety Committee (formerly Clinical Governance Committee)
- Transformation Committee
- Remuneration Committee
- Nominations Committee

It is proposed that a further Board Committee be established with the remit of providing additional assurance to the Board on financial and operational performance-related matters.

The draft terms of reference for the Committee are attached, which have been reviewed and supported by Board members at the informal meeting of the Board on 13 January 2016.

The Board is required to approve the appointments to each of the Committees and as such, it is proposed that the following Board members form the membership of the Committee:

- Dame Yve Buckland (Trust Chairman and proposed chairman of the Committee)
- Mr Tim Pile (Vice Chair and Non Executive Director)
- Mr Rod Anthony (Non Executive Director)
- Mrs Jo Chambers (Chief Executive)
- Mr Jonathan Lofthouse (Director of Operations)
- Mr Paul Athey (Director of Finance)

Additional individuals will be asked to join the meeting as the agenda dictates.

The Committee is proposed to be permanent.

REPORT RECOMMENDATION:

The Board is asked to :

- Approve the proposal to establish a Finance & Performance Committee of the Board
- Approve the proposed Finance & Performance Committee's terms of reference

- Approve the suggested appointments to the Committee

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	X	Patient Experience	
Clinical		Equality and Diversity		Workforce	X

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Provides greater oversight and assurance to the Board on financial performance and performance against key national & local targets.

PREVIOUS CONSIDERATION:

Considered by the Trust Board in an informal session on 13 January 2016.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE ASSURANCE COMMITTEE

Terms of Reference

1 CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Finance and Performance Assurance Committee (The Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2 AUTHORITY

2.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

2.2 The Committee will operate independently of the Trust's Audit and such other Committees that the Board creates, but will work to avoid duplicating discussion of issues.

3 PURPOSE

3.1 The Committee, within the framework of the Trust's strategy and annual corporate and financial plans, shall undertake detailed oversight and scrutiny of the Trust's financial and activity performance , including contractual performance and performance against key national performance targets to provide assurance to the Board on its financial stewardship, the robustness of its financial forecasts and on its regulatory returns.

4 MEMBERSHIP

4.1 The Committee will comprise of two Non-Executive Directors, the Chief Executive, the Director of Finance and the Director of Operations.

4.2 A quorum will be 3 members, of which there must be at least one Non-Executive Director and one Executive Director.

4.3 The Chair of the Committee will be the Trust Chairman and if the Chair is absent from the meeting then another Non-Executive Director shall preside.

5 ATTENDANCE

5.1 Trust Board members, who are not members of the Committee, may attend for all or part of the meeting by prior agreement with the Chair of the Committee.

5.2 Trust staff or advisers from outside the Trust will be required to attend relevant sections of meetings as appropriate.

5.3 The Associate Director of Governance & Company Secretary shall be secretary to the Committee and will provide administrative support and advice. The duties of the Associate Director of Governance & Company Secretary in this regard are:

- Agreement of the agenda with the Chair of the Committee and attendees with the collation of connected papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee as appropriate

6 FREQUENCY OF MEETINGS

6.1 Meetings will be held monthly including August.

7 DUTIES

The Committee shall, on behalf of the Board, monitor and where appropriate review in greater detail the information within the Corporate Performance Report and on any other information which it requires on finance and activity, financial forecasts and regulatory returns in order to:

7.1 Assess progress on the Trust's financial position and commissioned activity to provide assurance to the Board.

7.2 Monitor progress with performance against key national performance metrics, such as Referral to Treatment Time and cancer waiting time targets

7.3 Keep the Board informed on the robustness of plans and proposals which focus on improvement or recovery to address material deviation from the long term delivery plan or areas where poor performance against national or local targets are identified.

7.4 Assess the level of any key financial and performance risks to the Trust and to assess that the mitigating actions to manage these risks are sufficient to inform the Board appropriately.

7.5 Benchmark Trust performance through trend analysis and comparative data in order to highlight any specific concerns to the Board.

7.6 Scrutinise in greater detail the proposed annual budgets for revenue and capital and to recommend their adoption by the Board.

7.7 Monitor the development and delivery of the Cost Improvement Programme and recommend to the Board any concerns or opportunities for improved efficiencies or cost savings.

7.8 Look at detailed forecasts on the Trust's short and medium term financial position and financial plans to feed into the Board's implementation of its Strategy.

7.9 Ensure the Board is drawing upon suitable sources of information which are timely, reliable and comprehensive in relation to finance and performance.

7.10 Oversee the submission of returns to Monitor after these have been discussed and agreed at the Board taking into account the Board timetable and any other responsibilities.

7.11 To seek assurance on any additional matter referred to the Committee from the Board

8 REPORTING

8.1 The minutes of all meetings of the Committee shall be recorded and submitted, together with recommendations where appropriate, to the Board at its private session. A summary of the key matters discussed, including any action commissioned will be presented by the Chair of the Committee in public.

8.2 Following each Committee meeting, the minutes shall be drawn up and submitted to the Chair of the committee in draft format. The draft minutes will then be presented at the next Committee meeting where the person presiding at it will sign them. The approved minutes will be presented to the next immediate Trust Board meeting for information.

8.3 The Committee will report annually to the Board in respect of the fulfilment of its functions in connection with these terms of reference.

8.4 The Trust's Annual Report shall include a section describing the work of the Committee in discharging its responsibilities.

9 REVIEW

9.1 The terms of reference of the Committee shall be reviewed by the Board annually.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (2/16) 005

TRUST BOARD

DOCUMENT TITLE:	**Policy on Policies**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**3 February 2016**

EXECUTIVE SUMMARY:

As has been reported on a routine basis to the Quality & Safety Committee, much work is currently underway to refine and strengthen the Trust's policy governance framework.

Central to these plans is the development of a revised policy to set out the framework for developing, approving and management of Trustwide policies.

The attached presents a final draft of a revised Policy on Policies which the Trust Board is asked to approve. The key points of the policy are set out on Page 3 of the policy.

The policy was issued for formal consultation late in 2015/early 2016 and comments where regarded as being appropriate and relevant have been included in this version of the policy.

REPORT RECOMMENDATION:

The Trust Board is asked to approve the revised Policy on the 'Development, Approval and Management of Policies'.

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	x
Business and market share		Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity	x	Workforce	x

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

The need to strengthen the Trust's management of policies is included as an entry on the risk register of Quality & Safety Committee.

PREVIOUS CONSIDERATION:

The policy was consulted on in late 2015/January 2016.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINAL FOR APPROVAL

POLICY ON THE DEVELOPMENT, APPROVAL AND MANAGEMENT OF TRUSTWIDE POLICIES

Policy author	Associate Director of Governance & Company Secretary
Accountable Executive Lead	Chief Executive
Approving body	Trust Board
Policy reference	ROH/ORG/0XX

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:
1 – Policy Authors

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:
1 – All other staff

POLICY APPROVAL DATE:
TBC

POLICY IMPLEMENTATION DATE:
TBC

DATE POLICY TO BE REVIEWED:
TBC

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
2				New process to include sign off of minor modifications outside the formal approval process. New templates.
3				
4				

POLICY FOR THE DEVELOPMENT, APPROVAL AND MANAGEMENT OF TRUSTWIDE POLICIES

KEY POINTS

1. **Wherever possible**, policies should be no more than **twenty sides** of A4 in length (including front sheet, document history and key point page). Appendices may be attached if necessary.

2. All new and substantially reviewed policies must be quality assured by the Policy Review Group (PRG), a virtual group of key individuals, prior to submission for approval by the Chief Executive on the advice of Trust Management Committee

3. Consultation with groups of staff, service users or external bodies that will be affected by the introduction of the policy is expected before the policy is submitted for approval. Although a minimum period for consultation is not set, for new and substantially revised policies, there is a need to undertake sufficient, meaningful and credible consultation of a scale appropriate to the nature of the policy.

4. The most critical key points of or changes to new and revised policies will be communicated to all staff via the weekly e-mail bulletin after their approval for onward cascade to members of staff who may not have access to e-mail.

5. New and revised policies must be subjected to an initial equality impact assessment and, where necessary, a full equality impact assessment.

6. New or substantially revised policies are to be formally reviewed after **three years** unless there is a specific requirement to review earlier in the light of new national guidance, service change or to make an improvement .

7. Policy authors will be reminded of the need to review a policy **six months** prior to the review date to allow for sufficient time to organise for amendments to be made and consultation to occur if needed.

8. All policies must have an identified Policy Author and Accountable Executive Director clearly identified on the front page.

9. Each policy must identify a list of groups of staff to whom the policy is most applicable

10. A 'Key Points' section (a maximum of **one side** of A4) must be included, outlining the most significant elements contained in the policy. It must be emphasised within the policy that this list is designed to be a quick reference guide and should not be read in isolation of the full policy.

11. A comprehensive implementation plan must be developed for all policies.

12. All policies will contain an 'Auditable Standards/Monitoring Effectiveness' section that will outline the system to be used to monitor compliance.

13. Where possible, all policies must contain a flowchart or process map showing the key steps within the policy.

14. An electronic copy of approved and obsolete policies will be retained centrally.

15. Copies of all policies will be available on Trust's intranet.

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

POLICY FOR THE DEVELOPMENT, APPROVAL AND MANAGEMENT OF TRUSTWIDE POLICIES

Contents **Page Number**

APPENDICES

POLICY ON THE DEVELOPMENT, APPROVAL AND MANAGEMENT OF TRUSTWIDE POLICIES

1. INTRODUCTION

1.1 This document is designed to ensure a structured and systematic approach to the development, approval and management of Trust-wide policies. It establishes a framework to ensure that all Trust-wide policies are of a consistently high standard, are up to date and that staff have access to and implement them correctly. The policy also describes the format in which all new polices must be developed and produced, a series of principles that should be applied and a procedure to be followed.

1.2 This document relates to Trust-wide policies, defined as those impacting on the majority of staff within the Trust. Policies developed at and relevant to divisional or service level are expected to follow the same format detailed in this document, yet do not need to be presented to the Chief Executive for approval on the advice of the Trust Management Committee. Local arrangements must be made to develop, approve and manage policies in a manner consistent with that for Trust-wide policies. They must be wholly consistent with any overarching policy, Trust strategies and the corporate approach.

1.3 Other documents, such as procedures, protocols, guidelines, Patient Group Directions (PGD) and standards support the process for enabling staff to comply with a policy. As the various terms are open to different interpretation, the definitions adopted for the purpose of this document are set out in Section 4 below. It should be noted that no policy, procedure, protocol, guideline, PGD or standard supersedes what the law requires or the requirements and guidance of professional bodies or institutions, however they are designed to ensure adherence to these requirements.

2 SCOPE

2.1 The Policy is applicable to all staff who are involved with writing new policies or making changes to existing policies.

3 OTHER POLICIES OR DOCUMENTS TO WHICH THIS POLICY RELATES

3.1 It relates to all policies developed within the Trust as the guide for development, approval and management.

4. GLOSSARY AND DEFINITIONS

4.1 A **policy** is a written statement of intent, describing the broad approach or course of action the Trust is taking with a particular issue. Each policy must include specific steps (procedure) as to how it is to be accomplished. A policy enables management and staff to make correct decisions and deal effectively and comply with relevant legislation, Trust rules and good working practice. Once approved, policies are mandatory for all staff.

4.2 **Guidelines** are tools designed to close gaps between current practice (and the outcomes associated with current practice) and other alternative practices (and the outcomes associated with those practices). Guidelines are decision tools to help staff make informed decisions by making clear the benefits, harms and costs of different options.

4.3 **A (standard operating) procedure** is a documented series of related steps designed to accomplish a specific task in a specified chronological order. The procedure will

accomplish the goals and directives of a related policy. Procedures included within a policy are mandatory for all staff.

4.4 **Protocols** are formal sets of procedures to follow in order to achieve a specific course or outcome, specifically agreed for designated staff. A protocol sets out a precise sequence of activities to be adhered to.

4.6 **Patient Group Directions** (PGD) are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation or treatment.

4.5 **Standards** are statements specifying a required level of performance for the purpose of monitoring or auditing.

5. POLICY DEVELOPMENT PRINCIPLES

Policies must be developed in accordance with the following principles:

5.1 Any of the following can prompt the development of a new policy or the review of a current policy:

- Points of learning from a complaint, serious incident or other governance investigation
- Feedback from users, carers, staff, etc
- Need for change identified in another related policy
- Planned policy review cycle
- Changes in joint working arrangements
- New guidance from external organisations and regulators
- Changes in legislation
- New areas of professional practice
- Amendments identified which could improve the effectiveness of the policy

Please note, this is not an exhaustive list.

5.2 The front page of all policies must follow a standardised approach (see Appendix D).

5.3 Policies will be developed in accordance with the procedure outlined in Section 6 to ensure both that the governance arrangements are adequate and a standard structure and format is applied to enable consistency in presentation.

5.4 Policies will be developed with appropriate internal and external consultation, including contributions by expert groups of staff where necessary who may endorse the policy as part of the consultation process.

5.5 New and substantially revised policies must be quality assured by the Policy Review Group (PRG), a virtual group of key individuals from across the Trust, prior to submission for approval.

5.6 The standard approval route for new and substantially revised policies is through the Chief Executive, using their authority to do so delegated by the Trust Board. The Chief Executive will seek the advice of the Trust Management Committee to inform their decision-making. The Trust Board reserves a right to review and approve any policy.

5.7 Policies should, where possible, be no more than twenty sides of A4 long (including submission

proforma, front sheets, history log and key points page). Appendices, if required, should also be concise and as few in number as possible and must be referenced within the body of the policy. A request to justify a policy being lengthier than twenty sides will need to be made where necessary.

5.8 Policies will identify a list of groups of staff to whom they apply most essentially.

5.9 Policies will contain a 'key points' section at the front, on a maximum of one page, stating its most significant elements.

5.10 All policies, where possible, will contain a flowchart or process map, detailing the key steps that staff are required to follow in the policy, as an appendix.

5.11 An Auditable Standards/Monitoring Effectiveness section must be included to identify the way(s) in which any assessment of compliance with the policy will be undertaken. This must be determined by the Policy Author, taking into account achievability and the resources needed to undertake such auditing/ monitoring. In the case where auditing is required, then the frequency of the audit must be stipulated.

5.12 Policies will be reviewed by the policy author annually and be subject to a formal review and approval every three years or sooner if circumstances require, such as publication of new national guidance.

5.13 All policies must be subject to an initial equality impact assessment and a full equality impact assessment if directed by the initial assessment. The submission proforma (Appendix E) should indicate that the policy has been subject to this process and has been signed off by the Divisional General Manager, Deputy Director of Nursing & Clinical Governance or a relevant corporate manager.

5.14 An implementation plan to introduce and embed the requirements of the policy into the organisation will be developed. Actions forming the implementation plan, together with their relevant timescales for completion, must be discussed with and agreed by the relevant managers, clinicians and staff with responsibility for delivering the actions, prior to the implementation plan being presented with the policy for approval.

5.15 A copy of all Trust policies will be held centrally by the Trust's Governance team and will be accessible through the Trust's intranet. A separate archive of current and former versions of the policies will be retained by the Trust's Governance team.

6 ROLES AND RESPONSIBILITIES

6.1 Chief Executive

Overall responsibility for ensuring the Trust has appropriate policies in place to ensure the organisation works to best practice and complies with all relevant legislation.

6.2 Trust Board

a) The Trust Board is responsible for setting the strategic context in which organisational policies are developed.

b) The Trust Board is responsible for the formal review and approval of those policies presented at the discretion of the Accountable Executive Lead, including those which external agencies require to have Board approval.

c) The Trust Board has delegated powers of policy approval to the Chief Executive, who has chosen to discharge this duty through advice from the Trust Management Committee.

6.3 Associate Director of Governance & Company Secretary

a) Oversight and accountability for ensuring that effective arrangements are in place for the development, approval and management of policies.

b) Through the use of the PRG, the Associate Director of Governance & Company Secretary will undertake to quality assure the policies, check that all appropriate documentation is completed adequately and confirm that necessary consultation has been undertaken prior to the policy being presented for consideration at the Trust Management Committee. They will also ensure that the outcome of review by the Trust Management Committee is communicated back to the Policy author, including and required amendments

c) The Associate Director of Governance & Company Secretary will ensure that policies are lodged on the Trust intranet and are communicated effectively to the Trust when approved.

d) Undertake to ensure that the auditable standards in the policies are reviewed

e) The support of the Deputy Director of Nursing & Clinical Governance will be sought on matters requiring clinical judgement.

6.4 Governance Team

a) Ensure that an electronic database of policies is maintained and that documents are readily accessible to all relevant staff.

b) Initiate the scheduled review of policies by informing the author of the need six months prior to the review date.

c) Prepare the necessary paperwork for quality assurance and review by PRG when needed

d) Ensure appropriate systems for dissemination of agreed policies, including within the daily internal staff news issued by the communications department and other mechanisms where of sufficient profile.

e) Administer the approval process in line with this policy.

f) Ensure policies are posted on the Trust's intranet and internet, as appropriate.

g) Maintain accurate records of approval.

h) Maintain an accurate archive of the previous versions of any revised or reviewed policy.

i) Seek confirmation that all elements of the implementation plan have been completed once the final date in the plan is reached.

6.5 Accountable Executive Leads

Accountable Executive Leads are responsible for overseeing effective implementation of policies relevant to their areas of responsibility. Draft policies are to be reviewed by the relevant Accountable Executive Leads, as part of the consultation process, as appropriate, before presentation for approval to the relevant approving body.

6.6 Policy Author

a) Ensure that policies are implemented appropriately and, where necessary, audits compliance with those documents.

b) Ensure that all actions listed on the implementation action plan are completed within the timescales set.

c) Ensure appropriate review of the documents, either in line with the review timescale set at the time of approval or as a result of changes to practice, organisational structure or legislation.

d) Ensure comprehensive consultation has taken place with the relevant individuals or groups during the policy development process.

e) Ensure the necessary Equality Impact Assessment is carried out and signed off prior to entering the approval process and incorporate any necessary amendments to the policy arising from this assessment

f) To send the Governance Team the policy and all necessary appendices (see Appendix D) for presentation to the PRG and later to the Trust Management Committee for consideration and approval by the Chief Executive.

g) Audit compliance with policies

6.7 Line Managers

a) Ensure staff are aware of and have access to relevant policies and are given the opportunity to comment on draft policies sent out for consultation.

b) Work within approved policies.

c) Ensure staff have read and understood the relevant policies and work within them.

d) Ensure systems exist to identify staff training needs on the implementation of policies and take necessary action to address these where necessary.

6.10 All Staff

Ensure that they adhere to current policies in use across the Trust and specific to their work. Information regarding the failure to comply with a policy must be reported to the line manager and the incident reporting system used where appropriate.

7 POLICY DEVELOPMENT, APPROVAL AND MANAGEMENT PROCEDURE

7.1 **Document review:** When a requirement for a new policy is identified, the initiator must, in the first instance review existing documents to ensure that the issues are not already covered elsewhere to avoid duplication.

7.2 **Pre-approval input and review**: Policies must be sent to the Governance team who will submit it for quality assurance by the PRG. The PRG, a virtual group of key individuals, will review the policy for compliance against the requirements of this policy prior to submission for approval. After any amendments suggested by the PRG have been made, the policy, together with its various appendices, will be submitted by the Governance Team for review by the Trust Management Committee via the Associate Director of Governance & Company Secretary. Any new or substantially revised policies containing references to drug prescriptions, or referring to the prescribing, preparation or administration of medication, must be checked and agreed by the Drugs and Therapeutic Advisory Group prior to the policy being checked by PRG.

7.3 **Minor amendment:** Where only minor, or no, substantive amendments are proposed to an existing policy, it can be agreed directly with the Accountable Executive Lead without the need for consideration at a meeting. Evidence of this approval must be provided to the Governance Team via e-mail from the Policy Author.

7.4 **Policy format and structure:** The Policy Author is responsible for drafting / amending the policy in accordance with the requirements of this policy. The format and structure requirements are set out in Appendix D.

7.5 **Legislation:** The Policy Author must ensure that the policy complies with relevant legislation and good practice. Advice from the Trust's solicitors may be taken via the Associate Director of Governance & Company Secretary.

7.6 **Consultation:** The Policy Author must ensure that the key stakeholders (relevant expert committees, staff, groups, service users and carers) affected by the policy are involved in the consultation process. The Trust solicitors, as arranged by the Associate Director of Governance & Company Secretary, will also where necessary, be involved in the consultation process. The stakeholders with which the Policy Author should consult will be dependent upon the nature of the policy being developed. The process may include seeking views on what the approach adopted by a policy should be or providing a copy of a drafted policy to enable full and detailed consultation to take place. The Associate Director of Governance & Company Secretary or Deputy Director of Nursing & Clinical Governance should be approached for further guidance on the appropriate stakeholders to involve in the consultation, if required.

7.7 For new policies and policies that have undergone significant revision, it is expected that the consultation process be of a scale and duration appropriate to the nature of the policy. A minimum period of one month consultation is suggested but may be longer for more complex or contentious policies. Details of the consultation should be included within the policy submission sheet which accompanies the policy when presented for approval.

7.8 **Policy length:** Policies must be concise and where possible should not exceed twenty sides of A4 in

length, including the preamble but excluding appendices where used.

7.9 **Cross-referencing:** The Policy Author must ensure that where cross-referencing to other documents applies, other authors are notified as their documents may require amendment as a result.

7.10 **Equality impact assessment:** Draft policies presented for final approval must include a completed initial equality impact assessment (Appendix E) and a full equality impact assessment where required. Policies will not be forwarded for approval without a completed and approved assessment being received.

7.11 **Auditable standards/ Monitoring Effectiveness:** The process for monitoring and measuring compliance with the key elements of the policy must be included within the Auditable Standards section. This must include details of the monitoring system identified, who has responsibility for the monitoring, and how and when it will take place and where shortfalls are identified, the process for ensuring action is taken. The approving body must be satisfied that these are identified and resources are available to conduct the monitoring process before approving a policy.

If an audit is selected as a method of monitoring compliance with the policy:

- Ensure that the relevant staff have previously been informed of the required standards of performance.
- Specify clearly which of the standards are being measured through a structured audit
- Please note that all standards should be SMART (**S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**heoretically sound)
- Specify the frequency of the audit.

7.12 **Implementation:** The Policy Author will develop a plan to implement and embed the requirements of the policy. The action plans must make clear both the actions that have already been completed as part of the preparation for implementing the policy within the Trust, in addition to the timescales and responsibilities for activities planned following approval of the policy. The key actions within the plan should be classified into 'communications and engagement', 'training', 'resources' and 'monitoring effectiveness & evaluation'.

Confirmation will be sought by the Governance Team that all actions in the plan have been completed when the final date in the action plan is reached.

7.13 **Presentation for approval:** The Governance Team will arrange for the policy and accompanying supporting documentation to be forwarded to the Associate Director of Governance & Company Secretary for inclusion within meetings papers being issued to the TMC or Trust Board.

7.14 **Approval:** The approving body (CEO on the advice of TMC or Trust Board) must be satisfied that the policy has been developed in accordance with the requirements of this document before they approve a policy. Where a policy exceeds the twenty page limitation, the approving body must be satisfied that policies longer than this are justified.

Policies may be approved subject to some changes, which the author should make as soon as possible after the meeting at which the policy was considered. The amended version should be sent to the Accountable Executive Lead and the Associate Director of Governance & Company Secretary. Policies requiring considerable amendment must be revised by the policy author and resubmitted to the approving body as soon as practicably possible.

Subject to the judgement of the Accountable Executive Lead, a policy may also be presented to the

Trust Board for approval.

7.15 **Publication and communication:** The Governance Team will arrange for a PDF copy of the policy to be placed on the Trust's intranet and arrange for notification of the policy approval and key points of or changes to the policy to be included in the weekly e-mail communications or other internal communications vehicles, where of sufficient profile. Additional communications and launch measures will be arranged in conjunction with the Communications Department where needed. A MSWord version of the policies will be made available on request from the Governance Team.

The Policy Author must ensure that following approval as part of the implementation plan there is sufficient publication and awareness raising with key individuals or staff groups. This is to ensure that the most relevant staff are aware of the revised or new policy requirements and that adequate liaison takes place with relevant managers, clinicians and staff to ensure the effective implementation of the policy. This may include an analysis of training needs.

7.16 **Review:** All policies must be reviewed by the policy author on an annual basis to ensure that the contents remain current. The policy will also be subject to formal review every three years, being resubmitted for approval. Earlier review may be required in response following any event which highlights the need to review urgently a particular policy or following new legislation, NHS guidance or changes in clinical practice. Should there be a requirement to review formally a policy more frequently than three yearly, the reasons for this must be clearly stated in the policy.

7.17 **Reminder:** The Governance Team will provide a reminder to Policy Authors six months prior to a policy's scheduled review date.

7.18 **Retention:** The Associate Director of Governance & Company Secretary will forward an electronic copy of the approved policy with the equality impact assessment to the Governance Team, who will retain it centrally. This will be the official copy.

7.19 **Archiving:** When a new version of a policy is approved, the current version available on the intranet will be replaced. The obsolete versions will continue to be retained in a repository maintained by the Governance Team for archive purposes. A copy of the superseded policies will be made available on request from the Governance Team. Managers are asked to ensure that all locally-held hard copies of obsolete policies are destroyed.

8. CONSULTATION

8.1 An initial draft of this policy was shared with TMC members, Executive Team, key clinical & corporate leads and stakeholders for comments and input. Amendments based on this feedback have been included where possible and deemed appropriate.

9. AUDITABLE STANDARDS/MONITORING EFFECTIVENESS

9.1 In order to monitor the effectiveness of this policy the the Associate Director of Governance & Company Secretary will undertake to monitor compliance with this policy by reviewing that:

- Policies are submitted in the correct template;
- There is evidence that consultation has been undertaken prior to policies being submitted for approval;
- Policies have been reviewed by the PRG, as evidenced by the completed pre-approval checklists;

- Policies have been presented approved by the Chief Executive on the advice of the Trust Management Committee or Trust Board
- All policies submitted are accompanied by a comprehensive implementation plan
- Policies approved are disseminated to all staff via staff communications
- There is evidence that a reminder has been issued to Accountable Executive Leads and policy authors to highlight policies due to expire within the forthcoming six months
- Obsolete policies or policies that have been replaced by updated versions are stored within an archive
- There is evidence that Accountable Executive Leads have provided written consent to minor changes using discretionary authority
- The policy is available for access on the Trust's intranet

10. TRAINING AND AWARENESS

10.1 Managers are responsible for raising awareness of this policy amongst their staff who are involved in writing policies.

10.2 Ad hoc training in the policy development process will be available via the Governance Team, as required.

11. INCLUSION

11.1 The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced an Equality Policy Statement to reflect this.

12. REVIEW

12.1 This policy will be reviewed after three years.

13. REFERENCE DOCUMENTS AND BIBLIOGRAPHY

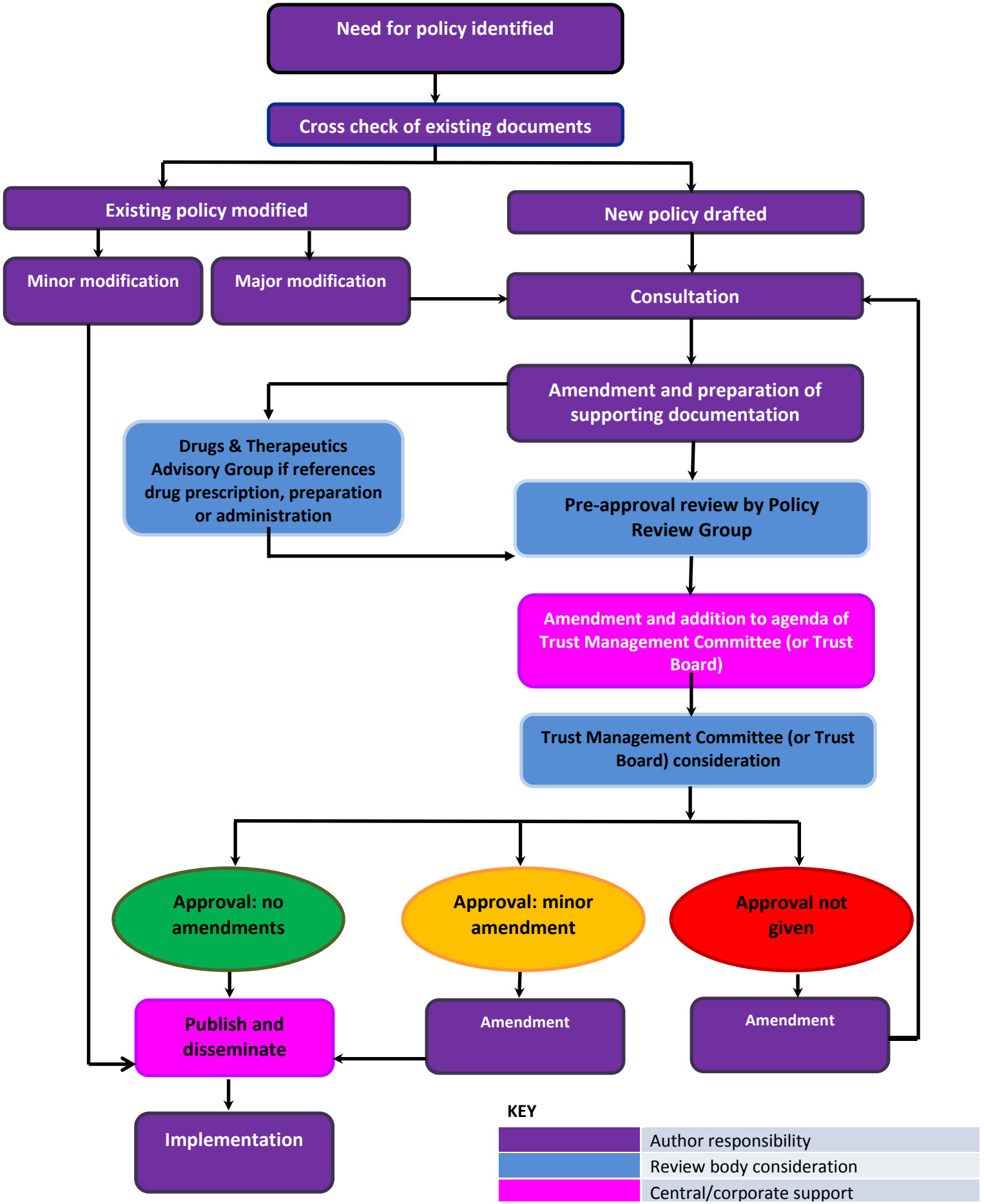
Reference document – None specifically

Bibliography – None

14. FURTHER ENQUIRIES

14.1 Further information regarding this policy is available from the Governance Team (roh-tr.governance@nhs.net) and the Associate Director of Governance & Company Secretary (0121 685 4353 or s.grainger-lloyd@nhs.net).

APPENDIX A – FLOWCHART FOR POLICY DEVELOPMENT AND APPROVAL



APPENDIX B – POLICY SUBMISSION PROFORMA

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST MANAGEMENT COMMITTEE

POLICY TITLE:	
ACCOUNTABLE EXECUTIVE LEAD:	
POLICY AUTHOR:	
DATE OF MEETING:	

POLICY STATUS: *[add X to the relevant box]*

NEW POLICY		**AMENDED EXISTING POLICY**	

SUMMARY OF KEY POINTS/CHANGES:

The [name of policy] is presented for approval.

The key points of the policy/changes to the policy[#] are:

The Chief Executive on the advice of the Trust Management Committee is requested to approve the policy, together with the proposed implementation plan.

The length of the policy is x pages; where this is in excess of 20 pages, please provide justification.

CONSULTATION:

[Please provide details of the consultation that has been undertaken on this policy, including groups and members of staff consulted and the duration of the consultation period]

EQUALITY IMPACT ASSESSMENT:

The development of the policy has involved an equality impact assessment and an initial impact assessment [and full impact assessment[#]] has been completed and approved by [job title].

delete if applicable

APPENDIX C – POLICY ASSURANCE CHECKLIST

The Royal Orthopaedic Hospital NHS Foundation Trust

POLICY PRE-APPROVAL REVIEW CHECKLIST

Name of policy: [NAME]
Policy author: [NAME] **Accountable Executive Lead:** [NAME]

AREA (PoP Ref)	CHECK POINT	YES/NO/ QUERY	COMMENTS
TITLE PAGE (APPENDIX D)	Is the title clear and unambiguous?		
	Are the target groups of staff clearly identified?		
	Has the correct approval body been identified?		
SCOPE (None specifically)	Is the scope and application of the policy clear?		
KEY POINTS (APPENDIX D)	Do the key points identified adequately and clearly summarise the salient points of the policy?		
RELATED DOCUMENTS (APPENDIX D)	Does the policy comprehensively reference other policies to which the policy relates?		
PRINCIPLES (APPENDIX D)	Are the principles of the policy clearly articulated? Have procedural steps been included in error within this section?		
ROLES AND RESPONSIBIL-ITIES (APPENDIX D)	Does the list of roles fully cover those individuals who will be expected to discharge a duty as a result of the policy being in place? Have procedural steps been included in error within this section?		
PROCEDURE (APPENDIX D)	Does the procedure provide logical, sufficient and adequately detailed steps?		
CONSULTATION (7.6)	Does the policy adequately describe the method used to consult on the policy?		
	Is the list of individuals with whom the consultation has taken place appropriate and comprehensive? Does it include external stakeholders where necessary?		
	For clinically-focused policies, have the views of clinicians from the appropriate areas and services been taken into account?		
	Has the consultation period lasted for a period of time commensurate with the nature of the policy?		
	Has the policy received support from the DTAG, other 'expert groups' or staff side groups where needed?		
LEGAL (7.5)	Has legal advice been taken and incorporated into the policy if needed?		

AREA (PoP Ref)	CHECK POINT	YES/NO/ QUERY	COMMENTS
AUDITABLE STANDARDS/ MONITORING EFFECTIVENESS (7.11)	Are the mechanisms by which the compliance with the policy may be confirmed realistic, clear and sufficient?		
	Where an audit is planned, is the frequency of this and the coverage of this clear?		
	Is it clear to where the outcome of the audit will be reported? Is it clear which individual will undertake the audit?		
TRAINING & AWARENESS (APPENDIX D)	Have the planned training needs been assessed and clearly articulated?		
	Is it clear where individuals will be able to access the training?		
REVIEW (12.1)	Is it clear that the policy will be reviewed in three years' time as a default?		
FURTHER DETAILS (APPENDIX D)	Are the sources of further information or key contacts listed?		
EQUALITY IMPACT ASSESSMENT (11.1)	Is an equality impact assessment been completed and appropriately signed off?		
FINANCES (7.12)	Is there evidence that the financial implications of the policy have been considered and agreed where necessary?		
FLOW CHART (APPENDIX A)	Is a flow chart included in the policy if it is appropriate to do so?		
	Is the flowchart logical and comprehensive and clearly outlines the key steps of the policy?		
APPROVAL (7.14)	Is evidence of sign off by the relevant Executive Lead provided?		
	Has a date for the presentation for approval been identified and agreed?		
COMPLIANCE WITH STANDARDS (None specifically)	Does the policy satisfy the requirements of the external standards where appropriate?		
IMPLEMENTATION (7.12)	Is the policy accompanied by a comprehensive implementation plan, including clear responsibilities and timescales for the completion of actions?		
	Is the final date for the completion of the implementation plan clear?		
FORMAT (APPENDIX D)	Are there any obvious formatting or typographical errors in the policy?		
	Does the policy exceed 20 pages and is the justification for this clear?		
LANGUAGE (None specifically)	Is the language and grammar used in the policy clear and accurate?		

Date policy reviewed by Policy Review Group:	
Date agreed ready for presentation for approval	

APPENDIX D - FRONT PAGE TEMPLATE

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

POLICY NAME

Policy author	
Accountable Executive Lead	
Approving body	
Policy reference	ROH/XXX/NNN [Assigned by Governance Team]

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:

1 – Name of group
2 – Name of group

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:

1 – Name of group

POLICY APPROVAL DATE:
Month and Year

POLICY IMPLEMENTATION DATE:
Month and Year

DATE POLICY TO BE REVIEWED:
Month and Year

DOCUMENT CONTROL AND HISTORY

Version No	Date Approved	Date of implementation	Next Review Date	Reason for change (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)

POLICY NAME

KEY POINTS

1.

2.

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PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

Contents page

Body of the Policy

Appendices

APPENDIX E – POLICY FORMAT AND STRUCTURE

Format	The policy must be prepared in Microsoft Word. The policy must be prepared using Calibri font as follows: • Title (front page) – Size – 20/bold • Headings – Size – 11/bold • Main text – Size 11 The policy footer must include the name of the policy and page numbering in Size 9 Calibri font
The Title Page see template at Appendix C	• Trust logo • Title of policy Plus boxed in section containing the following: • Policy author (title, not name) • Accountable Executive Lead (title, not name) • Approving body (CEO on advice of TMC or Trust Board) • Policy Reference (unique reference for the policy) Plus two boxed in sections containing the following: • Policy approval date • Policy implementation date • Date policy to be reviewed • Key groups of staff to whom the policy applies
The Key Points Page	No more than one side of A4, outlining the key points of the policy. This is to give the reader a quick briefing on what the policy covers but is not designed to replace the need to read the full policy.
The Contents Page	• List of sections, headings and page numbers • List of appendices and page numbers
The Policy	• Introduction: why the policy is necessary, to whom it applies. It may include reference to any relevant guidelines, statutory requirements or other recommendations • Scope: to whom the policy applies and where necessary, an indication of whether the policy applies to all patients or selected groups, including whether it applies to children as well as adults • Cross-referencing other policies: list any linked policies that should be read in conjunction with the policy. This may be referenced to an appendix if necessary. • Glossary and Definitions: an explanation of any terms used (if extensive, this may be referenced in an appendix) • Principles: the key policy issues underpinning the need for the document, the aims and standards which are intended to be achieved. • Roles and responsibilities: List the key duties for members of staff or groups who have a role in delivering the requirements of the policy • Procedure: consisting of a step-by step account of how the policy is to be achieved • Consultation: outline the process followed to engage stakeholders in the development of the policy and include details of the individuals and bodies involved and any material feedback that may have resulted in any changes to the policy being made. Be clear in this section that the views of those staff or groups on whom the policy will most impact have been taken into account. • Auditable standards/process for monitoring effectiveness: outline the process by which compliance with the policy will be monitored, by whom and how often.

	Include details of the key indicators that will be used to provide the evidence of compliance. • Training and awareness: provide details of measures by which staff will be made aware of the requirements of the policy. • Inclusion: include a standard statement as follows **'The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need.** • Review: Include a standard statement as follows: '**This policy will be reviewed in three years time unless requires earlier review'** • Reference documents and bibliography: a list of works that the author has used as a source, but are not referred to directly in the text. • Further enquiries: provide details of the individual(s) to whom questions about the policy should be directed.
The Appendices	• Additional material necessary to the delivery of the policy. • Consultation sheet • A flow chart showing the key steps within the policy must be attached where possible. • An Equality Impact Assessment that has is signed off • An implementation plan

APPENDIX F

EQUALITY IMPACT ASSESSMENT TEMPLATES

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Equality Impact Assessment

Initial Assessment form

The Initial Equality Impact Assessment (EIA) is a quick and easy screening process. It should:

1. Identify those policies which require a full EIA by looking at:

    - Negative, positive or no impact on any of the protected characteristics.
    - Opportunity to promote equality for the protected characteristics.
    - Data/feedback to prioritise if and when a full EIA should be completed

2. Justify reasons why a full EIA is not going to be completed

Division or Corporate area:	
Speciality/Service Area	
Executive Lead (enter name and designation):	
Title of Policy:	

Q1) What is the aim of your Policy?

Q2) State to which Trust strategic objective this Policy relates:

Q3) Who benefits from your Policy?

Q4) Do you have any feedback data that influences, affects or shapes this Policy?

Yes	No
☐ Please complete below.	☐ Please go to question 5

What is your source of feedback?

- ☐ Monitoring Data
- ☐ Previous EIAs
- ☐ National Reports
- ☐ Internal Audits
- ☐ Patient Surveys
- ☐ Complaints / Incidents / Claims / Litigation
- ☐ Focus Groups
- ☐ Equality & Diversity Training
- ☐ Other (please state)

What does this source of feedback reveal?

Q5) Thinking about each group below does or could the Policy have a negative impact on members of the protected characteristics below?

Protected Characteristic	Yes	No	Unclear
Age	☐	☐	☐
Disability	☐	☐	☐
Race	☐	☐	☐
Sex	☐	☐	☐
Gender Reassignment	☐	☐	☐
Sexual Orientation	☐	☐	☐
Religion or belief	☐	☐	☐
Pregnancy & Maternity	☐	☐	☐
Marriage & Civil Partnership	☐	☐	☐

Other socially excluded groups	☐	☐	☐

If the answer is "yes" or "Unclear" please complete a full EIA

Q6) Who was involved in the EIA and how?

Who – please specify.

How were they involved?

☐ Surveys
☐ Team Meeting
☐ Group Review
☐ Other

Please specify:

Q7) Have you identified a negative/potential negative impact (direct /indirect discrimination)?

No	☐	yes	☐

Q7a) If 'No' Explain why you have made this decision?

Q7b) If 'yes' explain the negative impact – you may need to complete a full EIA

If a negative impact has been identified please continue to undertaking a full impact assessment. If no negative impact has been identified please submit your Initial Equality Impact Assessment to roh-tr.governance@nhs.net

Justification Statement:
As member of ROH staff carrying out a review of an existing or proposal for a new service, policy or function you are required to complete this EIA by law. By stating that you have not identified a negative impact, you are agreeing that the organisation has not discriminated against any of the protected characteristics. Please ensure that you have the

evidence to support this decision as the Trust will be liable for any breaches in the Equality Legislation.

Completed by:

Name:	
Designation:	
Date:	
Contact number:	

This EIA has been approved:

Name:	
Designation:	
Date:	
Contact number:	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Equality Impact Assessment

Full Assessment Form

Having completed the Initial EIA Screening Form (Appendix A) which identified a negative or potential negative impact, you are required to complete this Full Equality Impact Assessment form. This will involve you questioning aspects of a proposed/existing policy, guideline or strategy and forecasting the likely effect on different groups.

Step 1) What is the impact?

1) Why have you carried out this Full Equality Impact Assessment?

Please mention any additional impacts in the box below. This could include contributing factors or conflicting impacts/priorities (e.g. environment, privacy and dignity, transport, access, signage, local demography) that has resulted in indirect discrimination or anyone else who will be impacted on by your policy, guideline or strategy.

Step 2) What are the differences?

2a) Identify the Equality group(s) that will be affected by the impact and state what the differences are:

Protected Characteristic	**Negative / Potential Negative Impact**	**Positive / Potential Positive Impact**	**How is the Equality group identified affected in a different way to others as a result of the policy, guideline or strategy?**
Age	☐	☐	
Disability	☐	☐	
Race	☐	☐	
Sex	☐	☐	
Gender Reassignment	☐	☐	
Sexual Orientation	☐	☐	
Religion or Belief	☐	☐	
Pregnancy & Maternity	☐	☐	
Marriage & Civil Partnership	☐	☐	
Other socially excluded groups	☐	☐	

2b) If this EIA indicates that there is insufficient evidence to judge whether there is differential impact please state why below.

Step 3) Consultation

3a) With whom have you consulted on your policy and when did the consultation take place?

3b) As a result of the consultation are there any further changes to the policy needed?

Step 4) Plan to address negative impact

4a) Please complete your action plan using the table below. Detail how you are going to address the negative impact, stating the timescales involved.

Protected Characteristic	Negative Impact	Action Required	Cost Implications	Expected Outcome	Lead (name and job title)	Timescale (specify dates)

Completed by:

Name:	
Designation:	
Date:	
Contact number:	

This EIA has been approved by:

Name:	
Designation:	
Date:	
Contact number:	

APPENDIX G – POLICY IMPLEMENTATION PLAN

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	
ACCOUNTABLE EXECUTIVE LEAD:	
POLICY AUTHOR:	
APPROVED BY:	
DATE OF APPROVAL:	

An implementation plan must be developed for all policies. This will ensure that a systematic approach is taken to the introduction of policies in order to secure effective working practices.

The following template provides a list of activities to consider as a starting point for thinking about implementation in a systematic manner.

IMPLEMENTATION PLAN OWNER: _____

REFERENCE	ACTION	RESPONSIBLE	COMPLETED? (YES/NO)	IF NO, PLANNED COMPLETION DATE	EVIDENCE	STATUS
1	*Communications and engagement*					
a						
b						
c						
d						
2	*Training*					
a						
b						
c						
d						
3	*Resources*					
a						
b						
c						
d						
4	*Monitoring Effectiveness & Evaluation*					
a						
b						
c						
d						

Final date when plan is expected to be fully implemented: _____

Status key:

Green	Fully on target	**Amber**	Some slippage but expected to meet timescale	**Red**	Significantly off target date or failed to complete	**Blue**	Completed

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Policy on the Development, Approval and Management of Trustwide Policies
ACCOUNTABLE EXECUTIVE LEAD:	Chief Executive
POLICY AUTHOR:	Associate Director of Governance & Company Secretary
APPROVED BY:	Trust Board
DATE OF APPROVAL:	February 2016

An implementation plan must be developed for all policies. This will ensure that a systematic approach is taken to the introduction of policies in order to secure effective working practices.

The following template provides a list of activities to consider as a starting point for thinking about implementation in a systematic manner.

ROHTB (2/16) 005 (b)

IMPLEMENTATION PLAN OWNER: Simon Grainger-Lloyd, Associate Director of Governance and Company Secretary

REFERENCE	ACTION	RESPONSIBLE	COMPLETED? (YES/NO)	IF NO, PLANNED COMPLETION DATE	EVIDENCE	STATUS
1	*Communications and engagement*					
a	Consultation period with key stakeholders across ROH	SGL	Yes	N/A	E-mails, hard copy suggestions and amendments made as a result of feedback	
b	Communication of key points of the new policy and revised process	SGL/SXB	No	29-02-16	Weekly e-bulletin	
c	Creation of a FAQ to be included on intranet and/or distributed via staff communications	SGL/SXB	No	16-02-16	FAQ factsheet	
2	*Training*					
a	Training of Governance Facilitator (policies & risk) in new process	SGL	No	29-02-16	E-mail discussions and meetings to discuss implementation of new process	
b	Provide examples of completed policies using new formats for any staff wishing to access these	SGL	No	29-02-16	Mini repository of example policies to be held jointly between CoSec & Governance Team	
c	Divisional governance facilitators to be updated on new process to ensure this feeds into discussions	SGL	No	29-02-16	Calendar invitations and material prepared for meeting to discuss new process	
3	*Resources*					
a	Ongoing source of expert advice to be available for staff creating policies or managing them within the organisation	SGL/ Governance Facilitator	Yes	N/A	CoSec and Governance Facilitator will be on hand to offer advice to staff when needed	
4	*Monitoring Effectiveness & Evaluation*					
a	Six month stocktake of compliance with Policy on Policies	SGL/ Governance Facilitator	No	1-09-16	Report to TMC in September-16 QA sign off sheets for new policies	

ROHTB (2/16) 005 (b)

REFERENCE	ACTION	RESPONSIBLE	COMPLETED? (YES/NO)	IF NO, PLANNED COMPLETION DATE	EVIDENCE	STATUS
b	Annual policy review	SGL/ Governance Facilitator	No	1-02-17	Report to TMC in February-17 QA sign off sheets for new policies	

Final date when plan is expected to be fully implemented: February 2017

Status key:

Green	Fully on target	**Amber**	Some slippage but expected to meet timescale	**Red**	Significantly off target date or failed to complete	**Blue**	Completed

ROHTB (2/16) 006

TRUST BOARD

DOCUMENT TITLE:	**Emergency Preparedness**
SPONSOR (EXECUTIVE DIRECTOR):	**Jonathan Lofthouse, Director of Operations**
AUTHOR:	**Stuart Lovack, Divisional General Manager – Division 4**
DATE OF MEETING:	**3rd February 2016**

EXECUTIVE SUMMARY:

The Board was advised at its workshop in January 2016, that in a letter from Dame Barbara Hakin, National Director: Commissioning Operations, NHS England, which had been received in December 2015, following the Paris terrorist attacks, NHS England together with the Department of Health and other national agencies was reviewing and learning from the incidents that occurred and would ensure that this was then reflected fully in the NHS England established Emergency Preparedness Resilience and Response procedures.

The Board was asked to approve Chair's action to submit the Trust's statement of readiness for a major incident to support the above.

The Chair's action was approved, pending formal ratification at a public Trust Board.

REPORT RECOMMENDATION:

Trust Board is asked to ratify the statement of readiness as agreed at the Trust Board workshop in January 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	X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	x
Business and market share		Legal & Policy	x	Patient Experience	
Clinical		Equality and Diversity		Workforce	x

Comments: Pages within the report refer in some manner to all of the key areas highlighted above.

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Risk to business continuity should readiness not be appropriately considered and preparations made.

PREVIOUS CONSIDERATION:

Trust Board workshop in January 2016.

The full statement of Emergency Preparedness (which referenced preparedness for a major incident) was

considered by the Trust Board at its meeting in September 2015.

FOR DECISION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Emergency Preparedness

Report to Trust Board on 3 February 2016

1 EXECUTIVE SUMMARY

1.1 The Board was advised at its workshop in January 2016, that in a letter from Dame Barbara Hakin, National Director: Commissioning Operations, NHS England, which had been received in December 2015, following the Paris terrorist attacks, NHS England together with the Department of Health and other national agencies was reviewing and learning from the incidents that occurred and would ensure that this was then reflected fully in the NHS England established Emergency Preparedness Resilience and Response procedures.

The letter directed that all NHS Trusts review the following immediately and provide assurance that:

• You have reviewed and tested your cascade systems to ensure that they can activate support from all staff groups, including doctors in training posts, in a timely manner including in the event of a loss the primary communications system;

• You have arrangements in place to ensure that staff can still gain access to sites in circumstances where there may be disruption to the transport infrastructure, including public transport where appropriate, in an emergency;

• Plans are in place to significantly increase critical care capacity and capability over a protracted period of time in response to an incident, including where patients may need to be supported for a period of time prior to transfer for definitive care; and

• You have given due consideration as to how the trust can gain specialist advice in relation to the management of a significant number of patients with traumatic blast and ballistic injuries.

1.2 The Board was asked to approve Chair's action to approve submission of the Trust's statement of readiness pending formal ratification at a public Trust Board. Approval was given.

1.3 The Board is therefore now asked to formally approve the Statement of Readiness in public.

2 Detail

2.1 The Royal Orthopaedic Hospital NHS Foundation Trust is a member of the emergency planning local area network which provides Emergency Planning Resilience and Response (EPRR) for Birmingham, Solihull and the Black Country NHS England – West Midlands. The Trust is supported by the Health Emergency Planning Team (HEPT) which is located at Selly Wharf, Selly Oak, Birmingham. The HEPT team ensure there is a co-ordinated / standardised approach adopted between the local NHS Healthcare Providers within the West Midlands.

2.2 A Memorandum of Understanding exists between the Royal Orthopaedic Hospital NHS Foundation Trust and NHS England to ensure we are prepared for an emergency and deliver our services in the event of a public health incident or outbreak.

2.3 In the event of an emergency the HEPT team will co-ordinate the local NHS response to an incident, ensuring relevant NHS providers are alerted and support the incident as appropriate. The local NHS network is galvanised through the establishment of the Local Health Resilience Forum. This meeting is administered and coordinated through the Health Emergency Planning Team.

2.4 The Trust has reviewed its requirements over the forthcoming months from the Health Emergency Planning Team as follows:

1. Assistance with the delivery of a table-top exercise, to be conducted on site at the Royal Orthopaedic Hospital NHS Foundation Trust.
2. Assistance with the delivery of commander training for the Executive Directors on site at the Royal Orthopaedic Hospital NHS Foundation Trust.
3. Assistance with the delivery of loggist training for staff on site at the Royal Orthopaedic Hospital NHS Foundation Trust.
4. Assistance with the review of the Trust's emergency planning risk register assumptions.
5. Assistance with the Trust's business continuity planning / management arrangements.
6. Review of the emergency planning best practice peer review documentation.

3 CONCLUSION

3.1 Based on information shared with nominated lead emergency preparedness offices and information with the Trusts core standards declaration (as attached), the Director of Operations asks the Board to take assurance as to the Trust's State of readiness and reaffirm its support of the statement of readiness in regard to an external incident as directed.

Jonathan Lofthouse
Director of Operations

26 January 2016

	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

TRUST BOARD

DOCUMENT TITLE:	**Activity Rectification Plan**
SPONSOR (EXECUTIVE DIRECTOR):	**Jonathan Lofthouse, Director of Operations**
AUTHOR:	**Jonathan Lofthouse, Director of Operations**
DATE OF MEETING:	**3 February 2016**

EXECUTIVE SUMMARY:

As part of the Trusts Monitor submission, an activity rectification plan was developed alongside a range of financial sensitivity analysis. The activity rectification plan brings together a range of actions that both seek to aid in year activity delivery and build a stronger foundation from which to build the 2016/17 delivery profile.

REPORT RECOMMENDATION:

- The Board is asked to note the progress being made against actions within the monitor activity rectification plan.
- The Board is asked to support the Director of Operations proposed supplementary work in support of robust consultant job planning and opportunities for day case development.

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		Communications & Media	
Business and market share		Legal & Policy		Patient Experience	x
Clinical		Equality and Diversity		Workforce	

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Aligned to activity performance set out within the Trust's operational plan

PREVIOUS CONSIDERATION:

Board Steering Group on 5 January 2016

FOR INFORMATION

FOR DISCUSSION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Activity Rectification Plan

Report to Trust Board on 3 February 2016

1 EXECUTIVE SUMMARY

1.1 As part of the Trusts rectification submission to monitor, an activity rectification plan was submitted. This activity rectification plan puts forward a number of system construct and process actions which when fully augmented are anticipated to produce both a stabilising effect to current elective delivery and provide a more robust footing for future ongoing activity.

2 TRANSFORMATION INTO ACTION

2.1 By way of assurance framework, the ongoing delivery of the activity rectification plan is subject to weekly confirm and challenge by the Director of Operations and Project Lead for Organisational Turnaround. Reports are updated on a weekly basis and shared formally with executive colleagues via Trust Management Committee.

2.2 Since the introduction of Transformation into Action during early December, the following performance position has been noted.

	30th Nov	7th Dec	14th Dec	21st Dec	28th Dec	4th Jan	11th Jan	18th Jan
Worst	176	288	298	149	89	238	298	298
Likely	182	297	308	154	92	245	308	308
Best	203	322	333	166	103	273	333	333
Actual	306	248	291	175	114	302	304	300
%> Worst	73.86%	-13.89%	-2.35%	11.41%	15.73%	26.89%	2.01%	0.67%

2.3 The performance differential between Worst and Best performance is 11.74%. The aggregate position from 30th November reflects 10.48% above the worst case, be that with two dips and a lessening of over overachievement. The performance should be considered alongside the Director of Finance's report as a number of assumptions had been made regarding case mix contribution vs. the impact of enhanced payments and additional working. The Trust is also aware that a large volume of consultants will not be operating over the Easter and half term periods which whilst again reflected in the future activity profile will see a stabilising of performance towards the Likely average.

2.4 The Director of Operations has taken some time since the January Board workshop to question and reflect upon what additional actions could be progressed with the intention

of sustaining the future activity wellbeing of the Trust. Rather than simply building on work already underway, the Director of Operations believes there exists two distinct risks and thus priorities that require further sustained work to mitigate. These being;

1. Consultant Job Planning
2. The segregation of inpatient and day case work

3 CONSULTANT JOB PLANNING

3.1 The approach to job planning at ROH remains traditional, with surgeons having access to physical resources such as Theatre and Clinics at the same time each week. In 2013 the Trust Board agreed to pursue the first round of job planning since implementation of the 'new' contract in 2003 and to capture the 'current state' of job plans, rather than lever any fundamental change in practices.

3.2 The operational consequences of the current approach to job planning are as follows:

- There is limited flexibility either at an individual or service team level to cross cover direct clinical care activities.
- There is limited opportunity for consultant engagement in problem solving outside of times assigned for direct patient care in theatre and clinic due to extensive off-site working during non-clinical time.
- An uneven utilisation of the Trust's theatre and clinic resources due to a predominant focus on provision of surgery Monday to Thursday and periods of time during the year when whole consultant teams are not delivering clinical activity due to attendance at professional conferences.
- Instances of patients experiencing extended length of stay due to limited post-operative consultant review.

3.3 There is a need for change in consultant job planning to more effectively balance the career development needs and professionalism of doctors, with the need for working patterns to be flexible and responsive to changing needs of the service and continuity of patient care. Without this change it is unlikely that the Trust will be able to achieve increased efficiency from the physical theatre and clinic resources and therefore deliver the activity plan.

3.4An electronic job planning tool has been procured to support delivery of change and a detailed project plan is being developed. The diagram in appendix one details the proposed timetable and approach.

3.5 The change will be led by the Director of Operations, Director of Workforce and OD and Medical Director. At the Trust Board meeting the Board will need to discuss it's unitary approach to handling all aspects of this change in order to maximise utilisation of physical resources and reduce the costs associated with premium-time working.

4 THE SEGREGATION OF INPATIENT AND DAYCASE WORK

4.1 The Theatre stock is our most high cost and in demand resource and therefore any efficiency that can be made would have a positive effect in allowing new/additional profitable work to be undertaken or if this were not possible, cost to be removed.

4.2 ROH is near unique in its merged pathway of allowing day case and inpatient flows to be managed through a single system and environment. Over the last two decades acute providers in the UK have moved incrementally to segregate day case and inpatient theatre environments in order to improve patient experience and realise efficiencies. As a result consultants have a mix of separate inpatient and day case theatre activities scheduled into their job plan.

4.3 As very nearly half of all ROH's elective work is processed as a day case admission, but treated with the main theatre complex, there exists significant opportunity to both redesign current working practices to achieve increased efficiency and create capacity to both grow income and increase market share.

5 RECOMMENDATION

5.1 The Director of Operations proposes a scoping piece of work, potentially engaging an external partner, to explore what efficiency gains may be achievable with both improved personal contribution and a redesigned work flow process. The Director of Operations proposes adding this action to the Activity Recovery Plan for work up.

5.2 The Board is asked to note the portfolio of actions under way and improving performance position.

Jonathan Lofthouse

Executive Director of Operations
29 January 2016

Overview of Job Planning 2016/17

- Establishing Demand
- Compiling work diaries
- Assessing capacity
- Reviewing existing job plans and objectives
- Deciding min No of patients per list

Preparing for the Job Plan Review (March)

AMDs, DGM, CSLs and CSMs

- Discussing approach
- Reviewing on-call commitments
- Deciding who does what
- Reviewing clinical activity and outcomes
- Education outcomes

Service/Team Discussions (April)

- Agreeing job plan work schedule
- Agreeing objectives
- Assessing compliance against pay threshold criteria
- Job Plan sign-off

Individual Job Plan Meetings (May)

- Service wide job plans reviewed for consistency
- Contracted PA levels compared with demand levels
- Samples of objectives quality assured
- Director of Ops approval

Quality Assurance (June)

- Pay threshold decisions made
- Salary changes approved and processed

Processing (July)

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (2/16) 007

TRUST BOARD

DOCUMENT TITLE:	**CQC Action Plan**
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:	**3 February 2016**

EXECUTIVE SUMMARY:

This brief report provides detail of the action plan developed in response to the CQC report received by the Trust on 4 December 2015.

The purpose of the action plan is to define, at a high level, the overall continuing quality improvement journey ROH is making and the improvement goals that the Trust will work towards over the next 8-12 months. The plan includes all of the 'MUST DO' recommendations in the CQC Quality Reports. Detailed plans are being developed for each project/work area. In addition detailed plans are in place to execute all of the 'SHOULD DO' actions at Trust level.

The plan outlines the Trust's overall ambition to be "first choice for orthopaedic care". It is therefore not the intention that the improvement goals will all be achieved by December 2016, but rather significant progress can be demonstrated against all of them. The plan includes a number of key milestones and these will be reported on at the monthly Quality and Safety Committee. The milestone dates are all the end of the month unless a specific date is recorded.

A separate monthly progress report will be produced to demonstrate progress against milestones and improvement goals. The dates in the plan will not change unless specifically agreed by the Quality and Safety Committee

REPORT RECOMMENDATION:

Trust Board is asked to :

- Note and discuss the action plan and proposals for monitoring delivery of the plan

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	x	Communications & Media	x
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:

Aligns to Trust objective to be ' the first choice for orthopaedic care'.
Aligns to CQC Regulations, 12, 13, 15, 17 , 18 and 20a

PREVIOUS CONSIDERATION:

The CQC action plan has previously been considered at the Board workshop on 13 January 2016, the Quality & Safety Committee on 27 January 2016 and by the Trust Management Committee on 27 January 2016. The action plan will also form a substantive element of the discussions at the Quality Summit on 2 February 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (2/16) 007 (a)

Introduction

The purpose of this plan is to define, at a high level, the overall continuing quality improvement journey ROH is making and the improvement goals that the Trust will work towards over the next 8-12 months. The plan includes all of the MUST DO recommendations in the CQC Quality Reports and detailed plans are being developed for each project/work area. In addition detailed plans are in place to execute all of the SHOULD DO actions at Trust level.

The plan outlines the Trust's overall ambition to be "first choice for orthopaedic care". It is therefore not the intention that the improvement goals will all be achieved by December 2016, but rather significant progress can be demonstrated against all of them. The plan includes a number of key milestones and these will be reported on at the monthly Quality and Safety Committee. The milestone dates are all the end of the month unless a specific date is recorded.

A separate monthly progress report will be produced to demonstrate progress against milestones and improvement goals. The dates in the plan below will not change unless specifically agreed by the Quality and Safety Committee.

Section A – Quality Improvement Programme

REQUIREMENT NOTICES

No	Regulation	Quality Improvement Project	Expected Outcome	Shortfall	KPI/Measure	Dependency/ Resources/ Support	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	5 Months Milestones (Jan – May 2016)	8 Months Milestones (Jan – Aug 2016) & Beyond
1	*Regulation 17 HSCA (RA) Regulations Act 2014 Good Governance*	Improvement in waiting times in OPD. Improvement in access to imaging services for patients Improved Patient Experience	Improved access and flow to OPD Improved access to diagnostic tests Implementation of standardised clinic rules at sub – speciality level	*OPD - The flow of patients through the OPD was not being effectively assessed and monitored to ensure patients were not kept waiting for appointments.* *There were not effective management arrangements in place over and within the OPD to assure a firm and consistent grip on the process of clinic booking and patient flow to improve waiting times and timely access to imaging services for patients*	Waiting times for clinic less than 60 minutes by May 2016 Waiting times for clinic less than 30 minutes by November 2016 Block booking of clinics to stop in line with timescale below: End April 2016: no more than 40% of clinics using block booking	Full introduction of the In Touch system in OPD. Upgrade to PAS system Development of a standardised clinic template	**Jonathan Lofthouse**	Janet Davies/ Enderjit Aujla	Roll out of training programme for all staff in use of IN TOUCH system commenced by end February 2016 Review and Implement SOP for clinic waits across all PODS and services within OPD. Development of a SOP for booking diagnostic tests prior to OPD appointment Commence review of all consultant clinic templates in order to develop a standardised clinic rules for use across sub-	Implementation of' In touch' system in OPD by April 2016. Audit of compliance with waiting time SOP to be reported to Divisional Clinical Governance Board by end April 2016 Implementation of SOP for booking diagnostic tests prior to clinic appointments. Findings presented to Divisional Clinical governance board New reports developed to track bookings, cancellations and waiting times by end April 2016 Monthly reports on clinic	No further action required Monthly audit of compliance reviewed by Divisional Clinical Governance Board

No	Regulation	Quality Improvement Project	Expected Outcome	Shortfall	KPI/Measure	Dependency/ Resources/ Support	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	5 Months Milestones (Jan – May 2016)	8 Months Milestones (Jan – Aug 2016) & Beyond
					End June 2016 No more than 30% of clinics using block booking End September 2016: no clinics will use block booking as a clinic template. All staff trained in use of' In Touch' software system by end March 2016.				specialities. Develop a local SOP to be followed in the event of a planned clinic cancellation	bookings, waiting times and cancellations to Divisional Governance Board by end June 2016. Develop roll out plan for implementation of revised clinic template	Complete review of all consultant templates by end September 2016 Implement changes to clinic templates by end December 2016 Half yearly report on waiting times, adherence to SOPs and patient experience to Divisional Governance Board by end October 2016.
2	*Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment*	Staff access to appropriate level of Safeguarding Training	All staff will have received the appropriate level of safeguarding training.	*Within OPD, inadequate numbers of staff had undertaken appropriate safeguarding training for both adults and children including the correct levels dependent on the level of contacts.*	100 % of nursing staff will have achieved: Level 2 Children's Safeguarding Training Level 1 Adult Safeguarding Training.	N/A	**Garry Marsh**	Evelyn O'Kane Paper detailing scope of training requirement to Clinical Quality Group by end January 2016.	Level 2 Children Safeguarding: 9 out of 12: staff to have completed Level 1 Adult Safeguarding 12 out of 12 staff to have completed	Level 2 Children Safeguarding: 12 out of 12 staff to have completed by end March 2016	Evidence of monitoring of mandatory requirement that all staff are compliant with KPI to be reported monthly to Divisional Governance Board.

No	Regulation	Quality Improvement Project	Expected Outcome	Shortfall	KPI/Measure	Dependency/ Resources/ Support	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	5 Months Milestones (Jan – May 2016)	8 Months Milestones (Jan – Aug 2016) & Beyond
3	*Regulation 15 HSCA (RA) Regulations 2014 Premises and Equipment*	Improved facilities for the care of paediatric patients on HDU	There will be a distinct paediatric facility on HDU which meets national and best practice standards	*Children were being cared for on an adult HDU which did not have either the facilities or space required to meet their needs.*	100% of children will be cared for in a distinct paediatric facility	Amendments to physical HDU environment, creation of additional toilet/washing facilities and segregation of Paediatric and adult zones	**Jonathan Lofthouse**	Stuart Lovack	Appoint architect by Jan 2016	Design development complete by end March 2016 Tender and evaluation complete by end April 2016	Construction begins June 2016 and completes October 2016. New paediatric premises available for use by end November 2016
4	*Regulation 15 HSCA (RA) Regulations 2014 Premises and Equipment*	Improved facilities for all adult patients on HDU ensuring compliance with DH MSSA requirements and compliance with NHS Contract	Separate Toilet and bathroom facilities will be available for male and female patients on HDU	*The responsiveness of HDU required improvement. The availability of one toilet means that both males and females used the facilities which is not acceptable and does not meet the NHS contract requirements. In addition, the accommodation of both children and adults on the same unit was contrary to national guidance.*	Full compliance with MSSA Guidance and requirements of the NHS Contract	Amendments to the physical environment within HDU environment to create an additional toilet / bathroom in order to meet MSSA regulations	**Jonathan Lofthouse**	Stuart Lovack	Identify additional facility Develop business plan and secure funding Draw up plans for new facility	Undertake building work to create additional facility Confirm compliance with MSSA requirements and NHS Contract requirements	No further action

No	Regulation	Quality Improvement Project	Expected Outcome	Shortfall	KPI/Measure	Dependency/ Resources/ Support	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	5 Months Milestones (Jan – May 2016)	8 Months Milestones (Jan – Aug 2016) & Beyond
5	*Regulation 18 HSCA (RA) Regulations Staffing*	Improved access to paediatric nurse cover	All Children will be cared for a by a Registered Children's Nurse	*HDU required paediatric trained nurses to care for children for the full length of their stay.*	100% of children in HDU will be cared for a Registered Children's Nurse	Successful recruitment to vacant posts	**Garry Marsh**	Talitha Carding	Approve the SOPs for admission of elective and emergency patients to HDU (action complete - approved December 2015) Develop implementation plan for SOPS and demonstrate completion to TMC Undertake further recruitment of registered children's nurses following unsuccessful recruitment on 11.12.2015. Three candidates applied and were shortlisted, none attended for interview. Adverts have been placed offering a number of options for paediatric nurses at ROH including a rotational programme, development of HDU skills and access to additional training. National Journals have been sourced and used to extend reach of advert. Complete 'Children's Critical care Passport' arrangements at BCH by end January 2016 Assess adult nurses against the passport competencies in line with trajectory agreed at TMC in December 2015.	No further action No further action An increase to a minimum of 2 Registered Paediatric nurses at all times to achieve RCN standards. Implement a revised preceptorship programme for all new starters to HDU No further action All adult nurses on HDU will have completed the paediatric competency document by end March 2016.	Audit implementation of revised Transitional Care Policy by end September 2016 Maintain appropriate nurse staffing levels. All new staff will have completed the preceptorship programme No further action No further action

No	Regulation	Quality Improvement Project	Expected Outcome	Shortfall	KPI/Measure	Dependency/ Resources/ Support	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	5 Months Milestones (Jan – May 2016)	8 Months Milestones (Jan – Aug 2016) & Beyond
									Implement rotation programme between paediatric HDU and in-patient ward.	Rotational programme between Ward 11 and HDU fully implemented	All nursing staff on ward 11 will have completed rotation to HDU by end December 2016. Maintain rotational programme . Monitor effectiveness through Divisional Governance Groups.
									Develop a programme of collaboration with BCH to access competency based training for all HDU nursing staff and present to TMC by end January 2016.	Develop roll out programme for competency based training with BCH	All nursing staff on HDU will have completed competency based training programmes at BCH by end October 2016 to include: Assisted Airway Course Paediatric Assessment Course
										Review and approve Transitional Care Policy by end March 2016 Complete implementation of Transitional Care Policy by end May 2016	Monitor compliance with Transitional Care Policy in line with policy audit plan

No	Regulation	Quality Improvement Project	Expected Outcome	Shortfall	KPI/Measure	Dependency/ Resources/ Support	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	5 Months Milestones (Jan – May 2016)	8 Months Milestones (Jan – Aug 2016) & Beyond
6	*Regulation 18 HSCA (RA) Regulations Staffing*	Improved access to paediatric medical cover	Completion of a review by RCPCH to include: Review of current arrangements for medical advice, nursing support and management Review of the processes for risk assessing children prior to admission Review of processes for management of the deteriorating child and the safety of arrangements for transfer through the Critical Care Network	*The arrangements in place were not adequate regarding the medical cover for the deteriorating child. By not having a paediatric doctor on the premises apart from twice a week and telephone support. This meant that visual assessment by a suitably qualified doctor was limited.*	Completion of RCPCH review	Royal College review of ROH's alternative medical model.	**Andrew Pearson**	Dr Da Silva	TORs for review were agreed on 24.12.2015 Establish timeframe for review.	Completion of review by end March 2016 (subject to the availability of RCPCH reviewers) Development of an action plan to respond to review recommendations	Monitoring arrangements for implementation of action plan in place

MUST DO

No	Regulation	Quality Improvement Project	Expected Outcome	Shortfall	KPI/Measure	Dependency/ Resources/ Support	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	5 Months Milestones (Jan – May 2016)	8 Months Milestones (Jan – Aug 2016) & Beyond
7	*Regulation 12: Safe Care and treatment*	Locked storage is available for intravenous fluids on HDU	IV Fluids will be stored in a locked cupboard.	*IV fluids were not locked away*	IV Fluids are secured in locked cupboard 100% of the time	N/A	**Garry Marsh**	Talitha Carding	Lock away all intravenous fluids. Completed December 2015 Undertake audit of compliance by end Feb 2016	No further action	No further action
8	*Regulation 20a: Requirements as to display of performance assessments*	Consistency in recording and reporting Safety Thermometer Data	Accurate completion and recording of Safety Thermometer data	*Inconsistency in reporting Safety Thermometer data* *Completion of the Safety Thermometer required improvement to ensure that all risks were appropriately identified on HDU*	Data accurately recorded and presented 100% of the time from end February 2016	N/A	**Garry Marsh**	Talitha Carding	Review process of Safety Thermometer data collection by end Jan 2016 Make recommendations for implementation of revised process Implement revised process	No further action required	No further action required
9	*Regulation 12: Safe Care and treatment*	Enable benchmarking against other Critical care Units	Upload of monthly data to ICNARC website	*The Trust had not started to contribute data to the Intensive Care National Audit & Research Centre (ICNARC) therefore it was not possible to benchmark it against other similar units. This had been identified at the last inspection but had not been fully resolved.*	100% benchmarking uploaded to ICNARC monthly from March 2016	Successful recruitment to admin role	**Jonathan Lofthouse**	Matt Payne	Secure Software – complete September 2015 Roll out Training programme- complete November 2015 Train department PA to upload data Enrol with ICNARC	Begin Upload to ICNARC by end March 2016 Monthly benchmarking reports to Divisional governance Board by end April 2016	No further action required
10	*Regulation 20: Duty of Candour*	Compliance with Regulation 20 - Statutory Duty of Candour	100% of all staff will comply with Duty of Candour	*The arrangements for the trust to discharge its duty of candour, although understood by staff, were not thorough*	100% of staff will comply with CQC DoC Regulation 20	N/A	**Garry Marsh**	Anne Crompton	Relaunch of policy and process within the Trust by end January 2016 Review of mandatory training by end February 2016	Implement revised mandatory training programme by end March 2016 Audit of compliance with DoC presented to QSC by end April 2016	Bi –annual audit of compliance with DoC added to QSC work plan

No	Regulation	Quality Improvement Project	Expected Outcome	Shortfall	KPI/Measure	Dependency/ Resources/ Support	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	5 Months Milestones (Jan – May 2016)	8 Months Milestones (Jan – Aug 2016) & Beyond
11	*Regulation 18: Staffing*	Improved staff attendance	All staff will be managed in line with Trust sickness/ absence policy.	*Sickness levels among staff had risen to almost twice the trust target in June 2015*	100% of all staff sickness will be managed in line with Trust Sickness/ absence Policy	N/A	**Jonathan Lofthouse**	Anne-Marie Williams	Provide evidence that Trust sickness management policy being fully adhered to within the Department to the Divisional Governance Board by end January 2016	Monthly monitoring of sickness rates at Divisional Governance Board	Monthly monitoring of sickness rates at Divisional Governance Board
12	*Regulation 18: Staffing*	Training and Development of staff	All staff will be up to date with mandatory training	*The compliance rate for mandatory training was falling short of the trust target by a significant amount.*	95% of staff In OPD will be up to date with Mandatory Training	N/A	**Jonathan Lofthouse**	Janet Davies	Develop schedule of training to ensure staff are meeting mandatory training.	A detailed plan to ensure that all staff are up to date with mandatory training presented to Divisional Governance Board Implementation of monitoring programme for all mandatory training at Divisional Governance Board	Implementation of monitoring programme for all mandatory training at Divisional Governance Board
13	*Regulation 17: Governance*	Sharing, learning and implementing actions from SIs	All staff will be aware of the process by which learning from incidents is disseminated and implemented	*OPD staff could not tell us if Governance put explanations and findings from investigations into writing to the patient as there had been no severe harm incidents in the OPD to test the procedure.*	95% of all staff will be able to describe how learning from incidents and implementation of actions is shared across the Trust	N/A	**Garry Marsh**	Anne Crompton	Relaunch of SI policy and process within the Trust Introduction to revised policy included as part of mandatory training programme	Audit of staff within OPD against principles outlined in SI Policy. Publication of audit findings and evidence of discussion at Divisional Governance Board	Bi –annual audit against principles of SI policy. Publication of audit findings and evidence of discussion at Divisional Governance Board

SHOULD DO

No	Regulation	Quality Improvement Project	Expected Outcome	Shortfall	KPI/Measure	Dependency/ Resources/ Support	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	5 Months Milestones (Jan – May 2016)	8 Months Milestones (Jan – Aug 2016) & Beyond
14	*Regulation 15: Premises and equipment*	Access in an emergency situation enabled	All side rooms will have adequate space to allow access to emergency equipment	*Side rooms were often used for children. We observed that this was problematic when side rooms had an additional bed to enable a parent or carer to stay alongside the child or adult. There was a risk that in an emergency situation it may be difficult for staff with emergency equipment to access the patient.*	N/A	Completion of refurbishment of HDU	**Jonathan Lofthouse**	Talitha Carding	Patient & Carer beds removed from side rooms November 2015 Source and procure recliner for parent use completed by December 2015	This action will be completed as part of the refurbishment of HDU detailed in action 3 above	No further action required once refurbishment complete
15	*Regulation 15 : Premises and equipment*	Adequate storage facilities for HDU equipment when not in use	All staff will have access to improved storage facilities	*There was very limited storage space.*	There will be no equipment stored in bays on HDU	Completion of refurbishment of HDU	**Jonathan Lofthouse**	Stuart Lovack	Scoping of additional storage creation within estates plan to be completed. Identification of additional storage facilities	This action will be completed as part of the refurbishment of HDU detailed in action 3 above	No further action once refurbishment complete
16	*Regulation 12: Safe Care and treatment*	All ward rounds will have MDT input	All patients will have a MDT ward round daily	*Ward rounds were generally not multi-disciplinary. However, the nurse allocated to that patient was present for all professional reviews. Multidisciplinary working can improve patient outcomes and provide effective patient care*	100% of ward rounds will have MDT input	Review of Consultant PAs on HDU	**Andrew Pearson**	Matt Payne	Review ward round process to include NHS England seven day services standard around MDT working. Present implementation plan to TMC in February 2016	Implementation of revised ward round to ensure compliance with NHS England seven day services standard around MDT working by end April 2016.	Audit of compliance undertaken and presented to Divisional Governance Board by December 2016
17	*Regulation 12: Safe Care and treatment*	Review of new to follow up ratio in all clinics	New to follow up ratio comparable with benchmarked Trusts	*The Trust had a high new to follow up ratio of 1:4.73*	New to follow up ratio will be appropriate to speciality 95% of the time	Dependent implementation of actions outlined in Action 1 above	**Jonathan Lofthouse**	Anne-Marie Williams (with support of Informatics team)	Develop reporting tool to capture new to follow up ratio at patient, speciality and consultant level	Review data to identify which clinic(s) have a high new to follow ratio at patient, speciality and consultant level Undertake analysis of data to establish if new to	Develop action plan for implementation of findings Implement action plan to reduce new to follow up ratio where identified as necessary

No	Regulation	Quality Improvement Project	Expected Outcome	Shortfall	KPI/Measure	Dependency/ Resources/ Support	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	5 Months Milestones (Jan – May 2016)	8 Months Milestones (Jan – Aug 2016) & Beyond
										follow up ratio can/ should be reduced Develop action plan for implementation of findings	Undertake bi-annual audit of all clinics new to follow up ratio and benchmark against comparable Trusts.
18	*Regulation 13: Safeguarding service users from abuse*	Access to services for patients with LD	Improved access to services for patients with a Learning Disability	*The particular help that patients with a learning disability might need in the outpatients services was not in place.*	100% of patients with a Learning Disability will be supported to have full access to all Trust Services	Full Implementation of revised LD Strategy	**Garry Marsh**	Evelyn O' Kane	Develop and launch a revised LD Strategy across the Trust	Implement revised strategy Undertake audit of compliance with principles of strategy and present findings to Trust Safeguarding Committee	Annual audit of compliance presented to Safeguarding Committee
19	*Regulation 12: Safe Care and treatment*	Improved Patient Experience	Removal of block booking of clinics Implementation of SOP for pre booking diagnostic tests prior to clinic appointment	*The clinic booking service was complicated and 'block booking' of patients for appointment slots was happening for some clinics. This led to different waiting times for some patients especially when doctors had not referred ahead for x-ray.*	No clinics will be block booked Block booking of clinics to stop in line with timescale below: End March 2016: no more than 40% of clinics using block booking End June 2016 No more than 20% of clinics using block booking End August 2016: no clinics will use block booking as a clinic template.	This action is dependant of completion of Action 1 above	**Jonathan Lofthouse**	Janet Davies	Commence review of all consultant clinic templates in order to develop a standardised clinic template for use across all services. Development of a SOP for booking diagnostic tests prior to OPD appointment	Develop roll out plan for implementation of revised clinic template Implementation of SOP for booking diagnostic tests prior to clinic appointment	Implementation of SOP for booking diagnostic tests prior to clinic appointment Complete review of all consultant templates by end September 2016 Implement changes to clinic templates by end December 2016 Half yearly report on waiting times, adherence to SOPs and patient experience to Divisional Governance Board by end October 2016.

No	Regulation	Quality Improvement Project	Expected Outcome	Shortfall	KPI/Measure	Dependency/ Resources/ Support	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	5 Months Milestones (Jan – May 2016)	8 Months Milestones (Jan – Aug 2016) & Beyond
20	*Regulation 12: Safe care and treatment*	Improved Patient experience	Reduction in waiting times for OPD clinics	*The improvements around how consultants ran their clinic appointments was patchy and needed firmer management*	Evidence that improved management practice has been applied to all clinics held in OPD by end October 2016 by compliance with the following metrics: Waiting times for clinic less than 60 minutes by May 2016 Waiting times for clinic less than 30 minutes by November 2016	This action is dependent on completion of Action 1 above	**Jonathan Lofthouse**	Janet Davies	Implement SOP for clinic waits across all PODS and services within OPD.	Audit of compliance with waiting time SOP to be reported to Divisional Clinical Governance Board by end April 2016.	Half yearly report on waiting times, adherence to SOPs and patient experience to Divisional Governance Board by end October 2016.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Corporate Performance Report – December 2015**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Director of Finance**
AUTHOR:	**Paul Athey, Director of Finance**
DATE OF MEETING:	**3rd February 2016**

EXECUTIVE SUMMARY:

The Corporate Performance Report is the main vehicle for reviewing the Trust's overall performance for the month and year to date. It covers quality, operational, staffing and financial performance to allow the Board to discuss any themes or issues arising and actions required as appropriate.

Quality is amber rated in December, with the following key points of note:

- There was 1 Grade 3/4 pressure ulcer, which is the 4th reported in 15/16 and therefore breaches the soft cap agreed with commissioners. This will result in a £1,000 fine
- There was 1 mixed sex accommodation breach reported in month.
- There were 4 SIRIs in month, consistent with the position in October and November
- All other Quality indicators were rated as green

Full detail and challenge of the quality elements of the Corporate Performance Report is undertaken at Quality and Safety Committee

Operational and Staffing issues are also rated as amber in December, with the following key points of note:

- Overall activity was slightly behind our original plan for December, but significantly above the revised plan which supports our revised forecast outturn of a £5.8m deficit reported to Monitor at the end of Month 8. Detailed information regarding activity performance is included within the Activity rectification plan paper.
- All Monitor risk assessment framework targets relating to access were achieved in December, and in Quarter 3 as a whole. Further detail is provided in the Monitor Governance Declaration Paper.
- 52 week breaches continue to increase, with 35 reported at the end of December. The Trust is continuing a dialogue with NHS England to identify a sustainable solution for spinal deformity services, and to ensure that a cap is placed on the growing level of fines.
- There were 2 occasions where cancelled patients were unable to be treated within 28 days of the cancellation.
- Theatre utilisation is red rated for the month, however this is impacted by the Christmas period. No theatres were formally closed for maintenance in December, so theatre session usage is calculated against the physical capacity available. Where theatres were not planned to be used, staffing was stood down appropriately.
- Mandatory training attendance continues to rise, however the proportion of staff with a PDR in place has reduced. Targeted actions are being taken with individual departments to address this.

Finance continues to be red rated, and additional pages have been added to the usual reporting to

incorporate performance against the revised financial plan submitted to Monitor in December, and to provide greater detail on CIP performance.

As part of the revised £5.8m deficit plan, the Trust modelled a deficit position of £987,000 in December, which would have increased our year to date deficit to £4,495,000. The actual position for December was a deficit of £756,000, £231,000 ahead of the revised plan. This was largely driven by the contribution from additional activity undertaken against the revised plan, with a continuation of savings in non-clinical areas also supporting this improvement. Full detail of the performance against plan is provided on the Finance (2) tab of the Corporate Performance Report.

As highlighted at January's Finance and Performance Committee, there are a number of key factors that will determine our success in delivering against, or improving upon, our revised plan deficit of £5.8m. Specifically, these include:

- Delivery of activity plan and the associated delivery of our income targets
- Management of our position with regards to contractual fines, in particular those relating to 52 week breaches
- Receipt of a further £320,000 of insurance payments
- Management of cost pressures linked to the deliverability of our clinical activity targets
- Continued control of non-clinical expenditure
- Delivery of CIPs

December's position highlights that good progress was made with regards to activity delivery, both in terms of overall numbers, and in terms of the case-mix of activity undertaken. Whilst this provides some headroom against our revised plan, it is important that these levels are maintained across the remaining period of the financial year.

As previously mentioned, the Trust are in active dialogue regarding 52 week fines, and our case is being considered by the Regional executive team in early February. Our current plan assumes fines are capped at £500,000, however the worst case scenario is that full fines continue to applied. These would exceed £1m by the end of the financial year.

Work is ongoing to realise the outstanding claims with regards to our insurance payments, however the Trust is struggling to get an adequate response from the NHSLA at this time. This issue is being escalated, however the realisation of this income in 15/16 remains a risk.

December's performance highlights that non-clinical expenditure remained below plan for the second successive month. This provides some assurance that the year end position on non-clinical expenditure can improve upon the forecast within our revised plan.

Performance against our CIP target slowed in December, however conversations that have taken place with leads during January have identified that this partly relates to an under-realisation of savings that have been achieved. It is still anticipated that savings of around £2,500,000 will be delivered. Further detail on CIPs is provided within the Corporate Performance Report.

There remain a few material items, most notably the treatment of 52 week fines, that could impact upon our year end position, however assuming these are delivered in line with the assumptions within our revised financial forecast, there Trust is still anticipating a year end deficit of no worse that £5.8m. If activity over-performance can be maintained, there is the potential for a slight improvement on this position.

REPORT RECOMMENDATION:

The Board are asked to note this report and discuss actions to be taken with regards particularly to the financial and activity issues highlighted.

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	X

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

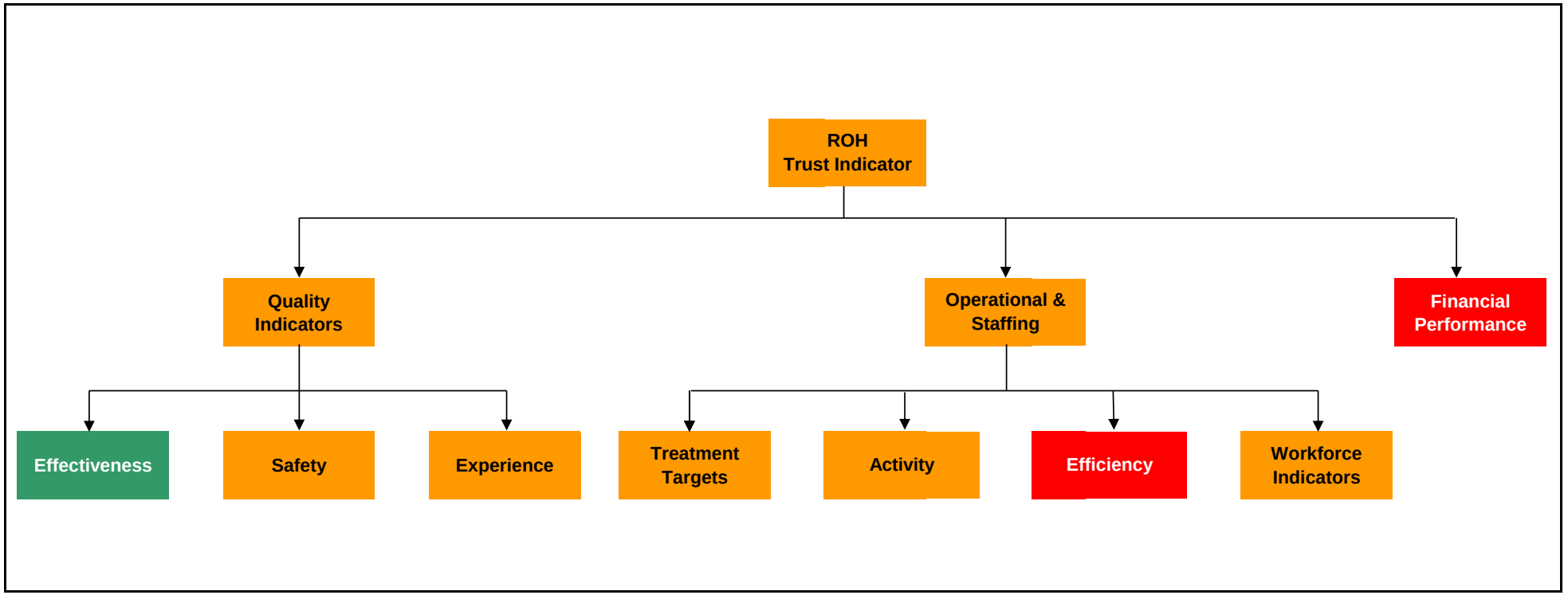
The report is integral to delivery of the strategy in that it provides an overview of current performance, and hence of potential future risk to the quality of care provided and the sustainability of the organisation.

It allows the Board to consider whether areas such as 'Safe and Efficient Processes', 'Fully Engaged Patients and Staff' 'Exceptional Patient Experience' and 'Creating a culture of excellence, innovation and service' are being met.

PREVIOUS CONSIDERATION:

This report builds upon the CPR reviewed by TMC in January

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending December 2015



Quarterly Detailed Report

Executive Summary as at December 2015

Headlines

- The financial deficit remains a significant concern, with a year to date deficit of £4.264m. This is however ahead of the £4.495m deficit anticipated as part of the modelling for a revised £5.8m year end deficit.
- The number of patients waiting for surgery continues to rise, with the backlog of patients waiting over 18 weeks reaching 780.
- Agency expenditure has reduced significantly, from £446,000 in October to £273,000 in December

	December 2015				
Monitor Compliance Framework Targets	**Target**	**Actual - Month**	**Actual - Quarter**	**Score**	**Detail Page**
Referral to treatment time - Non Admitted %	95%	91.99%	91.60%	0	6
Referral to treatment time - Admitted %	90%	86.28%	83.48%	0	6
Referral to treatment time - Incomplete Pathways %	92%	92.09%	92.07%	0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	86%	86%	0	6
Cancer 31 day wait for second or subsequent treatment - surgery	94%	100%	100%	0	6
Cancer 31 day wait from diagnosis to first treatment	96%	100%	100%	0	6
Cancer 2 week (all cancers)	93%	100%	100%	0	6
Clostridium Difficile cases	2 (Full Year)	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	Under Review
Indicative Monitor Financial Risk Rating	2

		December 2015			
Key Trust Targets		**Target**	**Actual**	**Trend**	**Detail Page**
Safety, Experience & Effectiveness	SIRIs	0-2	4	→	3
	Complaints	<=12	11	↑	4
	CQUINS	100%	99%	→	11
	Total Unexpected Hospital Deaths	0	0	↑	5
Efficiency & Workforce	Total Backlog Patients	<400	780	↓	6
	Incomplete 14 - 18 Week Waiters	<450	612	↓	6
	Total Admitted Patient Care Patients vs Plan	100%	96.9%	↑	7
	Unused Theatre Sessions	<44	77	↓	8
	Sickness	3.7%	4.1%	↑	9
Financial	Surplus	(£989k)	(£4,264)	↓	10
	CIP	£2,056k	£1,616k	↓	10
	Agency Expenditure	£295k	£237k	↑	11
	Locum Doctor Expenditure	£145k	£108K	→	11

Trust Summary

Safety Indicators as at December 2015

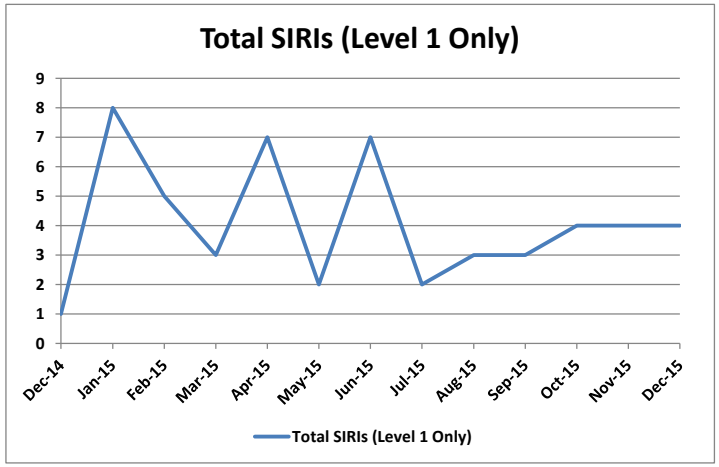
Headlines

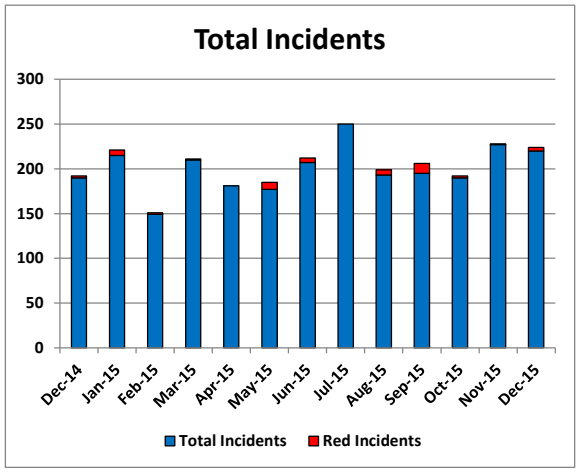
Total Medicine incidents have remained fairly stable in December and remained on target.

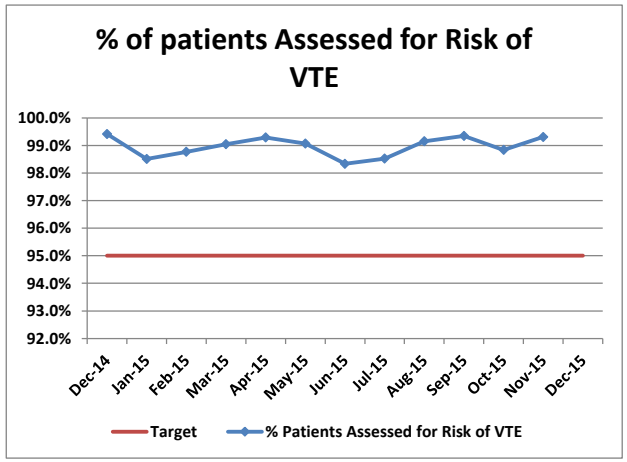
There were 4 SIRIs in month, which is the same level as previous month.

There was a mixed sex occurance in month.

	Monitor	National	CQC Standard		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	15/16 Full Year Position
Safety		N	4,16	Never Events	1	0	0	0	0	0	0	0	0	0	0	0	0	0
			4,16	Total SIRIs (Level 1 Only)	1	8	5	3	7	2	7	2	3	3	4	4	4	4
			4,16	SIRI per 1000 bed days	0.31	2.35	1.67	0.88	2.20	0.60	1.98	0.48	0.84	0.84	0.99	1.04	1.10	1.12
			4,16	Total Incidents	190	215	149	210	181	177	207	250	193	195	190	227	220	204
			4,16	Incidents per 1000 bed days	59.69	63.05	49.73	61.67	56.83	53.43	58.41	60.10	54.35	54.87	47.18	58.85	60.66	56.07
			4,16	Red Incidents	2	6	2	1	0	8	5	0	6	11	2	1	4	4
			9,16	Total Medicine Incidents Reported	20	15	18	30	24	13	26	39	11	19	16	26	23	22
			9,16	Medicine Incidents Reported per 1000 bed days	6.28	4.40	6.01	8.81	7.54	3.92	7.34	9.38	3.10	5.35	3.97	6.74	6.34	5.96
				Medicine Incidents with Harm	5	2	2	3	5	0	0	0	0	0	0	3	6	2
		N	1	Mixed Sex Occurrences	0	0	0	0	0	0	0	0	0	0	0	1	1	2
			9	% Patients Assessed for Risk of VTE	99.41%	98.51%	98.77%	99.04%	99.29%	99.06%	98.33%	98.53%	99.15%	99.34%	98.84%	99.31%		98.97%
			9	Incidence of Hospital Related VTE	1	5	1	3	3	4	6	2	4	2	2	5	2	30
			4	Patient Falls - Inpatients	5	3	4	9	5	1	5	7	4	9	9	7		6
			4	Patient Falls per 1000 bed days	1.57	0.88	1.34	2.64	1.57	0.30	1.41	1.68	1.13	2.53	2.23	1.81		1.58
				Avoidable Patient Falls with Harm	0	0	1	2	1	0	0	1	1	0	0	1		1
			4,16	% Harm Free Care	91.95%	97.89%	98.94%	97.14%	97.26%	98.02%	95.05%	95.24%	97.53%	99.04%	97.83%	99.04%	97.17%	97.40%





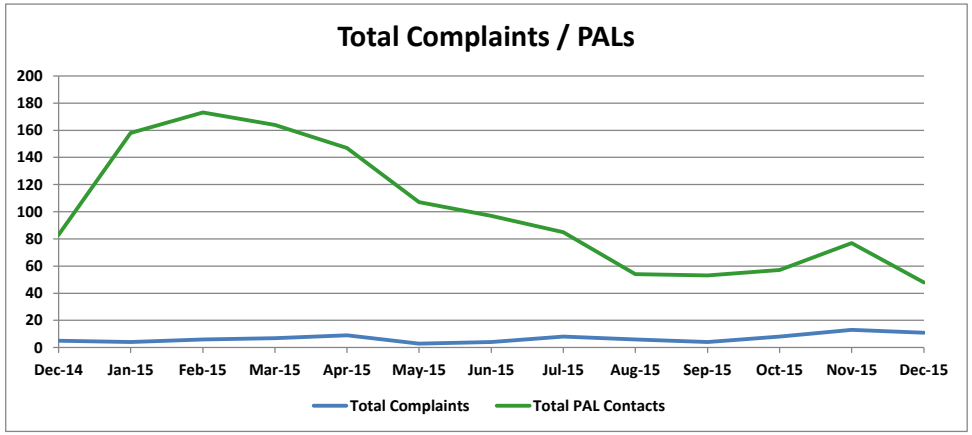


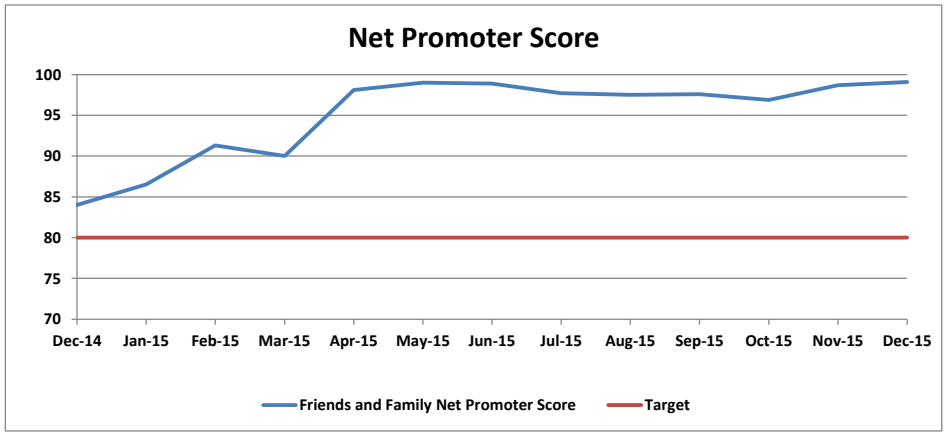
Experience Indicators as at December 2015

Headlines

- Total compliments have significantly increased in month from 304 to 467.
- Total PAL contacts have reduced in month from 77 to 48.

	Monitor	National	CQC Standard		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	15/16 Full Year Position
Experience			17	Complaints to Compliments Ratio	1:107	1:108	1:75	1:60	1:69	1:94	1:27	1:31	1:18	1:21	1:20	1:23	1:42	**1:36**
			17	Total Complaints	5	4	6	7	9	3	4	8	6	4	8	13	11	**7**
			17	Complaints reverted to informal <48 hrs	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.0**
			17	Formal	5	4	6	7	9	3	4	8	6	4	8	13	11	**7**
			17	Complaints per 1000 bed days	1.57	1.17	2.00	2.06	2.83	0.91	1.13	1.92	1.69	1.13	1.99	3.37	3.03	**0.22**
				Complaints Response Time (Average No of Days)	69	24	27	39	35	48	83	77	133	50	64	25	21	**60**
			17	Total PAL Contacts	83	158	173	164	147	107	97	85	54	53	57	77	48	**81**
			17	PALS Contacts per 1000 bed days	26.08	46.33	57.74	48.16	46.15	32.30	27.37	20.43	15.21	14.91	14.15	19.96	13.23	**22.64**
				Total PALS Concerns	52	79	96	86	59	50	64	55	39	35	33	48	28	**46**
			17	Total Compliments	534	433	449	418	619	283	106	251	106	85	159	304	467	**264**
			17	Compliments per 1000 bed days	167.77	126.98	149.87	122.76	194.35	85.42	29.91	60.34	29.85	23.92	39.48	78.82	128.76	**8.06**
				Food - Real Time Patient Survey	96.5%	96.4%	98.8%	94.7%	98.8%	98.8%	96.2%	98.8%		98.6%	99.5%	100.0%	100.0%	**98.8%**
			17	Friends and Family Net Promoter Score	84	87	91	90	98	99	99	98	98	98	97	99	99	**98**
				Friends and Family Response Rate	50.3%	61.0%	59.6%	52.0%	45.3%	48.0%		34.4%	37.0%	28.9%	26.4%	31.8%	20.2%	**34.0%**





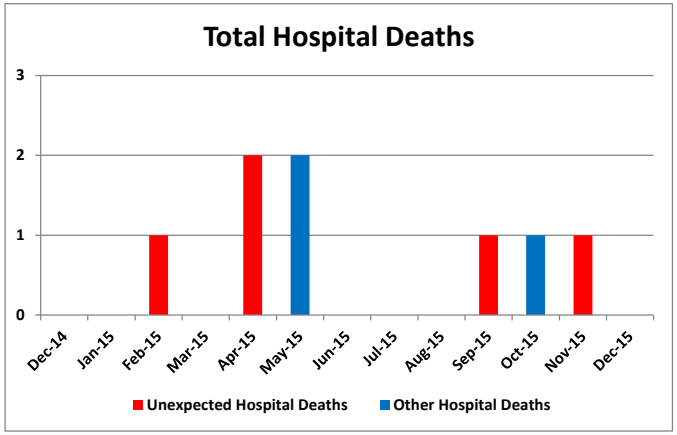
Quarterly Detailed Report
Effectiveness Indicators as at December 2015

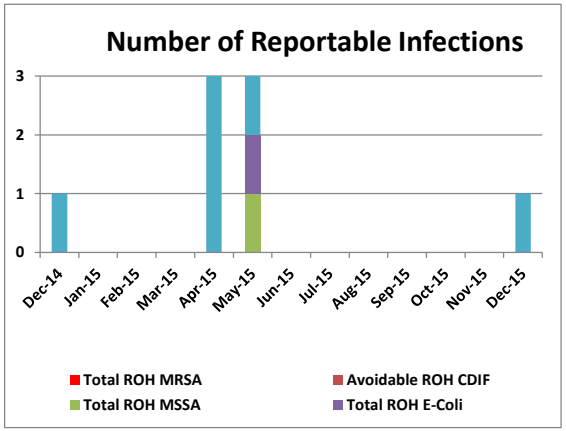
Headlines

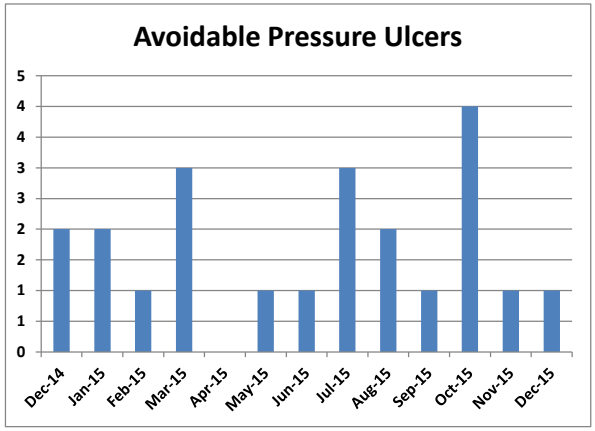
There were no hospital deaths or reportable infections in month.

There was a Grade 3 or 4 pressure ulcer in month. This breaches the contract ceiling, so is likely to result in a £1,000 fine

	Monitor	National	CQC Standard		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	15/16 Full Year Position
Effectiveness			4,18	Total Hospital Deaths	0	0	1	0	2	2	0	0	0	1	1	1	0	0.6
			4,18	Hospital Deaths per 1000 bed days	0.00	0.00	0.33	0.00	0.63	0.60	0.00	0.00	0.00	0.28	0.25	0.26	0.00	0.22
			4,18	Unexpected Hospital Deaths	0	0	1	0	2	0	0	0	0	1	0	1	0	0.3
				Other Hospital Deaths	0	0	0	0	0	2	0	0	0	0	1	0	0	3
			8	MRSA % Screened	111.00%	118.40%	121.80%	131.80%	175.00%	173.03%	169.60%	83.30%	96.30%	153.00%	150.00%	164.00%	172.00%	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	1	0	0	0	3	1	0	0	0	0	0	0	1	5
			8	Total ROH MSSA	0	0	0	0	0	1	0	0	0	0	0	0	0	1
			8	Total ROH E-Coli	0	0	0	0	0	1	0	0	0	0	1	0	0	2
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	0	0	0	0	0	0	0	1	0	0	2	0	1	4
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	2	2	1	3	0	1	1	2	2	1	2	1	0	10
			4	Avoidable Pressure Ulcers per 1000 bed days	0.63	0.59	0.33	0.88	0.00	0.30	0.28	0.72	0.56	0.28	0.99	0.26	0.28	0.43
				% Completion of WHO Checklist	97.81%	99.36%	98.90%	99.57%	99.64%	97.42%	99.12%	99.15%	99.07%	99.15%	99.86%	99.16%		99.07%





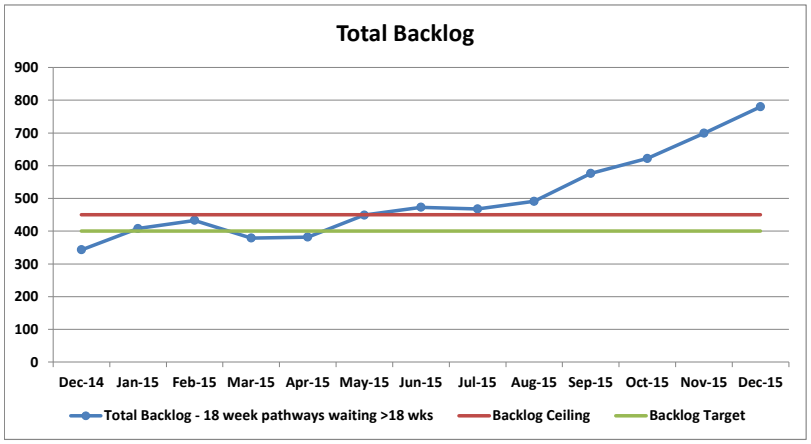


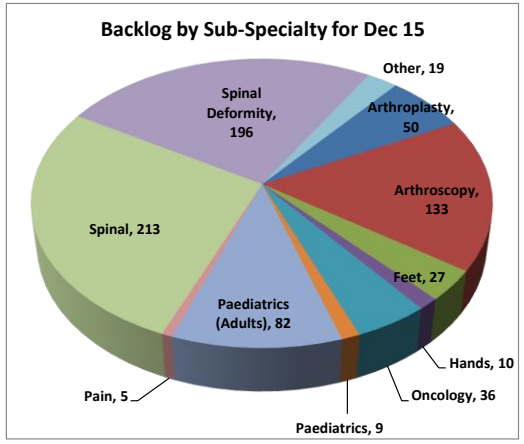
Quarterly Detailed Report
Treatment Targets as at December 2015

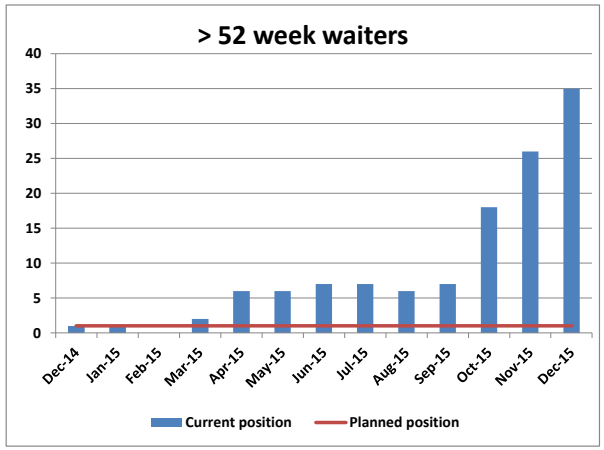
Headlines

- The 18 week incomplete RTT target was achieved in December on a trustwide basis. CCG commissioners have agreed to exclude spinal deformity patients from the calculation of fines relating to RTT. Performance excluding Spinal Deformity in December was 93.68%
- Long waiting patient numbers continue to rise, with 35 patients waiting over 35 weeks, 54 patients waiting over 45 weeks, and 780 patients on incomplete pathways over 18 weeks
- There were 2 cancelled operations not admitted within 28 days

	Monitor	National	CQC Standard		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-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	26	35	35
				Referral to treatment waits over 45 weeks	12	13	11	10	11	22	16	19	30	36	47	52	54	54
	M	N	4	Referral to treatment time - Non Admitted %	95.52%	95.58%	95.11%	95.07%	93.49%	96.12%	95.36%	93.91%	94.70%	93.80%	91.60%	93.88%	91.99%	**93.87%**
	M	N	4	Referral to treatment time - Admitted %	93.05%	92.17%	91.61%	90.17%	90.12%	91.47%	90.58%	89.48%	87.70%	87.04%	86.18%	83.48%	86.28%	**88.29%**
	M	N	4	Referral to treatment time - Incomplete Pathways %	95.20%	94.27%	93.94%	94.55%	94.38%	93.78%	93.69%	93.59%	93.28%	92.27%	92.07%	92.05%	92.09%	**93.02%**
			4	Non admitted Backlog - Pathways waiting >18 wks	119	149	153	124	115	115	144	176	166	163	196	259	346	346
			4	Admitted Backlog - Pathways waiting >18 wks	224	259	280	255	267	334	329	292	325	413	426	440	434	434
			4	Total Backlog - 18 week pathways waiting >18 wks	343	408	433	379	382	449	473	468	491	576	622	699	780	780
			4	Incomplete 14 -18 Week Waiters	520	581	540	522	396	466	461	421	482	565	554	574	612	612
				Non Admitted Median Wait (Weeks)	8.45	9.21	9.07	7.72	8.59	8.64	8.43	8.22	8.09	8.26	8.41	7.70	8.27	**8.29**
				Admitted Median Wait (Weeks)	10.61	11.12	11.59	10.63	9.60	9.98	9.50	9.33	10.36	9.92	9.66	9.68	9.37	**9.71**
				Incomplete Median Wait (Weeks)	6.40	6.66	5.53	5.60	5.65	5.50	5.43	5.75	5.96	6.15	5.83	8.88	6.75	**6.21**
	M	N	4	Cancer 2 week (all cancers)	97.30%	100.00%	100.00%	100.00%	100.00%	97.20%	100.00%	97.8%*	100.00%	100.00%	100.00%	100.00%	100.00%	**99.47%**
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100.00%	100.00%	100.00%	100%*	100.00%	100%*	100.00%	100%*	92.30%	100.00%	100.00%	100%*	100.00%	**98.97%**
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100.00%	100.00%	100.00%	100%*	100.00%	100%*	100.00%	100%*	100.00%	100.00%	100.00%	100%*	100.00%	**100.00%**
	M	N	4	Cancer 62 Day Waits for first treatment (from urgent GP referral)	83.33%	100.00%	100.00%	87.5%*	100.00%	66.70%	75.00%	100%*	100.00%	100.00%	87.50%	100%*	85.7%*	**100.00%**
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	99.79%	99.49%	99.87%	99.68%	99.53%	99.47%	99.38%	99.57%	96.52%	99.52%	99.72%	94.21%	99.09%	**98.40%**
		N	4	Cancelled Ops Not Admitted within 28 days	0	0	2	0	2	0	0	1	0	0	0	0	2	5
			1,21	Data Quality on Ethnic Group - Inpatients	94.24%	97.56%	97.13%	95.80%	96.86%	97.90%	96.42%	96.80%	96.90%	95.37%	95.47%	94.21%	95.21%	**96.13%**





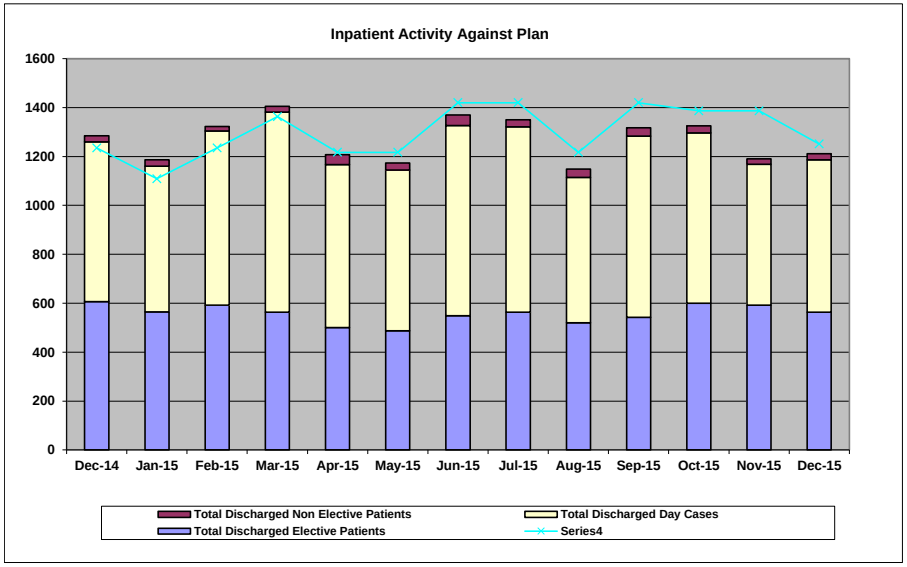


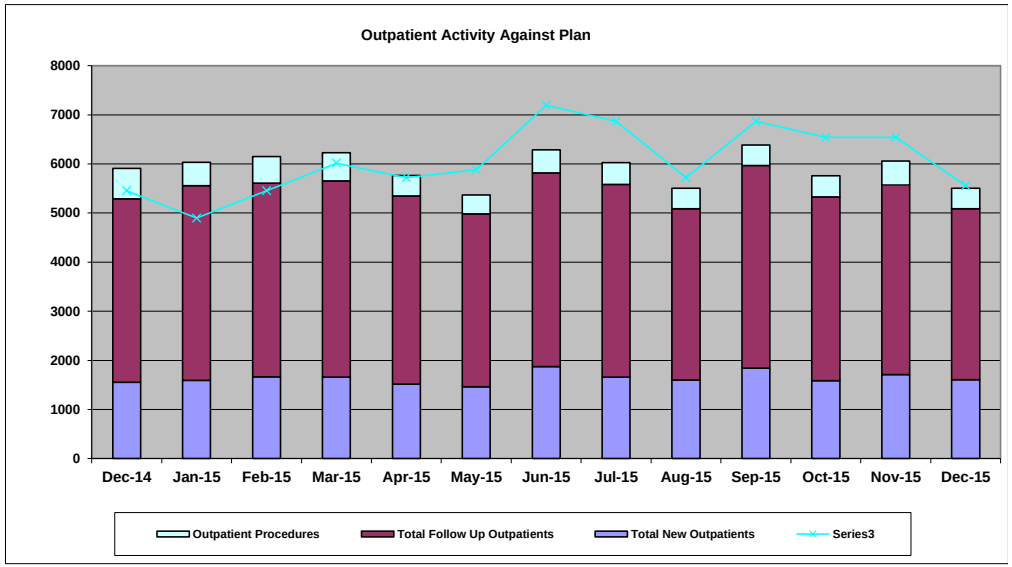
Activity Targets as at December 2015

Headlines

- Overall admitted patient care activity was broadly in line with November's activity, however this was a significant improvement on performance against plan
- Inpatient activity (Elective / Non elective) and general outpatients (New / Follow-up) were on or very near to plan for the month
- Day case activity and outpatient procedures remained behind plan for the month

	Monitor	National	CQC Standard		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	15/16 Full Year Position
Activity			4	Total Discharged Elective Patients	606	565	592	564	501	487	549	564	520	542	600	592	564	4919
			4	Total Discharged Non Elective Patients	25	27	18	24	41	28	44	28	34	35	29	23	25	287
			4	Total Discharged Day Cases	654	595	713	817	666	658	777	758	595	741	696	576	623	6090
			4	Total New Outpatients	1552	1591	1668	1658	1518	1466	1872	1656	1601	1844	1590	1714	1608	14869
			4	Total Follow Up Outpatients	3739	3968	3941	4000	3830	3516	3948	3930	3490	4126	3737	3857	3478	33912
			4	Outpatient Procedures	621	471	543	573	420	386	467	442	411	412	430	489	416	3873
				DC as a % of WL	45.13%	37.47%	42.93%	57.62%	48.61%	46.31%	58.12%	61.73%	45.56%	57.49%	57.24%	44.41%	51.28%	20.63%
			4	Elective as % Against Plan	105.0%	109.1%	102.6%	88.5%	90.8%	88.3%	85.3%	87.6%	94.2%	84.2%	95.5%	94.2%	99.4%	90.9%
			4	Non Elective as % Against Plan	78.1%	93.1%	56.3%	66.7%	169.0%	115.4%	155.5%	98.9%	140.2%	123.7%	105.0%	83.3%	100.3%	120.7%
			4	Day Cases as % Against Plan	104.5%	105.9%	113.9%	118.4%	103.9%	102.6%	103.9%	101.3%	92.8%	99.1%	95.3%	78.9%	94.5%	96.9%
			4	% New Outpatients Against Plan	103.1%	117.8%	110.8%	99.9%	96.5%	90.6%	94.7%	87.7%	101.8%	97.7%	88.5%	95.3%	105.2%	95.1%
			4	% Follow Up Outpatients Against Plan	111.9%	132.3%	117.9%	108.6%	106.4%	94.9%	87.2%	91.0%	96.9%	95.5%	90.8%	93.7%	99.4%	94.7%
			4	% Outpatient Procedures Against Plan	101.9%	86.1%	89.1%	85.3%	76.7%	68.5%	67.8%	67.2%	75.0%	62.7%	68.7%	78.1%	78.2%	71.1%



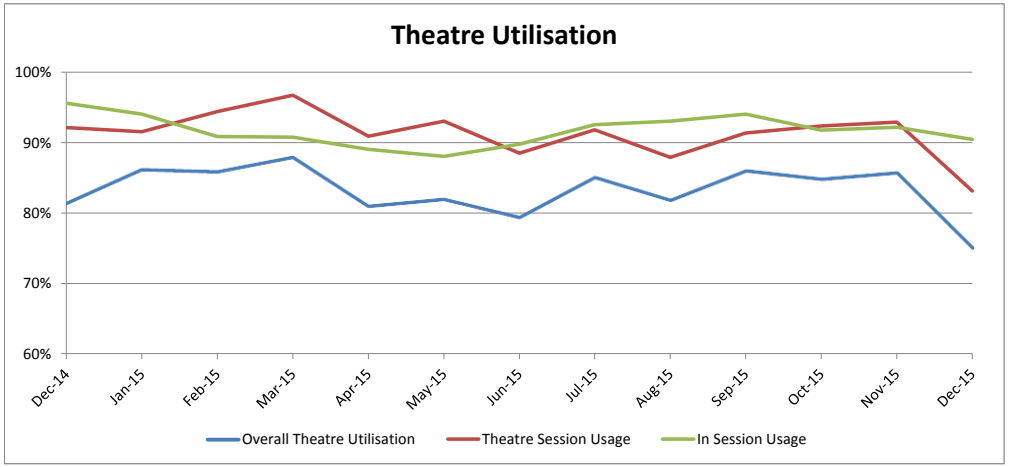


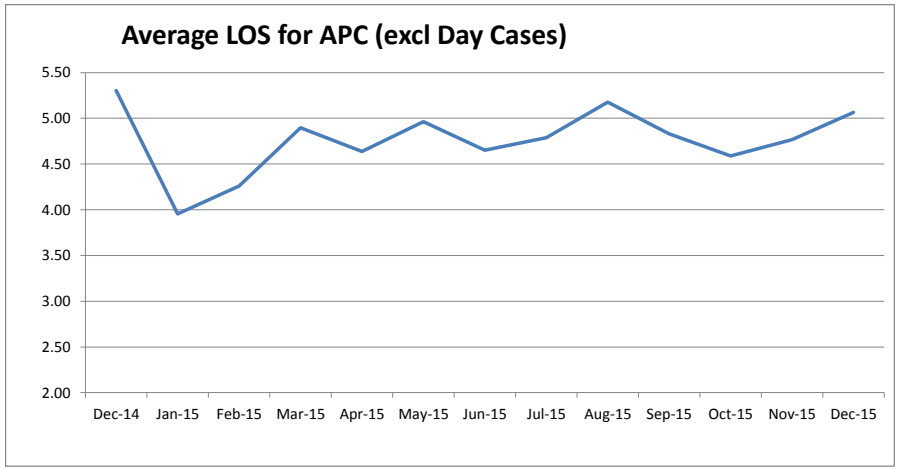
Quarterly Detailed Report
Efficiency Indicators as at December 2015

Headlines

- Theatre usage reduced as a result of the Christmas period, as did occupancy in paediatrics and HDU. The utilisation is calculated based on available physical resource, so looks low during the Christmas period. During December 2014, theatres were physically closed for maintenance work, so the figure for December 2015 is not comparable.
- Adult bed occupancy remained reasonably high as a result of bed closures over Christmas
- New to review outpatient ratios have been brought back towards contracted ratios

	Monitor	National	CQC Standard		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	15/16 Full Year Position
Efficiency			4	Overall Theatre Utilisation	81.38%	86.08%	85.77%	87.80%	80.97%	81.94%	79.42%	85.00%	81.81%	85.93%	84.76%	85.64%	75.17%	82.29%
			4	Theatre Session Usage	92.14%	91.54%	94.41%	96.74%	90.92%	93.04%	88.49%	91.82%	87.91%	91.38%	92.36%	92.89%	83.12%	90.21%
			4	In Session Usage	95.58%	94.04%	90.85%	90.76%	89.06%	88.06%	89.75%	92.56%	93.06%	94.04%	91.77%	92.20%	90.43%	91.21%
			4	Unused Theatre Sessions	21	38	24	14	36	27	55	40	48	38	36	30	77	43
			4	Number of Cases per Theatre Session	2.97	2.72	3.07	3.20	3.09	3.12	3.08	2.85	3.37	3.20	3.06	2.80	2.84	3.04
				Patient DNA								24	28	21	27	24	25	25
				Pat Cancelled on the day								19	12	20	23	16	15	18
				Pat Cancelled 1-3 days before								40	31	41	49	35	43	40
				Pat Cancelled 4-7 days before								25	23	33	21	21	26	25
				Hospital Cancelled on the day								10	10	8	8	15	10	10
				Hospital Cancelled 1-3 days before								36	42	42	56	46	46	45
				Hospital Cancelled 4-7 days before								46	32	27	32	31	28	33
			4	% Cancelled Operations by Hospital	0.58%	0.27%		2.78%	2.77%	4.35%	2.40%	0.78%	0.85%	0.63%	0.60%	1.28%	0.93%	0.34%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.43	2.67	2.42	2.55	2.87	2.63	2.55	2.80	2.66	2.60	2.68	2.45	2.35	2.62
			4	Pain Review-To-New Ratio	3.69	2.71	2.69	3.85	3.45	3.23	2.65	2.49	2.31	3.05	2.63	2.63	2.49	2.77
			4	Outpatient DNAs	9.21%	8.41%	7.82%	8.50%	10.12%	8.52%	8.48%	10.50%	12.11%	11.27%	10.17%	8.46%	9.31%	9.88%
			4	Bed Occupancy - Adults	69.20%	76.02%	79.93%	77.35%	67.10%	70.44%	78.83%	91.37%	84.76%	74.89%	89.73%	88.08%	85.49%	81.17%
			4	Bed Occupancy - Paediatrics	55.36%	55.36%	65.08%	74.91%	68.86%	66.67%	66.67%	88.42%	65.26%	80.95%	56.14%	65.19%	45.52%	67.07%
			4	Bed Occupancy - HDU	55.70%	67.42%	68.22%	75.56%	55.74%	58.74%	47.54%	62.99%	99.59%	58.85%	67.72%	75.33%	60.47%	65.22%
			4	Bed Occupancy - Private Patients	83.67%	84.29%	83.33%	54.25%	74.29%	76.96%	88.10%	82.03%	82.57%	86.19%	88.48%	87.14%	86.18%	83.54%
			4	Admissions on the Day of Surgery	464	421	445	411	359	379	414	413	403	419	474	460	386	3707
			4	AVLOS for APC (excl day cases)	5.30	3.96	4.26	4.90	4.64	4.96	4.65	4.79	5.17	4.83	4.59	4.77	5.07	4.83



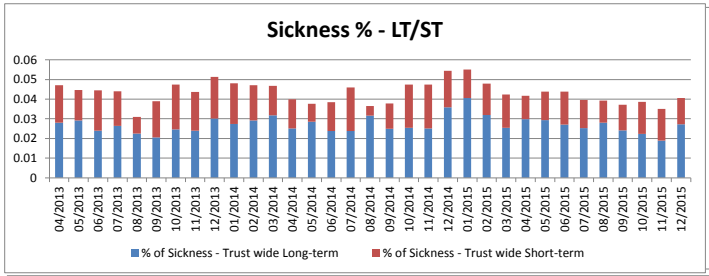


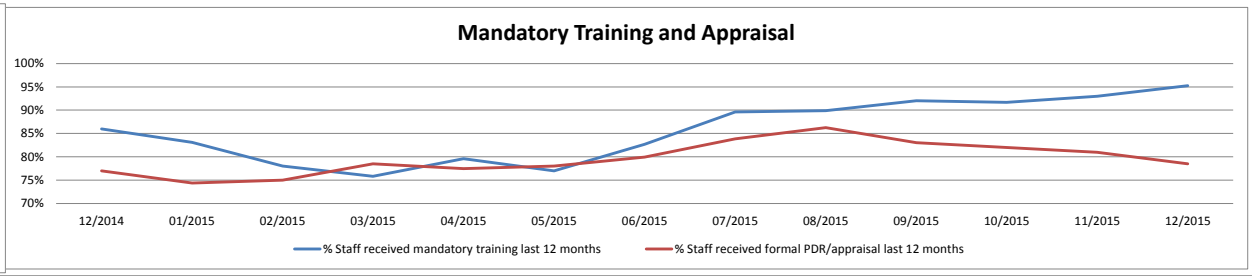
Monthly Report
Workforce Indicators as at December 2015

Headlines

- Mandatory Training at its highest rate in the last 2 years
- Vacancy position continuously on target for the last quarter
- Appraisals now require remedial action

	Monitor	Contract	CQC Standard		Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	MAA
WORKFORCE				Total WTE Employed as % of Establishment	94.4%	94.3%	95.4%	95.0%	93.2%	95.1%	94.0%	93.1%	92.9%	93.5%	93.1%	94.8%	94.2%	93.8%
				Staff Turnover (%) - Unadjusted	1059.2%	10.3%	10.6%	11.1%	1055.7%	10.9%	11.0%	11.4%	11.6%	12.5%	11.0%	11.7%	12.7%	12.8%
				Staff Turnover (%) - Adjusted	926.9%	9.0%	8.9%	9.3%	857.1%	8.9%	7.9%	8.3%	8.3%	8.9%	8.0%	8.2%	8.6%	10.3%
				% of Sickness - Trust wide	5.4%	5.5%	4.8%	4.2%	4.2%	4.4%	4.4%	4.0%	3.9%	3.7%	3.9%	3.5%	4.1%	4.0%
				% Staff received mandatory training last 12 months	86%	83%	78%	76%	80%	77%	83%	90%	90%	92%	92%	93%	95%	88%
				% Staff received formal PDR/appraisal last 12 months	77%	74%	75%	79%	77%	78%	80%	84%	86%	83%	82%	81%	78%	81%





Workforce Commentary

Sickness absence has increased slightly this month, as is typical for December. Our moving annual average (the underlying 12 month figure) remains amber this month, but continues its downward trend due to marked progress in December 2015 versus December 2014. 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 decreased slightly but remains green despite a non-clinical vacancy freeze, which in practice has affected very low numbers of posts.

The turnover figure for unadjusted (all leavers minus junior medical staff and excluding employees who retire and return to work,) has increased to red this month because there were 8 WTE more leavers i n December 2015 than there were in the corresponding month last year.

The mandatory training position is still improving, with an average of 92% for the last 6 months and the strongest single month performance in recent memory .

The appraisal position has returned to red this month, remedial action is currently being undertaken. Specific areas have been highlighted , and managers have been contacted appropriately.

Monthly Report

Finance Dashboard as at 31st December 2015

	Surplus £	Cash £	Capital spend £
Plan	(989k)	11,565k	3,107k
Actual	(4,265k)	12,343k	1,560k
Forecast for next month (YTD)	(1,559k)	10,743k	2,268k

Year to date			
	Actual	Plan	Risk Rating
Capital Servicing Capacity	-1.29	1.89	1
Liquidity Ratio	34.36	35.56	4
I&E Margin	-7.5%	-1.2%	1
I&E Margin Variance	-6.3%	-1.22%	1
Financial Sustainability Rating			2

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.

Creditors (payables) have increased in December, however approximately £926k relates to invoice disputes with UHB which were not resolved until the Agreement of Balances exercise in January 2016. Payment to UHB will be made in January 2016.

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.

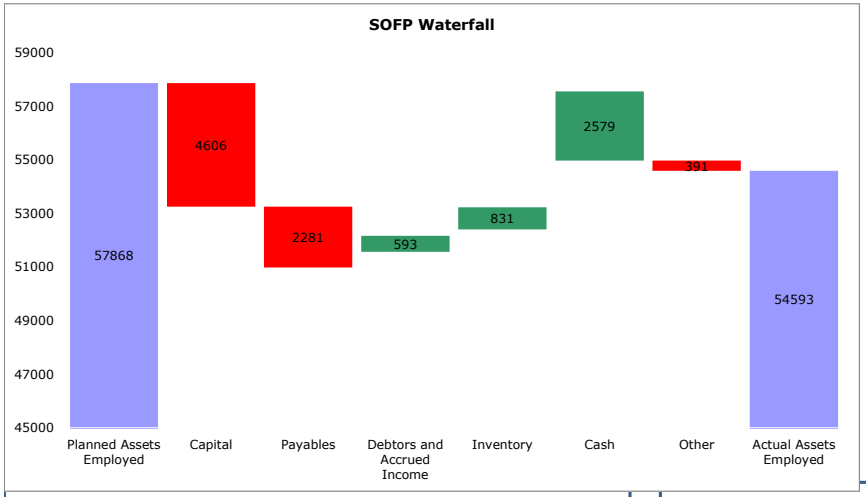
The I&E margin variances are showing significant variance to plan however.

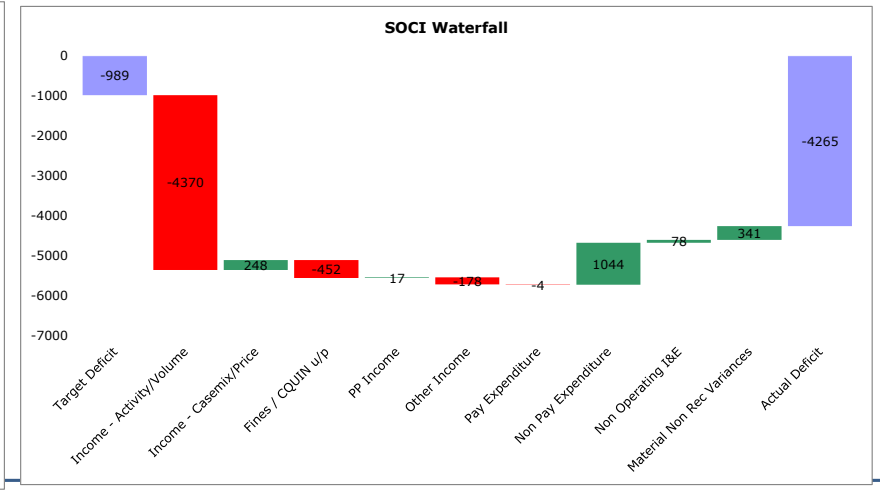
The Trust posted a deficit of £756,000 in December, increasing the overall year to date deficit to £4,265,000. The activity volume variance saw a smaller than usual increase in December as activity delivery was closer to the original plan (and significantly over the revised plan linked to a 5.8m year end deficit).

The escalating fines for 52 week breaches in spinal deformity, which reached £190,000 in month and £620,000 year to date, continue to lead to a material variance against plan. Whilst some minor fines and CQUIN underperformance was anticipated, there is a variance of £452,000 against plan in this area.

As a result of the year to date underperformance against the revised plan, the Board has agreed a revised deficit with Monitor of £5.8m from the £2.75m.

With regards to overall activity, a new rectification plan agreed is now in action, but year to date we have delivered only 91% of our original plan for Elective activity and 95% of our new and follow-up outpatients plan. The Transformation into Action exercise is underway to provide greater focus on activity, with some early positive signs as described in more detail in the subsequent tab reviewing performance against the revised plan for December.





Cash is higher than plan largely due to the capital spend being lower than expected and less payments made over the Christmas holidays.

Pay expenditure is slightly overspent at the end of December despite activity being lower than planned over the first 9 months of the year. Spend in theatres and nursing areas is above the average spend in 2014/15 and continues to rise relative to activity levels, with vacancy and sickness pressures in theatres being a big driving factor. December saw a slight improvement on plan, partly as a result of reduced use of agency during the Christmas period. This improvement was despite a one-off £80,000 cost linked to consultant back pay in spinal services.

Non Pay expenditure is below plan but this reflects the reduced activity being delivered by the Trust. Controls put in place from October onwards have seen a significant reduction in non clinical expenditure, partly linked to reduced use of interim staffing but also linked to escalation of approval limits for non clinical non pay spend.

Monthly Report

Finance Dashboard as at 31st December 2015

	Monthly Trends					Vs revised plan	
	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	DECEMBER PLAN	VARIANCE
Activity related income	-£5,758,504	-£6,131,720	-£6,375,185	-£5,851,203	-£5,640,768	-£5,141,279	-£499,489
Fines	£30,000	£35,000	£90,000	£145,000	£190,000	£45,000	£145,000
Other income	-£81,542	-£91,565	-£72,021	£55,483	-£71,166	-£89,145	£17,979
INCOME	**-£5,810,046**	**-£6,188,285**	**-£6,357,206**	**-£5,650,720**	**-£5,521,934**	**-£5,185,424**	**-£336,510**
CLINICAL EXPENDITURE (by Category)							
Senior Medical Staff (Surgical & CSS)	£418,342	£572,439	£498,388	£467,926	£555,939	£465,640	£90,300
Senior Medical Staff (Anaes/Rad/Phys)	£335,147	£342,335	£305,250	£343,619	£337,159	£334,624	£2,535
Junior Medical Staff	£288,502	£267,385	£272,005	£195,455	£257,631	£269,941	-£12,310
Wards	£551,441	£594,761	£614,973	£629,941	£586,228	£572,534	£13,694
Other Nursing	£210,003	£196,098	£223,951	£201,230	£197,274	£200,051	-£2,778
Theatres - Pay	£287,334	£302,232	£321,847	£332,056	£299,589	£280,083	£19,506
Theatres - Non Pay / Income	£348,750	£347,531	£373,039	£345,665	£327,063	£280,129	£46,934
Theatres - Implants	£725,055	£849,896	£816,737	£803,732	£777,709	£657,149	£120,560
Theatres - Other Clinical	£183,502	£178,762	£200,810	£191,555	£168,176	£187,110	-£18,934
Outsourced Services	£215,536	£120,953	£175,805	£175,973	£225,479	£167,099	£58,380
Therapies	£305,560	£337,323	£306,224	£336,358	£285,108	£313,575	-£28,467
Radiology	£171,332	£155,056	£169,325	£161,999	£149,808	£162,901	-£13,092
Pharmacy / Drugs	£151,892	£204,746	£180,925	£176,906	£155,972	£149,262	£6,711
Pathology	£155,059	£146,228	£174,196	£153,150	£164,308	£159,474	£4,834
Other	£2,170	£6,074	£4,848	£1,021	£3,756	£4,377	-£622
Contingency						£40,000	-£40,000
TOTAL CLINICAL EXPENDITURE	**£4,349,625**	**£4,621,819**	**£4,638,324**	**£4,516,588**	**£4,491,200**	**£4,243,948**	**£247,252**
NON CLINICAL EXPENDITURE (by Category)							
Theatres - Non Clinical	£22,896	£19,998	£16,496	£17,125	£15,861	£21,180	-£5,318
Facilities	£312,067	£258,594	£272,813	£285,517	£268,161	£277,319	-£9,158
Estates	£140,362	£145,109	£129,850	£149,980	£110,548	£137,239	-£26,691
Corporate - Executive	£141,789	£147,483	£119,049	£131,710	£118,583	£112,856	£5,727
Corporate - Operational Mgmt	£315,387	£326,684	£329,904	£313,759	£307,131	£311,642	-£4,512
Corporate - Support Services	£449,363	£416,370	£429,693	£298,335	£345,969	£375,210	-£29,241
Administration	£259,623	£257,712	£273,829	£258,445	£246,535	£258,020	-£11,485
Outsourced Services	£28,510	£39,897	£29,380	£22,426	£26,849	£31,866	-£5,018
Knowledge Hub	£27,145	£30,831	£33,049	£24,032	£20,054	£29,393	-£9,338
Central Budgets	£344,631	£396,791	£431,363	£349,894	£327,040	£373,324	-£46,285
TOTAL NON CLINICAL EXPENDITURE	**£2,041,774**	**£2,039,470**	**£2,065,426**	**£1,851,222**	**£1,786,730**	**£1,928,049**	**-£141,319**
TOTAL EXPENDITURE (exc. central budgets)	**£6,391,399**	**£6,661,289**	**£6,703,750**	**£6,367,809**	**£6,277,930**	**£6,171,998**	**£105,933**
(SURPLUS) / DEFICIT	**£581,353**	**£473,004**	**£346,545**	**£717,089**	**£755,996**	**£986,573**	**-£230,577**
Insurance		-£180,000					
REVISED (SURPLUS) / DEFICIT	**£581,353**	**£293,004**	**£346,545**	**£717,089**	**£755,996**	**£986,573**	**-£230,577**

Analysis

The Trust over-performed against its revised financial plan for December by £231,000

1,212 patients were discharged in December, against planned activity levels of 1,017 however these figures are slightly skewed by the impact of Christmas on the relationship between admissions and discharges. Reduced occupancy at the end of December results in a reduction in income relating to "work in progress", which explains why the percentage increase in discharges does not equate to an equivalent increase in income

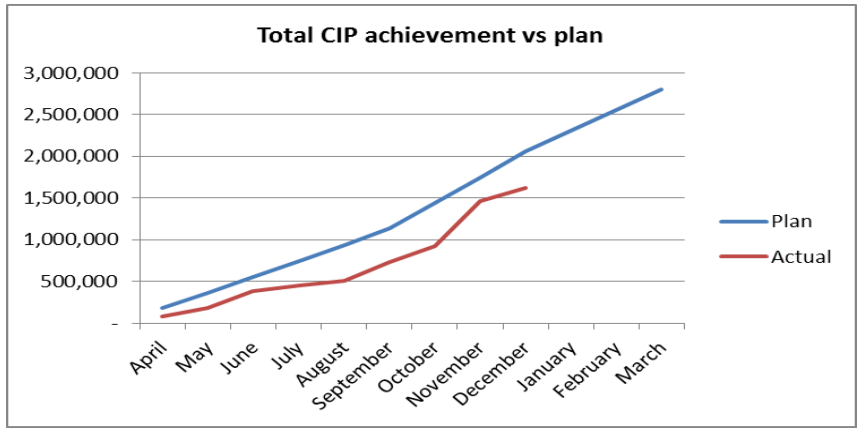
The revised deficit plan assumed that 52 week fines for Spinal Deformity patients would be capped at £500,000. The Trust is still in discussion with NHS England with regards to this position, and whilst support for this has been agreed with the local commissioning team, any variation to fines needs to be approved by the NHS England Regional Executive. The Trust are therefore still accruing on the basis of actual fines, which equated to £190,000 in December alone.

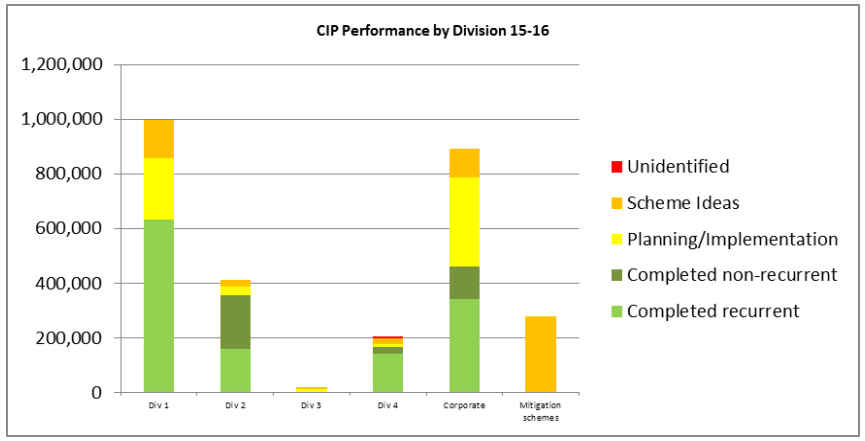
Clinical Expenditure exceeded plan by £247,000 in month, with the majority of this relating to the additional activity undertaken. There were two one-off items of expenditure; £80,000 relating to back-pay agreed in relation to changes in spinal consultant job plans and £35,000 relating to spinal cord monitoring. Excluding these items, the overspend would have been reduced to £172,000.

Non Clinical expenditure remained lower than planned, and whilst some of the underspend in areas such as Estates & Facilities was partly due to the downtime over the Christmas period, signs are promising that expenditure can be held at levels similar to those achieved in the last couple of months.

Monthly Report
CIP Dashboard as at 31st December 2015

CIP Schemes	Full Year Plan	Month 1-9 Actual	Remaining savings required
Division 1			
Reducing length of stay / Ward efficiency	215	215	0
Prosthesis savings	200	85	-115
Digital Dictation	150	108	-42
Hold non-essential vacancies	120	0	-120
Local schemes	312	226	-86
	997	**634**	**-363**
Division 2			
Medicines optimisation	108	108	0
Local schemes	302	247	-55
	410	**355**	**-55**
Division 3 – Local schemes	**18**	**0**	**-18**
Division 4 – Local schemes	**212**	**167**	**-45**
Corporate			
Coding partnership with EPS	150	103	-47
Locum savings – Direct Engagement / Preferred supplier	156	68	-88
Contribution from reopened private patients	100	53	-47
Local schemes	478	237	-241
	884	**460**	**-424**
TOTAL	**2,802**	**1,616**	**-1,186**





At the start of the financial year, the Trust Board agreed a cost improvement programme of £2,802k for 2015-16. Following a review of our forecast outturn position at the end of Month 5, it was anticipated that £2,500k of savings would be delivered

As at the end of Month 9, the Trust has recognised £1,616,363 of savings, against an original year to date plan of £2,056,000. £336,000 (21%) of savings to date are non-recurrent. Savings recognised in December were £157,000, against an in-month plan of £307,000. As the graph above shows, there was a slowdown in delivery in December following an upturn in October and November. The most significant elements of outstanding savings relate to Division 1 and Corporate areas. The shortfall has been picked up at Divisional performance meetings and with Executive leads, and the Trust continues to target overall savings of £2.5m.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (2/16) 009

TRUST BOARD

DOCUMENT TITLE:	**Nurse 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:	**3 February 2016**

EXECUTIVE SUMMARY:

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. This paper provides the Trust Board with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for December 2015 with additional information relating to fill rate and number of harms per in–patient area in order to develop a more robust analysis of the impact of staff fill rates on patient harm.

Trust Board is asked to note the following:

- That all in-patient wards at ROH with the exception of HDU are staffed to plan. Staffing shortfalls on HDU are managed by reduction in throughput and activity. Shifts are being staffed at a level that supports safe patient care
- Active recruitment is underway to address vacancies in HDU and Wards 2 and 12.
- Agency use in adult in patient areas continues to fall.

REPORT RECOMMENDATION:

The Board is asked to receive and note the report.

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:

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.

ROHTB (2/16) 009

PREVIOUS CONSIDERATION:
The report will be circulated to all matrons, general managers and ward sisters. Trust Management Committee considered the report on 27 January 2016.

ROHTB (2/16) 009

Nurse Staffing Report

REPORT TO TRUST BOARD – February 2016

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. This paper provides the Trust Management Committee with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for December 2015 with additional information relating to fill rate and number of harms per in–patient area in order to develop a more robust analysis of the impact of staff fill rates on patient harm.

2.0 Workforce Information: Trust overview of planned versus actual nursing hours

The overall nurse staffing fill rate for December 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. The actual staffing levels for December 2015 were manually entered into the data collection spreadsheet by the nurse in charge of the shift and verified by the senior sister and matron. Planned staffing hours are based on 2014/15 funded establishment which allows for a 1 to 8 RN to patient ratio on day shifts and a 1 to 12 ratio on night shifts. The planned hours are adjusted each month to allow for the number of days in the month.

Table 1 below provides further detail regarding nurse staffing fill rates for December 2015. The Unify Upload for December 2015 is provided in Appendix 1. In the absence of national guidance ROH will RAG rates each ward against a locally agreed framework as follows. Green, where actual available hours are within 5% of planned, amber within 5 and 10%, and red where the difference is greater than 10%.

Table 1: Detailed Ward Breakdown

	Day		Night	
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
1	92.9	89.9	100	91.9
2	98.0	89.5	95.7	93.5
3	96.7	85.3	100	90.2
12	100	101.0	102.1	101.0
11	108.4	97.0	100	100
HDU	90.1	43.1	87.9	-

It can be seen that a number of areas through December 2015 did not achieve >95% fill rate. The areas of greatest pressure are:

- Care staff on Ward 3. This shortfall has been caused by long and short term sickness which has reduced the number of staff available to cover shifts, which is being managed in line with the Trust sickness/ absence policy. Where possible bank and agency staff are being used to support shortfalls. There have been no patient safety incidents reported as a result of the deficit.
- Fill rates on HDU which is attributable to a high vacancy factor (4 WTE RNs) combined with long term sickness of care staff. It is of note that HDU does not admit patients when the required 1:2 nurse patient ratio cannot be achieved and therefore the impact of reduced staffing is to reduce activity through HDU. An active decision was taken not to backfill the care staff role through the latter part of December 2015 due to reduced activity and occupancy in HDU over the period. The current template that captures staffing hours is difficult to amend where planned hours change. In January the template used to gather staffing data will be amended to enable ward managers to alter planned hours over time so that future reports will accurately reflect clinical decisions made in response to patient acuity and demand.

2.1 Vacancy and Absence Data

Band 5 Registered Nurse vacancy rates at ROH remain low at 10.20 WTE with the majority of these in HDU as shown in Table 2 below:

Table 2: Band 5 Vacancy

Ward	Band 5 Vacancy
1	0
2	2.77
3	0
12	3.43
11	0
HDU	4
Total	10.20

Active recruitment to these posts is underway with a recent recruitment event leading to the appointment of 1.6WTE RNs. Sickness rates amongst registered nursing staff are satisfactory at 3.85% but the rate amongst non-registered staff is high at 9. 91%.

Ward sisters and matrons have been asked to review the reasons for this high sickness rate amongst this group of staff and to provide the Executive Director of Nursing and Governance with assurance that all sickness absence is being appropriately managed.

A recruitment campaign is underway in order to enable uplift of all ward establishments to 3RNs at night in line with the Trust Board decision to approve this recommendation from November 2015. Ward establishments require amending in order to reflect this change but this has not delayed recruitment to these posts. Recent appointments have however been to existing vacancies and advertisement of and recruitment to these posts will continue through Q4 2015/16.

The recent CQC report (December 2015) highlighted concerns about the availability of paediatric nurses on HDU. Further recruitment of registered children's nurses to HDU is in progress, following an unsuccessful recruitment event on 11.12.2015. Three candidates applied and were shortlisted but none attended for interview. Adverts have been placed offering a number of options for paediatric nurses at ROH including a rotational programme, development of HDU skills and access to additional training. National journals have been sourced and used to extend reach of advert.

2.2 Safe Staffing and Efficiency

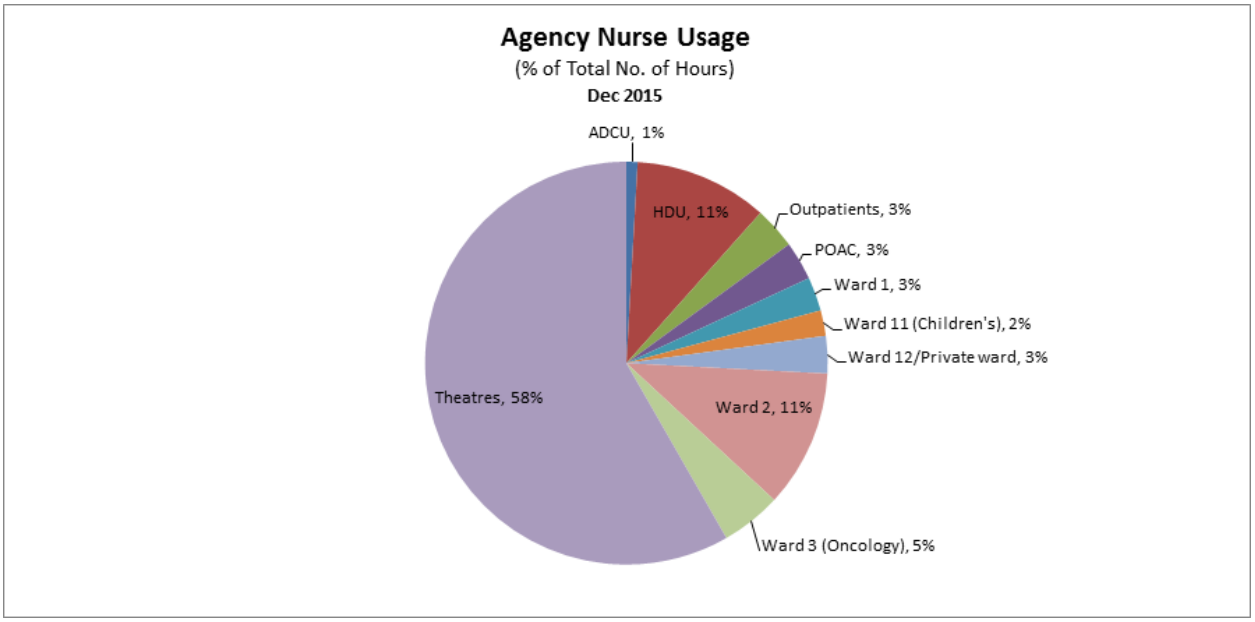
Caps on agency spend for Registered Nurses, mandated by Monitor, have been in place at ROH since 1 October 2015. The ceiling for ROH has been set at 10% which is a reflection of the relatively high use of agency staff at the Trust.

The Trust uses a modified version of the Shelford Safe Staffing tool which provides detail on level of bank and agency use by ward and enables daily assessment of staffing based on the acuity and dependency of patients. The data in Table 2 below is drawn from analysis of the daily reports whilst Table 3 presents agency use by area as a total of agency use across the Trust.

Table 2: Agency use (in –patient wards) as a total of all hours worked on ward

Dec-15	ALL STAFF Permanent	Bank	Agency
Ward 1	73.4%	20.9%	5.7%
Ward 2	71.7%	13.3%	15.0%
Ward 3	72.6%	18.2%	9.2%
Ward 11	91.5%	7.3%	1.2%
Ward 12 & 10	72.0%	21.6%	6.4%
HDU	82.5%	5.5%	12.0%
TOTAL ALL WARDS	75.7%	16.0%	8.3%

Table 3: Agency Use (as a total of all hours worked)



During December 2015 agency across in-patient areas was 8.3% of total staff hours worked in in-patient areas, which represents a reduction of 4.8% since November 2015. This was driven by a decrease in activity through December 2016 and it is anticipated that agency use across all wards will rise again in January and February 2016 due to increase in maternity leave.

The area of highest in-patient agency use continues to be Ward 2 which is driven by vacancy factor and by the need to provide additional support to patients with higher acuity. The introduction of a new 'Safe and Supportive Observation of Care Policy' in February 2016 will enable more effective assessment of the support needs of patients and provide TMC with assurance that additional staff used have been appropriately deployed.

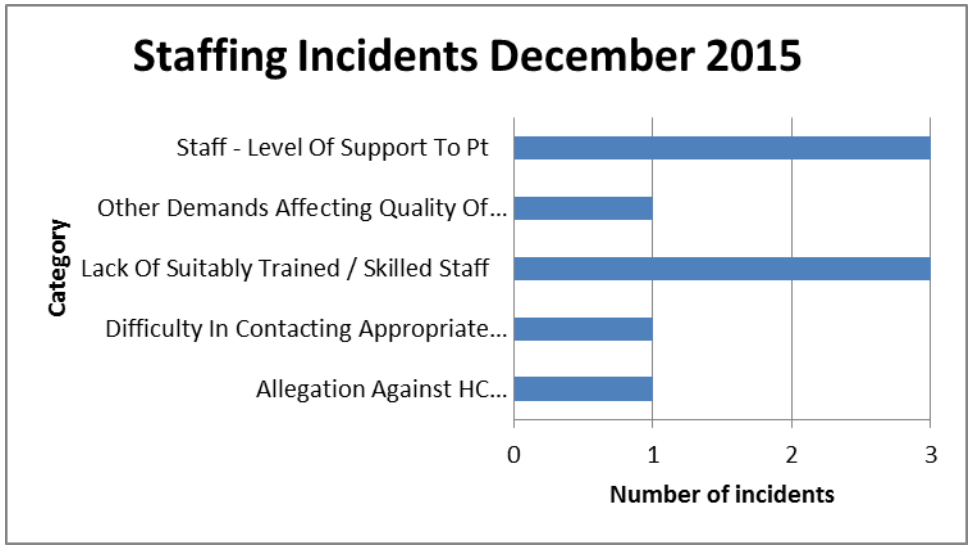
Agency use remains high in HDU driven by the need to source children's nurses and by a high vacancy factor. An action plan to address the specific staffing issues within HDU is in place.

The use of agency staff in Theatre however remains high at 58% of total use. This is driven by a high vacancy rate within the theatre team. A number of actions are in place to address this including the introduction of premium bank rates for staff who do additional shifts and a national recruitment campaign. The recruitment of overseas theatre staff to fill this gap is progressing and it is anticipated that the first cohort of 5 staff will be in post by May 2016.

3.0 Incident Reporting and Levels of Harm

Clinical areas are encouraged to report all Safe Staffing incidents. During December 2015 a total of 9 staffing incidents were reported across all areas. An analysis and review of the 9 safe staffing incidents reported during the period of December 2015 has been undertaken and is represented in the Table 4 below.

Table 4 Incident Categories



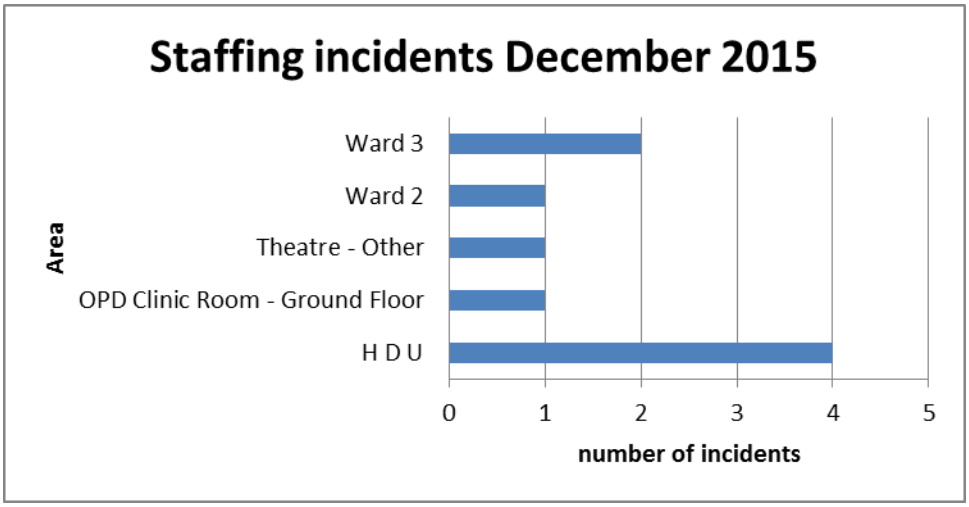
For consecutive months in this reporting period (2015/16) the level of support to patient is the highest incident category reported. Incidents reported in this category relate to:

- 2 where there was no supernumerary coordinator on HDU. An agency nurse was booked but was a paediatric nurse who couldn't look after adults.
- Patient unnecessarily delayed in recovery

It is of note that no direct patient harm is recorded as a result of any reported staffing incidents with 6 incidents reported in December 2015 were graded 'no harm', 1 was graded 'low harm' and 2 were graded as 'near miss'. Of the incidents graded as 'low harm' one involved a delay in giving patients antibiotics and pain relief and meets the criteria as a NICE red flag and the other occurred where a patient had an unnecessarily long tourniquet period.

Table 5 below shows the number of staffing incidents per ward and department. TMC are asked to note that whilst Hard Truths requires the Trust to report incidents by in-patient areas, best practice supports a Trust wide view being presented. This is why areas other than in-patient wards feature in the data below.

Table 5: Incidents by Ward



The highest number of incidents were reported on HDU which is consistent with the fill rate reported through the UNIFY return. Details of all staffing incidents recorded are available at Appendix 2. None of the incidents reported breach minimum NICE safe staffing guidelines although avoidance of breach was only possible on one shift on ward 3 where the night bleep-holder based themselves on the ward to provide support to the team.

3.2 Reporting of Red Flag Shifts and the Daily Staffing Huddle

Following the introduction of the Red Flag questionnaire 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'.

Staffing levels are monitored at the daily staffing huddle at which there is senior nurse representation. Dynamic risk assessment is undertaken including use of red flag escalation in order to ensure that all available resource is used effectively to mitigate any potential risk associated with nurse staffing. Discussion on the occurrence of red flags forms part of the conversation at the daily staffing huddle and staff are developing a good understand of the red flag system.

In December 2015, one (1) incident triggered the red flag questionnaire 'lack of suitably skilled staff'. This related to a delay in administration of pain relief on ward 2.

Whilst the daily staffing huddles provide a 'sense check' of the level of harm experienced on wards on a daily basis, it is likely that red flags are occurring more frequently than is being reported. For this reason a more focused communication and awareness raising campaign will be led by the Deputy Director of Nursing and Governance in February 2016.

4.0 Fill rates against harm measures

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. This finding is consistent with those presented in the previous two months.

Table 6 Shift Fill Rates against Harm/ Experience Measures by Ward

Measure	Ward 1	Ward 2	Ward 3	Ward 12	Ward11	HDU
Fill Rate % (day)	92.9	98	96.7	100	108.4	85.4
Vacancy	0	2.77	0	3.43	0	4
Number pressure ulcer		2		1		1
Number falls - inpatients	4	1	1	5	0	0
Number VTE	1			1		
Number of hospital acquired infections						1
Number staffing incidents		1	2			4
Number of Red flag Shifts			1			
Complaints		1	1			

5.0 Conclusion and Recommendations.

5.1 The Trust Board is asked to note that all in patient wards at ROH with the exception of HDU are staffed to plan. Staffing shortfalls on HDU are managed by reduction in throughput and activity. Shifts are being staffed at a level that supports safe patient care

5.2 Active recruitment is underway to address vacancies in HDU and Wards 2 and 12.

5.3 Agency use in adult in patient areas continues to fall.

5.4 The staffing report in February 2016 will include a review of staffing in OPD and ADCU areas .

7.0 Appendix 1: UNIFY upload November 2015

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		1595	1481	1031.5	927	682	682	682	627	92.9%	89.9%	100.0%	91.9%
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1114	1092	731.5	654.5	506	484	506	473	98.0%	89.5%	95.7%	93.5%
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1815	1754.5	1110	946.5	630	630	610	550	96.7%	85.3%	100.0%	90.2%
Ward 10 & 12	110 - TRAUMA & ORTHOPAEDICS		1988.6	1988.5	1382.1	1396	1056	1078	1012	1022	100.0%	101.0%	102.1%	101.0%
Ward 11	110 - TRAUMA & ORTHOPAEDICS		945	1024.5	295.5	286.5	594	594	44	44	108.4%	97.0%	100.0%	100.0%
HDU	110 - TRAUMA & ORTHOPAEDICS		1819.5	1639	307.5	132.5	1605	1411	0	0	90.1%	43.1%	87.9%	-

Incident Details Appendix 2

Incident Details

Incident Number	Cause Group	Details Of Incident	Area
16734	Allegation Against HC Professional/Non-Professional	Delay in giving patients antibiotics and pain relief (this was not due to staff shortages but was in relation to concerns about the competency of agency nurses)	Ward 2
16843	Other Demands Affecting Quality Of Pt Care	Delay in discharge from recovery (4 hours)	Ward 3
16717	Lack Of Suitably Trained / Skilled Staff	Staffing issues: 4 outstanding shifts, one covered the others unable to cover leaving dept short of staff to manage all areas adequately.	OPD Clinic

16758	Staff - Level Of Support To Pt	No supernumerary coordinator on HDU	H D U
16794	Staff - Level Of Support To Pt	Delay in discharging patient from recovery to HDU	H D U
16790	Staff - Level Of Support To Pt	No supernumerary coordinator on HDU, 6 adults one paediatric patient on a striker bed, agency nurse cancelled	H D U
16792	Lack Of Suitably Trained / Skilled Staff	Agency nurse had cancelled long day shift yesterday with her agency pulse agency, ROH did not know about the cancellation	H D U
16902	Difficulty In Contacting Appropriate Staff	Agency staff (scrub nurse) used and a combination of circumstances resulted in the patient having an unnecessarily long tourniquet period.	Theatre - Other
16849	Lack Of Suitably Trained / Skilled Staff	Red flag: Staff nurse booked for the night shift from Cromwell Agency did not arrived and because of this situation only one staff nurse remaining in the ward. Bleepholder provided cover.	Ward 3

ROHTB (2/16) 010

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:	**3rd February 2016**

EXECUTIVE SUMMARY:

At the Board meeting on 2 December, the Board received a reformatted version of the Board Assurance Framework. The changes made are designed to bring the Trust's Board Assurance Framework more into line with models of best practice elsewhere, including that of NHS England.

On the attached Board Assurance Framework, risks are grouped into two categories:

- Strategic risks – those that are most likely to impact on the delivery of the Trust's strategic objectives. These are entries shaded in blue on the attached.
- Escalated risks – those risks featuring on either the Trust Management Committee or Quality & Safety Committee risk register that have been added to the Board Assurance Framework on the basis that their pre-mitigated risk scores are sufficiently high to suggest that they could impact on the delivery of the Trust's business and its strategic plans

Of note for the Board in this version of the BAF is the addition of three new or substantially amended risks, which the Trust Management Committee which met in 27 January 2016 considered to be sufficiently high profile as to require adding to the Board Assurance Framework:

- Risk S804 – Adequacy of Business Intelligence /Information to be able to support the operational decision-making and day to day management of the organisation
- Risk S269 – Potential failure to deliver the activity targets set out in the annual operational plan
- Risk SXXX (yet to be assigned a reference) – Potential insufficiency of Paediatric nurse staffing on HDU

Also of note, are a number of risks proposed for de-escalation from the BAF on the basis that the risk is inherent or controls are in place which are sufficiently robust to allow the risk to be monitored at a local level or by one of the Board Committees. These risks are:

- S805 – ROH reputation
- S806 – The Trust is unable to respond to disruptive technology
- 178 – Compliance with use of WHO safety checklist
- 669 – Fitness for purpose of the Point of Care Testing equipment

It is acknowledged that the BAF remains an evolving tool and will be further updated based on feedback from the Board and other sources.

REPORT RECOMMENDATION:

Trust Board is asked to:

- review the Board Assurance Framework
- confirm and challenge that the controls and assurances listed to mitigate the risks are adequate
- agree with the proposed additions and removal of the risks as listed in the Executive Summary

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	x
Business and market share		Legal & Policy	x	Patient Experience	
Clinical		Equality and Diversity		Workforce	x

Comments: Pages within the report refer in some manner to all of the key areas highlighted above.

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:

Trust Board on 2 December 2016

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
Fin	803	Safe and efficient processes that are patient-centred	Risk to financial viability through the inability to manage internal costs, deliver key programmes or respond to tariff deductions	F & PC	4	5	20	Formal programme structure for transformation introduced. 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	4	5	16		As of the end of November, the Trust has delivered a financial deficit of £3,509,000 against a planned year to date deficit of £755,000. The principal reason for under performance concerns lower than planned performance against activity. The Trust continues to pursue transformation efficiency gains through its Transformation Programme, an activity recovery plan has been developed and additional focus is being given to CIP delivery.	Ongoing	2	5	10

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
WFOD	582	Highly motivated, skilled and inspiring colleagues	Risk of non-delivery of strategic objectives associated with leaders' ability to lead change, including cultural change.	Transformation Cttee	4	4	16	**January 2016:** The Transformation Committee received a presentation on Leadership and leadership development at its meeting in January. Further work is underway to prepare a People Strategy which will be considered by the Board in Quarter 4 2015/16 or Quarter 1 on 2016/17. **December 2015:** Initial discussion ref Leadership at TC in October and further presentation requested for December. Work ongoing with small group of consultants to shape medical engagement approaches. Conversations with consultants continue, aiming to integrate 'paired learning' approach. Leadership strategy in final stages of development. **September 2015:** 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. 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. Interventions	Presentation to Transformation Committee; RF report working group workstation 1 of TP, notes from Workforce & OD Committee	3	4	12		People strategy to be developed and the subject of the Transformation Committee in February and the Trust Board subsequent to this	Q4 2015/16	2	4	8

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					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
WFOD	798	Highly motivated, skilled and inspiring colleagues	The Board and organisation does not have adequate capacity or capability to change or does not organise its resources to change effectively, which could lead to the organisation being slow to respond to changing internal or external influences	Transformation Cttee	3	5	15	**January 2016:** Investment in transformation capacity; recruitment of Transformation team and other senior managers to lead change in operational areas is complete; 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.	3	4	12		Medical engagement strategy under development.	Jan-16	2	3	6

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
Fin	804	Safe, efficient processes that are patient-centred	There is a risk that Information and Business Intelligence is insufficient in quantity, usefulness or reliability to inform key operational decisions and to manage the business on a day to day basis or to help improve services.	F & PC	4	5	20	**January 2016:** Robust rigorous manual interrogation and verification of data. Triangulating key clinical indicator information. Manual daily huddle to validate pervious day's performance and assure the current day's performance through theatres. Deep dive and granular analysis & actions to improve performance on matters such as cancellations and delays out of recovery and length of stay. **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 affect 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	Daily huddle outputs and ACTION; Weekly 6-4-2 and list review by Director of Operations and review by Executive of weekly activity tracker and governance trackers for complaints, SIs and Duty of Candour incidents; monthly corporate performance report; safe staffing report; Internal Audit reports; Transformation Committee Reports; CQC report & action plan; IM&T Programme Board minutes; ad hoc report through Serious Incident and Root Cause Analysis/Lessons learned communications to staff	3	5	15		Developing an enhanced suite of measures to provide assurance of ongoing recovery plan and planning for future years. Embracing key performance measures to reduce waste waiting and performance variation and improve flow of patients from referral to follow up. Develop	Q4 15/16 - Q1 16/17	2	4	8

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
CEO	801	Delivering exceptional patient experience and world class outcomes	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.	Trust Board	4	3	12	The Trust is part of a national Vanguard model, which will provide opportunities to develop a quality improvement process and a set of quality indicators. The Trust engages 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.	3	3	9		Vanguard model will be used to influence the wider Health Economy as it develops and embraces a new way of working collaboratively. Existing controls are being developed through the appointments to the new organisational 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.	Ongoing	2	3	6

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
Fin	269	Safe, efficient processes that are patient-centred	There is a risk that the Trust may fail to deliver the activity targets set out in the Trust's annual operational plan, leading to a shortfall against the agreed Financial Outturn position for the year and potential poor patient experience	F & PC	4	4	16	**January 2016:** Fines removed for waits in excess of 18 week RTT. Activity rectification plan has been developed and approved by Monitor. Will meet activity rectification plan and anticipate will slight overachieve against it. The plan has been accepted by Monitor, however the action plan will take several months to embed. **November 2015:** 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. The rectification plan is in place and is being managed through twice weekly activity "Huddles" to match activity to the planned volumes and	Activity rectification plan; minutes of Trust Board & Finance & Performance Committee; Corporate Performance Report; outputs from daily huddles and ACTION;	3	4	12		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.	Ongoing	2	4	8

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
WFOD	S797	Highly motivated, skilled and inspiring colleagues	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	Trust Board	4	4	16	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	3	4	12		Freedom to Speak up Guardian role to be implemented to encourage staff to speak up to enable learning and to coach managers in response to safety incidents. Other actions as detailed in TP workstream 1	Feb-16	1	4	4
Strat	S799	Highly motivated, skilled and inspiring colleagues	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	Trust Board	4	3	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	3	3	9		Development of the leadership strategy and People Strategy due to be considered by the Transformation Committee and Trust Board in Q4 2015/16	Q4 15/16	2	3	6
CEO	S802	Developing services to meet changing needs, through partnership where appropriate	There is a risk that the Trust's operational model is unsustainable as a result of tariff changes, year on year efficiency requirement and the need to meet the requirements of an increasingly burdensome regulatory environment.	Trust Board	3	4	12	Effort is directed into continuing 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 embedding of the new organisational structure which brings new skills into the Trust.	Viable business plan. Key milestones met – growth, expenditure, CIPs, transformation initiatives. Evidence of alignment with commissioner intentions.	3	3	9		Development of the Trust's strategic plan and seek new opportunities for collaboration as part of the new Vanguard model. Further engagement of the work with Monitor on optimisation and efficiencies (The Perfect Day)	Q2 2016/17	2	3	6

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
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MD	S805	Developing services to meet changing needs, through partnership where appropriate	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	F & PC/ QSC	3	4	12	Constructively engagement 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	2	3	6		Current risk mitigations are regarded as adequate and sufficient, with no further action required. Consider de-escalation from BAF.	N/A	2	3	6
FIN	S270	Developing services to meet changing needs, through partnership where appropriate	National tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist	F & PC	4	4	16	Monitor 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 given the issues faced with the current year tariff and the first version of next year's tariff which has been seen. 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 technical working group to influence tariff development	3	4	12		**January 2016:** Delay to the publication of the new national tariff, which will allow some stability for the current year.	Mar-16	1	4	4

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
Cusec/DNG	S800	Safe, efficient processes that are patient-centred	Governance structure and processes are poorly understood with a result that they become a barrier rather than a tool for delivery	QSC	3	3	9	Governance team structure is now fully filled; clarity over separation of responsibilities between Director of Nursing & Clinical Governance and the Associate Director of Governance & Company Secretary; refinement of processes around incident reporting, policy governance, compliance with CQC Regulation 20 and complaints handling has made the processes more fit for purpose.	Structure chart; TOR; Awareness, understanding application of organisational structure and processes at sub Board level; effectiveness of the new structure; new complaints and Duty of Candour policies; new Policy on Policies; weekly trackers reviewed by Exec Team; Patient Safety & Quality report	2	3	6		Continue to embed the new governance structures, including those at Divisional Level. Training to be created for key processes and responsibilities. Audit effectiveness of new clinical governance policies.	Sep-16	1	3	3
MD	S806	At the cutting edge of knowledge, education, research & innovation	The Trust is unable to anticipate or respond to disruptive technology which creates a paradigm shift putting the ROH out of business	Transformation Cttee	2	4	8	Transformation Committee established to deliver transformational and technological changes in the organisation; R+D and Innovation given increasing focus through the development of plans for the Knowledge Hub.	Transformation Committee meetings; Quality meeting; plans to develop the Knowledge Hub	2	4	8		Current risk mitigations are regarded as adequate and sufficient, with no further action required. Consider de-escalation from BAF.	N/A	1	4	4

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
Ops	S832	Developing services to meet changing needs, through partnership where appropriate	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	Trust Board	3	3	9	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	2	3	6		Continue maintaining strategic focus and exploit opportunity for collaborative working and driving quality improvements at a national level through the Vanguard	Ongoing	2	3	6
DNG	S796	standards of care	The Board and organisation loses its focus on patient care so the ROH is no longer a patient-centric organisation	Trust Board	3	3	9	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/TMC. 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.	2	3	6		Governor representative to routinely observe Quality & safety Committee meetings; continued patient stories at Trust Board; improved membership engagement and plans to redevelop the membership & governor engagement plan.	Sep-16	2	3	6
DNG	SXXX	Delivering exceptional patient experience and world class outcomes	There is a risk that the Paediatric nurse staffing on HDU is insufficient to meet the needs of Paediatric patients that the Trust cares for	QSC	3	4	12	All four Paediatric nurses working on HDU have completed a two week rotation to BCH critical care unit to allow uplift and refresh of skills. New SOPs for admission of elective and emergency patients to HDU have been developed.	CQC action plan; SOPs; critical care passport evidence portfolio; presentation for CQC Quality Summit.	3	3	9		Actions contained within the CQC action plan around recruitment events for Paediatrics staffing and liasing with Birmingham Children's Hospital to develop a programme to access competency based training for all HDU staff. Developing a programme to assess adult nurses against the Paediatric passport and a rotational programme between Ward 11 & HDU by end of Feb 16. Further actions planned to be completed by May 2016.	May-16	2	2	4

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
OPS	7	Delivering exceptional patient experience and world class outcomes	Long waiting times for spinal deformity. Impact of BCH capacity on ROH's waiting list potentially causing delays and poor patient experience & outcomes. This risk has a significant potential financial impact year to date.	F & PC	5	4	20	**January 2016:** Further meeting with BCH and have requested additional triumvirate meetings with NHSE and BCH. Also scoping the potential to move a cohort of children at Nuffield. **December 2015:** Currently 11 patients over 52 weeks on the IP WL the majority of whom require treatment at BCH. Currently 31 patient suitable and families confirmed for Cromwell half of which are 30 plus weeks. Timetable planning during Jan to March 2016 to utilise as many ROH lists as possible. Weekly PTL being sent to NHS England plus fortnightly update on plan. Meeting with the team to produce trajectory for spinal def as per request of NHS England this week	Activity reports to the Board on a monthly basis from October 2015; correspondence with NHS England and BCH. Minutes from NED steering group on activity & finance.	4	4	16		Appointment of 2 additional spinal deformity consultants Active management of waiting list Sourcing additional capacity as required. 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	Jan-16	3	3	9
	27	Delivered by highly motivated, skilled and inspiring colleagues	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.	F & PC	5	4	20	**January 2016:** Four US PAs remain to join the Trust, with our first having joined the Trust on 18 January 2016. Our second is due to join us in mid March 2016, with the third expected at the start of May. Our fourth candidate is still to confirm a start date due to personal circumstances in the US. Amendment to remuneration for discussion at Board on 1 September. December 2015 four candidates for PAs remain. Urgent action needed by Director of Transformation and Clinical Lead to define final task assignment for all PAs + ANPs + junior doctors. Director of Operations approves request for locum doctor appointment	Updates to Transformation Committee on delivery of workstream 1. Minutes from Workforce & OD Committee. Agency staffing presentation to Trust Board workshop on 13 January. Agency staffing cost position as outlined in the CPR received by the Board on a monthly basis.	4	4	16		5 physicians associates have now been offered employment but are yet to all start. Working group now formed to develop working practices of PAs/ANPs/junior doctors; 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 definitive plan and start date.	Q4 15/16 - Q1 16/17	2	4	8

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DNG	178	Delivering exceptional patient experience and world class outcomes	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.	QSC	4	4	16	**January 2016:** Weekly audit demonstrates 100% compliance with WHO checklist. This has been consistently maintained over the past 3 months. Recommend reducing risk from 12 to 8. Awaiting November data **October 2015:** Owing to progress with local mitigation and improved underlying position statement , to be considered for downgrading and de-escalation to Divisional management once local IT solution in place. This system includes the locking out of fields means that this WHO cannot be progressed through stages without completion of the previous section. Compliance position with CCG also to be confirmed i.e. is September the last month where, if we are compliant, the threat of fines will be lifted by the CCG.	Compliance date; reports to Quality & Safety Committee; CPR; Patient Quality & Safety report; incidents database; Root Cause analyses	2	4	8		Continued monitoring and reinforcement with colleagues of the need to comply with requirements of WHO checklist guidance. Consider remitting management of this risk to Clinical Quality Committee and/or Quality & Safety Committee	N/A	2	4	6

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
DNG	275	Delivering exceptional patient experience and world class outcomes	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.	QSC	4	4	16	**January 2016:** Mitigations described in December 2015 are in place and are operational however recommend no change to risk status until evidence that good governance practice is consistent across all divisions. **December 2015:** A Governance Facilitator has been allocated to each Division and is responsible for disseminating learning from serious events/claims/complaints at the monthly Divisional meetings. Work is still required to ensure that the evidence that learning is embedded across the organization is robustly collated – update to be brought to the meeting in Jan 2016. Current risk rating reduced from 12 to 10. 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	3	4	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	Mar-16	2	2	4

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
MD	414	Delivering exceptional patient experience and world class outcomes	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, may occur if Trust is deemed to be an outlier.	QSC	4	4	16	**January 2016:** PROMS report presented to QSC in January 2016, which reported that the Trust's PROMs scores for Total Knee Replacements was an outlier against the national average position. **September 2015:** Update on PROMS to be presented to CGC in October or November 2015. Latest PROMS figures have been published and are undergoing analysis. ROH remains an outlier for TKR and revision TKR (as do 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.	Report to QSC; national comparative data; PROMs scores by consultant	3	4	12		**January 2016:** Additional set of metrics identified which would improve PROMS scores, including physiotherapy, enhanced recovery, improved pain management on wards, patient education, review of surgeon techniques & their individual results and organisation wide focus on supporting PROMs work. **September 2015:** Update on PROMS to be presented to CGC in October or November 2015. Latest PROMS figures have been published and are undergoing analysis.	Dec-16	2	4	8
Ops	669	Safe, efficient processes that are patient-centred	Assurance that point of care testing (POCT) equipment is fit for purpose and compliant with regulations.	QSC	4	4	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/TMC committees ROCS undertaken validation procedure against laboratory standard through the pre-operative assessment service. Patient information leaflet has been prepared is being used.	POCT policy; audits of POCT equipment testing; POCT patient information leaflet	2	4	8		All mitigating actions complete. Risk to be considered for removal from BAF for local management.	N/A	2	4	8

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
Ops	770	Safe and efficient processes that are patient-centred	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure,	QSC	4	4	16	**January 2016:** Two two-week blocks of maintenance each year. Further estates work planned for the future. **December 2015:** No update of this risk from theatre manager. There are plans to generally improve the theatre environment but this will not allow this plant to be replaced. In order to do this there would have to be a shut down of theatres which is currently not acceptable for service delivery. There is consideration within the Trust to build a new theatre block which would resolve this issue. Sept 2015 Reviewed by Head of Estates: no change for theatres 1, 2 and 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:	Estates maintenance schedule	3	4	12		Identification of plan for theatre maintenance	Q1 2015/16	2	2	4

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
					Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
Ops	666	Safe, efficient processes that are patient-centred	There is a risk that monitoring of performance against the 18 week RTT patient is ineffective, given that business intelligence & information is not accurate or timely	F & PC	4	4	16	**November 2015:** The issues continue although no further new issues have been identified and the data can be described as stable. 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. 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	CPR; internal audit report	3	4	12		**January 2016:** Outstanding Internal Audit review will inform the position. Monitoring issue will be resolved as new dashboard software becomes embedded and as 'In Touch' goes live in March 2016. 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.	Mar-16	2	4	8
DNG	30	Safe, efficient processes that are patient-centred	There is a risk that the Trust is non-compliant with the CQC safety domain - management of medicines	QSC	3	3	9	**January 2016:** Await publication of audit results and review the risks once these are available. Proposed to remove risk on basis that controls are effective and monitoring is routine in the Drugs and Therapeutics Committee. **December 2015:** Risk remains unchanged – plan to re-audit in mid-Dec **November 2015:** Risk remains unchanged. Quarterly medicines management audit is due December to cover the period Sept Oct Nov. Internal theatres audit continues with no additional concerns to report.	Minutes from Drugs and Therapeutics Committee; audits on medicines management; incident reports	2	3	6		Quarterly medicines management audit to confirm compliance.	Feb-16	2	3	6

Executive Lead	Risk Ref	Strategic Objective	Risk Statement	Primary Assurance Body	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	Target risk score		
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The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Declaration to Monitor – Quarter 3**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Jo Chambers, Chief Executive & Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**3 February 2016**

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 3 submission was due on the 29th January 2016.

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 29 January.

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 (2/16) 011 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUARTER 3 MONITOR DECLARATION

Report to Trust Board on 3 February 2016

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 3 submission was due on the 29th January 2015.

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 three months from the 1st October 2015 to 31st December 2015 is contained in the Trust's Corporate Performance Report.

2.1.3 The Trust's deficit stands at £4.265m at the end of Quarter 3, against a planned deficit of £0.989m. This has largely been driven by a significant underperformance on elective activity, which is 492 spells behind target in the year to date and day case activity which is 197 spells behind target. This, along with underperformance in other areas of activity such as outpatients and physiotherapy, has driven the Trust to a shortfall of c.£4m on planned income during the year. In addition to this, the impact of fines relating to breaches of the 52 week waiting time target in spinal deformity has had a material impact on the position, with £620,000 of fines currently recognised in the year to date position.

Pay is in line with planned levels, although there have been overspends in areas such as theatres, ward nursing and some corporate areas, offset by underspent allocations set aside for activity growth. Non Pay is c£1m underspent year to date, in line with expectations given the reduction in activity.

2.1.4 The Trust had planned to deliver a Financial Sustainability Risk Rating of 2 in Quarter 3 of 2015/16. The Trust has delivered this rating of 2, however it 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 for 2015/16, nor is it anticipated that it will be deliverable in 2016/17. 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 quarterly governance declaration requires the Trust 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. As part of the development of the proposed capital programme for 2016/17, a full review of the likely outturn for 2015/16 has been undertaken and is represented in our Quarter 3 return. As such, we are confident in being able to declare 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.

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 In previous returns during the 2015/16, the Trust has been highlighting a progressively deteriorating position regarding its active waiting patients. The Trust calculated a trajectory that would see it breach the 92% incomplete threshold during Q3/4 of 2015/16. The Trust has highlighted previously that the driving factor for such breach is directly related to the extensive waiting times currently occurring within spinal services. The Trust has sought to keep Monitor updated with it's in year discussions with NHS England and Birmingham Children's Hospital NHS Foundation Trust. A significant proportion of the over 18 week patients are on pathways that have restricted access to specialist operating and paediatric intensive care capacity.

3.2.2 Following discussions with Birmingham Cross City Clinical Commissioning Group during December 2015, agreement was reached to split out the Trust's data return to allow for a more transparent appreciation of such single speciality capacity constraints.

3.2.3 As of 25th January 2016 the Trust has 745 patients on 18 week pathway who have waited over 18 weeks. Of these 357 patients reside on a spinal pathway, this equating to 50.65% of the Trusts entire 18 week backlog.

3.2.4 With the support of Commissioners when the designated spinal deformity patients are removed from the Global return, the Trust returns to a compliant 18 week incomplete RTT position of circa 93.68% (December 2015 unify data).

3.2.5 Over more recent weeks ROH has experienced a more progressive dialogue with Birmingham Children's Hospital and with NHS England. Birmingham Children's Hospital has commenced work to scope the need to double spinal deformity capacity on its site. Whilst this is at a very early stage, it has been viewed as a much stronger signal for future service development.

3.2.6 More recently it has been highlighted that NHS England has not progressed negotiations with North Midlands Hospital which would have seen 25 patients per year transferred to that site for operative care from April 2016. Whilst this is of disappointment to ROH, a further direct dialogue between Trust Chief Operations Officers will be further explored.

3.2.7 Moving forward, assuming the commissioner-led agreement for duel pathway reporting continues throughout 2016/17, the Trust would have a developing confidence in being able to sustain its 18 week performance position for all services with the exception of spinal.

3.2.6 From a broader viewpoint, the Trust will be using its GooRoo capacity planning tool to check and challenge its capacity assumptions for 2016/17. This tool has recently been automated to the Trust PAS system to make in year service level refresh significantly more easily accessible.

3.3 Cancer 62 Day target

3.3.1 The Trust's performance against the cancer target for Quarter 3 was 86.4% of patients treated within 62 days, against a target of 85%, meaning that at an overall position, the target was exceeded.

Within the Quarter there were three individual patients with a shared pathway with another provider where the 62 day target was breached, giving an aggregate patients' breached score of 1.5 (= 0.5*3).

3.3.2 As described in previous submissions, it is difficult to predict future performance with any degree of accuracy because the numbers of cancer patients being referred are variable and within these the incidence of patients with complex cancer pathways is also unpredictable.

4.0 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 comprises the ROH, together with Robert Jones and Agnes Hunt Orthopaedic Hospital in Oswestry and Royal National Orthopaedic Hospital in Stanmore. Throughout Quarter 3, there have been several planning events held and Mrs Jo Chambers, CEO of the ROH, has been formally elected by the SOA members as the substantive lead CEO of the Vanguard.
- 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. To support the current cost control measures, however, the decision was taken to postpone this recruitment until the start of 2016/17. The skill set for the individual remains to be one of commercial acumen, experience of partnership working, supported by strengths around finance and risk.
- 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. The terms of reference for the Committee were refreshed during the quarter and the Committee has been retitled 'Quality & Safety Committee' to better reflect the nature of the assurances that it takes as part of its routine cycle of business. The membership of the Committee has also been restricted to three Non Executive Directors to ensure that it provides the wider Board with a more effective means assurance.
- The Audit Committee has met formally during the quarter – the agenda considered progress reports from internal and external audit, losses & compensations register, accounting policies, preparation work for the development of the 2015/16 annual report, the revised Board Assurance Framework, contract risks and a report back from the Chair of the Clinical Governance Committee (Quality & Safety Committee).
- On 4 December 2015, the CQC issued its report into the findings arising from the limited reinspection undertaken at the end of July 2015. The inspection focused on the Trust's High Dependency Unit and the Outpatient Department and a number of Must and Should Do recommendations were included in the report. In response, the Trust has developed an action plan to address these recommendations, which will be monitored through the

Quality & Safety Committee on a monthly basis.

- Some initial scoping and background work to develop the effectiveness of the Board was initiated, with a view to this being the subject of a Board workshop in March 2016.
- The Trust is continuing to addressing a number of matters relating to clinical & corporate governance as summarised in the table below:

Issue	Actions taken	Work in progress
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 Quality & Safety Committee
Policies It had been identified that Policy governance within the organisation currently required improvement, such that robust systems are in place to ensure that policies created are digestible and well-constructed, reviewed in a timely way and are presented for approval in a systematic way	Work has been undertaken to finalise the list of policies that are requiring a review. These have been prioritised for review and approval based on potential risk to the organisation and has been scheduled in for approval by the CEO on the advice of the Trust Management Committee. A refreshed Policy on Policies has been developed, which is currently under consultation for implementation in Spring 2016. This will provide a more effective framework for the development of policies going forward.	Work continues to improve policy governance. The Quality & Safety Committee is appraised of progress on a quarterly basis.
Risk Management Risk Management processes and risk registers need to be improved, such that escalation of key risks to the Board and Senior Management is effective and timely and entries on the relevant registers are meaningful	Work has been undertaken to refresh both the risk register and Board Assurance Framework format, and to refine the content such that risk descriptors are more robust and scoring is consistent	Work is underway to review the risk management strategy and policy to clarify the risk management procedure within the organisation and how risks are escalated and deescalated throughout the organisation.

4.2 The Audit Committee met in November and in respect to this declaration can offer the following positive assurances:

- Good progress had been made with the delivery of the internal audit plan, with some audits around some core financial systems and electronic staff records systems having been completed. Assurance was given that the Internal Audit plan would be delivered as agreed by the end of the year. 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.
- The improvements to the Trust's overall governance arrangements, such that reporting between Committees and upwards from clinical governance committees to the Quality & Safety Committee, was now more effective
- There was good progress with the delivery of 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 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 underway and the timetable for the preparation of the annual report & accounts was in hand.
- Good work was underway to reformat the Board Assurance Framework to make it simpler and in line with other best practice examples

The Committee challenged the following areas or noted the following the key risks:

- 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; slight slippage of the capital spend programme & the judgemental valuation of the Trust's property assets. As such, it was agreed that Audit work would be planned around these areas.
- The ongoing risk relating to stock control in theatres was identified. This would remain a risk until the new system is established.
- The impact of the changes to the Risk Assessment Framework and the tightened control of agency spend was noted to be significant burden to the Trust in terms of scrutiny and external oversight
- A report relating to contract risk was presented. The Trust had developed a rectification plan to address the most significant issue that it 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.

The following actions arose from the Committee:

- Progress with implementing the actions arising from the Board workshop held around the effectiveness of the Audit Committee and development of the Board Assurance Framework 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.
- The Committee remitted discussion of patient consent, particularly the actions to reduce consent on the day of surgery, to the Quality & Safety Committee. It was also suggested that Committee should maintain a 'watching brief' over the assurances relating to Controlled Drugs.
- A number of suggested amendments to the Committee's terms of reference (identified mainly during the workshop) were discussed and these are to be presented and considered by the Committee at its February meeting

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 Quality & Safety Report as assurance.

The Trust can confirm that there are no exception reports to be provided in Quarter 3 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

*Compliance actions were identified as part of the CQC review published on 4th December, which followed the reinspection in July 2015. A plan is in place to deliver the actions, which has been submitted to the CQC.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRANSFORMATION COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	19 January 2016
Guests	None
Presentations received	Workstream 1 – Leadership update
Major agenda items discussed	• • Highlight report including new KPIs • Workstreams 1 – 7 updates (by exception) • Frequency and format of future meetings
Matters presented for information or noting	• Nothing additional
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• 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 the Enhanced Recovery project was rated red due to lack of engagement from clinical stakeholders. A recent audit had demonstrated a departure from accepted clinical practice. Standard Operating Procedures are being developed at present which should assist. Within the same workstream, a delay with the electronic Patient Medicines Administration (ePMA) system project was reported. The Director of Strategy & Transformation is arranging a meeting with all contractors to discuss a resolution. • A more comprehensive update on Workstream 5 was requested for the next meeting and in the meantime a separate meeting would be convened to discuss the workstream.
Positive assurances and highlights of note for the Board	• Pleasing progress was noted across most workstreams overall. • 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, including their private practice indemnity model and an assessment of its applicability to the ROH was being considered • Workstream 1: a detailed presentation was delivered to the Committee around leadership. A future Board workshop will be used to discuss the definition of leadership within the context of the ROH, alongside

	culture. The full people strategy is to be developed shortly and presented to the Transformation Committee at the March meeting. • Workstream 2: It was suggested that the main focus of the next meeting could be on productivity and utilisation; the outpatient work continues to progress well. • Workstream 3: Digital dictation user group and benefits realisation forum is now well embedded • Workstream 4: The positive progress with projects in this workstream, including support to the 'Transformation into Action' work and the launch of the new ROH website • Workstream 6: e-procurement has stalled however will be picked up as part of a forthcoming prioritisation e exercise being undertaken • Workstream 7: The research and academic strategies were reported to be under development. In terms of the launch of the Knowledge Hub, the academic strategy was under development by the Workforce function.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A separate meeting of a subset of the Transformation Committee will be organised to discuss Workstream 5 in particular • The Communications Team was asked to scope some engagement work with those communities that are not usual patients of the Trust. This is to be undertaken initially as a six-week exercise with more detailed planning over further months • It was agreed that the outcome of the last staff engagement work would be presented to the Board at a forthcoming meeting • Culture and leadership is to be a topic for debate at a future Board workshop, which is to include information on best practice leadership development elsewhere • Further work is to be undertaken to finalise the set of duties that lie with the new Physician Associates • An action plan is to be developed to address the issues concerning Enhanced Recovery reported at the meeting
Decisions made	• The new terms of reference for the Committee as approved by the Trust Board were adopted by the Committee.

Tim Pile
VICE CHAIR AND CHAIR OF THE TRANSFORMATION COMMITTEE

For the meeting of the Trust Board scheduled for 3 February 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	27 January 2016
Guests	Evelyn O'Kane, Safeguarding Lead Mustafa Ahmed, Interim Governance Manager Kirti Moholker, Consultant Lead for Outcomes Anne-Marie Williams, Divisional General Manager (Division 1)
Presentations received and discussed	Patient Related Outcome Measures (PROMs) position
Major agenda items discussed	• CGC terms of reference (for adoption) • Report back from the Quality Committee • Clinical Audit & Effectiveness Committee (draft terms of reference) • Safeguarding Committee update • CQC action plan • Quality Improvement Priority update • Quality & Patient Safety report • Clinical risk register • Policy governance update & improvement plan • Update on the operation of the new divisional structure
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	• The Safeguarding Lead joined the meeting to discuss the key points from recent Safeguarding Committee meetings and to present the Safeguarding Strategy. The actions being undertaken to satisfy the Safeguarding requirements within the CQC action plan were outlined, which included additional training for clinical staff in safeguarding responsibilities. Further work was noted to be needed to complete a more comprehensive Safeguarding training Training Needs Assessment to assess the position against national guidance. • A presentation from the Trust lead on Outcomes in respect of PROMs was received. It was noted that while outcomes for Primary Hip Replacements was positive in comparison with the national average, this was not the case for Primary Knee Replacements. A number of findings would suggest that the position could be improved by including increased physiotherapy, enhanced recovery, improved pain management on wards, patient education, review of

	surgeon techniques & their individual results and organisation wide focus on supporting PROMs work. Assurance was provided that where there were any pockets of poor performance in relation to PROMs scores, then there was sufficient attention to address these outliers. • On the Corporate Performance Report, it was noted that the Friends and Family Test results had dipped, a matter that was being reviewed • The Committee reviewed the clinical risk register and noted that good mitigations were in place to manage the risks described
Positive assurances and highlights of note for the Board	• The new terms of reference made provision for a member of the Council of Governors to observe future meetings of the QSC; while she could not attend on this occasion, Sue Arnott was pleased to be invited and to join the meetings from February onwards • Good progress was reported with the delivery of the Trust's 13 Quality Priorities and those proposed for 2016/17 were also discussed, which included a reduction in waiting times, reduction in cancelled operations and improved PROMs scores • An improved position in terms of hydration of patients prior to surgery was reported, which moved the Trust closer to the NICE guideline of water to be imbibed up to two hours before surgery • The draft terms of reference for a new subcommittee, the Clinical Audit & Effectiveness Committee were reviewed and it was pleasing to see the forum be established for principal oversight of PROMs, clinical audit and clinical outcomes • The CQC action plan was discussed and good progress was reported across all areas of the plan, although further work to address Paediatric nursing requirements on HDU was needed. • The Patient Quality & safety report was presented as an ongoing work in progress and a number of suggested amendments and refinements were suggested. • The Committee noted the pleasing performance with addressing the backlog of policies that had exceeded their review date; the new Policy on Policies was reported to be due for presentation at the Board meeting in February 2016 • An update on the effectiveness of the new operational structure was provided by Rob Rose, Divisional General Manager for Division 2. It was reported that there was currently much focus on improving the activity position and to reduce length of stay for patients. All divisions were

	now assigned a Governance Facilitator to help with supporting the discussions around performance against clinical indicators.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A further update on the plans for the launch of the Knowledge Hub are to be presented at the next meeting to include the relationship with the Clinical Quality Committee • An update on progress with the Never Events assurance plan is to be presented at the next meeting • An update on consent is to be presented to the Committee in September
Decisions made	• The Committee formally adopted its revised terms of reference • A further update on PROMs was agreed as necessary for a future meeting to explore some of the issues raised in greater detail.

Kathryn Sallah
NON EXECUTIVE DIRECTOR AND CHAIR OF THE QUALITY & SAFETY COMMITTEE

For the meeting of the Trust Board scheduled for 3 February 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Friday 04 March 2016

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 9th March 2015 at 1300h 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 1300h.

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** 9 March 2016 : 1400h – 1600h

TIME	ITEM	TITLE	PAPER REF	LEAD
1400h	1	Apologies and welcome	Verbal	Chair
1402h	2	Declarations of interest	Verbal	All
1405h	3	Minutes of previous meeting on 9 December 2015	ROHGO (12/15) 011	Chair
1410h	4	Update on actions arising from previous meeting	ROHGO (12/15) 011 (a)	Chair
1415h	5	Finances and activity: • Submission to Monitor and Control Total • Recovery plan • Establishment of a Finance & Performance Assurance Committee	Presentation	PA TP YB
1445h	6	Strategic context: • Vanguard • Sustainability and Transformation Plans	ROHGO (03/16) 007	Chair
1505h	7	Quality Account - Governor Selected Indicator	ROHGO (03/16) 002 ROHGO (03/16) 002 (a)	KS
1515h	8	Update on Transformation	ROHGO (03/16) 003 ROHGO (03/16) 003 (a) Presentation	TP
1530h	9	Governor Matters: • Feedback • Elections	Verbal	All
1540h	10	Feedback from Patient and Carers/ Council	Verbal	SN
1550h	11	For information: • Corporate Performance Report • Safe staffing report • Quarterly Complaints Report	ROHGO (03/16) 004 & 004 (a) ROHGO (03/16) 005 & 005 (a) ROHGO (03/16) 006 & 006 (a)	
	Date of next meeting: Wednesday 11 May 2016@ 1400h – 1600h in Trust Headquarters			

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 6 April 2016

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 6 April 2016 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.

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** 6 April 2016: 1100h – 1330h

Members attending

Dame Yve Buckland	Chairman	(YB)
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	Director of Operations	(JL)
Mr Paul Athey	Finance Director	(PA)
Mr Andrew Pearson	Medical Director	(AP)
Mr Garry Marsh	Director of Nursing & Clinical Governance	(GM)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(AC)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]
Ms Stacey Keegan-Lea	Matron	(SK-L)	

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies – Tim Pile & Phil Begg	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	Patient story - *Dementia Care*	ROHTB (4/16) 002	SK-L
1125h	4	Minutes of Public Board Meeting held on the 2 February 2016 *for approval*	ROHTB (2/15) 025	Chair
1130h	5	Trust Board action points: *for assurance*	ROHTB (2/15) 025 (a)	Chair
	5.1	Improvements in translation services	Verbal	GM
1140h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (4/16) 003 ROHTB (4/16) 003 (a)	YB/JC
1150h	7	Board workplan 2016/17: *for approval*	ROHTB (4/16) 004 ROHTB (4/16) 004 (a)	SG-L

CORPORATE PERFORMANCE & ASSURANCE				
1155h	8	One year operational plan and budget sign off: *for approval*	ROHTB (4/16) 005 ROHTB (4/16) 005 (a)	PA
1215h	9	Care Quality Commission improvement plan – delivery of actions to date: *for assurance*	ROHTB (4/16) 007 ROHTB (4/16) 007 (a)	GM
1220h	10	Quality Account Priorities – 2016/14: *for approval*	ROHTB (4/16) 017 ROHTB (4/16) 017 (a)	GM
1225h	11	Corporate Performance Report: *for assurance*	ROHTB (4/16) 008 ROHTB (4/16) 008 (a)	PA
1235h	12	Safe Staffing Report: *for assurance*	ROHTB (4/16) 009 ROHTB (4/16) 009 (a)	GM
1240h	13	Trust response to the Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings: *for assurance*	Presentation	GM
1250h	14	National staff survey results and action plan: *for assurance*	ROHTB (4/16) 012 ROHTB (4/16) 012 (a) ROHTB (4/16) 012 (b)	AC
ASSURANCE UPDATES FROM THE BOARD COMMITTEES				
1300h	15	Audit Committee including revised terms of reference: *for approval*	ROHTB (4/16) 010 ROHTB (4/16) 011 (a) ROHTB (4/16) 011 (b)	RA
1305h	16	Transformation Committee	ROHTB (4/16) 013	RA
1310h	17	Finance & Performance Committee	ROHTB (4/16) 014	RA
1315h	18	Quality & Safety Committee	ROHTB (4/16) 015	KS/TS
1320h	19	Council of Governors	Verbal	YB
1325h	20	Charitable Funds Committee (minutes)	ROHTB (4/16) 016	FK
	21	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 4th May 2016 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

AGENDA
COUNCIL OF GOVERNORS

Venue Board Room, Trust Headquarters **Date** 11 May 2016 : 1400h – 1600h

TIME	ITEM	TITLE	PAPER REF	LEAD
1400h	1	Apologies and welcome	Verbal	Chair
1402h	2	Declarations of interest	Verbal	All
1405h	3	Minutes of previous meeting on 9 March 2016	ROHGO (3/16) 008	Chair
1410h	4	Update on actions arising from previous meeting	Verbal	Chair
1415h	5	Chief Executive's update	ROHGO (5/16) 002 ROHGO (5/16) 002 (a)	JC
1425h	6	DRAFT Annual Report (including Quality Account) & Accounts 2016 (PRIVATE ITEM)	ROHGO (5/16) 003 ROHGO (5/16) 003 (a) ROHGO (5/16) 003 (b) ROHGO (5/16) 003 (c)	SGL AC PA
1445h	7	Update on the work of the Finance & Performance Committee	Verbal	TP
1455h	8	Staff survey results and action plan	ROHGO (5/16) 004 ROHGO (5/16) 004 (a) ROHGO (5/16) 004 (b)	TS
1515h	9	Quality & Safety walkabouts	Presentation	AC
1530h	10	Governor Matters: • Feedback • Elections	Verbal	All
1540h	11	Feedback from Patient and Carers/ Council	Verbal	SN
1550h	12	For information: • Corporate Performance Report • Safe staffing report • Quarterly Complaints Report – *Q4 not yet available* • Divisional structure	ROHGO (05/16) 005 & 005 (a) ROHGO (05/16) 006 & 006 (a) ROHGO (05/16) 007	
	13	Any other business	Verbal	
	Date of next meeting: Wednesday 14 September 2016 @ 1400h – 1600h in Trust Headquarters			

MINUTES

Council of Governors - Version 0.2

Venue Boardroom, Trust Headquarters **Date** 9 March 2016 @ 1400h

Members present

Yve Buckland	Chairman	YB
Alan Last	Lead Governor	AL
Rob Talboys	Public Governor	RTa
Stella Noon	Public Governor	SN
Jean Rookes	Public Governor	JR
Marion Betteridge	Public Governor	MB
Sue Arnott	Public Governor	SA
Anthony Thomas	Public Governor	AT
Petro Nicolaides	Public Governor	PN
Carol Cullimore	Public Governor	CC
Karen Hughes	Staff Governor	KH
Alex Gilder	Staff Governor	AG
Sue Lococo	Staff Governor	SL
Ronan Treacey	Staff Governor	RTr
Richard Burden	Appointed Governor	RB
Paul Sabapathy	Appointed Governor	PS

In attendance

Tim Pile	Vice Chairman & Non Executive Director	TP
Rod Anthony	Non Executive Director	RA
Frances Kirkham	Non Executive Director	FK
Paul Athey	Non Executive Director	PA
Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	SGL

Minutes	**Paper Ref**
1 Apologies and welcome	**Verbal**
Apologies were received from Andy Clarke. Jo Chambers and Kathryn Sallah had also given their apologies as they had hoped to attend the meeting. As Stella Noon's term of office would expire before the next meeting, all thanked Stella for her role as a governor of the Trust and gave recognition for the extensive corporate knowledge for which Stella was well known. The Chairman thanked Stella	

particularly for her personal support during her period since she had taken up office.	
2 Declarations of interest	**All**
There were no declarations of interest registered.	
3 Minutes of the previous meeting on 9 December 2015	**ROHGO (12/15) 011**
The minutes of the previous meeting were agreed to be an accurate record of discussions held.	
4 Update on actions arising from previous meetings	**Verbal**
It was noted that the majority of the matters arising concerned the Trust's activity position which was included on the formal agenda.	
5 Finances and activity	**Presentation**
The Director of Finance joined the meeting to present an overview of the key requirements on the Trust in terms of finance. It was noted that a control total of £3.2m had been set by Monitor for the ROH, which would be very challenging to achieve. The suspension of fines by commissioners for 52 week waits in respect of spinal deformity cases would assist the position, but as yet had not be agreed. It was reported that the Board had taken a number of steps to drive up productivity and look at our costings. Tim Pile emphasised that driving activity upwards was key to the success of the Trust; cost reduction also needed to be addressed however. The introduction of a Finance & Performance Committee was key to the Board oversight of finance and operational performance, which was now reviewing data not seen previously and was informing the Board of the situation at a granular level. It was reported that the Committee took a view prospectively and gained a sense of activity trends, as well as matters such as cancelled appointments and reasons behind these. It was reported that the Trust Chairman was currently chairing the Committee, although this was for a period of turnaround and was driven by data and understanding the plans and then would step back to a more routine assurance position. It was reported that two consultants had come forward to suggest a different way of working for their areas, based on learning from elsewhere. To hit the Monitor target a step change would be needed to drive the organisation harder to look at opportunities, such as this process re-engineering more closely. The flow through of patients is to be addressed and an activity rectification plan had been developed which included a large number of activities, some of which were transformational. The introduction of daily huddles was mentioned, which provided daily oversight and empowerment of staff to resolve issues via ACTION cards. The opportunity for improvement was reported to be significant. Alex Gilder asked how confident that the increase in activity seen over the last few weeks was not the routine pick up that had been seen to occur in previous years	

towards the year end. It was reported that there was a good indication that the revised position was due to a focus on planning forward through the 6-4-2 meetings which considered the pipeline of activity. It was acknowledged however, that the effort in the last quarter could skew the position and rapid progress during the first quarter was needed. The five year plan and engagement with the Vanguard work might play into the sustainability plan and involve partners to help the organisation achieve the objective.

It was noted that the lack of activity around the hospital at times supported, in a visual way, the overall positon that the Trust was in at present. The Chairman advised that this had also been challenged at Board level and assurance was given that the position would improve.

It was suggested that early warning indicators were needed in future to pick up when there might be issues. Tim Pile reported that the Transformation Team was focussing on this, including a close link to the patient journey end to end. A set of data supports this view.

Ronan Treacy suggested that the issue was partly due to the architecture that did not gel with the regulatory environment and highlighted that the commissioner fining regime did not assist; fundamentals needed to be right with current people before further appointments were arranged. The Chairman agreed and reported that there was a clear view that the position was not just about the clinical and medical workforce productivity, with the workforce being key and needing to be engaged given that they understood the position from a 'front line' perspective.

Karen Hughes commented that staff could highlight issues but there had not been the resource previously, thereby placing reliance on the Transformation Team to help.

Some new data systems were reported to be being introduced, however to date some of the basic processes were manual. 'In Touch', which would be introduced shortly, was noted to be a system that would provide outpatient information that was not available previously around clinic utilisation.

It was noted that refurbishment of theatres was needed and the impact of this on the capital plan and activity position was discussed. The Chairman acknowledged that there was a link between theatre equipment and activity, particular concerning the recent issues with the laminar flow. The Director of Finance advised that there was a limited opportunity for capital financing for this work, however caution needed to be exercised in view of the current financial constraints. A case would need to be developed to support this work and demonstrate the benefits. Work was underway to carefully schedule of key pieces of work to coincide with the theatre downtime. Other options might need to be considered to maintain patient flow, including 'pop up' theatres and shared arrangements with partners.

It was agreed that the governors would be kept up to date with the activity rectification work.

ACTION: Further update on the activity and financial position at the next meeting	
6 Strategic context	**ROHGO (3/16) 007**
The strategic context was discussed, which was noted to concern collaboration and partnership working at present, including the development of the Sustainability and Transformation Plan footprint. An update was provided on the Vanguard work. It was noted that the Vanguard provided several opportunities for the Trust, including the ability to influence at a national level and an opportunities for sharing 'back office' functions. The regional position was outlined, including the joint working between University Hospitals Birmingham NHSFT and Heart of England NHSFT, which would create a major influence in Birmingham. Sandwell and West Birmingham Hospitals NHS Trust on the other hand, was being positioned to face out into the Black Country. The Chairman reported that there had been recent discussions with local partners around opportunities of working together. It was suggested that engaging clinicians with the plans was necessary and the matter needs to be handled with care from this perspective. The Director of Finance left the meeting.	
7 Quality Account – governor selected indicator	**ROHGO (3/16) 002** **ROHGO (3/16) 002 (a)**
The Associate Director of Governance & Company Secretary presented a long list of quality priorities for 2016/17 which had been drawn together from various sources of feedback, both internally and from external stakeholders. The Governors were asked to select an indicator to sponsor, which was agreed by a vote on a shortlist following discussions. The Governors selected the measure which reduced the number of operations being cancelled on the day of surgery as their sponsored indicator.	
8 Update on Transformation	**ROHGO (3/16) 003** **ROHGO (3/16) 003 (a)** **Presentation**
Tim Pile presented an overview of the work of the Transformation Team. The imperative to drive change in the organisation was outlined, with people being part of that change. A strategy had been developed and needed to be challenged and driven through the organisation. Incremental change was needed and caution was required to balance 'business as usual' requirements and transformational work. Good progress was reported to be being made on the incremental work, with less progress on the transformational work.	

The various workstreams within the Transformation Programme were reviewed; it was noted that progress on Workstreams 2 and 3 was good. It was noted that the entire external system was in flux at present and there was a need to adapt to keep up with the changes. It was suggested that using people to drive the shorter term change showed that current systems were inadequate but would generate benefit in the longer term. The Transformation Team had been heavily involved in the 'Transformation into Action' work and has been useful for the gravitas and reputation of the team. It was noted that the work of the Transformation Team was changing the culture of the organisation and all had a role to play. It was suggested that collaborations with other organisations might help with the work around the preventative strategies, including a commercial team or research organisation. It was noted that there was little bandwidth to do this at present however. Some of the work could be clinician led including a partnership with weight management for instance. The MSK link to GP work will also help. Learning from elsewhere could also be explored including from other countries.	
9 Governor matters	**Verbal**
Sue Arnott reported that she had attended the Quality & Safety Committee at which Kathryn Sallah and Tauny Southwood were in attendance. She advised that there was a good level of challenge on how matters in progress could be monitored. Research & Development was a matter of concern for the Committee and it was reported that the R & D Committee had not met for a while. It was suggested that Professor Begg, who was the Executive Lead for research could join a future meeting to discuss the approach to R & D. Anthony Thomas reported that he attended the Estates Group, which was working well and his comments had been taken on board.	
ACTION: Prof Begg to join a future meeting to discuss Research & Development	
10 Feedback from the Patient & Carers' Council	**Verbal**
Stella Noon reported some concern about the operation of the Patient & Carers' Council, as the support for the council was not consistent and needed to be finalised. It was agreed that the schedule of meetings for the next 12 months would be issued. Membership of the Council was discussed and it was agreed that Marion Betteridge would join the meeting. The new patient handbook was discussed and would be launched shortly. It was reported that the previous signage of the hospital was to be reinstated.	

Privacy and dignity group was attended by Jean Rookes, which was currently looking at policies within its remit.	
ACTION: The forward schedule of Patient and Carers' Council meeting to be issued	
11 Matters for information	**ROHGO (3/16) 004** **ROHGO (3/16) 004 (a)** **ROHGO (3/16) 005** **ROHGO (3/16) 005 (a)** **ROHGO (3/16) 006** **ROHGO (3/16) 006 (a)**
The Council noted the reports available for information. The lack of staff in HDU was discussed in connection with the safe staffing report and it was noted that this related to qualified intensive nurses; an advert would be issued shortly. In terms of the complaints report, it was agreed that the divisional structure would be useful for the governors to see. It was suggested that the number of complaints relative to activity is more useful than absolute numbers.	
ACTION: The Divisional Structure to be issued	
Details of next meeting	**Verbal**
The next meeting is planned for 11 May 2016 at 1400h – 1600h in the Boardroom, Trust HQ.	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Jo Chambers, Chief Executive**
DATE OF MEETING:	**11 May 2016**

EXECUTIVE SUMMARY:

This report provides an update to board members on the national context and key local activities not covered elsewhere on the agenda.

The report also provides a summary of key discussions and decisions taken by the Trust Management Committee at its recent meeting.

REPORT RECOMMENDATION:

The Council is asked to note and discuss the contents of this report

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:

The contents discuss a number of developments which have the potential to impact on the delivery of a number of the Trust's strategic ambitions

PREVIOUS CONSIDERATION:

Trust Board on 4 May 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Council of Governors on 11 May 2016

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 focus of attention has continued to be strong financial management at the end of 2015/16 to ensure that the overall performance of the NHS delivers against the Department of Health spending limit (DEL).

2.2 Contract negotiations for 2016/17 were due to be completed by week commencing 25 April, with some flexibility for resolution during the week. Any contracts not agreed during the week or unlikely to be agreed will automatically be entered into arbitration.

3 Local Context

3.1 Following detailed and constructive contract negotiations the Trust expects to be in a position to agree its contracts within the timescales required. In relation to the local 'host' Clinical Commissioning Group contracts, the Trust has reached agreement on all main terms and conditions with the exception of a national CQUIN (Commissioning for Quality and Innovation) relating to a reduction in antimicrobial use. The ROH has a specialist Bone Infection Unit and adherence to the CQUIN scheme would bring unintended detriment to the patients we treat. The Trust, in partnership with Birmingham Cross City CCG, has jointly requested a variation to the national CQUIN with a proposal to substitute it with a local CQUIN potentially linked to our vanguard work. We are currently awaiting feedback from the national lead.

3.2 In relation to the specialised services contract with NHS England, the Trust has worked hard with commissioners and our partners at Birmingham Children's Hospital (BCH) to reach an agreement whereby the Trust has additional operating capacity at BCH to enable more patients with longer waiting times to be operated on. At the time of writing the report there is an agreement in principle which paves the way for this longstanding capacity constraint to be addressed.

3.3 The first Birmingham and Solihull Sustainability and Transformation Plan System Leaders Board meeting took place in April 2016, chaired by Stephen Dorrell and led by Mark Rogers, CEO of Birmingham City Council. Governance arrangements have been put in place to enable engagement and action at an appropriate level, with all activities overseen by a Council Leaders and Health Chairs group. The immediate priority is to address the overall gap in the STP area whilst developing transformation plans for the longer term.

4 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

4.1 In addition to routine business meetings with partners, other key stakeholder and partnership engagement activities over the period include:

- Attended Birmingham & Solihull STP System Board
- Attended West Midlands CEO meeting
- Chaired the Leadership Transformation Theme Group
- Birmingham & Solihull Leaders and Chairs meeting (on behalf of Yve Buckland)
- Delivered key note address at the 'Inside Government's: The Future of NHS Finance Forum' (Case study: Lessons from a Vanguard NHS Hospital Trust in Planning for Financial Stability)

5 UPDATE FROM TRUST MANAGEMENT COMMITTEE (APRIL 2016)

5.1 Since the last meeting of the Board on 6 April 2016, the Trust Management Committee (TMC) was held on 27 April 2016.

5.2 **27 April 2016**

TMC considered the following items to be of note to the Board:

- The final decision regarding the proposed implementation of a new Theatre Stock Management System ('EDC Gold') was delegated to a sub-committee of TMC to work through the remaining issues before final approval at the Executive Team meeting on 3rd May 2016.
- Following on from a discussion about the recent stock count that took place, TMC debated the role of supplier representatives in theatres. TMC gave an agreement in principle to sign up to a new Medical Industry Accreditation scheme which will ensure that representatives have undergone the necessary checks before they can access the theatre environment.
- A report on the Trust's self-assessment against the Equality Delivery System was presented to the meeting, highlighting priority areas for action for 2016/17 which were subsequently endorsed by TMC.

- TMC approved a new partnership with 'HealthTec' who offer a website portal for all work experience applications, enabling a more open, inclusive and fair selection process than the Trust has at present. This was supported by further discussions on how the Trust can build cultural sensitivities into all services that we offer, working towards a more inclusive offer to staff and patients.
- Divisions have been asked to ensure that their staff survey action plans include detailed responses on how they will work with staff to ensure they feel comfortable to raise concerns, an area of the staff survey which remains a priority.
- A full business case for a replacement Theatre Management System ('THEATREMAN') was discussed and TMC was asked to note that there was an additional £40k capital cost that would need to be factored into the capital programme. Additional revenue costs would be absorbed in Division 2's current run rate. TMC gave approval to the case.
- An outline business case for IT network improvements was presented to TMC for discussion. It was noted that, once the site review had taken place and an indicative costing plan drawn up, that the existing funding identified for infrastructure improvements within other business cases (with IT dependencies) should be factored into the overall cost.
- Car Park Management Policy: This policy proposes an increase in visitor parking fees. Assurance was sought that patients and the Patients Council had been consulted on this policy as adequate consultation was not evident. The policy will return to TMC in May, with evidence of full engagement to arrive at the recommendations proposed.

5.3 TMC acknowledged that a number of risks had presented themselves throughout the meeting which would need to be captured on the Corporate Risk Register, including:

- Role of supplier representatives in theatres
- Tight timeframes for implementation of EDC Gold (Theatre Stock Management) and THEATREMAN (Theatre Management) systems, with (monthly) £10k cost implication of renewing ORMIS on month by month basis
- Resilience in IT team and mapping of key projects and interdependencies (including testing electrical resilience before network upgrade)
- Staff not feeling that they can raise concerns and the implications this may have for patient and staff safety
- ROH non-compliance with specific areas of Equality Delivery system self-assessment

From May 2016 TMC meetings onwards, there will be an additional item on the agenda to discuss any risks that arise throughout the meeting, and to agree whether these need to be captured on the Board Assurance Framework or Corporate Risk Register.

6 RECOMMENDATION(S)

6.1 The Council is asked to note the contents of the report, and

Jo Chambers
Chief Executive
28 April 2016

ROHGO (5/16) 004

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Staff Survey 2015**
SPONSOR (EXECUTIVE DIRECTOR):	**Ms Anne Cholmondeley, Director of Workforce & OD**
AUTHOR:	**Ms Anne Cholmondeley, Director of Workforce & OD**
DATE OF MEETING:	**11 May 2016**

EXECUTIVE SUMMARY:

The attached report presents to the Council the National Staff Survey results for 2015. It highlights continued good practice on appraisal, flexible working and health and well-being indicators. Regrettably, causes for concern continue in relation to perception of the organisation as a place to work and receive treatment as well as fairness, effectiveness and confidence in incident reporting.

The Divisional management teams are currently developing specific strategies to address the issues of concern and further develop best practice in their areas. Work continues corporately to build confidence in and perception of fairness with regard to reporting of errors and incidents. In addition the survey provides additional information to inform the development of the Leadership strategy.

REPORT RECOMMENDATION:

The Council is asked to:

- DISCUSS the survey findings and endorse the priority areas for action and the next steps.
- NOTE that more detailed action plans are in development at a corporate and divisional level and will be presented at Trust Management Committee.

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	x
Clinical	x	Equality and Diversity		Workforce	x

Comments: Pages within the report refer in some manner to all of the key areas highlighted above.

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Highly motivated, skilled and inspiring colleagues

PREVIOUS CONSIDERATION:

Trust Management Committee and Trust Board

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

National NHS Staff Survey 2015

Report to Council of Governors on 11th May 2016

1 EXECUTIVE SUMMARY

1.1 This report presents to the Board the National Staff Survey results for 2015. It highlights continued good practice on appraisal, flexible working and health and well-being indicators. Regrettably, causes for concern continue in relation to perception of the organisation as a place to work and receive treatment as well as fairness, effectiveness and confidence in incident reporting.

1.2 The Divisional management teams are currently developing specific strategies to address the issues of concern and further develop best practice in their areas. Work continues corporately to build confidence in and perception of fairness with regard to reporting of errors and incidents. In addition the survey provides additional information to inform the development of the Leadership strategy.

2 Background

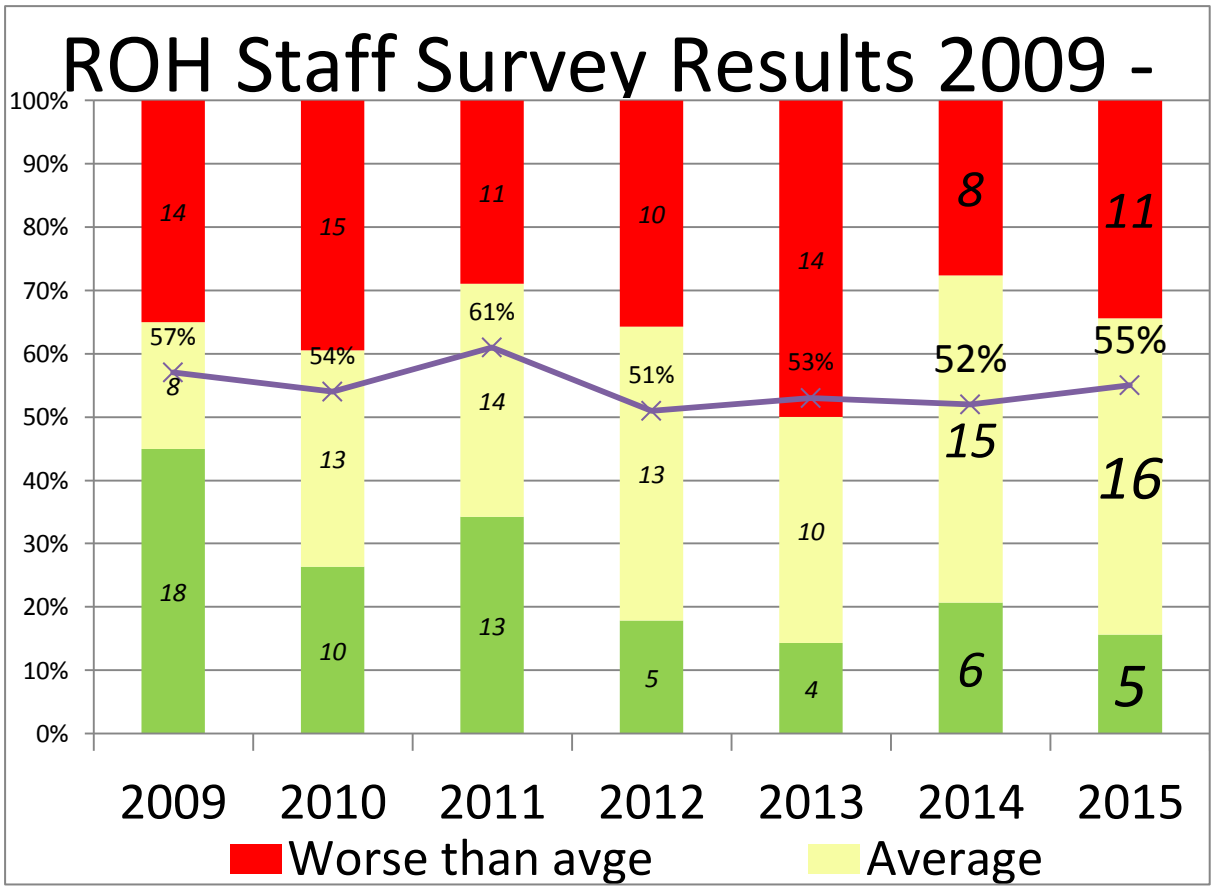
2.1 The National Staff Survey is undertaken from September to December each year and is administered by an accredited survey provider on behalf of the Trust.

2.2. This year all staff were surveyed, rather than just a sample. In total 505 staff took part in the survey and this is a response rate of 55%, which is above average compared to our peer organisations. For comparison, the response rate in 2014 was 52%.

2.3 The survey has thirty two key findings, framed within the four staff pledges from the NHS Constitution, together with three additional themes of equality and diversity, errors and incidents and patient experience measures.

3 Overall Results

3.1 The overall results show a slight deterioration compared to 2014. Each key factor is scored and ranked compared to other Acute Specialist Trusts, creating three broad categories of above average, average and below average. The graph below shows the trend since 2009 in performance in these broad categories .



3.2 In addition, attached in appendix one is an exert from the survey report which summarises the changes in key findings since 2014 and the Trust's ranking, compared with all acute specialist trusts in 2015.

3.3 The four key findings where the ROH compares most favourably with peers are:

- Percentage of staff appraised in the last 12 months
- Percentage of staff satisfied with the opportunities for flexible working patterns
- Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse
- Percentage of staff suffering work related stress in the last 12 months
- Percentage of staff feeling pressure in the last three months to attend work when feeling unwell

3.4 The five key findings where the ROH compares least favourably with peers are:

- Fairness and effectiveness of procedures for reporting errors, near misses or incidents
- Staff confidence and security in reporting unsafe clinical practice
- Quality of non-mandatory training, learning or development
- Staff motivation at work
- Staff recommendation of the organisation as a place to work or receive treatment

4 Divisional or Staff Group Analysis

4.1 When considering the results at Divisional level, staff reporting a positive experience are most prevalent within Estates and Facilities and Corporate functions (save for four metrics). Staff reporting the worst experience are within Patient Access Division, a relatively small number of staff but nonetheless a cause for concern.

4.2 At a staff group level, positive results are reported by staff within physiotherapy, maintenance, healthcare assistants, scientific and corporate functions (save for two indicators).

4.3 The staff groups reporting the least positive experience are radiography, general management, general nursing and administration. In terms of impact, the two most concerning within this are general nursing and administration due to overall numbers and the direct potential impact on patients with regard to the quality of care delivered.

4.4 In relation to the four worst scoring indicators the results of note are detailed below.

Indicator	Highest Scores	Lowest Scores
Fairness and effectiveness of procedures for reporting errors, near misses & incidents	Healthcare assistants and Maintenance	Medical staff and general nurses
Staff confidence and security in reporting unsafe clinical practice	Other general nurses and Healthcare assistants.	Medical staff and radiography
Quality of non-mandatory training, learning or development	General Nurses, Healthcare Assistants and scientific staff	General management and administration.
Staff motivation at work	Medical staff, other general nurses and physiotherapy	AHPs (not physiotherapists) and administration
Staff recommendation of the organisation as a place to work or receive treatment	Healthcare Assistants and maintenance staff	Radiography, AHPs (not physiotherapy) and general management.

5 ANALYSIS

5.1 On balance we have not seen the positive improvements we would have hoped for over the last twelve months, particularly from increased focus on internal communications, increased learning opportunities and rewarding staff contribution.

However, at the time of the survey, the new divisional management teams had been in place for less than two months and there were considerable concerns within the organisation about the cost and effectiveness of interim managers. In addition, events relating to controlled drug concerns had only been concluded over the summer of 2015 and therefore were still felt by staff to be very much a recent event.

5.2 Since the summer of 2015 there has been considerable work on incident reporting, sharing of learning and re-building of trust in relation to the management of critical incidents. Informal conversations with staff the results relating to fairness and effectiveness of incident reporting and confidence to do so, relate to two factors, residual ill-feeling concerning the management of controlled drugs concerns in the early part of 2015 and the ineffectiveness of the processes and system for incident reporting. As the survey was undertaken in the autumn of 2015, the process improvements had clearly not yet taken effect. In addition considerable work continues to be undertaken within the nursing profession concerning professional accountability for delivery of good quality nursing care, which is perceived as unfair blame by some nursing colleagues. This is a significant piece of attitudinal change which the Director of Nursing and Clinical Governance will continue to lead over the coming year.

5.2 The results in relation to motivation and overall recommendation of the organisation as a place to work and receive treatment are general indicators of overall staff satisfaction. The 'free text comments' of the survey provide further insights. There are a number of comments concerning the increase in senior managers and a perception that, as a result of additional investment in these posts, there has been insufficient investment in frontline services/staff. In addition there is a theme reported around a perceived disconnect between the Trust values and the behaviour of some managers, with a typical quote being " I find it hard to see how the rest of the employees of the hospital can authentically 'buy in' to the culture of values".

5.3 However, it is also clear that some staff do feel valued and supported, identify with the need for the organisation to change, support the current leadership team's work in improving standards and tackling inappropriate behaviour.

6. ACTIONS TO DATE

6.1 The priority areas for action are:

- building staff confidence and security to raise concerns about unsafe clinical practice
- improving management response to reported errors and clinical incidents to increase the perception of fairness and effectiveness of incident reporting
- continuation of building overall management and leadership capability.

6.2 The staff survey results have been shared at Trust Management Committee and Trust Consultative Committee. Each Divisional leadership team has a detailed report of the results for their own area and are being supported to develop an action plan, specific to their area. Particular focused support is being given to Patient Support and Patient Access. Each Division is required to finalise their plan for review at the end of April. Each Division has been asked to pay particular attention to the priority areas detailed in 6.1 together with specific staff group related matters in their own area.

6.2 The Director of Nursing and Clinical Governance continues to work on matters relating to improvements in incident reporting processes, sharing of learning and education of the nursing workforce in relation to professional accountability. The Divisions are now embedding governance discussions within services in order to improve the quality of learning from incidents and sharing of best practice. It is also expected that the Trust will implement a new role of Freedom to Speak up Guardian, which will be created to build confidence to raise concerns and improve the effectiveness of responsiveness when concerns are raised.

6.3 Many of the findings support ongoing concerns about the quality of management and leadership in the organisation. These results represent further information to inform the Leadership strategy under development by the Director of Workforce and OD, which will be the subject of future Board discussion following work with the Executive Team.

7. NEXT STEPS

7.1. The process of formulation of specific action plans from the survey at both a Divisional and Trust level are in progress and will be complete by the end of April 2016. It is intended that these will be presented to Trust Management Committee for assurance and then delivery of these by Divisions will be overseen at Workforce and OD Committee and for the organisation as a whole at TMC via a six monthly report.

8. RECOMMENDATIONS

8.1 The Council is asked to:

- NOTE the survey findings and priority areas for action and the next steps.
- NOTE that more detailed action plans are in development at a corporate and divisional level and will be presented at Trust Management Committee.

Anne Cholmondeley
Director of Workforce & OD

31 March 2016

APPENDICES:

Appendix 1 – Summary of Key Findings – Change since 2014 and Ranking Compared to all Acute Specialist Trusts

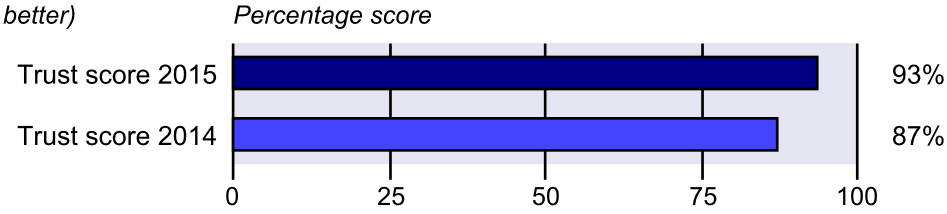
3.2 Largest Local Changes since the 2014 Survey

This page highlights the Key Finding that has improved at The Royal Orthopaedic Hospital NHS Foundation Trust since the 2014 survey.

WHERE STAFF EXPERIENCE HAS IMPROVED

✓KF11. Percentage of staff appraised in last 12 months

(the higher the score the better)



3.2. Summary of all Key Findings for The Royal Orthopaedic Hospital NHS Foundation Trust

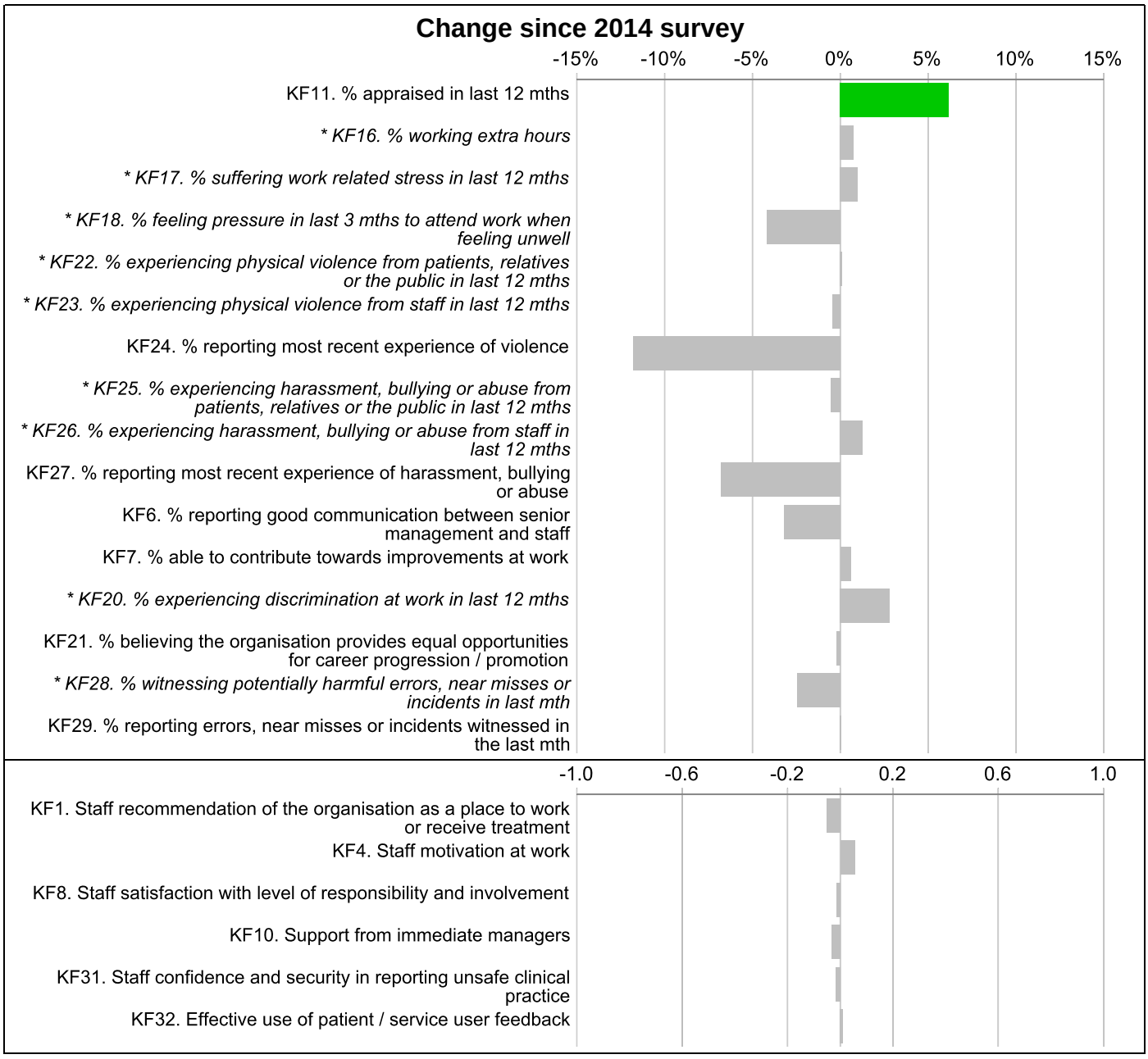
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2014 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2014 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2014 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for The Royal Orthopaedic Hospital NHS Foundation Trust

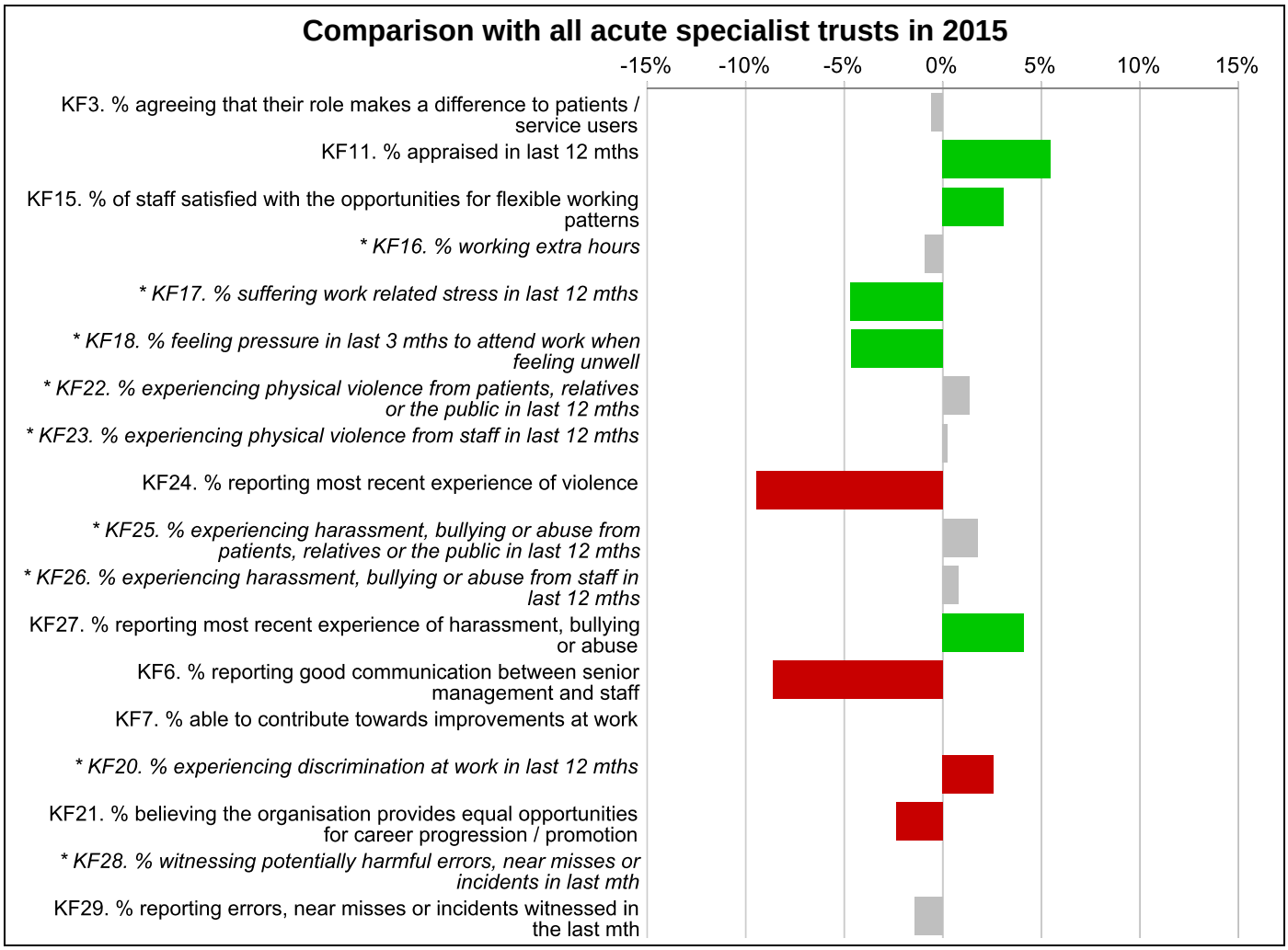
KEY

Green = Positive finding, e.g. better than average.

Red = Negative finding, e.g. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.2. Summary of all Key Findings for The Royal Orthopaedic Hospital NHS Foundation Trust

KEY

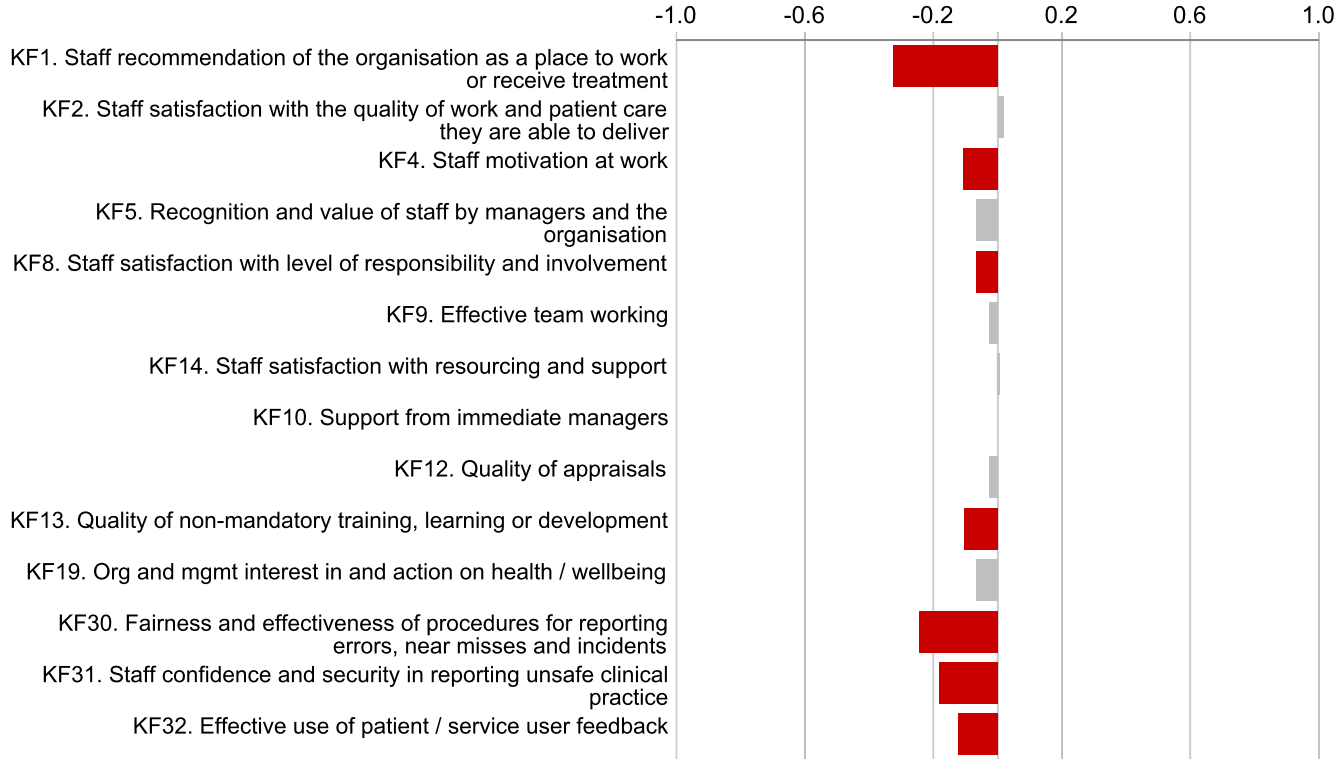
Green = Positive finding, e.g. better than average.

Red = Negative finding, e.g. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all acute specialist trusts in 2015 (cont)



3.3. Summary of all Key Findings for The Royal Orthopaedic Hospital NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2014.

! Red = Negative finding, e.g. worse than average, worse than 2014.

'Change since 2014 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2014 survey.

-- Because of changes to the format of the survey questions this year, comparisons with the 2014 score are not possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2014 survey	Ranking, compared with all acute specialist trusts in 2015
STAFF PLEDGE 1: To provide all staff with clear roles, responsibilities and rewarding jobs.		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	! Below (worse than) average
KF2. Staff satisfaction with the quality of work and patient care they are able to deliver	--	• Average
KF3. % agreeing that their role makes a difference to patients / service users	--	• Average
KF4. Staff motivation at work	• No change	! Below (worse than) average
KF5. Recognition and value of staff by managers and the organisation	--	• Average
KF8. Staff satisfaction with level of responsibility and involvement	• No change	! Below (worse than) average
KF9. Effective team working	--	• Average
KF14. Staff satisfaction with resourcing and support	--	• Average
STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential.		
KF10. Support from immediate managers	• No change	• Average
KF11. % appraised in last 12 mths	✓ Increase (better than 14)	✓ Above (better than) average
KF12. Quality of appraisals	--	• Average
KF13. Quality of non-mandatory training, learning or development	--	! Below (worse than) average
STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, well-being and safety.		
Health and well-being		
KF15. % of staff satisfied with the opportunities for flexible working patterns	--	✓ Above (better than) average
* *KF16. % working extra hours*	• No change	• Average
* *KF17. % suffering work related stress in last 12 mths*	• No change	✓ Below (better than) average
* *KF18. % feeling pressure in last 3 mths to attend work when feeling unwell*	• No change	✓ Below (better than) average
KF19. Org and mgmt interest in and action on health / wellbeing	--	• Average

3.3. Summary of all Key Findings for The Royal Orthopaedic Hospital NHS Foundation Trust (cont)

	Change since 2014 survey	Ranking, compared with all acute specialist trusts in 2015
Violence and harassment		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	• Average
KF24. % reporting most recent experience of violence	• No change	! Below (worse than) average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	• Average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	✓ Above (better than) average
STAFF PLEDGE 4: To engage staff in decisions that affect them, the services they provide and empower them to put forward ways to deliver better and safer services.		
KF6. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF7. % able to contribute towards improvements at work	• No change	• Average
ADDITIONAL THEME: Equality and diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	! Above (worse than) average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	! Below (worse than) average
ADDITIONAL THEME: Errors and incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	• No change	• Average
KF29. % reporting errors, near misses or incidents witnessed in the last mth	• No change	• Average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	--	! Below (worse than) average
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	! Below (worse than) average
ADDITIONAL THEME: Patient experience measures		
KF32. Effective use of patient / service user feedback	• No change	! Below (worse than) average

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Corporate Performance Report – March 2016**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Director of Finance**
AUTHOR:	**Paul Athey, Director of Finance**
DATE OF MEETING:	**11th May 2016**

EXECUTIVE SUMMARY:

The Corporate Performance Report is the main vehicle for reviewing the Trust's overall performance for the month and year to date. It covers quality, operational, staffing and financial performance to allow the Board to discuss any themes or issues arising and actions required as appropriate.

Quality is amber rated in March, with the following key points of note:

- Complaints increased to 20 – this is the highest monthly total since September 2013
- PALs contacts increased to 154 – the highest monthly total since the equivalent month in 2015.
- There was only 1 SIRIs in month - the lowest monthly total since December 2014
- All effectiveness metrics were rated as Green

Full detail and challenge of the quality elements of the Corporate Performance Report is undertaken at Quality and Safety Committee

Operational and Staffing issues are also rated as amber in March, with the following key points of note:

- Overall activity was behind our original plan for March, but broadly in line with the revised plan which supports our revised forecast outturn of a £5.8m deficit reported to Monitor at the end of Month 8.
- Hospital cancellations on the day reduced to 5 – the lowest monthly total in 2015/16
- Average length of stay reduced significantly to 4.00 days

Finance continues to be red rated, with draft accounts showing a year-end financial position as follows:

	£m	
Underlying Deficit *(including accrued level of stock adjustment)*	**(5.337)**	*Comparable assumptions to the (£5.844m) revised planned deficit*
Additional fines over and above planned level	(0.501)	
Revised Underlying Deficit	**(5.838)**	
Capital to Revenue Transfer	2.300	
Net impairment charged to SOCI	(1.724)	
Additional stock write off above accrued levels (still under investigation)	(0.925)*	

Trust Deficit	**(6.187)**
Consolidation of charitable funds	(0.118)
Deficit as per draft annual accounts	**(6.305)**

*The draft annual accounts include a £1.325m write off relating to stock, an element of which had already been accrued into the underlying management accounts position. The stock write off is currently under further investigation, with additional scrutiny provided by internal audit.

REPORT RECOMMENDATION:

The Board are asked to note this report

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	**X**

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

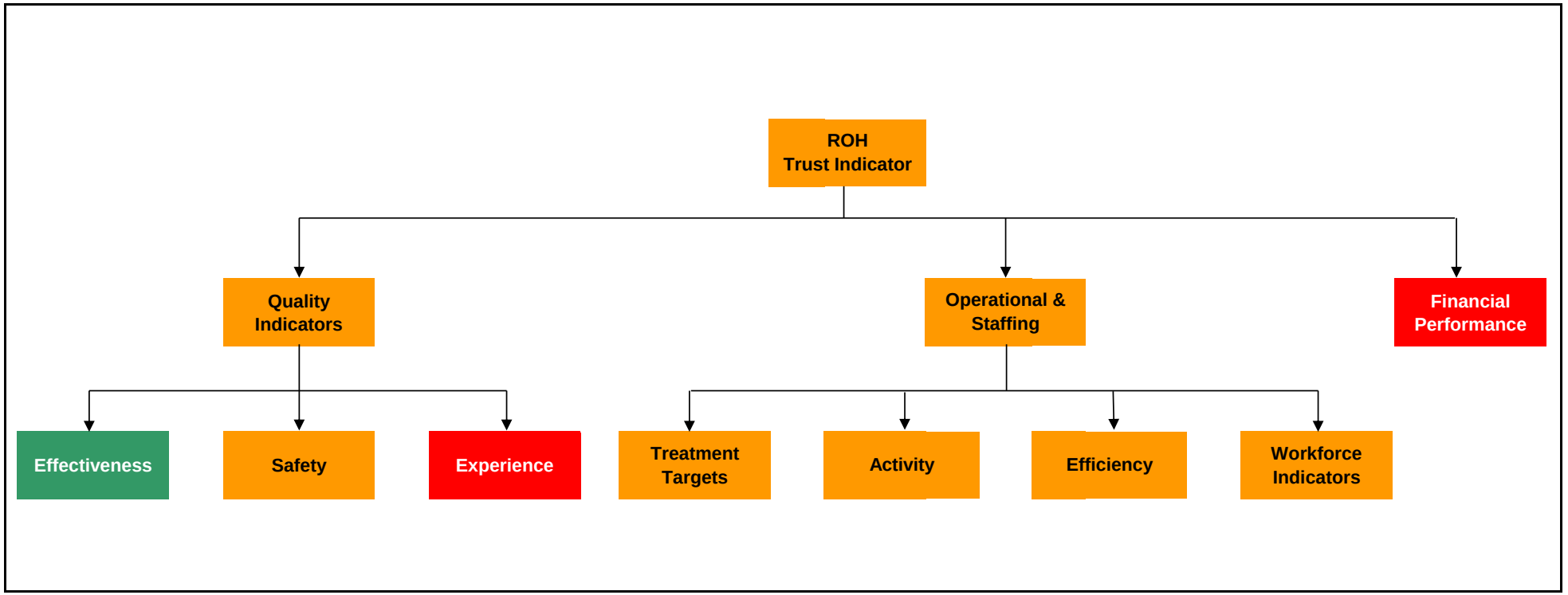
The report is integral to delivery of the strategy in that it provides an overview of current performance, and hence of potential future risk to the quality of care provided and the sustainability of the organisation.

It allows the Board to consider whether areas such as 'Safe and Efficient Processes', 'Fully Engaged Patients and Staff' 'Exceptional Patient Experience' and 'Creating a culture of excellence, innovation and service' are being met.

PREVIOUS CONSIDERATION:

This report builds upon the CPR reviewed by TMC in April. Reviewed by Trust Board in May.

Royal Orthopaedic Hospital NHS Foundation Trust
Corporate Performance Report
For the Month Ending March 2016



Quarterly Detailed Report
Executive Summary as at March 2016

Headlines

- Agency expenditure continues to reduce, from £446,000 in October to £227,000 in March.
- CIP achieved for the financial year is in line with the revised annual plan.
- Total Backlog patients increases to 753 from 650 in February.

Monitor Compliance Framework Targets	March 2016 Target	Actual - Month	Actual - Quarter	Score	Detail Page
Referral to treatment time - Non Admitted %	95%	90.37%	89.03%	0	6
Referral to treatment time - Admitted %	90%	80.12%	80.95%	0	6
Referral to treatment time - Incomplete Pathways %	92%	92.03%	92.03%	0	6
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	80%	93%	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%	0	6
Cancer 2 week (all cancers)	93%	100.0%	99.0%	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	Under Review
Indicative Monitor Financial Risk Rating	2

Key Trust Targets		March 2016 Target	Actual	Trend	Detail Page
Safety, Experience & Effectiveness	SIRIs	0-2	1		3
	Complaints	<=12	20		4
	CQUINS	100%	98%		11
	Total Unexpected Hospital Deaths	0	0		5
Efficiency & Workforce	Total Backlog Patients	<400	753		6
	Incomplete 14 - 18 Week Waiters	<450	608		6
	Total Admitted Patient Care Patients vs Plan	100%	91%		7
	Unused Theatre Sessions	<44	51		8
	Sickness	3.7%	-	-	9
Financial	Surplus	(£2,000)	(£6,187)		10
	CIP	£2,500	£2,535		10
	Agency Expenditure	£295	£227		11
	Locum Doctor Expenditure	£145	£95		11

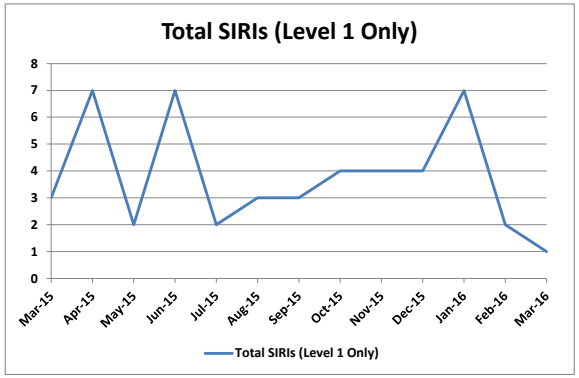
Quarterly Detailed Report
Safety Indicators as at March 2016

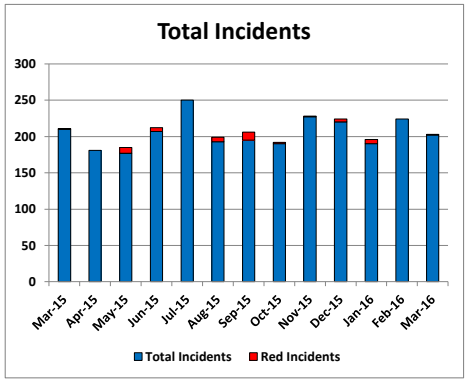
Headlines

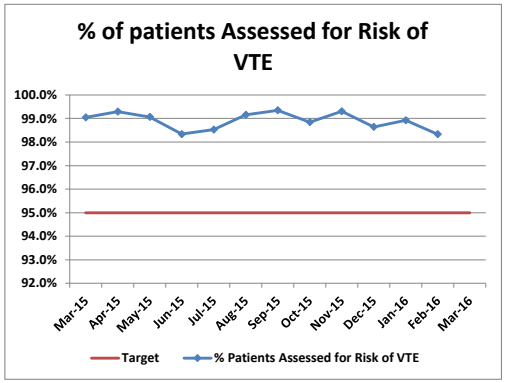
- % of Harm Free Care was up to 100% during the month.
- Total medicine incidents in month have increased and remains above the target for the month.
- Patient falls have reduced during the month but sill remains higher than the target.

	Monitor	National	CQC Standard		Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	15/16 Full Year Position
Safety		N	4,16	Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			4,16	Total SIRIs (Level 1 Only)	3	7	2	7	2	3	3	4	4	4	7	2	1	4
			4,16	SIRI per 1000 bed days	0.88	2.20	0.60	1.98	0.48	0.84	0.84	0.99	1.04	1.10	1.75	0.53	0.28	0.09
			4,16	Total Incidents	210	181	177	207	250	193	195	190	227	220	190	224	202	205
			4,16	Incidents per 1000 bed days	61.67	56.83	53.43	58.41	60.10	54.35	54.87	47.18	58.85	60.66	47.45	59.38	56.73	55.69
			4,16	Red Incidents	1	0	8	5	0	6	11	2	1	4	6	0	1	4
			9,16	Total Medicine Incidents Reported	30	24	13	26	39	11	19	16	26	23	19	28	23	22
			9,16	Medicine Incidents Reported per 1000 bed days	8.81	7.54	3.92	7.34	9.38	3.10	5.35	3.97	6.74	6.34	4.75	7.42	6.46	6.02
				Medicine Incidents with Harm	3	5	0	0	0	0	0	0	3	6	2	4	3	2
		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	99.04%	99.29%	99.06%	98.33%	98.53%	99.15%	99.34%	98.84%	99.31%	98.64%	98.92%	98.33%		98.88%
			9	Incidence of Hospital Related VTE	3	3	4	6	2	4	2	2	5	2	5	2	1	38
			4	Patient Falls - Inpatients	9	5	1	5	7	4	9	9	7		6	7	6	6
			4	Patient Falls per 1000 bed days	2.64	1.57	0.30	1.41	1.68	1.13	2.53	2.23	1.81	0.00	1.50	1.86	1.68	1.48
				Avoidable Patient Falls with Harm	2	1	0	0	1	1	0	0	1		1	1	0	1
			4,16	% Harm Free Care	97.14%	97.26%	98.02%	95.05%	95.24%	97.53%	99.04%	97.83%	99.04%	97.17%	93.91%	96.23%	100.00%	97.13%

On Target	Of Concern	Action Required
0		>=1
0-2	3-4	>=5
>=0.83	0.83-1.50	>1.50
>200	170-200	<170
>50	40-50	<40
>-20	11-19	<=10
1.5-3.5	0.8-1.5 / 3.5-4.8	<0.8 or >4.8
0		>0
≥ 95%		<95%
<=3	4	>=5
<=1.2	1.2-1.5	>=1.5
>=95%	90%-95%	<90%







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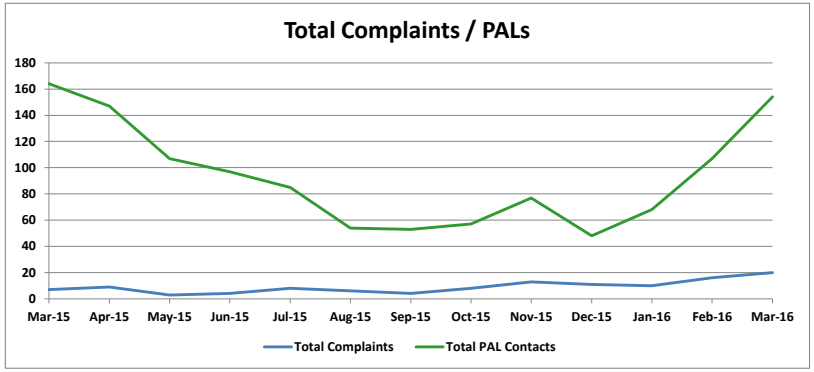
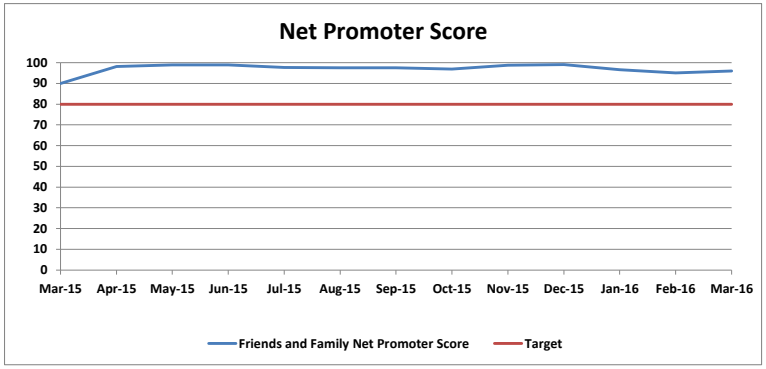
Quarterly Detailed Report
Experience Indicators as at March 2016

Headlines

- Total complaints have increased in month from 16 to 20.
- Total PALS contacts have increased in month from 107 to 154.

	Monitor	National	CQC Standard		Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	15/16 Full Year Position	On Target	Of Concern	Action Required
Experience			17	Complaints to Compliments Ratio	1:60	1:69	1:94	1:27	1:31	1:18	1:21	1:20	1:23	1:42	1:34	1:27	1:38	**1:35**	>'01:10	1:5-1:10	<01:5
			17	Total Complaints	7	9	3	4	8	6	4	8	13	11	10	16	20	**9**	<=12	13-18	>=19
			17	Complaints reverted to informal <48 hrs	0	0	0	0	0	0	0	0	0	0	0	0	0	**0.0**			
			17	Formal	7	9	3	4	8	6	4	8	13	11	10	16	20	**9**			
			17	Complaints per 1000 bed days	2.06	2.83	0.91	1.13	1.92	1.69	1.13	1.99	3.37	3.03	2.50	4.24	5.62	**0.21**	<3.6	3.6-5.3	>5.3
				Complaints Response Time (Average No of Days)	39	35	48	83	77	133	50	64	25	21	24	23	26	**51**			
			17	Total PAL Contacts	164	147	107	97	85	54	53	57	77	48	68	107	154	**88**	<=60	61-74	>=75
			17	PALS Contacts per 1000 bed days	48.16	46.15	32.30	27.37	20.43	15.21	14.91	14.15	19.96	13.23	16.98	28.37	43.25	**24.36**	<17.5	17.5-21.6	>21.6
				Total PALS Concerns	86	59	50	64	55	39	35	33	48	28	28	61	55	**46**			
			17	Total Compliments	418	619	283	106	251	106	85	159	304	467	338	430	751	**325**	>=20	11-19	<=10
			17	Compliments per 1000 bed days	122.76	194.35	85.42	29.91	60.34	29.85	23.92	39.48	78.82	128.76	84.42	114.00	210.90	**7.36**	>5.6	3.0-5.6	<3.0
				Food - Real Time Patient Survey	94.7%	98.8%	98.8%	96.2%	98.8%		98.6%	99.5%	100.0%	100.0%	98.0%	99.2%	95.4%	**98.5%**			
			17	Friends and Family Net Promoter Score	90	98	99	99	98	98	98	97	99	99	97	95	96	**98**	>80	75-80	<75
				Friends and Family Response Rate	52.0%	45.3%	48.0%		34.4%	37.0%	28.9%	26.4%	31.8%	20.2%	38.4%	30.8%	8.1%	**31.8%**			



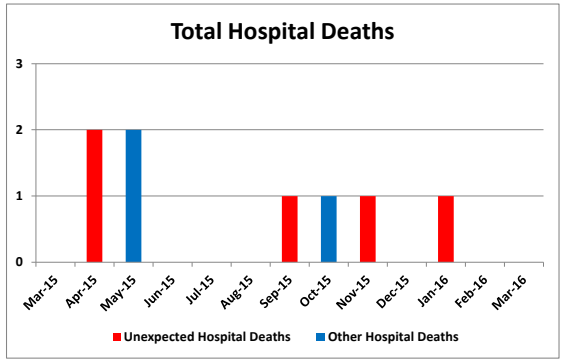


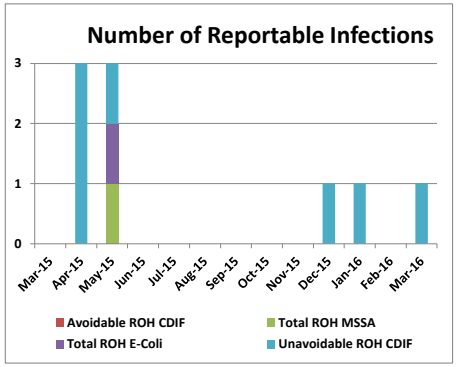
Quarterly Detailed Report
Effectiveness Indicators as at March 2016

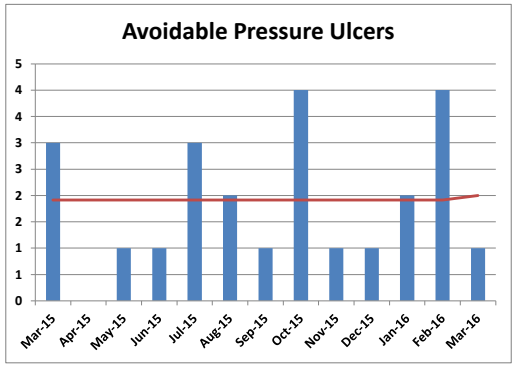
Headlines

- The number of unexpected hospital deaths has been zero in month.
- Total avoidable pressure ulcers (Grades 1 & 2) have decreased from 4 to 1 in month.

	Monitor	National	CQC Standard		Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	15/16 Full Year Position	On Target	Of Concern	Action Required
Effectiveness			4,18	Total Hospital Deaths	0	2	2	0	0	0	1	1	1	0	1	0	0	0.7	0	1	>=2
			4,18	Hospital Deaths per 1000 bed days	0.00	0.63	0.60	0.00	0.00	0.00	0.28	0.25	0.26	0.00	0.25	0.00	0.00	0.02	0	0-0.5	>0.5
			4,18	Unexpected Hospital Deaths	0	2	0	0	0	0	1	0	1	0	1	0	0	0.4	0		>0
				Other Hospital Deaths	0	0	2	0	0	0	0	1	0	0	0	0	0	3			
				Avoidable ROH CDIF	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
				Unavoidable ROH CDIF	0	3	1	0	0	0	0	0	0	1	1	0	1	7			
			8	Total ROH MSSA	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0		>=1
			8	Total ROH E-Coli	0	0	1	0	0	0	0	1	0	0	0	0	0	2	0		>=1
			4	Total Avoidable Pressure Ulcers (Grades 3 & 4)	0	0	0	0	1	0	0	2	0	1	0	0	0	4	0		>=1
			4	Total Avoidable Pressure Ulcers (Grades 1 & 2)	3	0	1	1	2	2	1	2	1	0	2	4	1	17	<=2	3	>=4
			4	Avoidable Pressure Ulcers per 1000 bed days	0.88	0.00	0.30	0.28	0.72	0.56	0.28	0.99	0.26	0.28	0.50	1.06	0.28	0.48	<0.83	0.83-1.17	>1.17
				% Completion of WHO Checklist	99.57%	99.64%	97.42%	99.12%	99.15%	99.07%	99.15%	99.86%	99.16%	99.79%	98.57%	99.86%	99.80%	99.22%	100%	95-99.9%	<95%







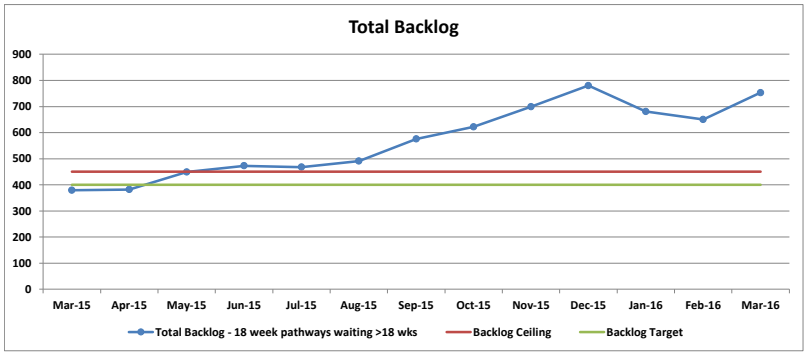
Quarterly Detailed Report
Treatment Targets as at March 2016

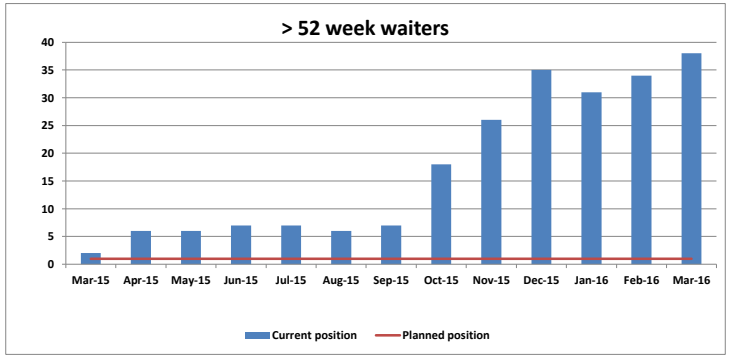
Headlines

- Cancer 62 waits for first treatment reduced to 80% in month.
- There was one patient not admitted within 28 days following cancellation of their operation

	Monitor	National	CQC Standard		Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	15/16 Full Year Position
Treatment Targets		N	4	Referral to treatment waits over 52 weeks	2	6	6	7	7	6	7	18	26	35	31	34	38	**38**
				Referral to treatment waits over 45 weeks	10	11	22	16	19	30	36	47	52	54	54	50	46	**46**
	M	N	4	Referral to treatment time - Non Admitted %	95.07%	93.49%	96.12%	95.36%	93.91%	94.70%	93.80%	91.60%	93.88%	91.99%	88.72%	89.33%	90.37%	**92.77%**
	M	N	4	Referral to treatment time - Admitted %	90.17%	90.12%	91.47%	90.58%	89.48%	87.70%	87.04%	86.18%	83.48%	86.28%	81.52%	81.23%	80.12%	**86.33%**
	M	N	4	Referral to treatment time - Incomplete Pathways %	94.55%	94.38%	93.78%	93.69%	93.59%	93.28%	92.27%	92.07%	92.05%	92.09%	92.06%	92.01%	92.03%	**92.76%**
			4	Non admitted Backlog - Pathways waiting >18 wks	124	115	115	144	176	166	163	196	259	346	244	232	289	**289**
			4	Admitted Backlog - Pathways waiting >18 wks	255	267	334	329	292	325	413	426	440	434	437	418	464	**464**
			4	Total Backlog - 18 week pathways waiting >18 wks	379	382	449	473	468	491	576	622	699	780	681	650	753	**753**
			4	Incomplete 14 -18 Week Waiters	522	396	466	461	421	482	565	554	574	612	627	645	608	**608**
				Non Admitted Median Wait (Weeks)	7.72	8.59	8.64	8.43	8.22	8.09	8.26	8.41	7.70	8.27	9.21	9.32	7.83	**7.83**
				Admitted Median Wait (Weeks)	10.63	9.60	9.98	9.50	9.33	10.36	9.92	9.66	9.68	9.37	10.81	10.89	10.57	**10.57**
				Incomplete Median Wait (Weeks)	5.60	5.65	5.50	5.43	5.75	5.96	6.15	5.83	8.88	6.75	6.69	5.90	6.16	**6.16**
	M	N	4	Cancer 2 week (all cancers)	100.00%	100.00%	97.20%	100.00%	97.8%*	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.90%	100.00%	**99.38%**
	M	N	4	Cancer 31 day wait from diagnosis to first treatment	100%*	100.00%	100%*	100.00%	100%*	92.30%	100.00%	100.00%	100%*	100.00%	100.00%	100.00%	100.00%	**99.25%**
	M	N	4	Cancer 31 day wait for second or subsequent treatment - surgery	100%*	100.00%	100%*	100.00%	100%*	100.00%	100.00%	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)	87.5%*	100.00%	66.70%	75.00%	100%*	100.00%	100.00%	87.50%	100%*	71.40%	100.00%	100.00%	80.00%	**92.59%**
		N	4	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	99.68%	99.53%	99.47%	99.38%	99.57%	96.52%	99.52%	99.72%	94.21%	99.09%	99.50%	99.42%	99.74%	**98.72%**
		N	4	Cancelled Ops Not Admitted within 28 days	0	2	0	0	1	0	0		0	2	0	1	1	**7**
			1,21	Data Quality on Ethnic Group - Inpatients	95.80%	96.86%	97.90%	96.42%	96.80%	96.90%	95.37%	95.47%	94.21%	95.21%	94.79%	94.45%	95.93%	**95.87%**

On Target	Of Concern	Action Required
Ahead of Plan		Behind Plan
≥ 95%		<95%
≥ 90%		<90%
≥ 92%		<92%
<170	170-190	>190
<250	250-270	>270
<400	420-460	>460
<500	500-550	>550
93%		<93%
96%		<96%
94%		<94%
85%		<85%
>=99%		<99%
0		>0
95		<95





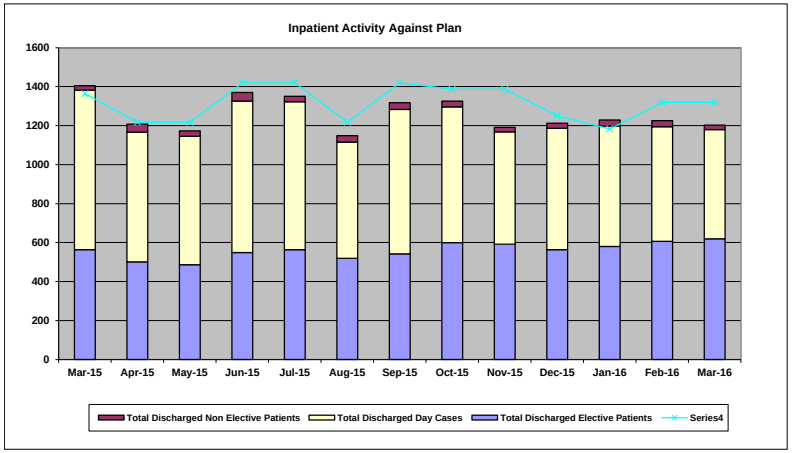
Activity Targets as at March 2016

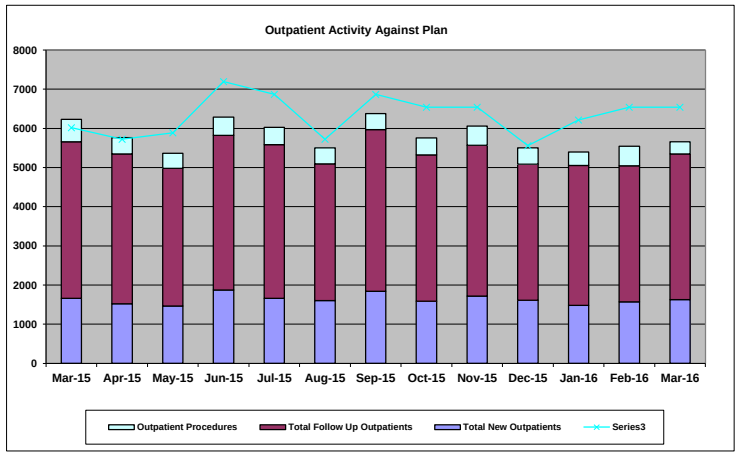
Headlines

- Total discharged elective patients has increased to 620 in month.
- Total new outpatients has increased in month to 1624 cases.
- Total discharged day cases reduced in month from 587 from 560 but still remains below target.

	Monitor	National	CQC Standard		Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	15/16 Full Year Position
Activity			4	Total Discharged Elective Patients	564	501	487	549	564	520	542	600	592	564	580	607	620	**6726**
			4	Total Discharged Non Elective Patients	24	41	28	44	28	34	35	29	23	25	32	32	23	**374**
			4	Total Discharged Day Cases	817	666	658	777	758	595	741	696	576	623	617	587	560	**7854**
			4	Total New Outpatients	1658	1518	1466	1872	1656	1601	1844	1590	1714	1608	1478	1573	1624	**19544**
			4	Total Follow Up Outpatients	4000	3830	3516	3948	3930	3490	4126	3737	3857	3478	3578	3475	3724	**44689**
			4	Outpatient Procedures	573	420	386	467	442	411	412	430	489	416	342	494	311	**5020**
				DC as a % of WL	57.62%	48.61%	46.31%	58.12%	61.73%	45.56%	57.49%	57.24%	44.41%	51.28%	56.24%	51.63%	52.63%	**20.63%**
			4	Elective as % Against Plan	88.5%	90.8%	88.3%	85.3%	87.6%	94.2%	84.2%	95.5%	94.2%	99.4%	108.1%	101.5%	103.7%	**94.2%**
			4	Non Elective as % Against Plan	66.7%	169.0%	115.4%	155.5%	98.9%	140.2%	123.7%	105.0%	83.3%	100.3%	135.7%	121.8%	87.5%	**119.1%**
			4	Day Cases as % Against Plan	118.4%	103.9%	102.6%	103.9%	101.3%	92.8%	99.1%	95.3%	78.9%	94.5%	99.0%	84.5%	80.6%	**94.6%**
			4	% New Outpatients Against Plan	99.9%	96.5%	90.6%	94.7%	87.7%	101.8%	97.7%	88.5%	95.3%	105.2%	86.5%	87.5%	90.3%	**93.3%**
			4	% Follow Up Outpatients Against Plan	108.6%	106.4%	94.9%	87.2%	91.0%	96.9%	95.5%	90.8%	93.7%	99.4%	91.5%	84.4%	90.5%	**93.2%**
			4	% Outpatient Procedures Against Plan	85.3%	76.7%	68.5%	67.8%	67.2%	75.0%	62.7%	68.7%	78.1%	78.2%	57.5%	78.9%	49.7%	**68.8%**

On Target	Of Concern	Action Required
100%	90-99%	<90%
100%	90-99%	<90%
100%	90-99%	<90%
100%	90-99%	<90%
100%	90-99%	<90%
100%	90-99%	<90%
100%	90-99%	<90%
100%	90-99%	<90%
100%	90-99%	<90%





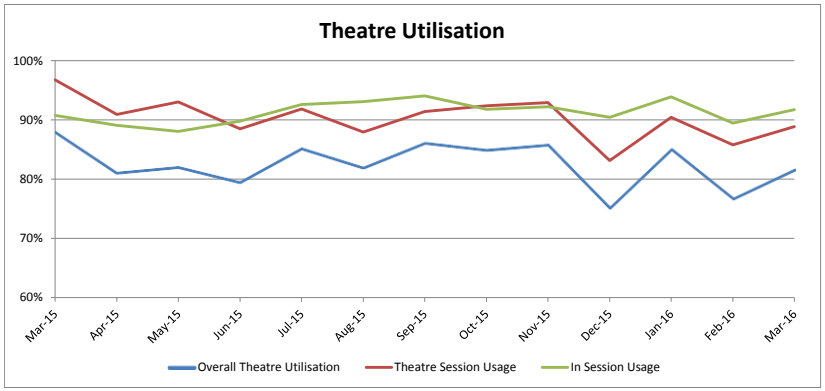
Quarterly Detailed Report
Efficiency Indicators as at March 2016

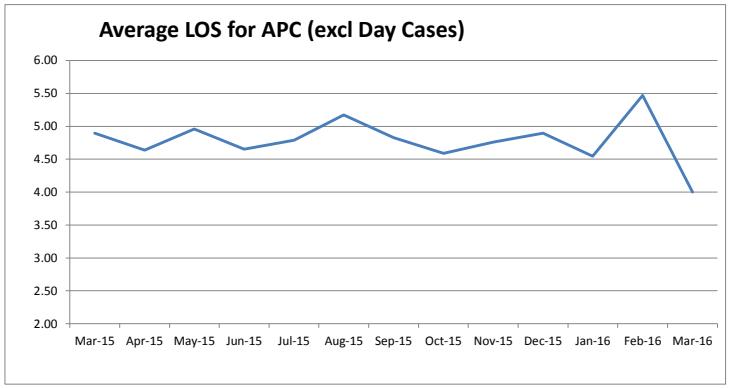
Headlines

- Total T&O Review - To New Ratio has increased in month.
- Number of theatre sessions have reduced in month.
- Number of cases per theatre session has reduced in month.

	Monitor	National	CQC Standard		Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	15/16 Full Year Position
Efficiency			4	Overall Theatre Utilisation	87.80%	80.97%	81.94%	79.42%	85.00%	81.81%	85.93%	84.76%	85.64%	75.17%	84.89%	76.71%	81.52%	81.98%
			4	Theatre Session Usage	96.74%	90.92%	93.04%	88.49%	91.82%	87.91%	91.38%	92.36%	92.89%	83.12%	90.44%	85.78%	88.86%	89.75%
			4	In Session Usage	90.76%	89.06%	88.06%	89.75%	92.56%	93.06%	94.04%	91.77%	92.20%	90.43%	93.86%	89.43%	91.73%	91.33%
			4	Unused Theatre Sessions	14	36	27	55	40	48	38	36	30	77	41	61	51	45
			4	Number of Cases per Theatre Session	3.20	3.09	3.12	3.08	2.85	3.37	3.20	3.06	2.80	3.05	2.98	3.08	2.80	3.03
				Patient DNA					24	28	21	27	24	25	14	25	24	24
				Pat Cancelled on the day					19	12	20	23	16	15	21	11	19	17
				Pat Cancelled 1-3 days before					40	31	41	49	35	43	52	46	49	43
				Pat Cancelled 4-7 days before					25	23	33	21	21	26	30	29	20	25
				Hospital Cancelled on the day					10	10	8	8	15	10	15	21	5	11
				Hospital Cancelled 1-3 days before					36	42	42	56	46	46	32	54	39	44
				Hospital Cancelled 4-7 days before					46	32	27	32	31	28	28	32	47	34
			4	% Cancelled Operations by Hospital	2.78%	2.77%	4.35%	2.40%	0.78%	0.85%	0.63%	0.60%	1.28%	0.87%	1.30%	1.85%	0.44%	0.26%
			4	Total T&O Review-To-New Ratio (including Spinal)	2.55	2.87	2.63	2.55	2.80	2.66	2.60	2.70	2.47	2.38	2.57	2.48	2.45	2.60
			4	Pain Review-To-New Ratio	3.85	3.45	3.23	2.65	2.49	2.31	3.05	2.69	2.67	2.49	7.39	2.29	3.58	3.19
			4	Outpatient DNAs	8.50%	10.12%	8.52%	8.48%	10.50%	12.11%	11.27%	10.17%	8.46%	9.35%	9.11%	8.65%	11.65%	9.87%
			4	Bed Occupancy - Adults	77.35%	67.10%	70.44%	78.83%	91.37%	84.76%	74.89%	89.73%	88.08%	85.49%	87.27%	88.38%	76.87%	81.90%
			4	Bed Occupancy - Paediatrics	74.91%	68.86%	66.67%	66.67%	88.42%	65.26%	80.95%	56.14%	65.19%	45.52%	63.44%	81.99%	68.10%	68.02%
			4	Bed Occupancy - HDU	75.56%	55.74%	58.74%	47.54%	62.99%	99.59%	58.85%	67.72%	75.33%	60.47%	97.96%	56.38%	62.87%	66.56%
			4	Bed Occupancy - Private Patients	54.25%	74.29%	76.96%	88.10%	82.03%	82.57%	86.19%	88.48%	87.14%	86.18%	87.10%	83.25%	76.50%	83.22%
			4	Admissions on the Day of Surgery	411	359	379	414	413	403	419	474	460	422	433	442	495	5113
			4	AVLOS for APC (excl day cases)	4.90	4.64	4.96	4.65	4.79	5.17	4.83	4.59	4.76	4.90	4.55	5.47	4.00	4.78

On Target	Of Concern	Action Required
>=81%	76%-81%	<76%
>=90%	87%-90%	<87%
>=90%	87%-90%	<87%
>=44	45-57	>57
>3.0	2.8-3.0	<2.8
<=0.4%	0.5%-0.8%	>0.8%
<2.55	2.55-2.8	>2.8
<3.65	3.65 - 4.0	>4.0
>82%	75-82%	<75%
>50%	45-50%	<45%
>80%	75-80%	<75%
>60%	55-60%	<55%
<4.3	4.3-4.7	>4.7



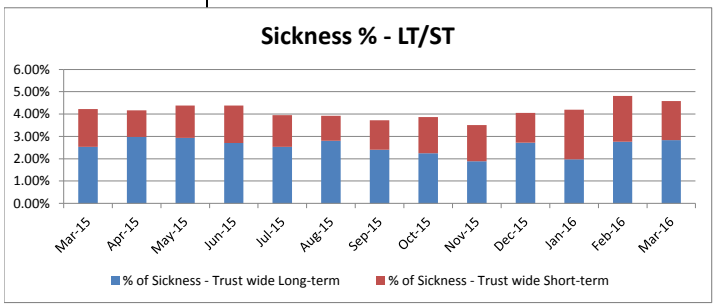


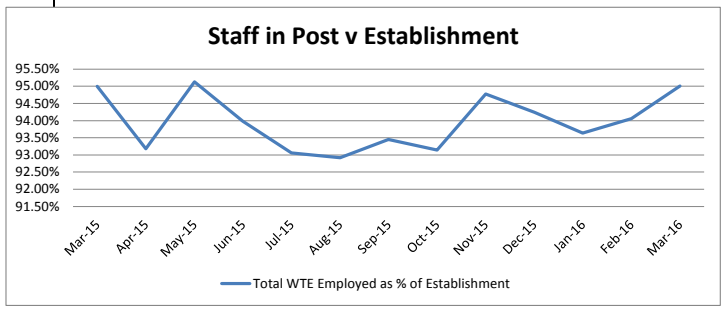
Monthly Report
Workforce Indicators as at March 2016

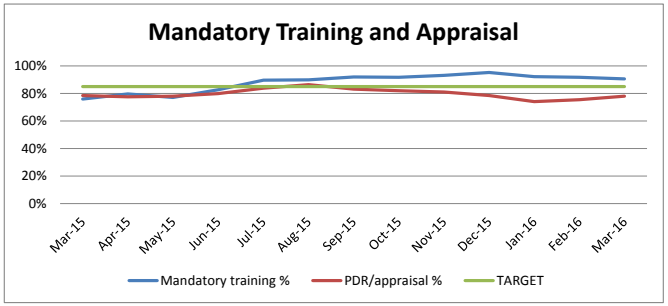
Headlines

- Mandatory Training remaining on target for since Jul 15
- Decrease in sickness absence, especially short term
- Appraisals have required actioned for each month of the past quarter

	Monitor	Contract	CQC Standard		Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	MAA
Workforce				Total WTE Employed as % of Establishment	95.00%	93.18%	95.13%	93.98%	93.06%	92.92%	93.45%	93.14%	94.77%	94.24%	93.64%	94.06%	95.01%	
				Staff Turnover (%) - Unadjusted	11.07%	10.56	10.86%	10.98%	11.37%	11.59%	12.50%	11.03%	11.71%	12.67%	12.57%	12.21%	12.02%	N/A
				Staff Turnover (%) - Adjusted	9.30%	8.57	8.87%	7.92%	8.28%	8.29%	8.90%	7.96%	8.16%	8.61%	8.74%	8.38%	7.91%	
				% of Sickness - Trust wide	4.23%	4.17%	4.38%	4.39%	3.95%	3.93%	3.72%	3.87%	3.51%	4.06%	4.19%	4.81%	4.58%	4.23%
				% Staff received mandatory training last 12 months	76%	80%	77%	83%	90%	90%	92%	92%	93%	95%	92%	92%	91%	N/A
				% Staff received formal PDR/appraisal last 12 months	79%	77%	78%	80%	84%	86%	83%	82%	81%	78%	74%	75%	78%	N/A







Workforce Commentary

Sickness absence has decreased this month, and returned to amber. The 12 month average figure has increased slightly, this is because there was more people absent in March last year compared to this year, the position still remains amber.

The vacancy position taken from the ledger has improved again this month, recruitment activity and the number of new starters are still increasing.

The turnover figure for unadjusted (all leavers minus junior medical staff and excluding employees who retire and return to work,) has reduced again this month, but has remained amber.

The mandatory training position has had a marginal decrease this month: managers have been informed of the dates when their staff are due to expire.

The appraisal position is continuing a steady increase, however further actions are still required. Divisional General Managers are liaising with HR in order to produce trajectories to improve the appraisal situation.

Monthly Report

Finance Dashboard as at 31st March 2016

	Surplus £	Cash £	Capital spend £
Plan	(2,000k)	6,831k	5,060k
Actual	(6,187k)	10,598k	3,212k
Forecast for M1 16/17	(506k)	9,032k	130k

Year to date			
	Actual	Plan	Risk Rating
Capital Servicing Capacity	-0.68	1.37	1
Liquidity Ratio	14.60	16.70	4
I&E Margin	-8.84%	-2.47%	1
I&E Margin Variance	-6.37%	-1.22%	1
Financial Sustainability Rating			2

Capital spend is lower than planned 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 2015-16. The reported difference below reflects the impairments during the year totalling £1.883m. This is accounted for by reflecting £1.724m through the I&E, increasing the deficit position, and £159k is reflected through the revlaution reserves on the balance sheet decreasing the reserves. An alternative site valuation was conducted at the end of the year, this will reduce our depreciation levels going foward into 16/17. The original plan was based on the previous type of valuation and therefore this is contributing the £7.6m variance in Month 12 and the asset value was planned to be much higher.

The capital to revenue transfer has reduced the reserves at the end of the year by £2.300m.

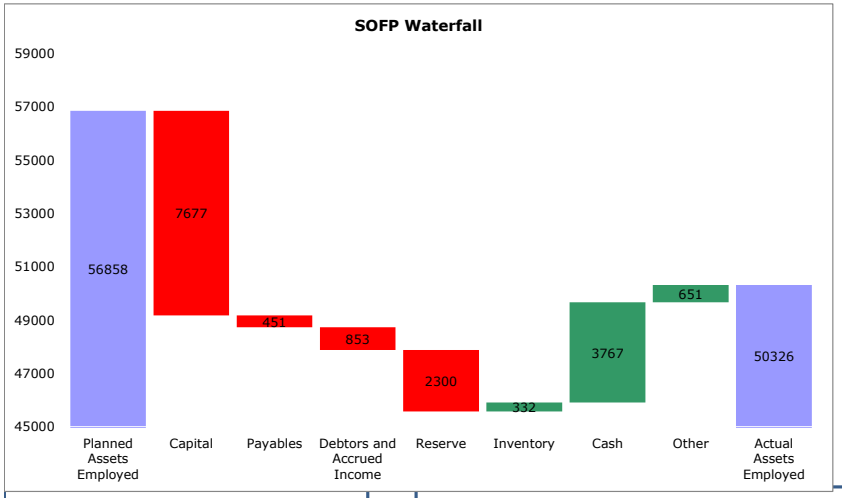
As a result of the deficit, both planned, and the variance to plan, the Trust rates as a 1 for the capital servicing capacity, and the I&E margin ratio. This therefore beings down our overall FSR rating to a 2, despite our strong liquidity.

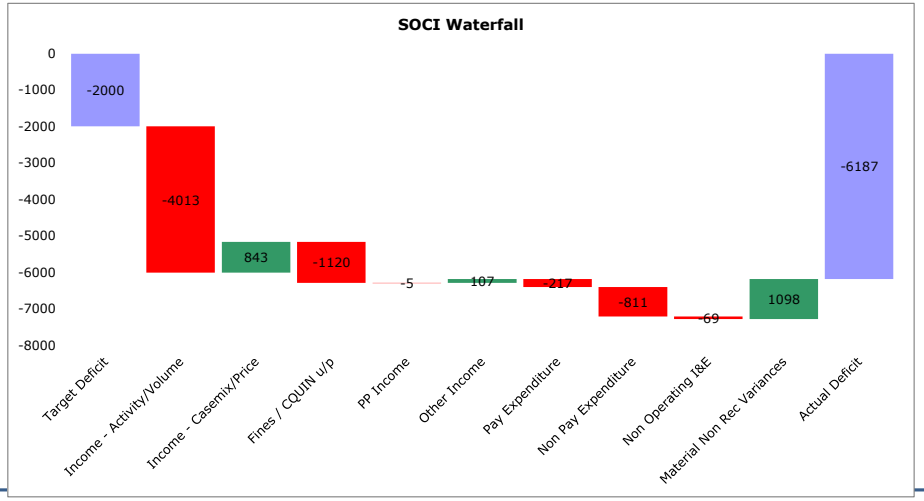
The I&E margin variances are showing significant variance to plan however.

The waterfall below shows the draft Trust deficit for 2015/16 of £6,187k. This includes a capital to revenue transfer which reduces the deficit by £2,300k, offset by an asset impairment that increases the deficit by £1,724k. The position also includes a stock write off of £1,325k. An internal audit investigation is currently being conducted by Baker Tilly to investigate the large descrepancies identified by the year end stock take.

An alternative site valuation has been completed to revalue our building assets. This is done once a year and is based on an indices method. The valuation performed ensures that we have an accurate asset base life for the site and due to the new method in valuation from last year to this year, our depreciation levels will be reduced for the year 2016/17.

Fines for CQUIN and 52 Week waiters are being provided for in the amount of £1,120k due to the underperformance against contracts.





Cash is higher than plan largely due to the capital spend being lower than expected from the original plan.

Pay expenditure is overspent at the end of the financial year along with activity being lower than planned over 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. On the 18th April our annual plan was submitted to monitor which captures the reduced agency use that has taken place over the previous 6 months and therefore we should see agency spend continue to fall.

The Trust continues to recruit substantial nurses on wards to reduce our reliance on temporary staffing. The nursing agency task and finish group is held weekly and will continue to do so throughout 16/17. This group has seen good results by implementing actions such as enhancing management information around the reasons for agency usage on the wards and in theatres. Full reviews of agency being used in every department around the Trust will continue into 2016/17 for the Trust to challenge and reduce unnecessary spend.

The Transformation in Action Exercise is still continuing to provide greater focus on delivery of activity and continues to address current blocks in the system. Since December 2015, there has been an increase in inpatient activity but it is acknowledged that the focus on the activity levels needs to continue into and past 2016/17. Final activity figures for the financial year are as follows:
Admitted patient care episodes - 14,954 against an original year plan of 15,756 cases
Outpatient activity cases - 69,253 against an original year plan of 76,177 cases

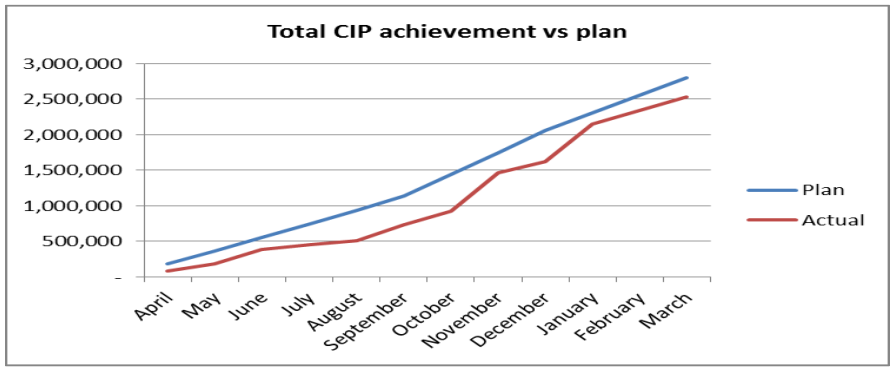
Non Pay expenditure includes £1.325m of stock write off, which is currently under investigation.

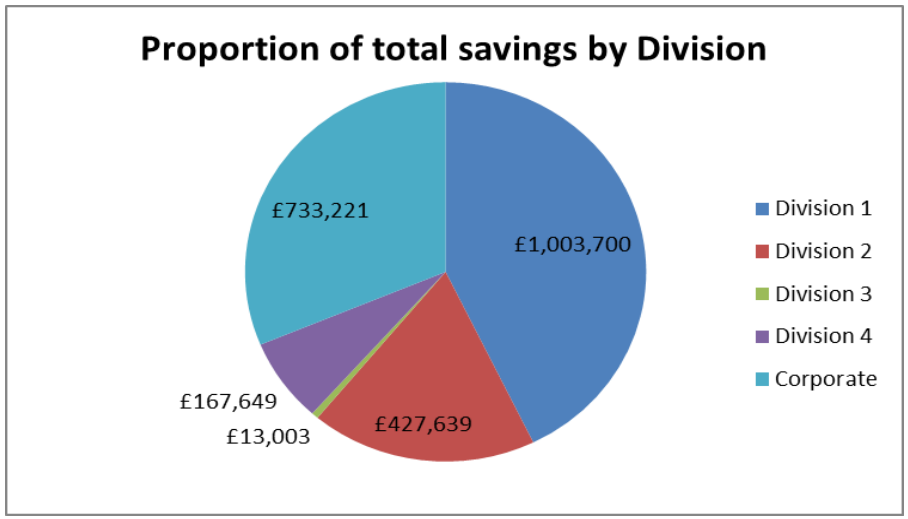
Material Non Recurrent variances includes £2.300m of capital to revenue transfer support, with a (£1.724) reduction relating to asset impairment.

Monthly Report

CIP Dashboard as at 31st March 2016

CIP Schemes	Full Year Plan	Month 1-12 Actual	Remaining savings required
Division 1			
Reducing length of stay / Ward efficiency	215	290	75
Prosthesis savings	200	85	-115
Digital Dictation	150	188	38
Hold non-essential vacancies	120	139	19
Local schemes	312	302	-10
	997	**1004**	**7**
Division 2			
Medicines optimisation	108	108	0
Local schemes	302	320	18
	410	**428**	**18**
Division 3 – Local schemes	**18**	**13**	**-5**
Division 4 – Local schemes	**205**	**168**	**-37**
Corporate			
Coding partnership with EPS	150	156	6
Locum savings – Direct Engagement / Preferred supplier	156	113	-43
Contribution from reopened private patients	100	79	-21
Local schemes	766	574	-192
	1172	**922**	**-250**
TOTAL	**2,802**	**2,535**	**-293**





At the start of the financial year, the Trust Board agreed a cost improvement programme of £2,802k for 2015-16. Following a review of our forecast outturn position at the end of Month 5, it was anticipated that £2,500k of savings would be delivered.

The draft final accounts position shows that the Trust has generated £2,535,260 of savings against the revised full year plan of £2,500,000. £801,844 (32%) of savings were delivered non recurrently. Savings recognised in March were £198,469, against an in-month plan of £247,104. Divisions 1 and 2 met their revised CIP targets for the year, achieving savings of £1,003,700 and £427,639 respectively. 75% of Division 1's savings were achieved recurrently, with only 37% of Division 2's savings being achieved recurrently. Both Division 4 and Corporate areas have finished short of their targeted savings, although the majority of Division 4's savings (86%) were achieved recurrently.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHGO (5/16) 006

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Nurse Staffing Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Nursing and Clinical Governance**
AUTHOR:	**Ms Anne Crompton, Deputy Director of Nursing and Clinical Governance**
DATE OF MEETING:	**11th May 2016**

EXECUTIVE SUMMARY:

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. This paper provides the Trust Management Committee with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for March 2016.

REPORT RECOMMENDATION:

The Council is asked to note:

- note that the vacancy rate has increased in March 2016.
- note that fill rates across the Trust are greater than 95% with the exception of Wards 1 and 3 and HCA fill rates in Ward 11 and HDU.
- Active recruitment is underway to address vacancies in HDU, Wards 12 and Theatres.
- A review of the Health Care Assistant Workforce will be completed by end May 2016 driven by high bank and agency use within this staff group.
- Agency use is highest in areas of greatest vacancy (HDU) and there is emerging evidence that ward usage is falling as a total of spend. Agency use will remain high in Theatres due to the high vacancy rate.

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:					

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 report will be circulated to all matrons, general managers and ward sisters. The report was considered by the Trust Management Committee at its meeting on 27 April 2016 and by Trust Board on 4 May 2016.

ROHGO (5/16) 006

Nurse Staffing Report

REPORT TO TRUST BOARD: May 2016

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. This paper provides the Trust Management Committee with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for March 2016 with additional information relating vacancy and plans for recruitment to vacant posts.

2.0 Workforce Information: Trust Overview of Planned Versus Actual Nursing Hours

The overall nurse staffing fill rate for March 2016 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. The actual staffing levels for March 2016 were manually entered into the data collection spreadsheet by the nurse in charge of the shift and verified by the senior sister and matron. Planned staffing hours are based on funded establishment which provides a minimum ratio of 1 to 8 on day shifts for all adult in patient wards. The planned hours are adjusted each month to allow for the number of days in the month and the number of open beds in the ward area.

Table 1 below provides further detail regarding nurse staffing fill rates for March 2016. The Unify Upload for March 2016 is provided in Appendix 1. In the absence of national guidance ROH will RAG rates each ward against a locally agreed framework as follows: Green, where actual available hours are within 5% of planned, amber within 5 and 10%, and red where the difference is greater than 10%.

Table 1: Detailed Ward Breakdown

	Day		Night	
Ward	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
1	89.4%	89.2%	100.0%	96.8%
2	98.6%	95.9%	96.8%	106.7%
3	92.0%	93.5%	101.6%	91.9%
12	99.4%	97.2%	97.8%	95.7%
11	100.6%	74.6%	100.1%	66.7%
HDU	100.4%	42.8%	101.7%	-

It can be seen that a number of areas through March 2016 did not achieve >95% fill rate. The areas of greatest pressure are:

- Registered and non-registered day staff on Ward 1. This shortfall has been partly caused by long and short term sickness particular amongst non-registered staff, which has reduced the number of staff available to cover shifts and is being managed in line with the Trust Sickness/Absence Policy. The Registered Nurse gap is caused by a vacancy factor of 2, which have been recruited to and await a start date. The acuity and dependency of patients are monitored daily through the staffing huddle.
- Fill rates on Ward 3 where the shortfall has been caused by long and short term sickness particular amongst non-registered staff, which has reduced the number of staff available to cover shifts and is being managed in line with the Trust Sickness/Absence Policy. Additionally the Charge Nurse is rostering three Registered Nurses to night duty where possible in line with the agreement supported by Trust Board in November 2015. The rationale for this decision is to support the timely administration of pain relief to this vulnerable patient group. This has reduced the availability of staff nurses to cover day shifts and where possible bank and agency staff are being used to support shortfalls. The acuity and dependency of patients is monitored on every shift to ensure no patient harm occurs. No patient harm has resulted from the reported deficit.
- The fill rate for HCAs on HDU is caused by long term sickness, which is being managed appropriately through the Trust Sickness/ Absence Policy. The roster has been managed such that shifts which do not clinically require additional support are not backfilled.
- The fill rate for non-registered staff is a consequence of the decision to support the night shift with a HCA member of staff to enable adequate break cover and a nurse in charge. Nights on the paediatric ward are unfunded. The ward template will be amended during April 2016 to reflect this

2.1.1 Vacancy and Acuity Data

Band 5 Registered Nurse vacancy rates at ROH have risen this month to 13.9 WTE which is an increase of 6.78 WTE since February 2016. The majority of these are in HDU and Ward 12 as shown in Table 2 below:

Table 2: Band 5 WTE Vacancy (based on figures from finance February 2016)

Ward	Band 5 Funded Establishment	Band 5 Vacancy	Band 2 Funded Establishment	Band 2 Vacancy
1	11.53	2	8.24	0
2	11.80	1	9.05	0
3	13.09	0.4	6	0.7
12	21.12	4.7	7.79	1.6
11	13.80	2	2.6	0
HDU	18.32	3.8	1.80	0
Total	89.66	13.9	35.48	2.3

TMC are advised that the nurse vacancy factor at ROH will rise following the amendment of ward budgets in April 2016 to reflect the amended ward establishment.

A number of key actions are in place to address recruitment at ROH and are listed below:

- The Nursing Workforce group has been re-established and met on 21st April 2016. The group will oversee the development of targeted recruitment campaigns and introduce accurate vacancy monitoring across the Trust. At present there is no central repository of vacancy information and the vacancy data is held locally at ward and department level.
- An active recruitment campaign is underway to recruit to Band 5 posts in both in-patient wards and HDU. 5 nursing staff were successfully appointed on 18.04.2016.
- The recruitment campaign will continue in order to enable uplift of all ward establishments to 3 Registered Nurses at night in line with the Trust Board decision to approve this recommendation from November 2015. Ward establishments will be amended from April 2016 in order to reflect this change but this has not delayed recruitment to these posts.
- Overseas recruitment is being further explored by the HR team to enable recruitment of general rather than theatre specific nursing team members. Mediplacements, our recruitment organisation, have very recently engaged a partner organisation based in Brighton to assist in European searches which will enable recruitment of nurses with Level 5 in International English Language Testing System (IELTS) to work as HCAs whilst they study for Level 7 to enable registration within the UK. This step will significantly increase the pool of nurses available for recruitment. Discussion between ROH and Mediplacements is underway.

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Table 3 below shows the recommended staffing levels based on the daily acuity tool by ward for March 2016. TMC are asked to note that the Paediatric Ward is not included in this table because the acuity tool used is not appropriate for children and therefore an alternative appropriate tool is being sourced through links with Birmingham Children's Hospital. In the meantime work has been undertaken to map current ward staffing and

establishments against the Royal College of Nursing (RCN 2013) standards. A separate paper will be presented to TMC on 27th April 2016.

Table 3: Acuity by ward

Ward	Recommended WTE	Actual WTE	Budgeted WTE
1	29.09	26.91	22.97
2	24.37	27.14	23.35
3	28.28	28.62	24
12	25.77	37.15	33.91
HDU	19.81	23.90	26.79

It can be seen that whilst most wards staff beyond their funded establishment (a feature of the un-amended ward budget which still includes bank rather than substantive posts), the acuity tool suggests that staffing requirements were met through March 2016. The areas of greatest disparity (recommended vs actual) are Ward 12, where the ward layout and environment means that a different model of nursing care is delivered to enable safe support and supervision of all patients, and HDU which is a consequence of the flexible staffing model employed.

Amendment of the budget, from April 2016, to reflect the decision to uplift night shifts to three Registered Nurses will address this anomaly to some extent however TMC are advised that additional work is required to ensure that the data collected via the acuity tool is valid. The Deputy Director of Nursing and Governance is currently reviewing the use of the Safe Staffing tool at ROH and will make recommendations for changing the way data is collected and validated by the end of April 2016. This will include a review of the tool used to calculate staffing needs on Ward 12 which takes into account the specific environmental challenges to the delivery of responsive nursing care.

2.2 Safe Staffing and Efficiency

Caps on agency spend for Registered Nurses, mandated by Monitor, have been in place at ROH since 1 October 2015. The ceiling for ROH has been set at 10% which is a reflection of the relatively high use of agency staff at the Trust. During March 2016 overall nurse agency use at ROH was 10.7% which reflects a downward trend in usage as shown in Table 4 below. Table 4 shows the trend line for total nurse agency use across the Trust.

Table 4: Registered Agency use as a % of total cost (Whole Trust

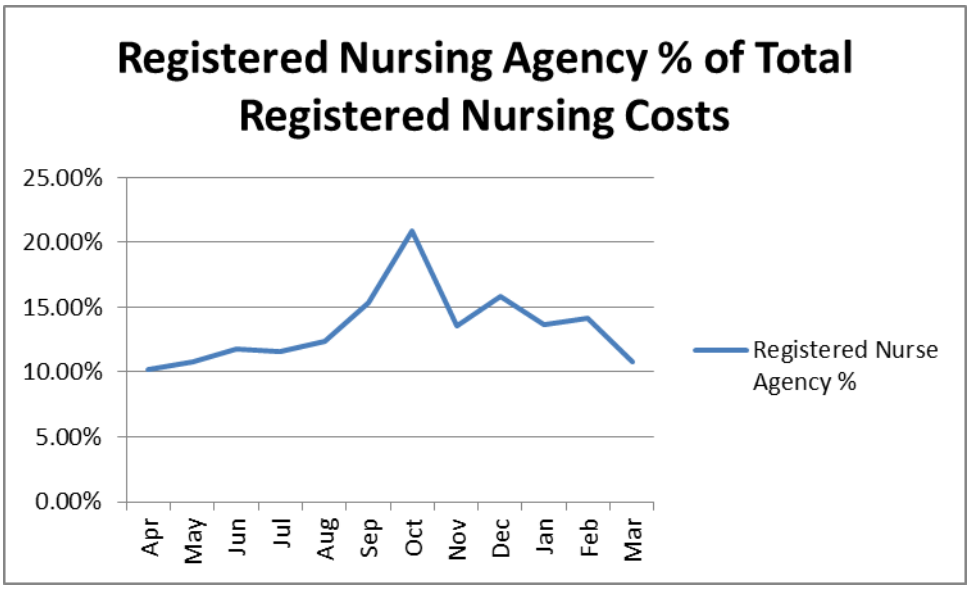
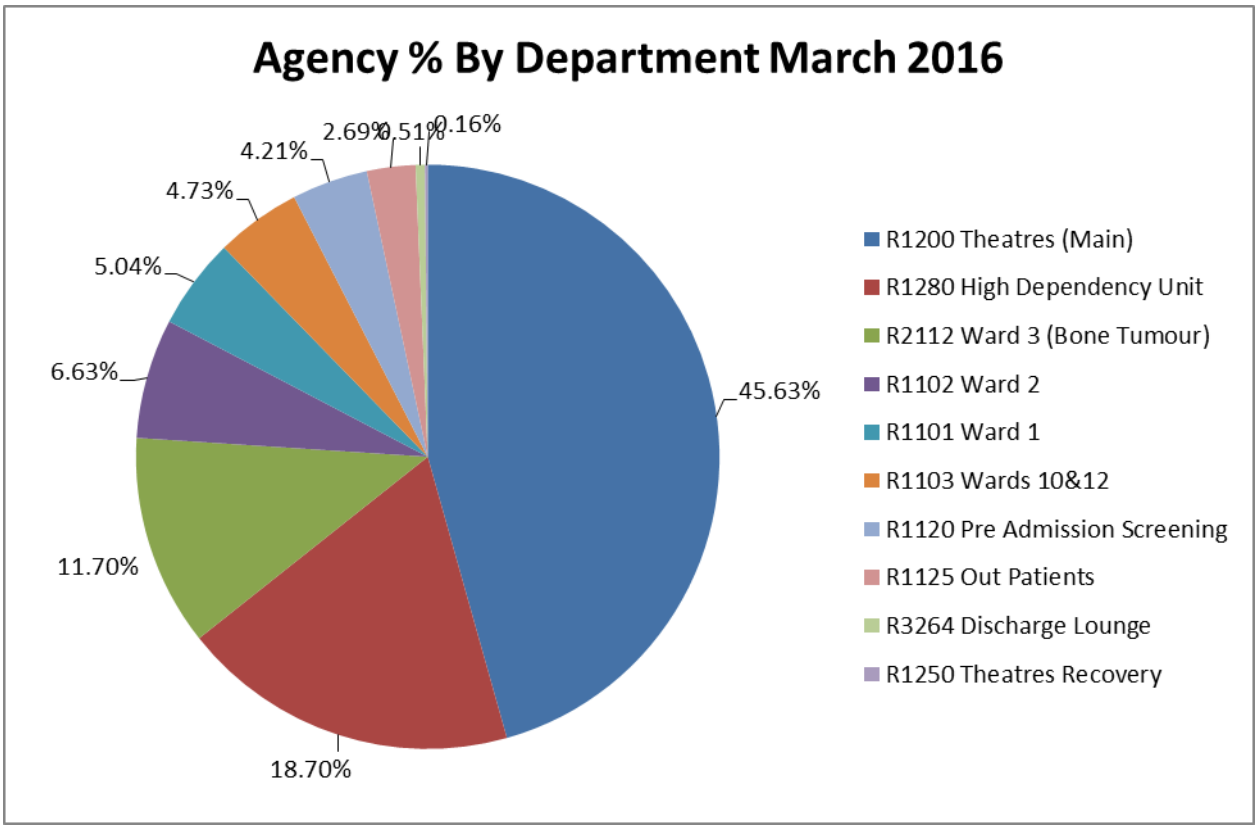


Table 5 presents agency use by area as a total of agency spend across the Trust.

Table 5: Agency use (as a percentage of total spend)



The use of agency staff in Theatre remains high at 45.63 % of total use, however the agency staffed used work regularly at ROH and are familiar with guidelines and processes. The high usage is driven by a high vacancy rate within the theatre team as reported in February 2016. Agency use will remain high in theatres for the immediate future in order to enable safe delivery of services.

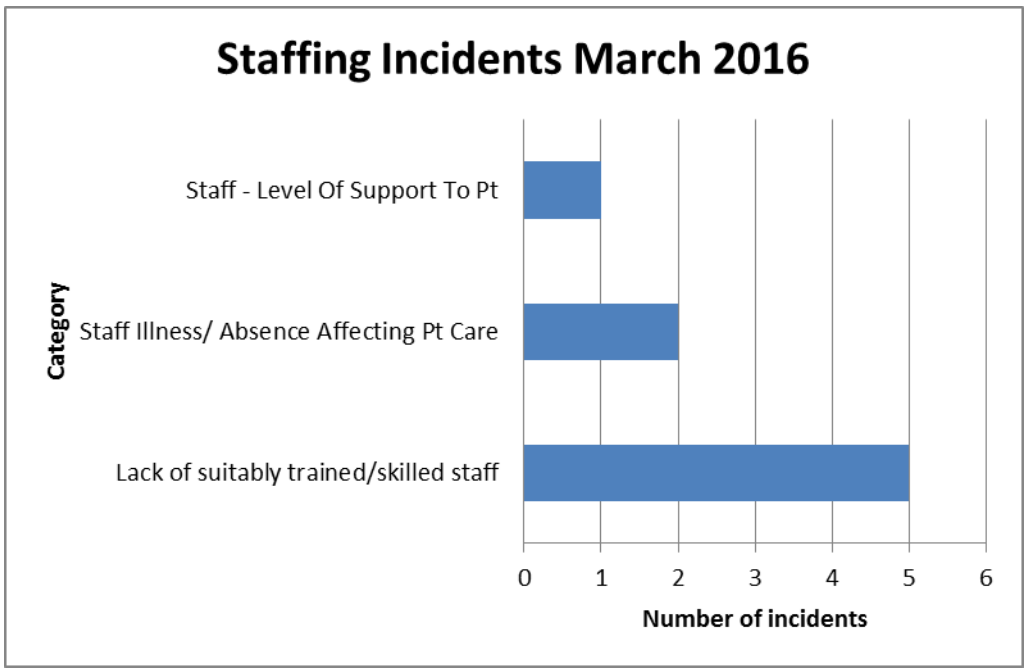
It is however of note that the percentage of total spend used by theatres has increased over time whilst that of in-patient wards has continued to reduce. All wards, with the exception of HDU are demonstrating agency use of less than 10% of total spend, in line with Monitor requirements. The continuation of the daily 'Safe Staffing' huddle ensures that nurses are moved between wards to cover shortfalls if necessary and that agency use is cancelled if not required. The continued high use of agency staff in HDU is driven by the vacancy factor and by the need to ensure that all shifts are appropriately staffed with Registered Children's Nurses.

3.0 Incident Reporting and Levels of Harm

In addition to the Safer Nurse Staffing tool being used and interpreted, clinical areas are encouraged to report all Safe Staffing incidents. In March 2016, a total of 8 staffing incidents were reported. Of these 2 are duplicates bringing the actual total to 7 and of these, 1 is not a patient safety incident. This compares to a total of 7 reported in February 2016. The number of reported staffing incidents remains low and all ward teams have been reminded of the importance of accurately reporting staffing gaps to enable identification of themes and concerns.

Of the 7 incidents reported, five were categorised as no harm and two as low harm. The low harm incidences related to a delay in undertaking patient observations and delay in providing pain medication. 4 of the 7 incidents met the criteria for NICE Red flags. It is positive to note that nursing teams are reporting and recording Red Flags as they occur. A detailed breakdown of each incident is provided in Appendix 2. Table 6 below provides a breakdown of incident by category.

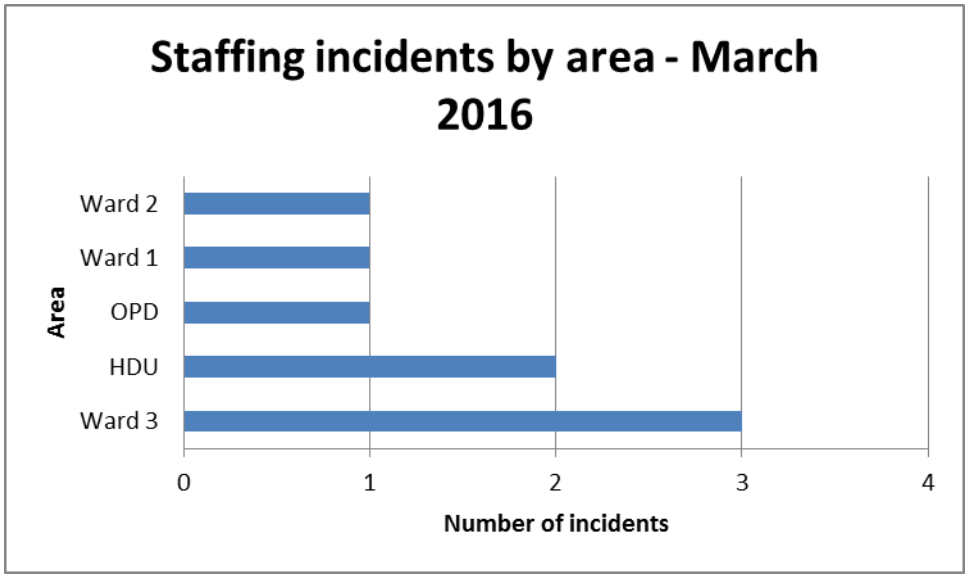
Table 6: Incident categories



3.1 Incidents by area/ward:

Three of the reported staffing incidents were on Ward 3 (two reports of same incident) ; two were on HDU and one on Ward 1, OPD and Ward 2. Table 7 below shows the distribution across all ward areas.

Table 7: incidents by ward area



4.0 Conclusion and Recommendations.

4.1 The Trust Board is asked to note that the vacancy rate has increased in March 2016.
4.2 The Trust Board is asked to note that fill rates across the Trust are greater than 95% with the exception of Wards 1 and 3 and HCA fill rates in Ward 11 and HDU.
4.3 Active recruitment is underway to address vacancies in HDU, Wards 12 and Theatres.
4.4 A review of the Health Care Assistant Workforce will be completed by end May 2016 driven by high bank and agency use within this staff group.
4.5 Agency use is highest in areas of greatest vacancy (HDU) and there is emerging evidence that ward usage is falling as a total of spend. Agency use will remain high in Theatres due to the high vacancy rate.

7.0 Appendix 1: UNIFY upload March 2016

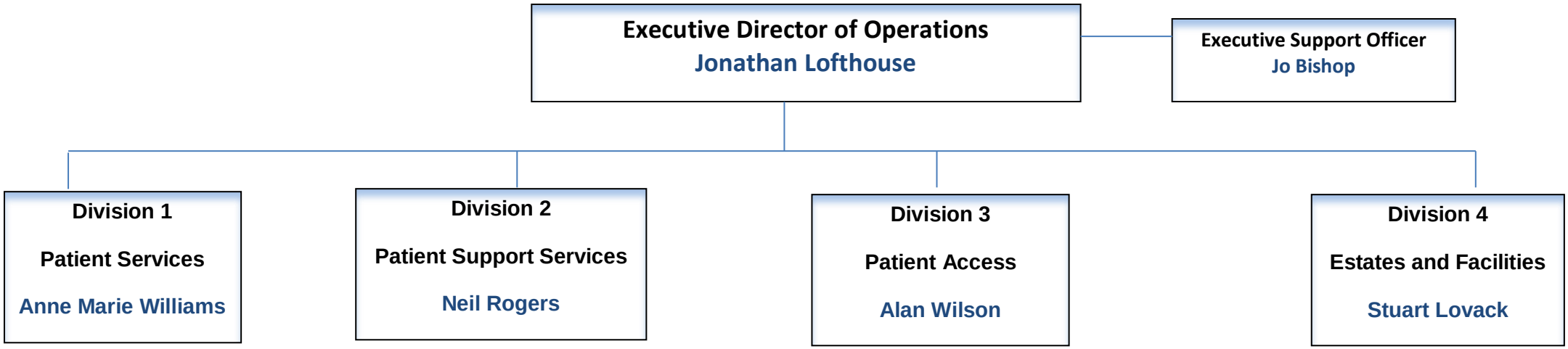
Ward name	Main 2 Specialties on each ward		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
	Specialty 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		1632.5	1459.5	1000	891.5	682	682	682	660	89.4%	89.2%	100.0%	96.8%
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1438	1418	958.5	919	682	660	682	728	98.6%	95.9%	96.8%	106.7%
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1800	1656	1147.5	1072.5	620	630	620	570	92.0%	93.5%	101.6%	91.9%
Ward 10 & 12	110 - TRAUMA & ORTHOPAEDICS		1781	1771	1385.8	1347.25	1023	1001	1023	979	99.4%	97.2%	97.8%	95.7%
Ward 11	110 - TRAUMA & ORTHOPAEDICS		1128	1134.5	336	250.5	693	694	66	44	100.6%	74.6%	100.1%	66.7%
HDU	110 - TRAUMA & ORTHOPAEDICS		1677.8	1684.25	279.5	119.5	1452	1476	0	0	100.4%	42.8%	101.7%	-

Appendix 2: Incident Details March 2016

Incident Number	Cause Group	Details Of Incident	Area
17368 (no harm)	Staff - Level Of Support To Pt	Staff were not aware that patient had dementia and therefore no provision for additional support was in place on receipt of patient. The patient was transferred to a main bay near the nurses station for observation and transferred onto a high low bed for safety and additional support was sourced	Ward 2
17354 (no harm)	Lack Of Suitably Trained / Skilled Staff	Agency nurse had not turned up for his shift. It emerged that his shift had been cancelled. This incident is still under investigation; however issue will be raised at ward managers meeting on Monday 25th April 2016 to review process for recording cancellation of agency shifts. This is duplicate of incident 17355 below	Ward 3
17355 (no harm)	Lack Of Suitably Trained / Skilled Staff	There was only one staff nurse for the night shift as they agency nurse did not turn up. It emerged that the agency staff member had been cancelled. This is a duplication of incident 17354 above.	Ward 3
17469 (low harm)	Staff Illness/ Absence Affecting Pt Care	Ward was short of one Band 2, one trained nurse had to be sent to another ward. This resulted inpatient observations not being carried out on time, however the decision to move the nurse was based on clinical need in another ward and the ward was left with acceptable levels of staff. Once the clinical issue was resolved, the nurse was returned to the ward.	Ward 3
17393 (low harm)	Lack Of Suitably Trained / Skilled Staff	Only one trained nurse on duty with three clinics running. This incident is still under investigation but no patient harm resulted from this event	OPD
17473	Lack Of Suitably	Shortfall in staffing, only two staff nurses rather than four due to inability to fill the nurse bank requests.	

Incident Number	Cause Group	Details Of Incident	Area
(no harm)	Trained / Skilled Staff	The investigation has identified that the off duty was not checked the day before by the nurse in charge, which would have prevented occurrence of this issue. The team were advised of the correct process for management of off duty at the ward meeting on the 09.04.2016 as follows: • Daily by the nurse in charge to ascertain that the next 24 hours of shift is covered. • Nurse in charge is responsible for taking action to correct shortfall as early as possible and to record any changes (such as agency cancellation) on off duty.	Ward 1
17340 (no harm)	Lack Of Suitably Trained / Skilled Staff	HDU band 5 paediatric nurse did not arrive for shift, leaving 2 children on HDU with no paediatric nurse. However an adult nurse with competencies was available to provide care in line with the escalation plan.	HDU
17367 (no harm)	Staff Illness/ Absence Affecting Pt Care	A member of staff was marked as being off sick but turned up to work on the morning. The staff member who reported this incident has been advised that this is not a patient safety issue as the staffing requirements for the shift were met.	HDU

Operations Division Overview



The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Friday 06 May 2016

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 11th May 2016 at 1400h 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 1400h.

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

Notice of Public Board Meeting on Wednesday 1 June 2016

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 1 June 2016 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.

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** 1 June 2016: 1100h – 1330h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair & Non Executive Director	(TP)
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	Director of Operations	(JL)
Mr Paul Athey	Finance Director	(PA)
Mr Garry Marsh	Director of Nursing & Clinical Governance	(GM)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(AC)	
Prof Phil Begg	Director of Strategy & Transformation	(PB)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]
Ms Navina Evans	Observer		

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies – Mrs Kathryn Sallah, Mr Andrew Pearson	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	Patient story	Presentation	GM
1125h	4	Minutes of Public Board Meeting held on the 2 February 2016 *for approval*	ROHTB (5/16) 014	Chair
1130h	5	Trust Board action points: *for assurance*	ROHTB (5/15) 014 (a)	Chair
1140h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (6/16) 002 ROHTB (6/16) 002 (a)	YB/JC
CORPORATE PERFORMANCE & ASSURANCE				
1200h	7	Performance reports: *for assurance*	ROHTB (6/16) 004 ROHTB (6/16) 004 (a) ROHTB (6/16) 004 (b)	PA/GM
1220h	8	Safe Staffing Report: *for assurance*	ROHTB (6/16) 005 ROHTB (6/16) 005 (a)	GM
1230h	9	NHS Improvement annual declarations 2015/16: *for approval*	ROHTB (6/16) 006 ROHTB (6/16) 006 (a)	SGL

			ROHTB (6/16) 006 (b)	
ASSURANCE UPDATES FROM THE BOARD COMMITTEES				
1240h	10	Audit Committee	Verbal	RA
1245h	11	Transformation Committee	ROHTB (6/16) 007	TP
1250h	12	Quality & Safety Committee	ROHTB (6/16) 008	FK
1255h	13	Council of Governors	Verbal	YB
1300h	14	Charitable Funds Committee (minutes)	ROHTB (6/16) 009	FK
	15	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 6th July 2016 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.

MINUTES

Trust Board (Public Session) - DRAFT v0.6

Venue Boardroom, Trust Headquarters **Date** 4 May 2016: 1100h – 1300h

Members present

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair	(TP)
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)
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]
Mrs Evelyn O'Kane	Matron	(EO'K)	
Ms Karen Cope	Safeguarding Lead	(KC)	
Ms Sally Xerri-Brookes	Head of Communications	(SX-B)	

	Paper Reference
1 Apologies	**Verbal**
Apologies for absence were received from Kathryn Sallah, Tauny Southwood and Andrew Pearson. Stella Noon was welcomed to the Board as a member of the public given that her term of office as a governor had come to a conclusion. Stella was thanked for her dedication to the ROH and support to the Trust and the Chair in particular. She had been an active governor and an important link to the Patient and Carers' Forum. Governors present at the meeting were Sue Arnott, Marion Betteridge and Paul Sabapathy. The role of the governors at the Public Board meeting was as observers. Attendance at meetings gives them the opportunity to assure themselves about Board matters. The Chairman invited them to ask questions.	

2 Declarations of Interest	**Verbal**
No Declarations of Interest had been received since the last meeting and no declarations had been made in connection with any item.	
3 Patient Case – an illustration of the work we do	**Presentation**
The Board was joined by Matron Evelyn O'Kane and Karen Cope to discuss safeguarding issues. The Board watched a video of the story of a young teenage patient who had received treatment both at the ROH and the Cromwell Hospital. It was noted that the patient had made the decision to be treated in London supported by the ROH. The key points of the discussion were: • Delivery of care needed to be seamless if using facilities elsewhere to treat patients, so the patient's experience was as uncomplicated as possible. • In this case, initially staff had been concerned about the robustness of communication given the shared treatment, however this proved to be unfounded. • The Director of Nursing & Clinical Governance suggested that the video and story could be used as a reflective tool to determine whether the ROH's other patients experienced the same levels of care and to assist other patients planning to go through the same process. • The Communications Team was to be thanked for its support in developing the video. A second story was presented discussing a child Safeguarding case, where early identification of a Safeguarding issue had been made by a clerical member of staff, which resulted in a successful referral to a safeguarding national body. The Chief Executive asked how the Trust could be assured on its approach to safeguarding given that only a few safeguarding cases were reported by the Trust each year. It was reported that staff received appropriate training in how to spot potentially vulnerable patients. Additionally, by increasing the number of staff with higher level training this would impact positively on awareness of Safeguarding matters. It was noted the training plans linked into some elements of the CQC action plan. Safeguarding training in the Trust was extended to non-clinical staff and Safeguarding training for the Board was planned. In terms of how staff who made a referral were treated, the Board was advised that debriefing support and counselling were used as appropriate. The Director of Nursing & Clinical Governance reported that all Safeguarding cases were scrutinised, including external bodies and agreed that safeguarding needed to be linked to the drive to improve incident reporting and raising issues of concern. Karen Cope and Evelyn O'Kane were thanked for their attendance and insights.	
4 Minutes of the Public Board – 6 April 2016	**ROHTB (4/16) 028**

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 (4/16) 028 (a)**
The Paperless Board initiative had stalled due to annual leave and sickness absence, however this was now being picked up with a view to reporting back again in July. The development of the new Corporate Performance Report was underway and oversight would be provided by the Finance & Performance Committee**.**	
6 Chairman's and Chief Executive's update	**ROHTB (5/16) 003** **ROHTB (5/16) 003 (a)**
The Chief Executive reported since the last Board meeting that: • Some industrial action had taken place; the impact and consequences of this were discussed. The Director of Operations reported that there had not been any detectable negative impact as a result of the junior doctors' strikes, aside from a reduction in capacity in Outpatients; theatre capacity had been maintained at expected levels. The Outpatient appointments needing to be rescheduled were for patients requiring follow up rather than new patients, however not all the cancelled appointments had yet been rescheduled. Locums had been used to work through the strike period in some areas and overall significant work had been undertaken to minimise disruption. • The new Sustainability and Transformation footprint, led by the Birmingham City Council Chief Executive, was developing well. At the first round of meetings, there had been a briefing on the economy as a whole, the highlights of which were discussed. The financial deficit in the region was heavily impacted by deficits in Social Care and the significant deficit carried by Heart of England NHSFT. While this gap remained and, if all current trends continued, by 2022, on a cumulative basis, a £767m deficit would have accrued in the Birmingham and Solihull system. The key pieces of work to address this were: realisation of NHS Right Care, delivery of efficiencies set out in the Carter review and a reduction in avoidable urgent care demand. • The theatre stock system replacement discussed at Trust Management Committee (TMC) was highlighted. A subcommittee of TMC had met to review the issues and, subject to minor clarification, EDC Gold would be used as a replacement. This would dovetail with plans for the theatre management system. • Nationally, 80% of Trusts were in deficit, with a £2.4bn deficit expected by the year end. The main focus on key savings would be through vertical integration and accessing improvement bodies. Measures of success in the future were likely to include an 'Outstanding' rating by the Care Quality Commission, financial balance and full delivery of the Carter efficiencies.	

There is to be a drive to work across organisational boundaries to support the wider position, although this was against a context of under development of local system working. The ROH would be included in these arrangements. The Chairman reported that: • She had chaired an NHS Providers conference in the West Midlands on 26 April and supported the position set out by the CEO about the exceptionally challenging circumstances surrounding the NHS finances nationally and regionally. • The inaugural Harrison lecture on the history of Orthopaedic care would take place on 12 May 2016 and invited Board members to attend. • The ROHBTS ball would be held on 13 May at Hogarths Hotel, Dorridge where the Trust Board would be represented. • In terms of the launch of the Knowledge Hub on 28 April, the key note speaker, Prof David Adams, Dean of the Medical School of Birmingham University, had been well received. And there was general accord that the Knowledge Hub was now moving forward as part of the Trust's Strategy. The Chief Executive agreed this had been a pleasing piece of work. • NED recruitment was discussed. The approach to be taken was under consideration, with a view to reducing costs and it was likely that appointments would be made in summer • The Board had held a successful strategy review day and a clear set of priorities had been articulated that would come back to the Board for sign off.	
7 Communications and engagement quarterly update	**ROHTB (5/16) 004** **ROHTB (5/16) 004 (a)**
The Head of Communications joined the meeting to present an overview of progress with delivery of the communications and engagement strategy. Some good examples of partnership working were discussed. Consistently 30,000 people were visiting the website each month and the website continued to evolve based on feedback. Support to the 'Transformation into Action' had been a key development since the last report. Other work included improving patient feedback mechanisms, harmonising the format of the majority of hospital letters, support to national nurses' day and planning for the bicentenary of the Trust. The Director of Nursing & Clinical Governance suggested that consideration be given to better communicating to staff the clinically focussed outcomes of the work being undertaken in support of patient services and it was noted that the majority of the work was not around activity and finance. In terms of support to the Trust's Charity, a baseline communications plan had been developed. Beyond this, a visit was planned to the Director of Fundraising at	

Birmingham Children's Hospital, to harness best practice and understand the support framework to manage donations.	
8 Corporate performance report	**ROHTB (5/16) 005** **ROHTB (5/16) 005 (a)**
The Director of Finance reported that the current key areas of focus were around finance and patient experience. A draft end of year position was being worked through, however a number of accounting adjustments needed to be taken into consideration, including the impact of theatre stock on the underlying position. From a Cost Improvement Programme point of view, the Trust had delivered the position agreed at Month 5 and exceeded savings delivered in 2014/15. The stock position was discussed, including the distinction between consignment stock and the Trust's own stock. There was currently a mismatch between the rise in stock on the ledger and the physical stock counted. The Board was reminded that a better stock control system was to be brought in 2017 and alongside this there had been a tightening up of the controls. There was general agreement that procurement needed to be looked at to ensure that there were also proper controls in place. The increase in complaints was discussed, however the number month on month appeared to be decreasing. There was a possibility that PALS contacts had increased, meaning that people were choosing to resolve issues through informal routes as a preference. Medicines' incidents had been scrutinised and an in depth report on falls would be considered by the Quality & Safety Committee in June. There had been 18 Grade 2 pressure ulcers reported, however a robust action plan was in place to manage these. A fining regime for Grade 3 & 4 pressure ulcers was in place which would be reinvested by commissioners. The collection of the Net Promoter Score was discussed. Further work was planned to increase the collection further and generate a better response rate. The Chief Executive reported a degree of non-compliance with the requirements of the Friends and Family Test (FFT) collection had been identified, therefore when the actions to rectify the position were delivered the position might show a deterioration as additional feedback could be collected. It was suggested that a benchmarked position should be identified. It was noted that there had been a significant increase in compliments in addition to the increase in complaints, possibly due to increasing expectations. It was suggested that trends should be given due focus. The position in terms of cancellations was discussed. Hospital on the day cancellations was improving, however the number of cancellations due to patient choice was significant. The run rate was comparable with other organisations.	
9 Safe staffing report	**ROHTB (5/16) 006** **ROHTB (5/16) 006 (a)**
The Director of Nursing & Clinical Governance presented a detailed overview of the	

nurse staffing position. The key points discussed were: • Dips in staffing reflected not backfilling in some wards. The red rated areas were explained, which included not being able to fill care assistant roles. • From a vacancy point of view, in budget setting some agency and temporary staffing expenditure would be translated into substantive funding. A recruitment and retention group had been established and consideration was being given to European nurse recruitment. The need to retain good people was agreed to be a key area of focus. • Overall, wards had sufficient staff to meet acuity of patient needs. • HDU and theatres used temporary staffing, but there had been some successful recruitment of substantive staff. • The 'red flag' incident system was being used. • The needs of healthcare assistants in the Trust would be given good focus in future. • A specific 'red flag' around a dementia patient was discussed and it was reported that one to one care had not been available at the time. A policy had since been approved defining when one to one care was appropriate. • The daily huddles and outputs of 6-4-2 meetings were being used to inform nurse staffing patterns. The heath rostering planning tool would also match planned resources against patients booked for procedures. Cover for the High Dependency Unit was based on beds open rather than all beds on the unit. • A rolling programme of recruitment of nurses was in place, however there remained some challenges in Paediatric nursing. The key risks with continuous recruitment were highlighted, which included insufficient funding to support the additional staffing.	
10 Quarter 4 workforce report	**ROHTB (5/16) 007** **ROHTB (5/16) 007 (a)**
The Director of Workforce & OD presented a summary of workforce activity, the key points being: • The first mindfulness cohort would start in June. • Medical learning partnerships would start shortly, working on collaborative improvements with general managers. • The Trust had received a positive report from Health Education England, which the Board was invited to review.	

- There had been a visit from NHS Improvement (NHSI) concerning agency staff, which was a constructive conversation and included discussion of medical locums and procurement on a national scale.

- Three nurses from the Philippines had joined.

- The staff profile was reviewed and a growth in admin and clerical staff had been seen to support transformation and IT.

- Overall the workforce was stable, however some turnover had been seen in the Patient Access and Corporate areas. Marketing would be used to support recruitment strategies.

- In terms of industrial action, preparations were in place to implement the new junior doctor contract and planning of revised rotas would involve junior doctors working in the organisation.

- Regarding plans to reduce temporary staffing, it was noted that the use of Physician Associates (PAs) was key. A revised control total for agency usage meant that the Trust needed to reduce the current £600k run rate, half of which was associated with locum doctors. Two PAs are in post now and one due in August, although removing the locum doctors supporting these roles was still underway. There were some cultural issues which were being addressed around the authority of PAs to act within the organisation. The £300k agency expenditure saving was therefore challenging. There had been a challenge from NHSI around changing medical practice and this needed to be driven further though the Executive function.

- The Director of Nursing & Clinical Governance noted that there were plans for the Schwartz Rounds to be led by the Head of Nursing, however he suggested that this needed to be led by someone with an appropriate interest in this work, which need not necessarily be the Head of Nursing.

- In terms of the patient safety leadership conference, it was suggested that the agenda needed to reflect the challenges the ROH faced. It was noted that part of the ethos was to share practice elsewhere and highlight the responsibilities of staff. It was suggested that consideration be given to the individuals who might lead the change debate at the conference.

- The freeze in recruitment to non-clinical posts was discussed and a question asked about how these were being filled at present. All non-clinical posts were being reviewed and fixed term appointments were being used to cover the roles. The reasons for the use of temporary staff in fixed term appointments were outlined and assurances were given that these are appropriate.

- The Chairman highlighted the plan to bring back a people strategy in July and a reporting framework would be developed to ensure that the Board was focussed on the right things, which included workforce matters. A balanced

scorecard approach would be useful. • In terms of junior doctors who might move abroad as a result of the current dispute over terms and conditions, the scale of the opportunity might not be as big as initially thought. In the meantime positive engagement would be progressed and re-engineering rotas would involve staff.	
11 Annual inclusion report	**ROHTB (5/16) 008** **ROHTB (5/16) 008 (a)**
Mrs Kirkham left the meeting at this point. The Director of Workforce & OD presented the self-assessment against the Equality Delivery System (EDS2) and reported that the draft had been shared and discussed by the Trust Management Committee. There had been some marginal gains in terms of data disclosure this year suggesting people were acting in an open way. It was suggested that ethnic diversity also could be considered in relation to the Board team and Trust Management Committee, where it might be desirable where possible, to strive towards better representation. The close match between the demography of the people served by the organisation and staff demographics in the report was noted but at the same time the Trust needed to reflect the multi ethnicity of wider Birmingham. The Chief Executive asked whether the internal assessment for Domain 3 (Empowered, engaged and well supported staff) included staff from the protected groups. It was noted that the position needed to be more fully investigated, involving individuals from these groups. It was agreed that clear priorities and recommendations were needed from the report in terms of key actions to take, goals, targets and outcomes. The Board asked that Equality and Diversity form part of the Human Resources Strategy.	
ACTION: AC to review the scoring for Domain 3 of the EDS assessment **ACTION: AC to develop an Equality & Diversity Strategy as part of the HR Strategy**	
12 Board Assurance Framework - Quarter 4 update	**ROHTB (5/16) 009** **ROHTB (5/16) 009 (a)**
The Associate Director of Governance & Company Secretary reported that the Board Assurance Framework was in the form seen by the Audit Committee at its April meeting. The format of the BAF was becoming established in the organisation and contained the key risks to the delivery of the Trust's strategic objectives and organisational goals. The feedback from the Audit Committee suggested that there was a need to better signpost the Board to the critical risks for the Board to be focussed on, which would be addressed in the next version of the BAF, along with inclusion of the risks to the sustainability of the organisation agreed at the recent Board strategy day. The Board was asked and agreed that there was merit in including a standing item on each agenda to consider any risks which had arisen through debate at the	

meeting that may warrant including on the BAF or the Corporate Risk Register. The Chair of Audit Committee suggested that the risk around business intelligence in particular needed focus. The Chief Executive suggested that the focus of the risks needed to be sharpened and should continue to be developed. It was noted that both Internal and External Audit had praised recent improvements and the development of the BAF.	
ACTION: **SGL to update the BAF to include risks to the sustainability of the organisation agreed at the Board strategy day** **ACTION:** **SGL to add an item to the agendas of each Board to capture risks which may have emerged through discussion at the meeting**	
13 Monitor declaration - Quarter 4	**ROHTB (5/16) 010** **ROHTB (5/16) 010 (a)**
The Chief Executive presented the Quarter 4 governance submission to Monitor which had been approved by a Committee of the Chief Executive and Chairman. The risks to the delivery of the stretching targets were highlighted. It was reported that a further request had been received from NHS Improvement to remodel the contract requirements.	
14 Audit Committee update	**ROHTB (5/16) 011**
The report was taken for receipt and noting.	
15 Finance & Performance Committee update	**ROHTB (5/16) 012**
The report was taken for receipt and noting.	
16 Quality & Safety Committee	**ROHTB (5/16) 013**
The Director of Nursing & Clinical Governance highlighted that the report from the VTE themed review had been received which was positive overall, but highlighted non-compliance with the VTE policy by a few individuals. A review of the quality impact assessment process for Cost Improvement schemes had been undertaken and this had provided good assurance.	
17 Any Other Business	**Verbal**
There was none.	
Details of next meeting	**Verbal**
The next meeting would be held on 24 May 2016 at 1230h to consider the annual report and accounts 2015/16.	

PUBLIC SESSION

Next Meeting: 1 June 16 , Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

Last Meeting: 4 May 2016, Boardroom @ Trust Headquarters

Members present: Yve Buckland (YB), Tim Pile (TP), Rod Anthony (RJA), Frances Kirkham (FK), Jo Chambers (JC), Jonathan Lofthouse (JL), Paul Athey (PA), Garry Marsh (GM)

In Attendance: Anne Cholmondeley (ACh), Phil Begg (PB)

Apologies: Kathryn Sallah, Tauny Southwood and Andrew Pearson

Secretariat: Simon Grainger-Lloyd (SGL)

Last Updated: 27 May 2016

Reference	Agenda item	Paper Ref	Date raised	Action	Owner	Completion Date	Response submitted/Progress update	Status
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	~~03/02/2016~~ 6-July-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. Further development work currently underway. Names of individuals suggested to trial the system have been put forward. Further update in July 2016.	
ROHTBACT. 018	Annual inclusion report	ROHTB (5/16) 008 ROHTB (5/16) 008 (a)	04/05/2016	Review the scoring for Domain 3 of the EDS assessment	AC	01-Jun-16	Verbal update on outcome at meeting	
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~~ ~~03-Feb-16~~ ~~06-Apr-16~~ Jun-16	Work underway to develop the material presented to the Finance & Performance Committee into a revised version of the Corporate Performance Report	

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 ~~6-Apr-16~~ Jun-16	Will be built into the new CPR or equivalent	
ROHTBACT. 014	Patient Case – an illustration of the work we do	Presentation	06/04/2016	Quality & Safety Committee to consider the future plans for screening dementia patients	SGL	25-May-16	Deferred to July meeting	
ROHTBACT. 015	One year operational plan and budget sign-off	ROHTB (4/16) 005 ROHTB (4/16) 005 (a)	06/04/2016	Case studies from the material considered by the Finance & Performance Committee to be presented to the Trust Board	SGL	01-Jun-16	Deferred to July meeting as F & PC did not meet in May	
ROHTBACT. 016	Trust response to the Cavendish Review	Presentation	06/04/2016	Trust Management Committee to consider the plan to operationalise the Care Certificate	GM	25-May-16	Deferred to meeting in June	
ROHTBACT. 020	Board Assurance Framework	ROHTB (5/16) 009 ROHTB (5/16) 009 (a)	04/05/2016	Update the BAF to include risks to the sustainability of the organisation agreed at the Board strategy day	SGL	06-Jul-16	ACTION NOT YET DUE	
ROHTBACT. 013	Self-assessment 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	Training arranged for 20 July 2016	

ROHTBACT. 019	Annual inclusion report	ROHTB (5/16) 008 ROHTB (5/16) 008 (a)	04/05/2016	Develop an Equality & Diversity Strategy as part of the HR Strategy	AC	06-Jul-16	Will be developed as part of the People Strategy	
ROHTBACT. 021	Board Assurance Framework	ROHTB (5/16) 009 ROHTB (5/16) 009 (a)	04/05/2016	Add an item to the agendas of each Board to capture risks which may have emerged through discussion at the meeting	SGL	01-Jun-16	Added as agreed	

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:

SLA with St Mary's Hospice	~~December 2015 February 2016~~ April 2016	Still in process of securing the SLA with St Mary's.
Improvements in translation services	~~December 2015 February 2016~~ April 2016	Included on agenda of April meeting

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:	**1 June 2016**

EXECUTIVE SUMMARY:

This report provides an update to board members on the national context and key local activities not covered elsewhere on the agenda.

The report also provides a summary of key discussions and decisions taken by the Trust Management Committee since the Board last met.

REPORT RECOMMENDATION:

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

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:

The contents discuss a number of developments which have the potential to impact on the delivery of a number of the Trust's strategic ambitions

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 1 June 2016

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 Board has separately considered a number of documents and commentaries on the overall national financial position and the extent of deficit, particularly in the hospital provider sector. The national 2015/16 Quarter 4 position for the provider sector is £2.45 billion reflecting a deterioration from the forecast at Quarter 3 of £460 million. The deterioration has been driven by:

- Continuing high level use of contract and agency staff
- Fines and readmission penalties (levied on providers by commissioners)
- Significant impact of delayed transfers of care
- Failure to deliver planned levels of cost improvement schemes
  (NHS Providers, On the Day Briefing 20.5.16)

2.2 There continues to be much national discussion on the scale of the 'ask' of the NHS, which requires a sustained level of efficiency to be achieved which exceeds anything achieved to date by the NHS, and at the same time significant transformation of services is required, including extending the scope of 7 day services. NHS England has signalled that some providers will need to plan further savings in 2016/17 in order to meet the national control totals agreed as the NHS seeks to get back into financial balance overall *(Simon Stevens, CEO NHS England, HSJ, 20.1.16).*

2.3 It has been announced that the funding for national Vanguards has been reduced for 2016/17, with some vanguards withdrawing from the programme. The National Orthopaedic Alliance will receive less funding than anticipated but still a significant amount is available to develop the quality initiative; activities have been scaled back to accommodate the reduction and some pieces of work will be slipped into 2017/18. In overall terms, the project will focus on defining and agreeing the quality markers against which all participating organisations will then benchmark themselves and develop an improvement plan drawing on best national and international practice in all areas of orthopaedics.

2.4 Simon Stevens, CEO of NHS England has indicated that it is considering forming groups of health service organisations into 'Combined Authorities' to bring together multiple commissioners and providers in order to simplify decision making and service change within STPs (Service and Transformation Plans); this would mirror the move being made by local councils to join functions across a larger area, for example in Greater Manchester. The proposed changes are being considered by about half of all STP leaders and would result in different governance arrangements to drive through changes.

3 Local Context

3.1 The Trust signed both of its principle contracts within the framework set after considerable and complex negotiations. Further work has been undertaken to develop a trajectory which will enable the Trust to remain compliant with the Referral to Treatment standards and a tripartite agreement with commissioners and Birmingham Children's Hospital NHS Foundation Trust (BCH) has cleared the way for additional operating sessions at BCH for more complex cases. This is a significant step forward and enables more of our long waiting patients to be treated; detailed plans are being worked up in partnership with BCH.

3.2 The overall contractual and regulatory requirements for 2016/17 pose an extremely challenging set of targets and a stretching control total. The Trust is working on detailed plans to enable these targets to be met through a combination of operational improvements and cost improvements which will be monitored through an integrated turnaround and improvement programme. The Finance and Performance Assurance Committee will undertake detailed scrutiny on behalf of the Board and be the primary assurance vehicle.

3.3 The Birmingham and Solihull Sustainability and Transformation Plan (STP) continues to be developed for initial submission on 30 June 2016. Strategy leads from each organisation are working on the details with input from Finance Directors. The Chief Officers have met at an away day to consider how the system can work better together given the competing priorities facing members of the group and there has been an initial Leaders and Chairs meeting.

4 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

4.1 In addition to routine business meetings with partners, other key stakeholder and partnership engagement activities over the period include:

- ROH Long Service Awards for colleagues who have given over 20 years of service to the NHS
- Birmingham & Solihull STP System Board
- Attended the International Society of Orthopaedic Centres (ISOC) Conference in London, as part of the Specialist Orthopaedic Alliance

- West Midlands Public Service Board
- Birmingham & Solihull System Board Away Day – delivered session on 'System Leadership' following engagement exercise with all partner CEOs

5 UPDATE FROM TRUST MANAGEMENT COMMITTEE (APRIL 2016)

5.1 Since the last meeting of the Board on 4 May 2016, the Trust Management Committee (TMC) was held on 25 May 2016.

5.2 **25 May 2016**

TMC considered the following items to be of note to the Board:

- The start date for implementing a new Theatre Inventory Management System ('EDC Gold') has been delayed by the NHS Supply Chain to 5 September 2016, with go-live likely to be 12 weeks later. This will mean that the preparatory work for this new system will need to take place alongside the work for THEATREMAN (our new Theatre Management System), and implementation of EDC Gold will be around 4 weeks after THEATREMAN. The risks of undertaking these projects simultaneously and resourcing requirements will be assessed, along with the risks to CIP delivery (both Divisions 1 and 2) of non-pay savings linked to having the inventory management system in place from Quarter 2.
- The High Dependency Unit (HDU) and Recovery Step Down Escalation Standard Operating Procedure (SOP) was presented to TMC. Of note to the Board is the marked improvement in patient delays out of recovery, which have reduced significantly since the SOP was introduced, with no breaches of the 4 hour target since April 2016.
- A business case for additional anaesthetic consultant and staff grade posts was presented to TMC. The additional posts are to address the current expenditure on Additional Duty Hours (ADH) which are incurred due to the shortfall in Direct Clinical Contact time. It was agreed that this required further input from Finance & HR colleagues to assess the impact of job planning and activity delivery, before coming back to the June TMC meeting.
- TMC discussed the 2016/17 Activity Delivery plan. A programme of staff engagement begins in early June to make sure that all improvement schemes are owned and understood at a service delivery level.
- There is continued concern around unfilled clinical vacancies in Division 1.
- Division 2 reported a lack of capital funding available for investment in medical equipment, given that significant attention is required to replace items that are beyond their useful life and no longer have maintenance cover; this concern is to be risk assessed for executive review.
- It was agreed that physical intervention/restraint training needs to be progressed with HR, estates and nursing, with more pace as this is one of the key recommendations from the CQC inspection report.
- Progress against 2016/17 CQUINs and CIPs will be tracked by the newly established Turnaround & Improvement Steering Group on a month by month basis. New

performance management system reporting and programme reports are being developed to give better visibility of actions and key milestones to underpin delivery; these will start to be trialled in June 2016.

6.3 The following policies were reviewed by TMC:

- Job Planning Policy for Consultants (SOP) – recommended for approval by CEO
- Car Parking Policy – recommended for approval by CEO
- Uniform & Dress Code Policy – subject to minor additions, this was recommended for approval by CEO. It was agreed that it would be important to develop a clear plan for communicating this policy to all staff.

6.4 TMC acknowledged that a number of risks had presented themselves throughout the meeting which would need to be captured on the Corporate Risk Register, including:

- Slippage on Theatre Inventory Management system CIP
- Effective storage of medical records
- Implications should there be of lack of process to retain oversight of staff competencies
- Activity risk and impact on patient experience and financial position
- Funding to replace theatre equipment beyond its useful life (immediate and longer term)
- Delay in physical intervention/breakaway training implementation

7 RECOMMENDATION(S)

7.1 The Board is asked to discuss the contents of the report, and

7.2 Note the contents of the report.

Jo Chambers
Chief Executive
27 May 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Finance & Performance Report – April 2016**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Director of Finance**
AUTHOR:	**Various**
DATE OF MEETING:	**1st June 2016**

EXECUTIVE SUMMARY:

This paper, alongside the Quality report, is intended to replace the old Corporate Performance report as the mechanism for reporting performance against the Trust's key targets and performance metrics. It is intended that this structure will provide a consistent reporting style from Board level down to Divisional reporting.

The report covers the main performance metrics related to finance, activity, operational efficiency and operational workforce. As would be expected in Month 1 of the new financial year, the majority of finance and performance indicators are broadly in line with planned levels.

REPORT RECOMMENDATION:

Trust Board is asked to note this report and discuss actions to be taken with regards to the issues outlined in the 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	X	Environmental	X	Communications & Media	
Business and market share	X	Legal & Policy	X	Patient Experience	
Clinical	X	Equality and Diversity		Workforce	X

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

The Finance & Performance Report, alongside the Quality Report, demonstrates performance against a number of key metrics linked to the delivery of the Trust objectives.

PREVIOUS CONSIDERATION:

This report was considered by TMC in May 2016.

FINANCE & PERFORMANCE REPORT

APRIL 2016

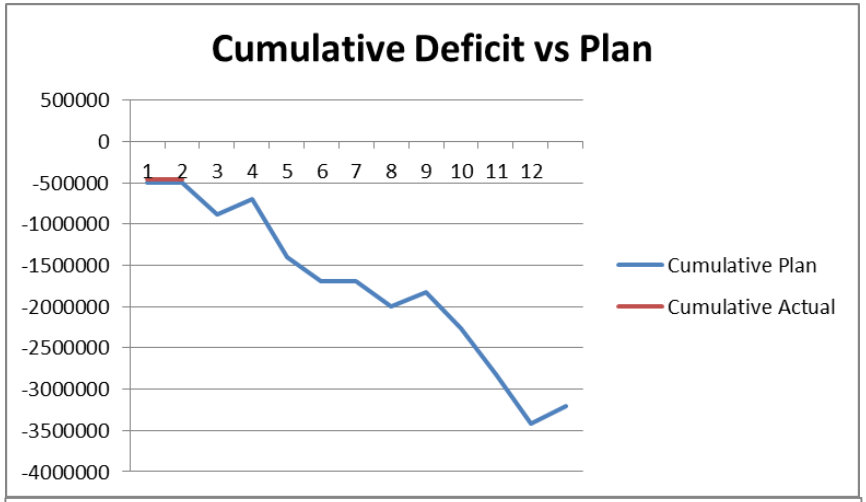
CONTENTS

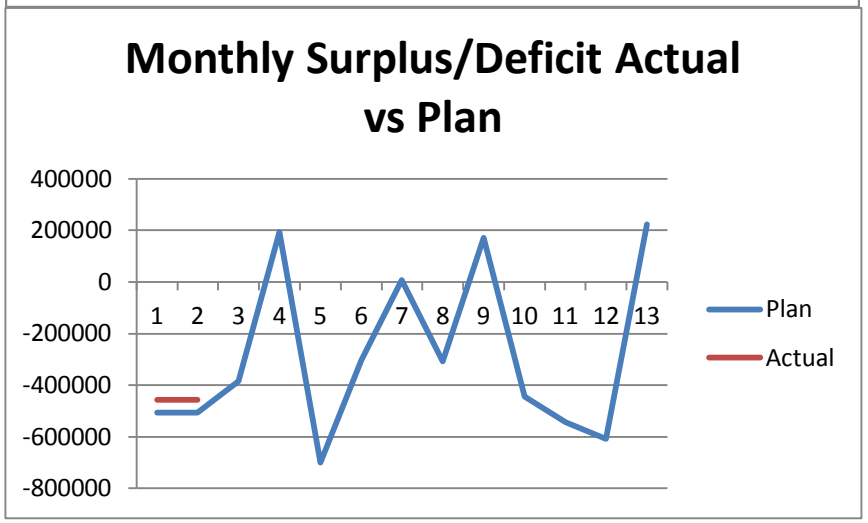
INTRODUCTION

The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

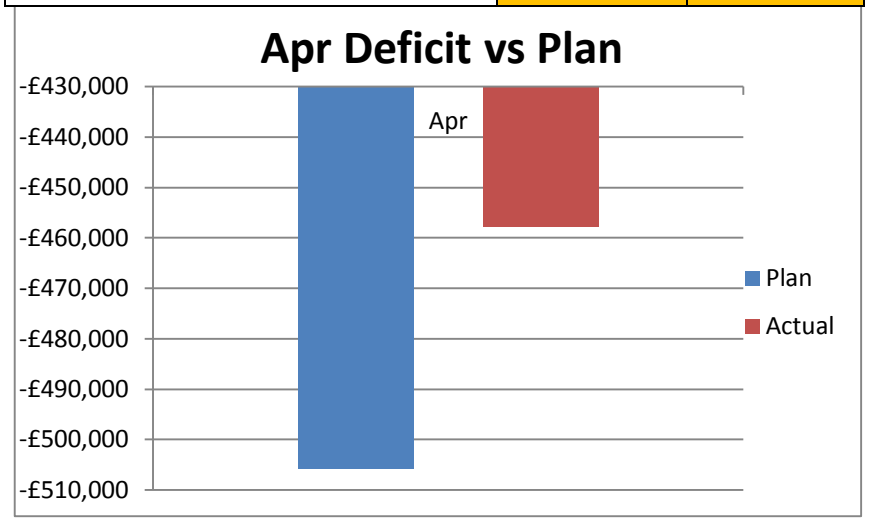
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. **Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Financial Sustainability Risk Rating (FSRR)**





NHSI Financial Sustainability Risk Rating (FSRR)		
	Plan	**Actual**
Capital Service Cover	1	1
Liquidity	4	4
I&E Margin	1	1
I&E Margin – Variance against plan	2	4
Overall FSRR	2	2



INFORMATION

The Trust delivered a deficit of £457,000 in April against a planned deficit of £506,000. As expected for a Month 1 position, performance against budget is reasonably stable across all areas, with income breaking even against plan which expenditure was slightly below planned levels. CIP performance is behind plan for Month 1, however this was offset by underspends in other areas.

The deficit position results in the Trust achieving ratings of 1 for both our Capital Service Cover and I&E Margin metrics as part of the NHSI Financial Sustainability Risk Rating. The achievement of a 1 in any metric caps the overall performance level for the Trust at a maximum rating of 2, despite receiving the highest available rating for liquidity and performance against plan.

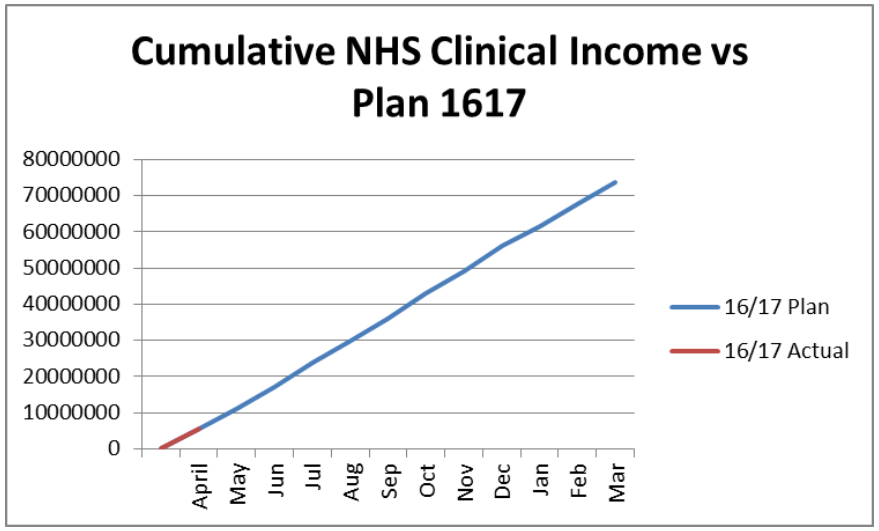
ACTIONS FOR IMPROVEMENTS / LEARNING

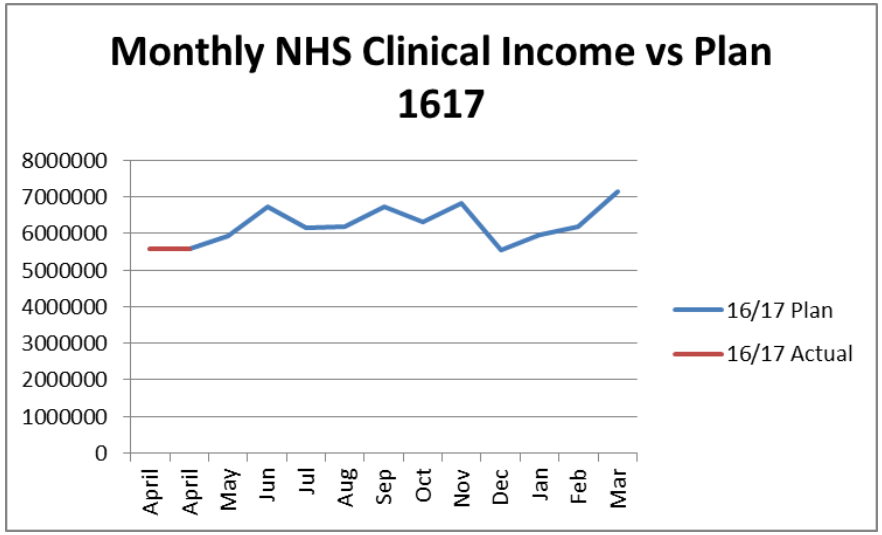
See income & expenditure tabs for more details

RISKS / ISSUES

Achievement against the overall financial target for the Trust remains a challenging ask, and it is vital that the combination of activity deliver, cost control and efficiency improvements are all achieved to enable the target to be hit.

2. **Income – This illustrates the total income generated by the Trust in 2016/17, including the split of income by category**





NHS Clinical Income – April 2016			
	Plan	**Actual**	**Variance**
Inpatients (inc XBDs)	2,761	2,799	38
Day Cases	635	680	45
Outpatients	677	656	(21)
Critical Care	198	180	(18)
Therapies	210	213	3
Pass-through income	200	183	(17)
Other variable income	380	364	(16)
Block income	507	523	16
TOTAL	5,567	5,598	31

NHS Clinical Income – April 2016			
	Plan	**Actual**	**Variance**
Inpatients (inc XBDs)	2,761	2,799	38
Day Cases	635	680	45
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Therapies	210	213	3
Pass-through income	200	183	(17)
Other variable income	380	364	(16)
Block income	507	523	16
TOTAL	5,567	5,598	31

INFORMATION

NHS Clinical income over-performed by 0.5% in April, largely driven by additional income in day case and inpatient spells. Whilst inpatients over-performed by 49 cases, case-mix was noticeably lower than planned, with an average elective tariff received of £4,876 against a plan of £5,226 (6.7% reduction on plan). This had the impact of offsetting all the volume gains, such that the remaining over-performance actually relates to excess bed day income rather than the underlying spell income.

Day cases demonstrated the opposite trend, with activity slightly underperforming but being offset by a 9.8% increase in average tariff.

Outpatients underperformed from an income point of view, driven by a significant reduction in the number of outpatient procedures undertaken in month. More information is provided below in the risks section.

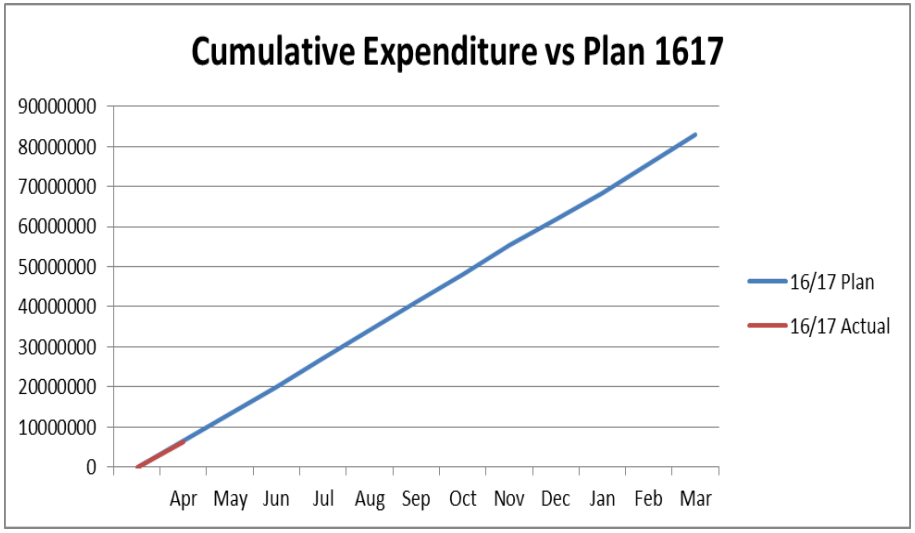
ACTIONS FOR IMPROVEMENTS / LEARNING

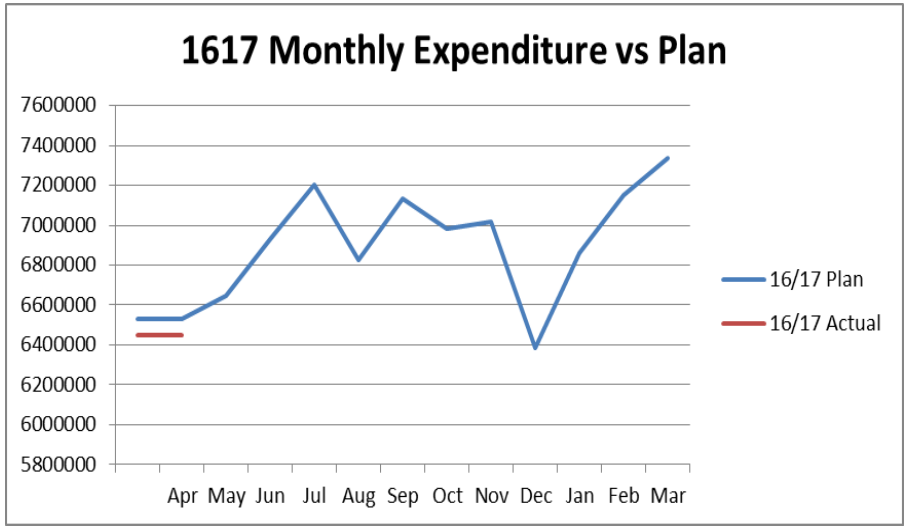
It is expected that the reduction in inpatient case-mix is linked to a reduction in operating in spinal services during April. Continued monitoring will review whether the April position is likely to continue, or whether case-mix will return to planned levels. It should be noted that inpatient case-mix was also noticeably lower in April 2015 than it was across the rest of the financial year.

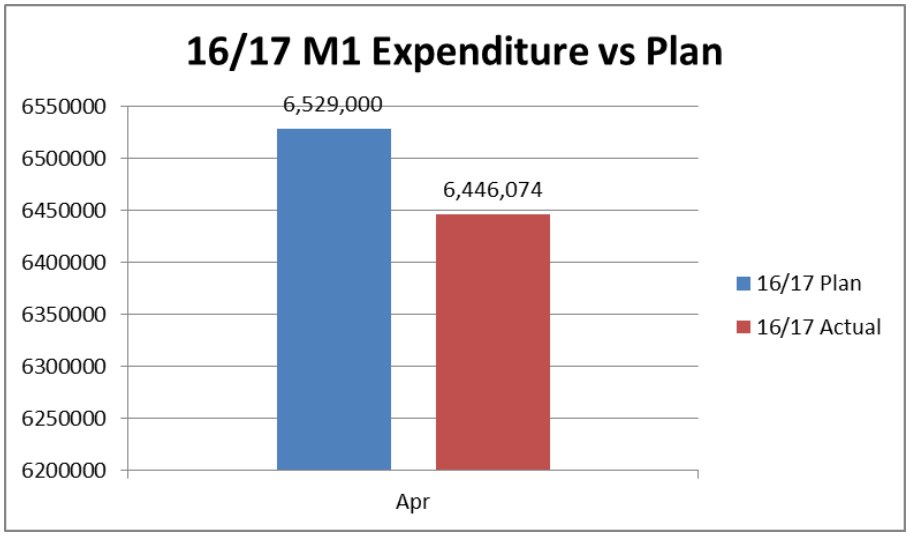
RISKS / ISSUES

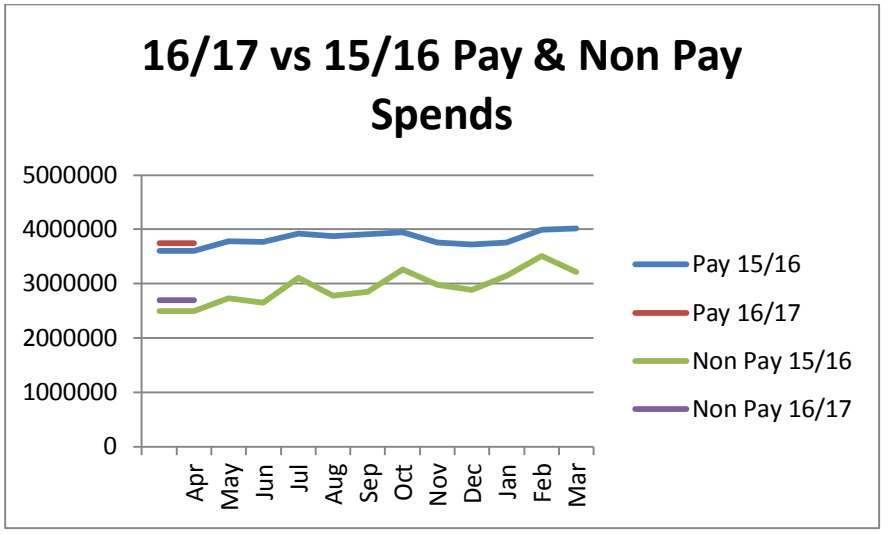
Early indications are that activity levels are underperforming in May which could put pressure on income levels in Month 2.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2016/17, compared to historic trends









INFORMATION

Expenditure levels underperformed by £83,000 in April. This was linked to a range of factors including:

- The impact of the revaluation of assets in the 15/16 accounts, reducing depreciation charges by £30,000 against planned levels (which already included an element of CIP relating to this change)
- Underspends on oncology implants and other prosthesis, potentially reflective of the reduced inpatient case-mix
- Management of resources in theatres and ward areas to remove capacity during theatre downtime.

Agency expenditure dropped considerably to £295,000 against a run rate of £364,000 over the last 5 months (and £460,000 over 15/16 as a whole). This reduction was planned however, so does not impact on the overall performance against plan (see agency section below).

Pay and Non Pay expenditure in April 2016 is greater than the equivalent spend in April 2015 by 4% and 8% respectively, however that should be considered alongside the 7% increase in NHS Clinical income between the same time periods.

ACTIONS FOR IMPROVEMENTS / LEARNING

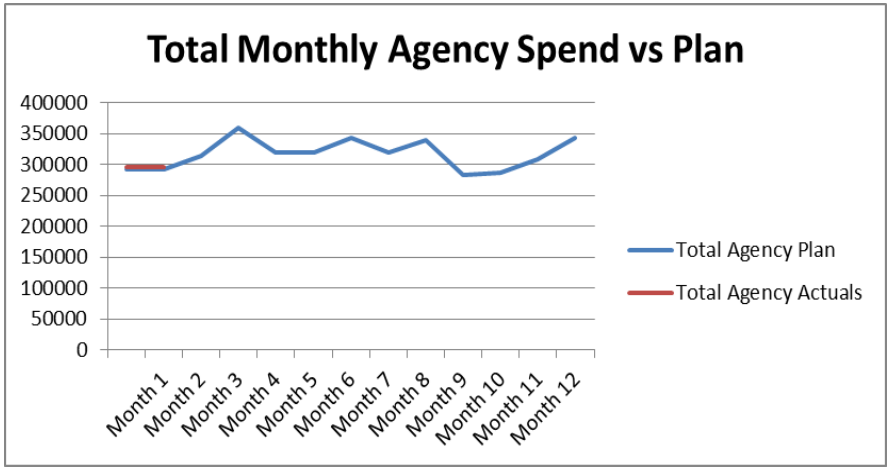
Divisions 1 & 4 are showing as overspent after Month 1, however in the case of Division 1, this is largely due to the phasing of CIP delivery with a number of schemes due to kick-in from Quarter 2 onwards.

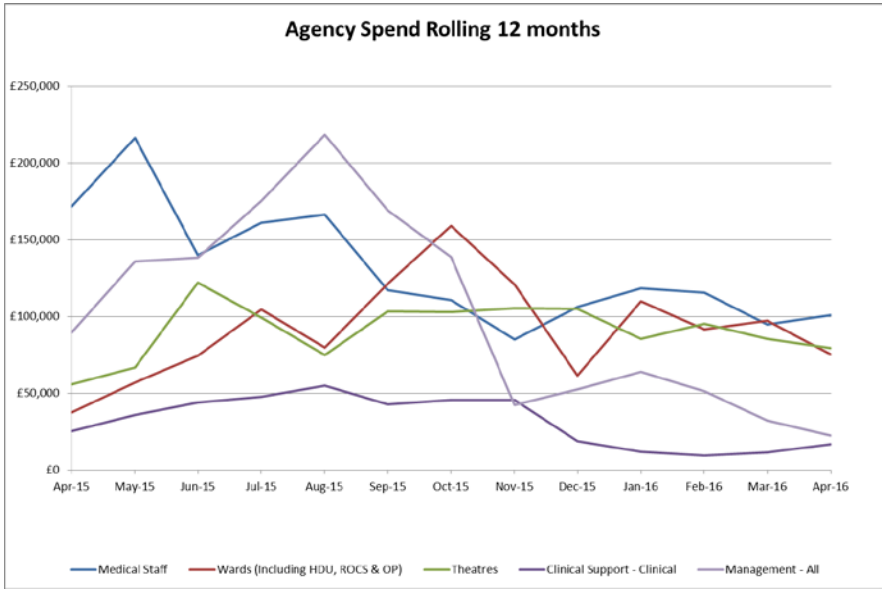
Division 4 have pressure areas relating to bank usage in domestics and porters which are currently being investigated.

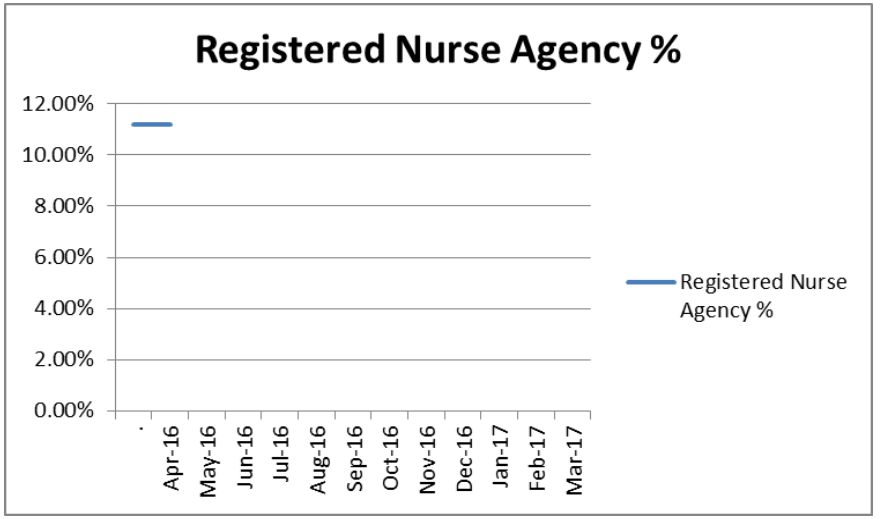
Work is ongoing to agree the costs linked to the delivery of the growth activity included within the 2016/17 financial plan to ensure that the reserve for these costs is allocated appropriately into divisional budgets.

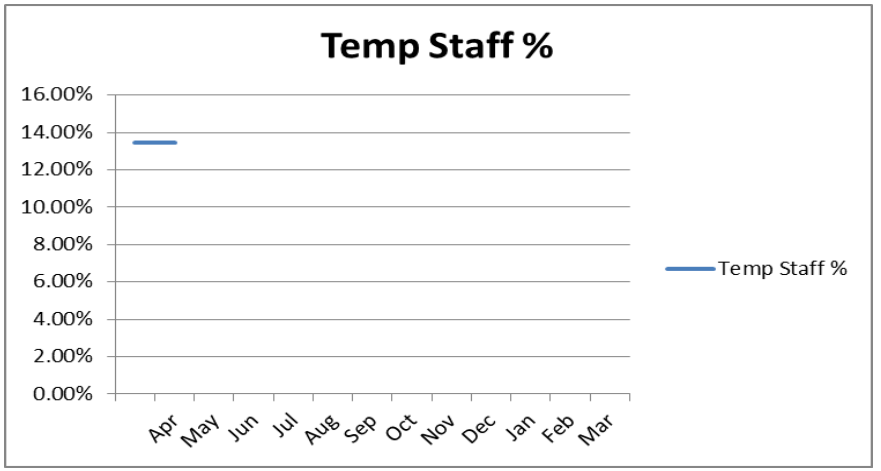
RISKS / ISSUES

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2016/17, and performance against the NHSI agency requirements









INFORMATION

Agency expenditure dropped considerably to £295,000 against a run rate of £364,000 over the last 5 months (and £460,000 over 15/16 as a whole). This is in line with the planned trajectory required to deliver the agency cap set by NHS Improvement.

Reviewing agency spend over a 12 month period, it is clearly that there has been a considerable reduction in the two largest areas of spend in the first 6 months of 2015/16, namely medical locums and management interims. Whilst medical locum spend still represents the largest element of current Trust spend, this has remained at around £100,000 per month for the last 7 months, having peaked at over £200,000 in May 2015. Expenditure on management interims has reduced dramatically from a high point of £219,000 in August 2015 to £23,000 in April 2016.

13.5% of total pay spend in April 2016 related to temporary staffing. This reduced from 16.4% in March 2016.

The proportion of registered nursing pay costs relating to agency staff was 11.2% in April.

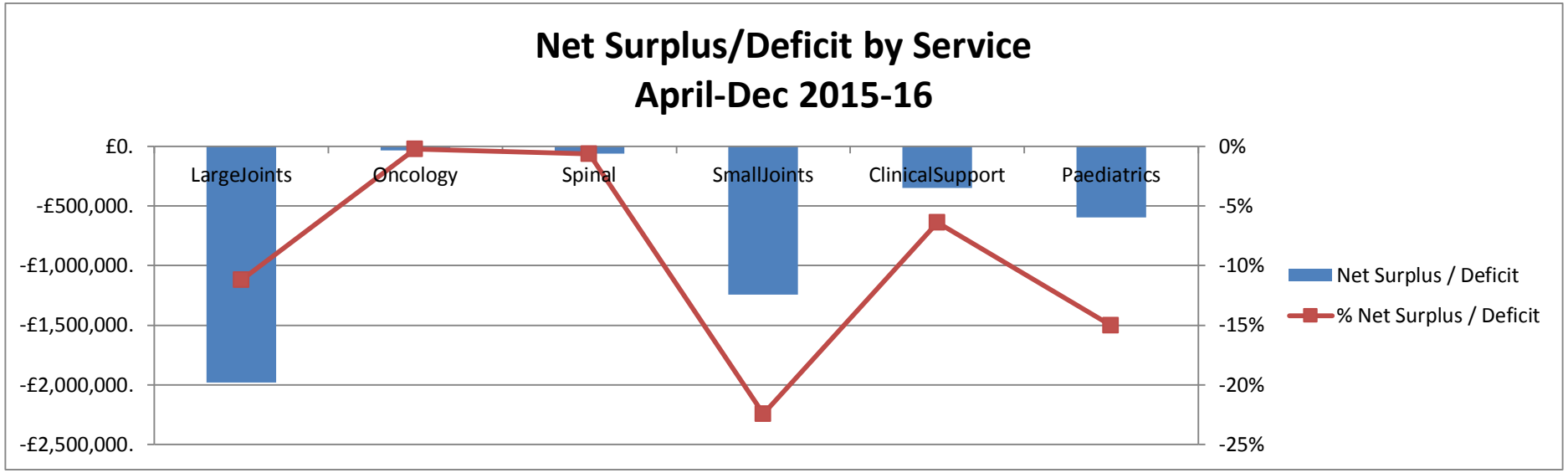
ACTIONS FOR IMPROVEMENTS / LEARNING

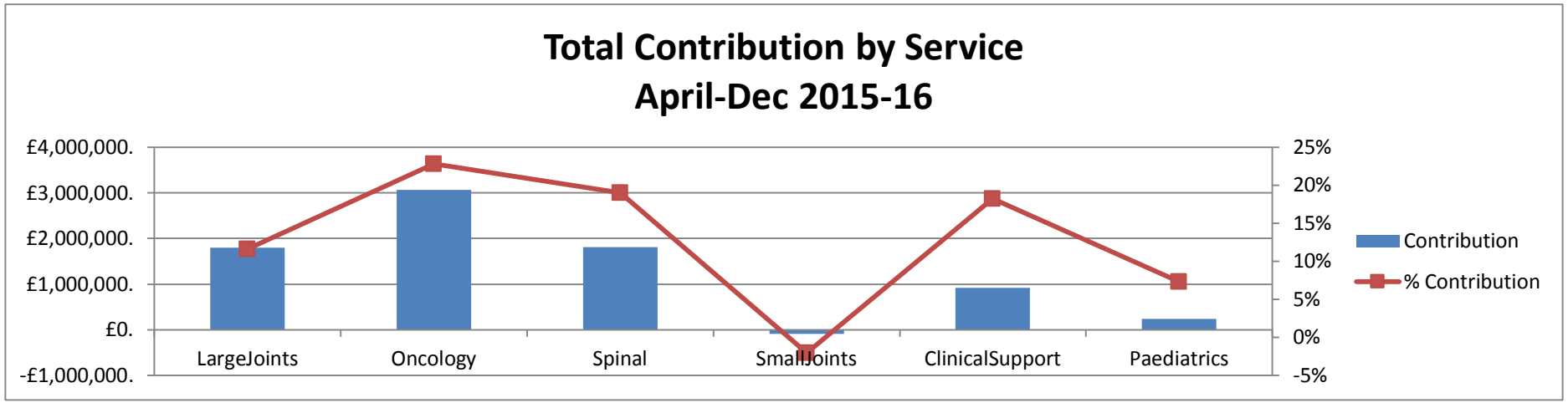
Continued focus on agency expenditure is vital if the Trust is to deliver against both its cap target and its overall financial plan. The implementation of the HealthRoster system over the next few months will support this process, as will the integration of the new PAs and theatre nurses from the Phillipines.

RISKS / ISSUES

Plans need to be in place and milestones delivered in a timely fashion to ensure that agency costs are removed when new starters are fully integrated into teams.

5. Service Line Reporting – This represents the profitability of service units, in terms of both consultant and HRG groupings





INFORMATION

The graphs above, and the associated narrative, relate to the first 9 months of 2015-16. SLR reports are currently in the process of being developed for Q4.

The first graph is showing the contribution each service is generating, currently the Trust target is set at >20%. It can be seen that only the Oncology service is currently achieving this target. All other services are currently generating less than 20% with Small joints providing a negative contribution of £86k outlining that their direct costs are higher than income generated before applying any Trust overheads. This is mainly due to Tariff configuration and service provision. Currently services are being reviewed in terms of all day sessions for certain operation types to improve theatre utilisation and patient throughput.

It can be seen that once the finance costs for overheads, depreciation and interest are applied then all service lines are running at a net loss, this is reflected in the overall Trust position of a £4.2m deficit in the first 9 months of 2015-16.

The main reason Oncology and Spinal are producing a smaller loss compared to the other service lines is mainly due to reconstruction services, Bone Tumour and Spinal Deformity operations within these services.

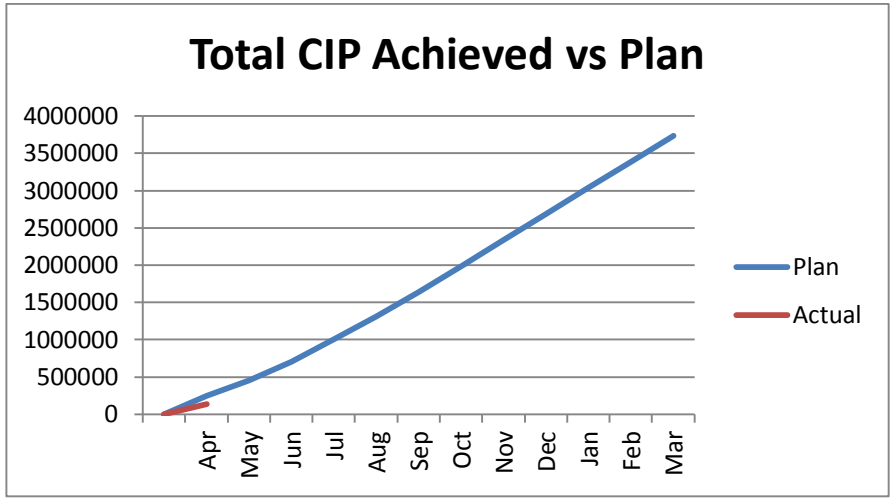
Large Joints are currently creating the highest gross loss, due to theatre utilisation, case mix and increased direct costs in relation to HRG tariff funding.

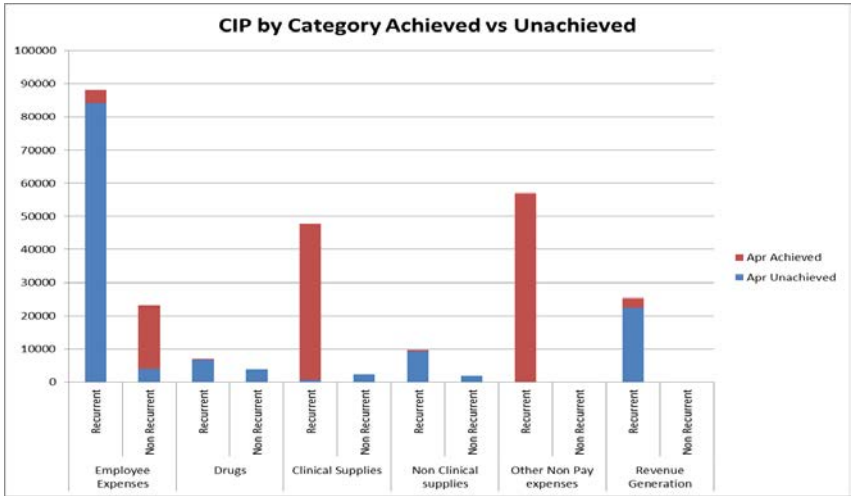
ACTIONS FOR IMPROVEMENTS / LEARNING

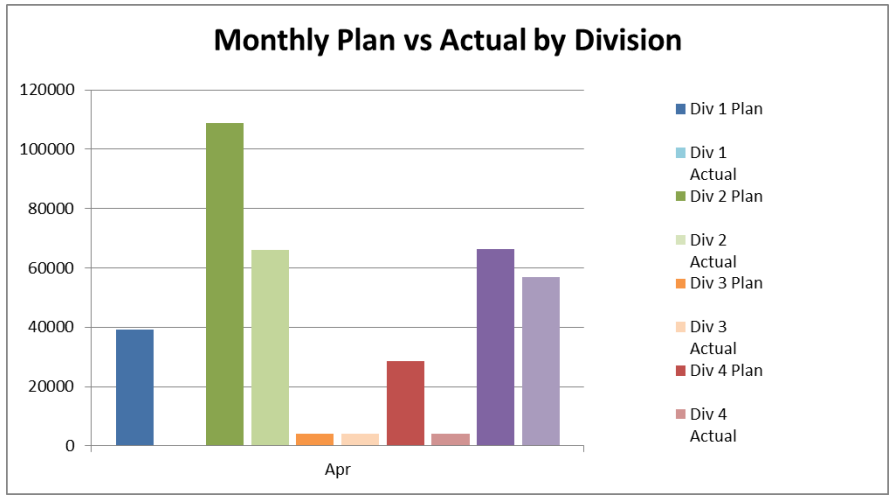
It is important that the use of SLR is embedded into the Trust, as this information provides the vehicle to challenge clinical and price variation at all levels. SLR reporting will form part of the divisional reporting moving forwards, and will be challenged at monthly performance meetings.

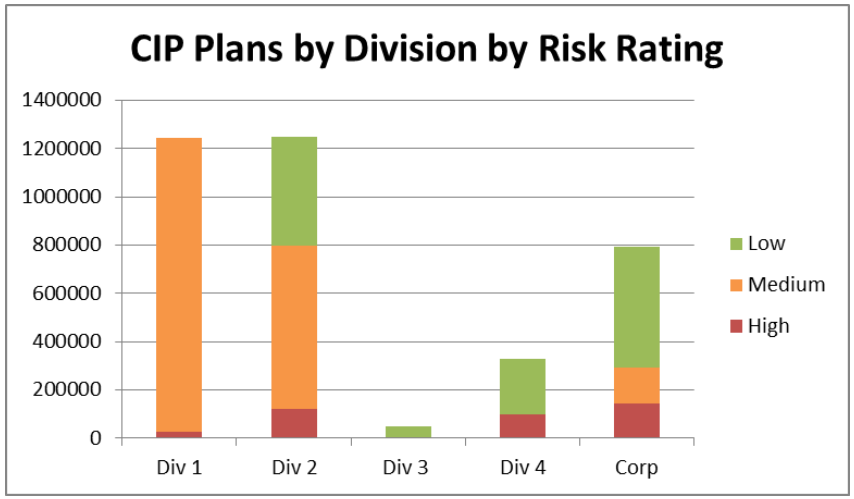
RISKS / ISSUES

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2016/17









INFORMATION

As at the end of Month 1, the Trust has recognised £131k of savings, against a plan of £215k. £19k (15%) of savings to date are non-recurrent.

£66k of the CIP achieved in month relates to Division 2, achieving 61% of their target set for April. £57k relates to depreciation savings in the Corporate department. The balance relates to smaller savings in Divisions 3 and 4. No savings have yet been released in Division 1.

The majority of CIP schemes are still rated as medium or high risk in terms of likely delivery. Further work is required by CIP leads to ensure that these schemes are delivered, and that additional mitigation schemes are developed to cover any future slippage.

The majority of Quality Impact Assessments for in year CIP schemes have been development and are due to be reviewed by the Director of Nursing & Governance and the Medical Director for formal sign off. These will then be monitored through the Quality Committee. The use of the Quality Committee as an assurance route for QIAs will ensure a more timely process of review during 2016-17.

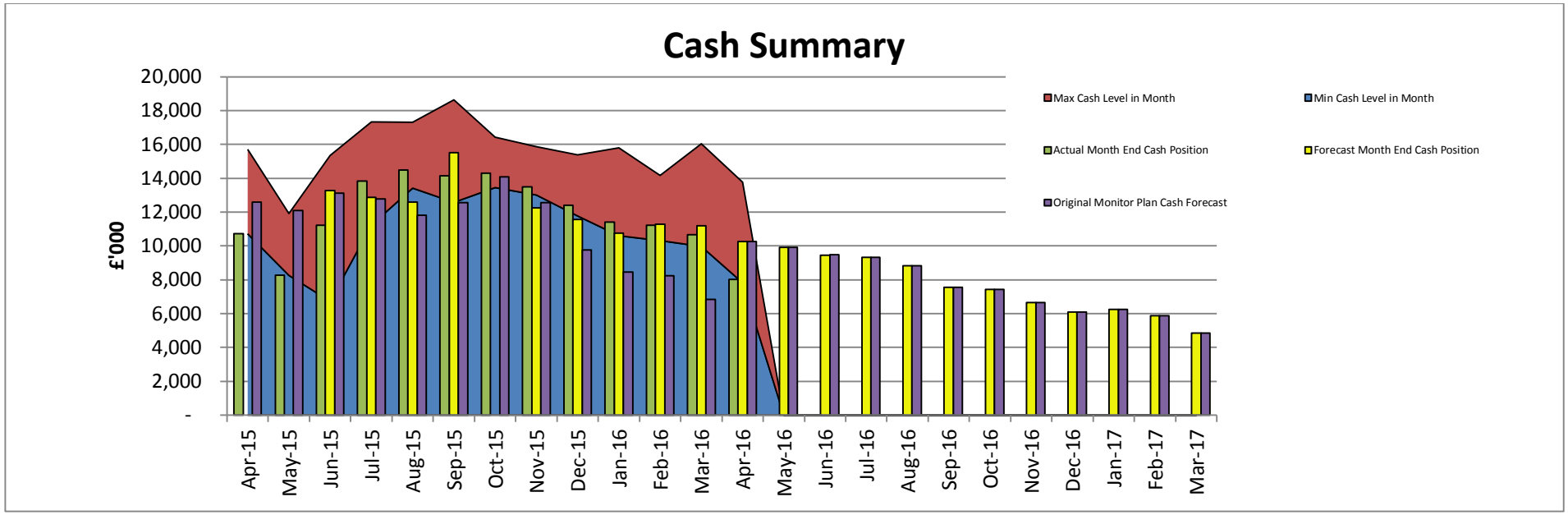
ACTIONS FOR IMPROVEMENTS / LEARNING

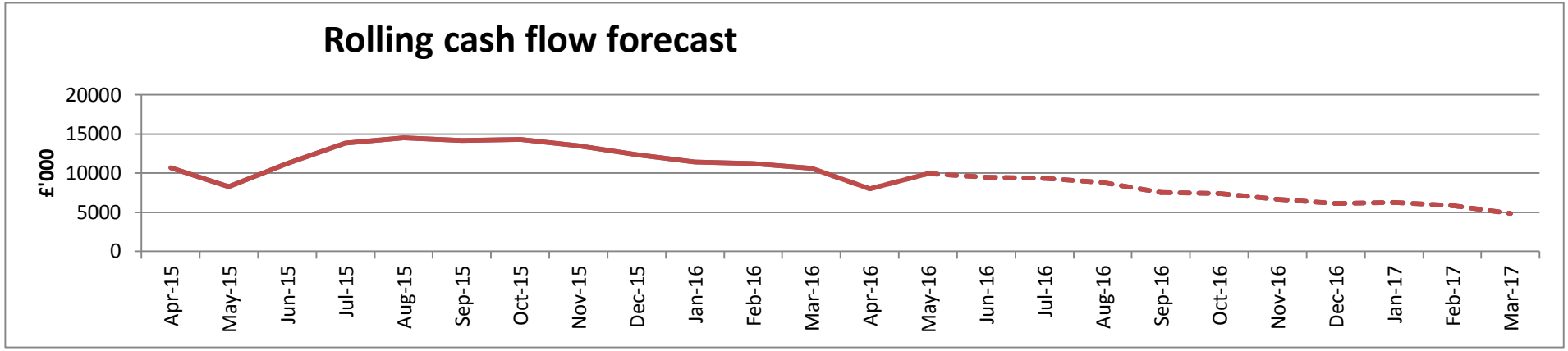
There are still gaps in some areas with regards to the required CIP documentation, largely relating to implementation plans and QIAs. Leads are reminded that all schemes require an outline description for approval, followed by an implementation plan, benefits realisation review and QIA, prior to the initiation of the scheme.

RISKS / ISSUES

The CIP target of £3.67m represents a significant challenge to the Trust. It is vital that we remain on target in the early months as it will not be possible to make significant clawbacks against this level of savings target later in the year.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet





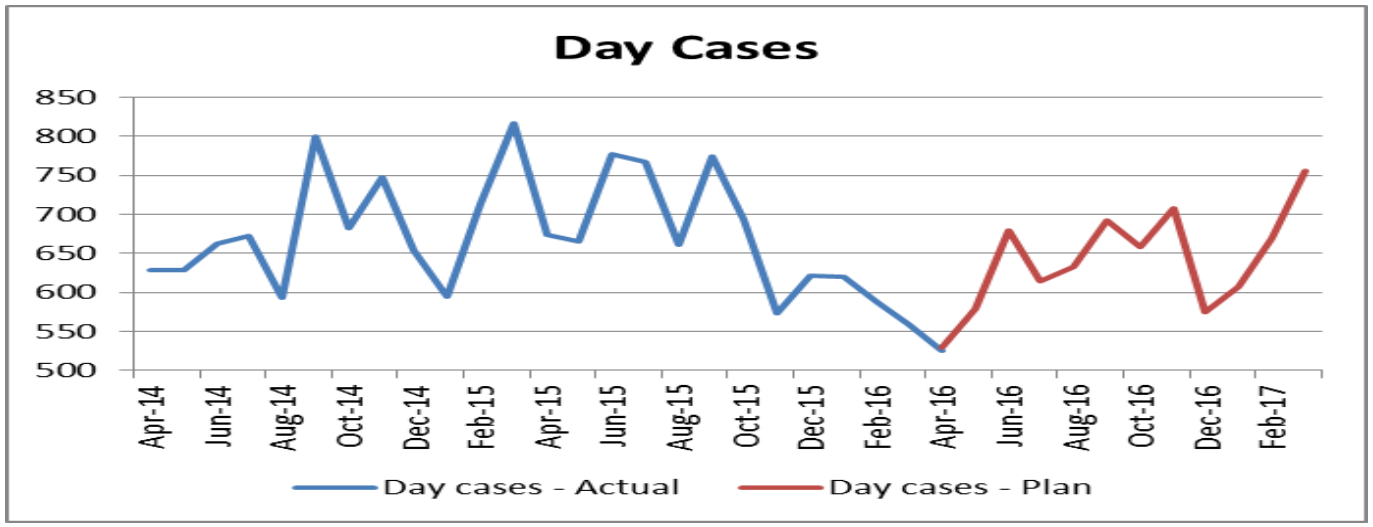
INFORMATION

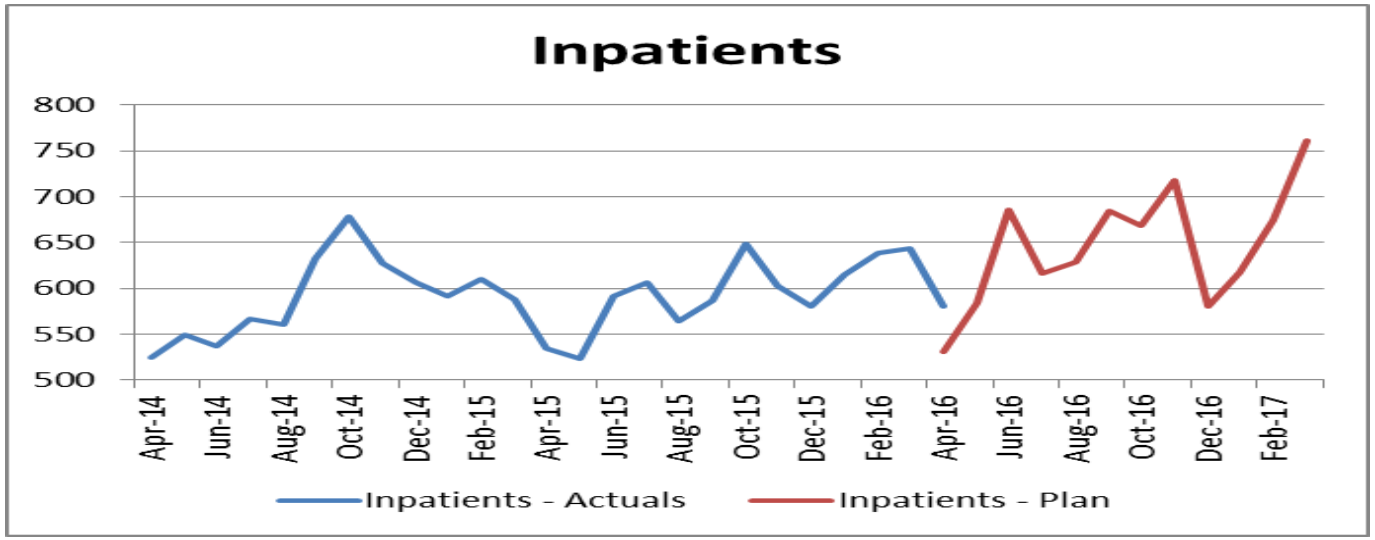
Cash levels remain in line with planned levels at the end of April 2016. The Trust is forecasting an end of year cash balance of circa £5m, which relies upon the delivery of our deficit plan and the control of capital spend within the budget that has been set.

ACTIONS FOR IMPROVEMENTS / LEARNING

RISKS / ISSUES

8. Activity: Admitted Patient Care – This illustrates the number of inpatient and day case discharges in the month, and year to date





INFORMATION

The level of effort and focus from the latter part of last year was carried forward into April and ensured a solid start to this financial year with an over-performance against target in respect to activity numbers for April 2016 (case mix issue previously documented).

The weekly 642 meeting and daily management huddles continue to be the mechanisms by which forecasted activity levels are scrutinised against the respective targets.

A comprehensive process review is currently underway to enhance current practices which are largely cumbersome and inefficient, particularly in respect to the high number of handoffs and delays created by such handoffs. Upon completion, the process review will incorporate a proposal for some administrative staff to be realigned with a number of posts being given up as part of a divisional CIP.

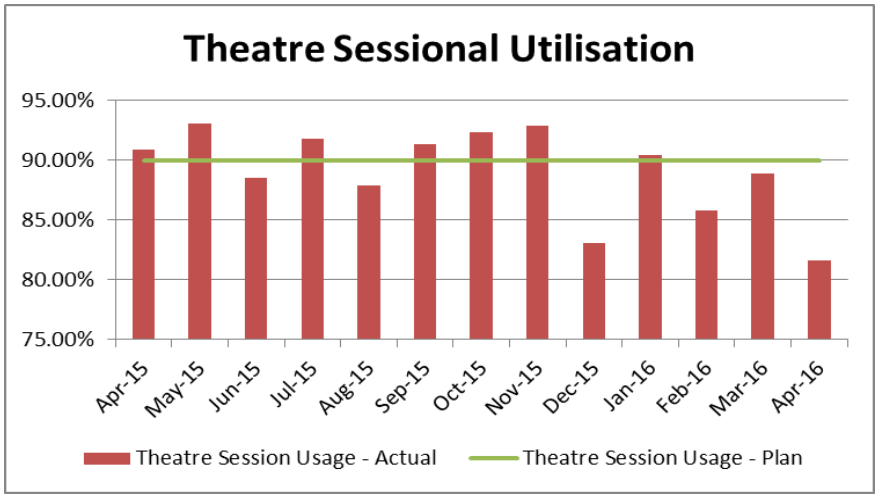
ACTIONS FOR IMPROVEMENTS / LEARNING

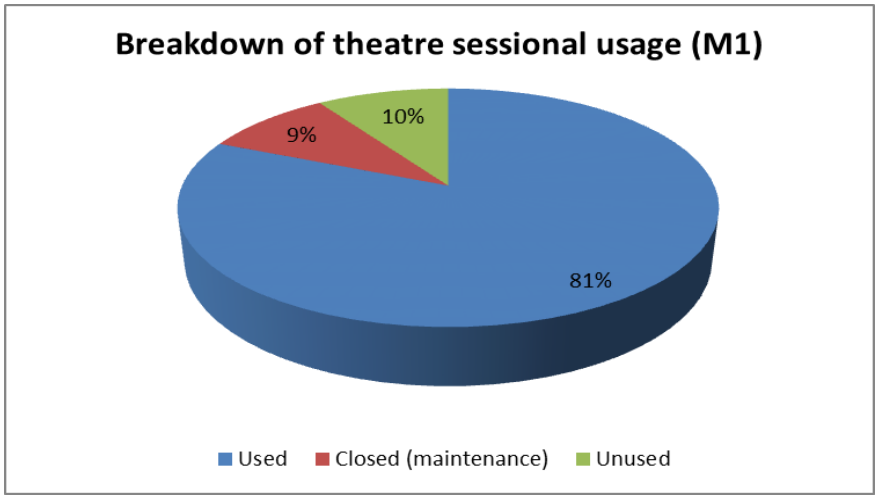
Complete the process review and fully understand the resource implications.

RISKS / ISSUES

The 642 meetings have indicated a not insignificant level of leave being taken over the coming weeks, with consultants who were committed to supporting last year's activity recovery plan are now starting to take their annual leave. At the time of writing there are currently 51 x 4 hour fallow theatre sessions within the next 6 weeks (starting w/c 23rd May 2016) the majority of which fall in the next two weeks which corresponds with half term. In addition a further 20 sessions will be lost due to the bank holiday and a further 10 sessions due to the safety conference.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used





INFORMATION

April 2016 utilisation down partly due to a 6 day period of shut down for 3 theatres (1, 2 and 4) for maintenance at the start of the financial year.

As previously eluded, a number of consultants have started to take their annual leave having been heavily engaged in supporting last year's activity recovery plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

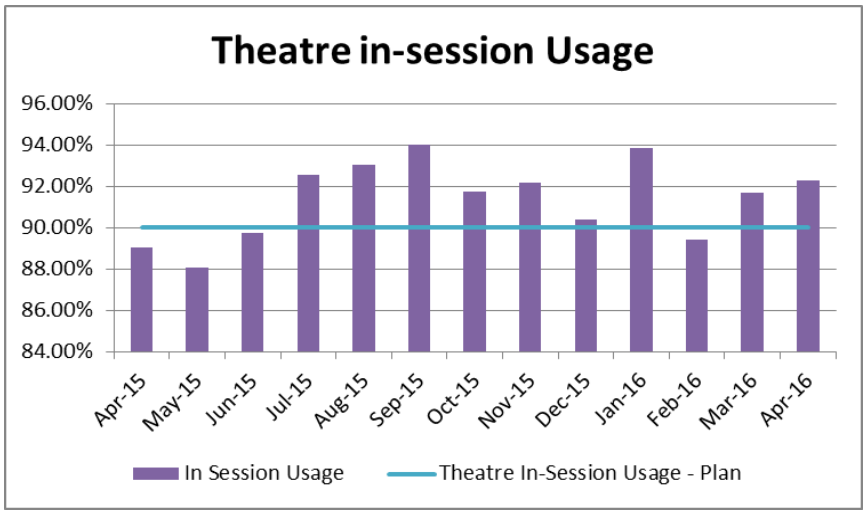
Operational teams have been tasked effective 1st June 2016 with protecting theatre activity at the expense of all other job planned activity, e.g. redirecting those consultants engaged in SPA or other clinical activity to cover theatres whenever gaps are left due to annual leave. This is currently being worked through but requires careful planning given the potential impact to patient pathways earlier into their treatment plan and the need to build some consultant surgeons waiting lists.

RISKS / ISSUES

As indicated above, the requirement to protect theatre activity will take some time to work through which the DGM's and CSM's are currently engaged in. Job planning could deliver this more sustainably but there will be issues for those smaller teams.

Need to ensure theatres have the ability to staff all lists, 5 days per week given.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



Add graph showing theatre in-session usage by month (cutting & gasing time only) – may need to wait for Theatreman for this

INFORMATION

The weekly 642 meeting is the forum through which booked theatre lists are challenged from a utilisation perspective, seeking to ensure that the maximum amount of time is used to treat patients with consultant average procedure times and known turnaround times forming the basis of discussion. Subsequent actions are followed up by the appropriate CSM or Team Leader directly with consultants and lists updated as necessary.

ACTIONS FOR IMPROVEMENTS / LEARNING

Continue to challenge and maximise use of available theatre time.

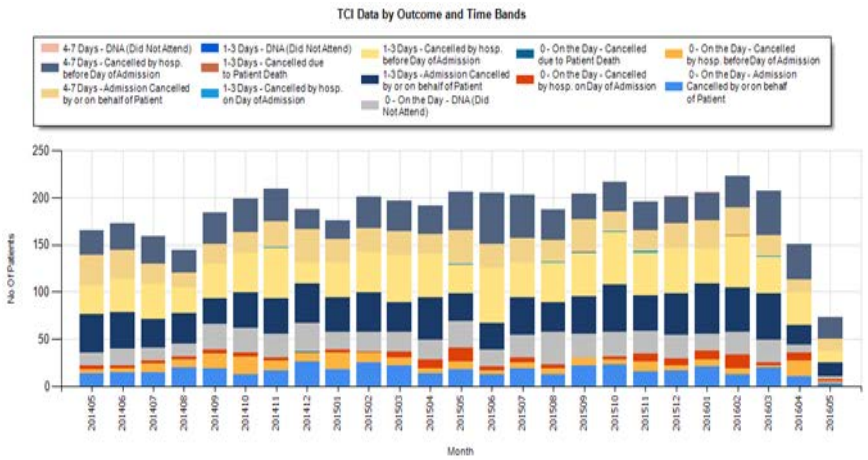
Work required around spinal deformity theatre lists where typically 1 large and complex case is booked, though recent history suggests that there may be time available to now add an additional smaller case at the end.

RISKS / ISSUES

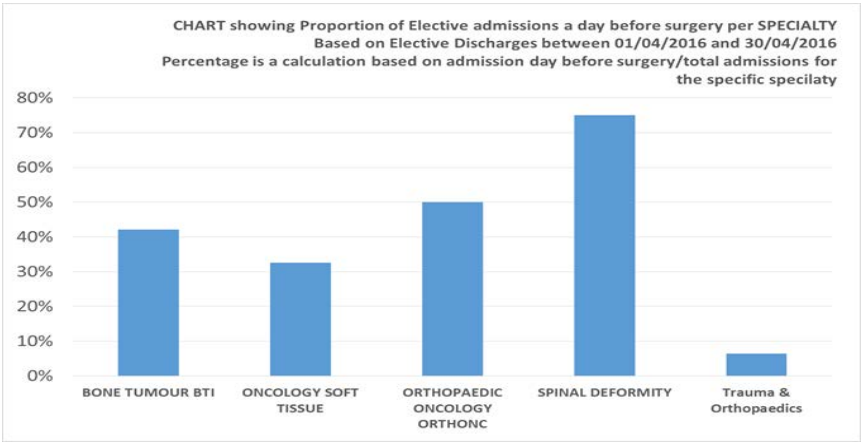
Need to engage with the Spinal Deformity consultants and be mindful potential issues associated with additional booked activity given some of the variation in case length which inevitably will not be known until the day.

11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

Cancellations by patient / hospital

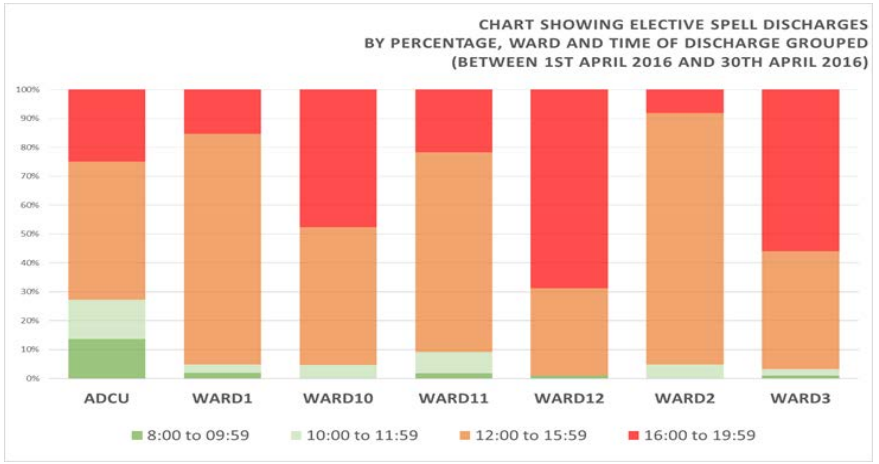


Admission the day before surgery



Delays out of recovery

Time of day patients discharged



INFORMATION

Actions identified and in progress in respect to patient cancellations, as documented within Patient Journey I,I with workstreams in both Divisions 1 and 3. Text reminders are now in place for outpatient appointments and inpatient TCI's, whilst functionality within the InTouch system to mandate the updating of key patient demographics such as mobile telephone number was made live on 26th May 2016 (with manual update to PAS whilst further technical issues are resolved).

Work continues on the wards in respect to timely discharge and admissions prior to the day of surgery, again with key actions identified and in progress via Patient Journey II, including MDT ward rounds with consultants, full implementation of enhanced recovery programme and timely action of TTO's

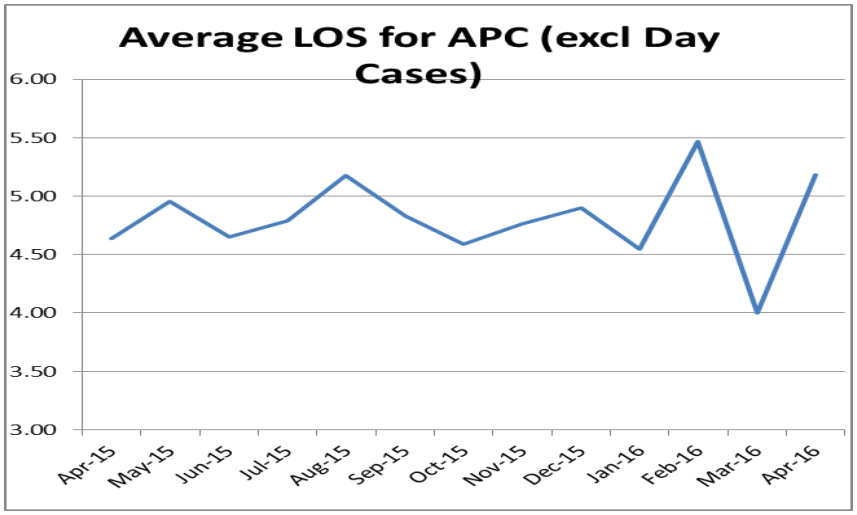
ACTIONS FOR IMPROVEMENTS / LEARNING

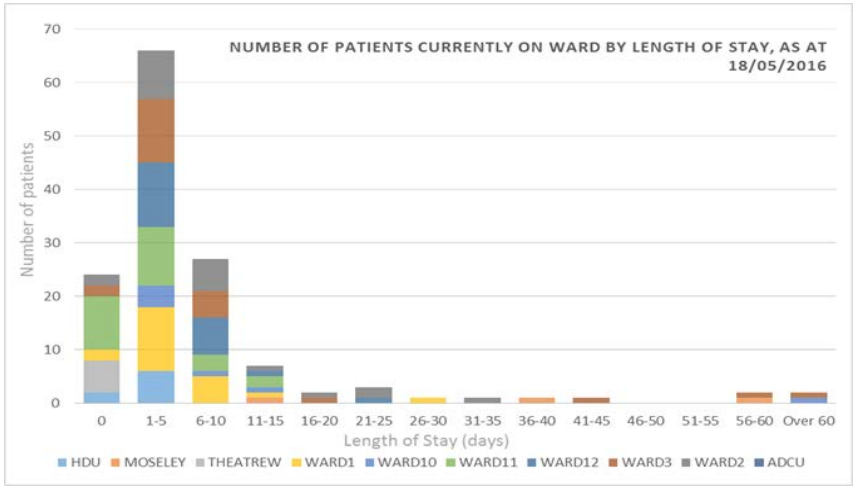
A system demo for NetCall is scheduled for 30th June 2016 with the Senior Operational team and IT representatives. NetCall provide a contact centre platform that integrates auto telephone call and text reminders for outpatient and inpatient appointments, allowing patients to seamlessly be transferred to teams that can help patients rearrange appointments and ensure appointment slots are not wasted via DNA's or late cancellations.

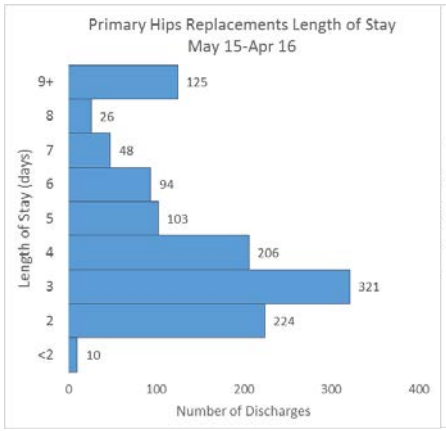
RISKS / ISSUES

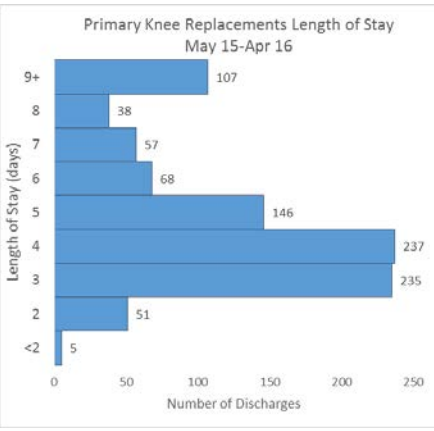
Clinical engagement is key to a significant number of Patient Journey II actions, and as previously raised via TMC the clinical leadership structure within Division 1 is an ongoing concern with a number of posts currently vacant. A meeting is scheduled for 1st June 2016 with Executive and Divisional management colleagues (Divisions 1 and 2) to discuss structural requirements and agree a recruitment campaign.

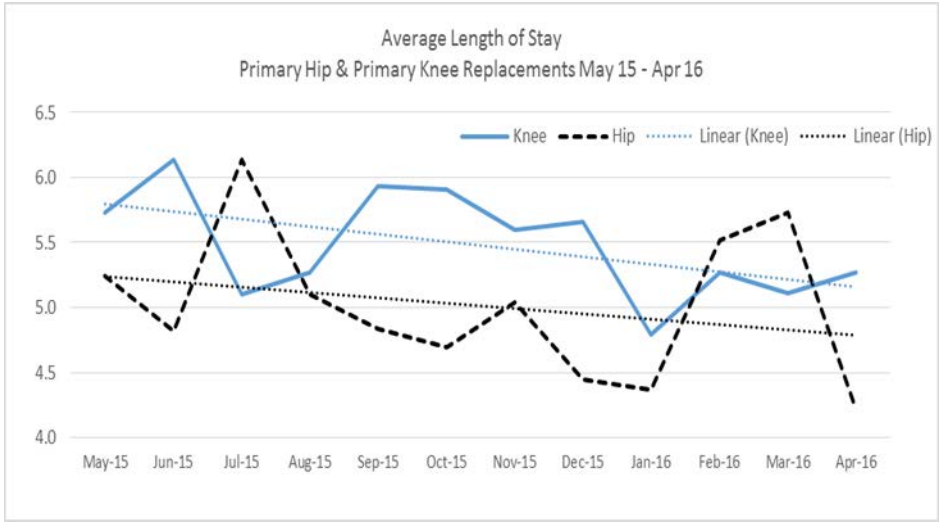
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

As per the actions associated with Patient Journey II, work is ongoing in respect to length of stay.

The latest weekly report (issued 19th May 2016) indicates there are currently 21 patients with a length of stay greater than 10 days, with senior nursing staff sighted on these and updating weekly action plans.

ACTIONS FOR IMPROVEMENTS / LEARNING

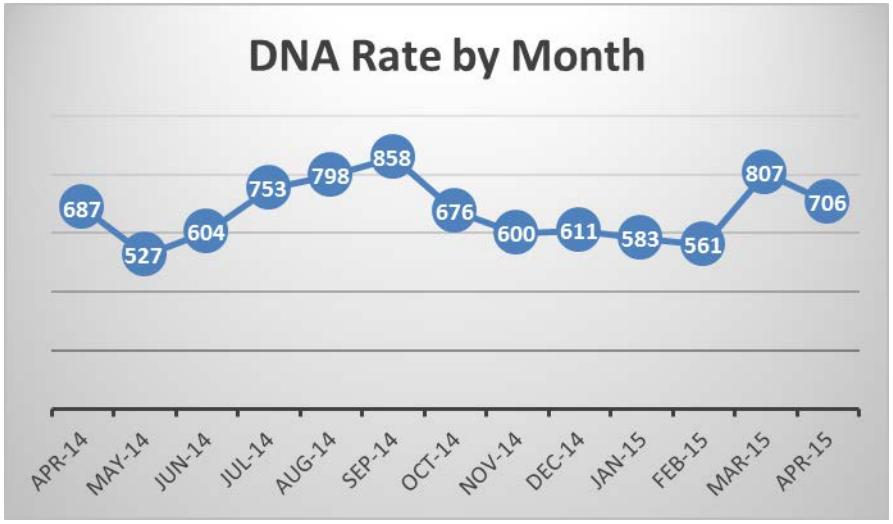
Completion and implementation of revised job plans to ensure consultants fulfil their post-operative care responsibilities in a timely manner.

Wider take up of the Consultant of the Week model of working to more effectively manage patients throughout their pathway.

Cohort management of Bone Infection patients and introduction of the Bone Infection MDT with the aim of significantly reducing LOS for this group of patients.

RISKS / ISSUES

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients



Graph showing average waiting time in outpatients by month

Graph showing under / overbooking of clinic by specialty

INFORMATION

Actions identified and in progress in respect to DNA's as documented within Patient Journey II with workstreams in both Divisions 1 and 3. Text reminders are now in place for outpatient appointments and inpatient TCI's, whilst functionality within the InTouch system to mandate the updating of key patient demographics such as mobile telephone number was made live on 26th May 2016 (with manual update to PAS whilst further technical issues are resolved).

Work is in progress in respect to new to follow up ratios with Clinical Service Managers reviewing data at consultant level, with some activity now capped by our commissioners as per recent notices received.

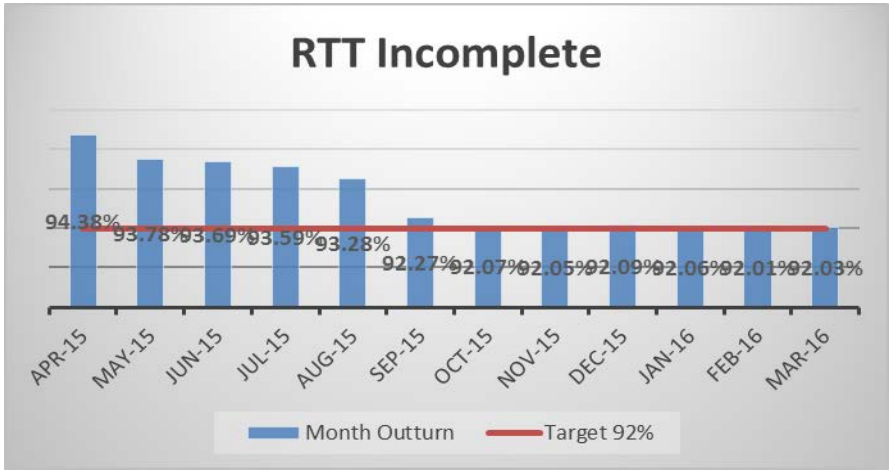
ACTIONS FOR IMPROVEMENTS / LEARNING

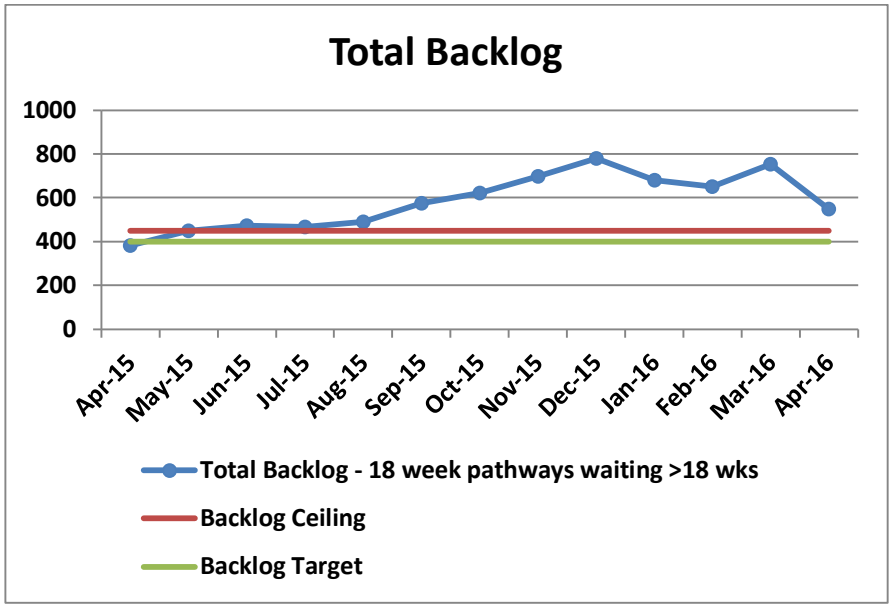
A system demo for NetCall is scheduled for 30th June 2016 with the Senior Operational team and IT representatives. NetCall provide a contact centre platform that integrates auto telephone call and text reminders for outpatient and inpatient appointments, allowing patients to seamlessly be transferred to teams that can help patients rearrange appointments and ensure appointment slots are not wasted via DNA's or late cancellations.

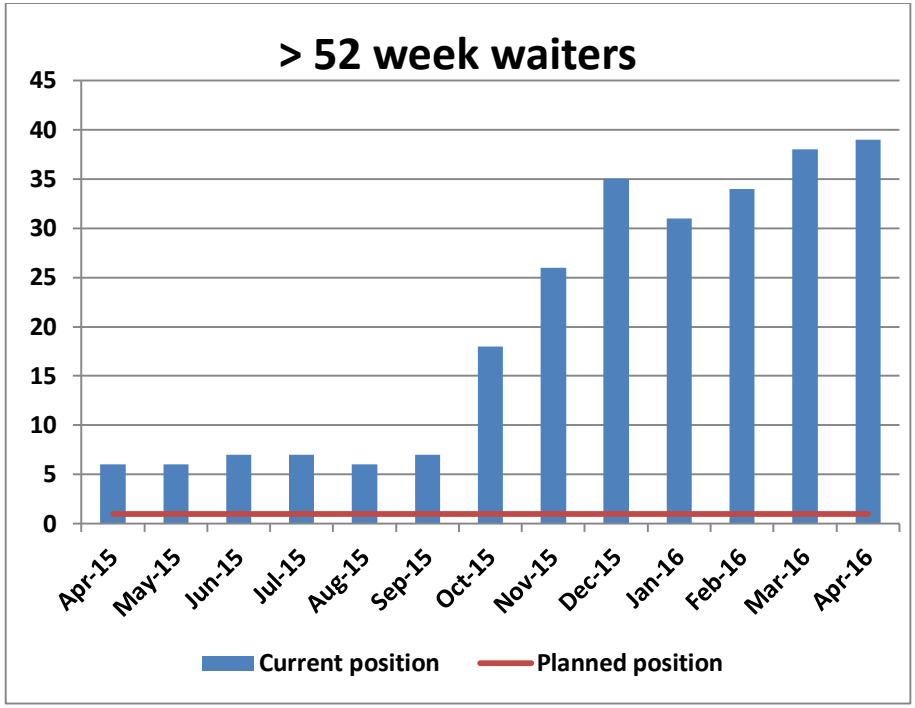
RISKS / ISSUES

Clinical engagement will be required to reduce new to follow up ratios which due to clinical need may not universally apply across all subspecialties.

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets	Target / Trajectory	Actual (April)	Actual (YTD)
52 week waiters	40	39	
18 week RTT	92%	92%	
Cancer (2 week wait)	93%	100%	100%
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	100%
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	100%
Cancer (62 days)	85%		

INFORMATION

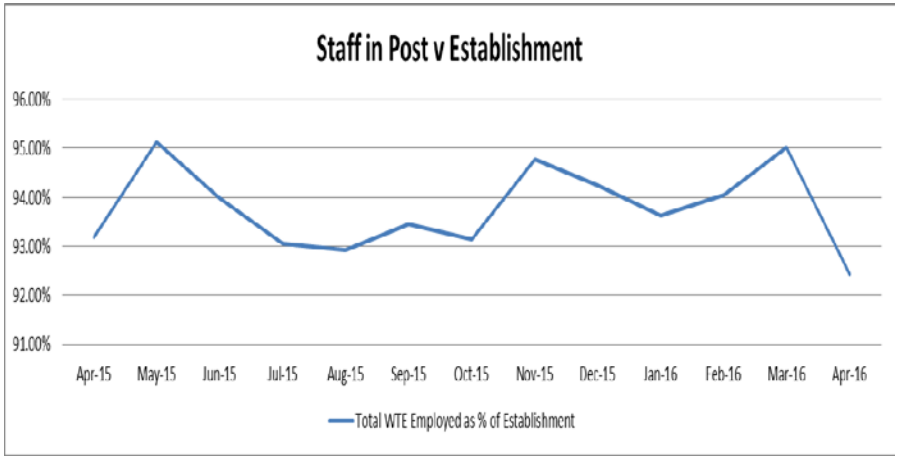
As part of the contact round discussion the Trust has been required to sign up to deliver against a number of performance trajectories, namely against the 92% Incomplete Standard and in respect to 52 Week Breaches.

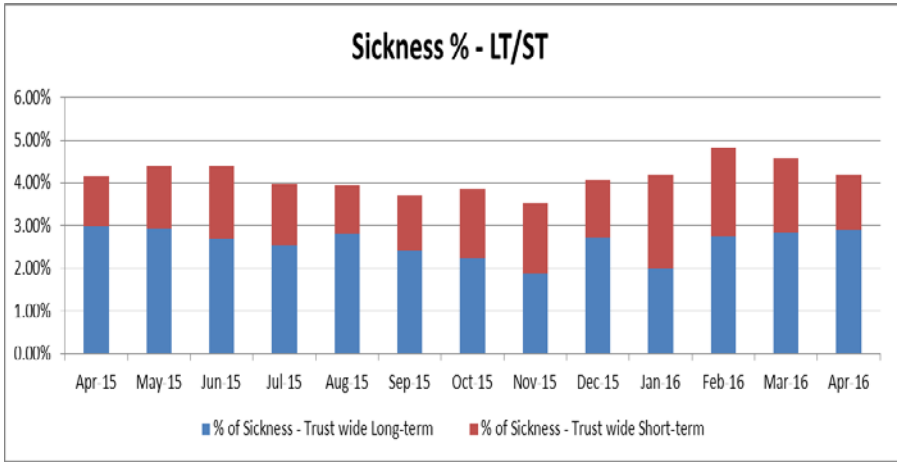
ACTIONS FOR IMPROVEMENTS / LEARNING

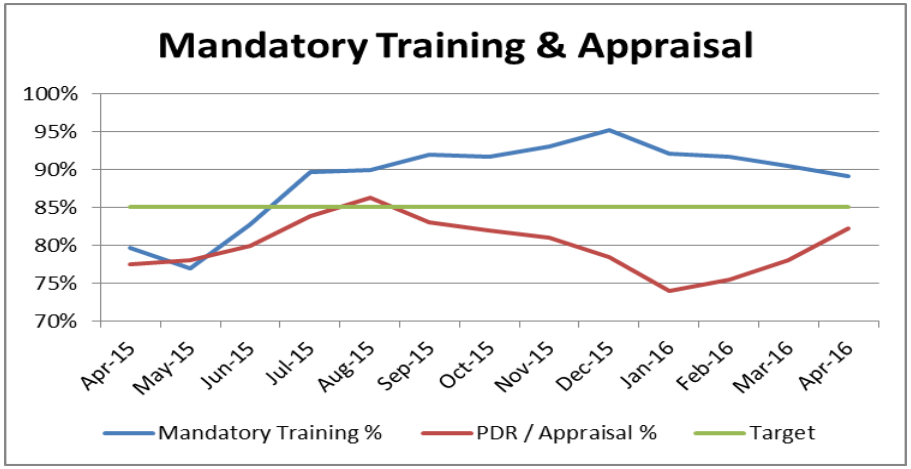
Effective use of additional operating lists at BCH, with potential requirement to treat further 52 weeks breaches in an alternative setting.

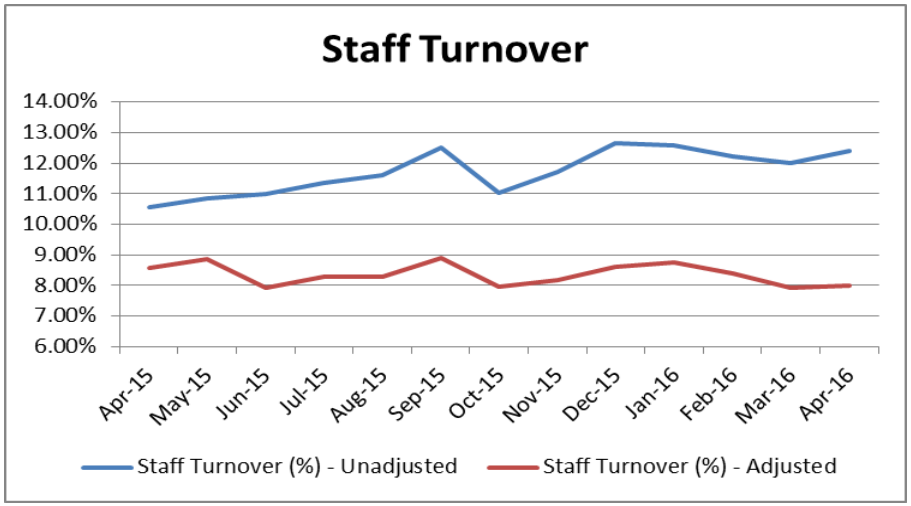
RISKS / ISSUES

15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training









INFORMATION

The vacancy position worsened as expected (to a 7.6% vacancy rate) pending recruitment to substantive posts arising from increases in establishment, particularly in nursing areas.

Sickness absence decreased in April, particularly short term absence, following the introduction of a new policy effective from 1 April.

Statutory and Mandatory training worsened by 2% to slip into high amber, possibly at the expense of increased effort into appraisal, which moved up by 4%.

ACTIONS FOR IMPROVEMENTS / LEARNING

Statutory and Mandatory training and appraisals have been discussed at Divisional Boards in May to seek to maintain progress on appraisal, whilst not slipping back with training.

RISKS / ISSUES

GOVERNANCE DEPARTMENT

QUALITY REPORT

MAY 2016

EXECUTIVE DIRECTOR: GARRY MARSH *DIRECTOR OF NURSING AND GOVERNANCE*
DEPUTY DIRECTOR: ANNE CROMPTON *DEPUTY DIRECTOR OF NURSING AND GOVERNANCE*
AUTHOR: MUSTAFA AHMED *GOVERNANCE MANAGER*

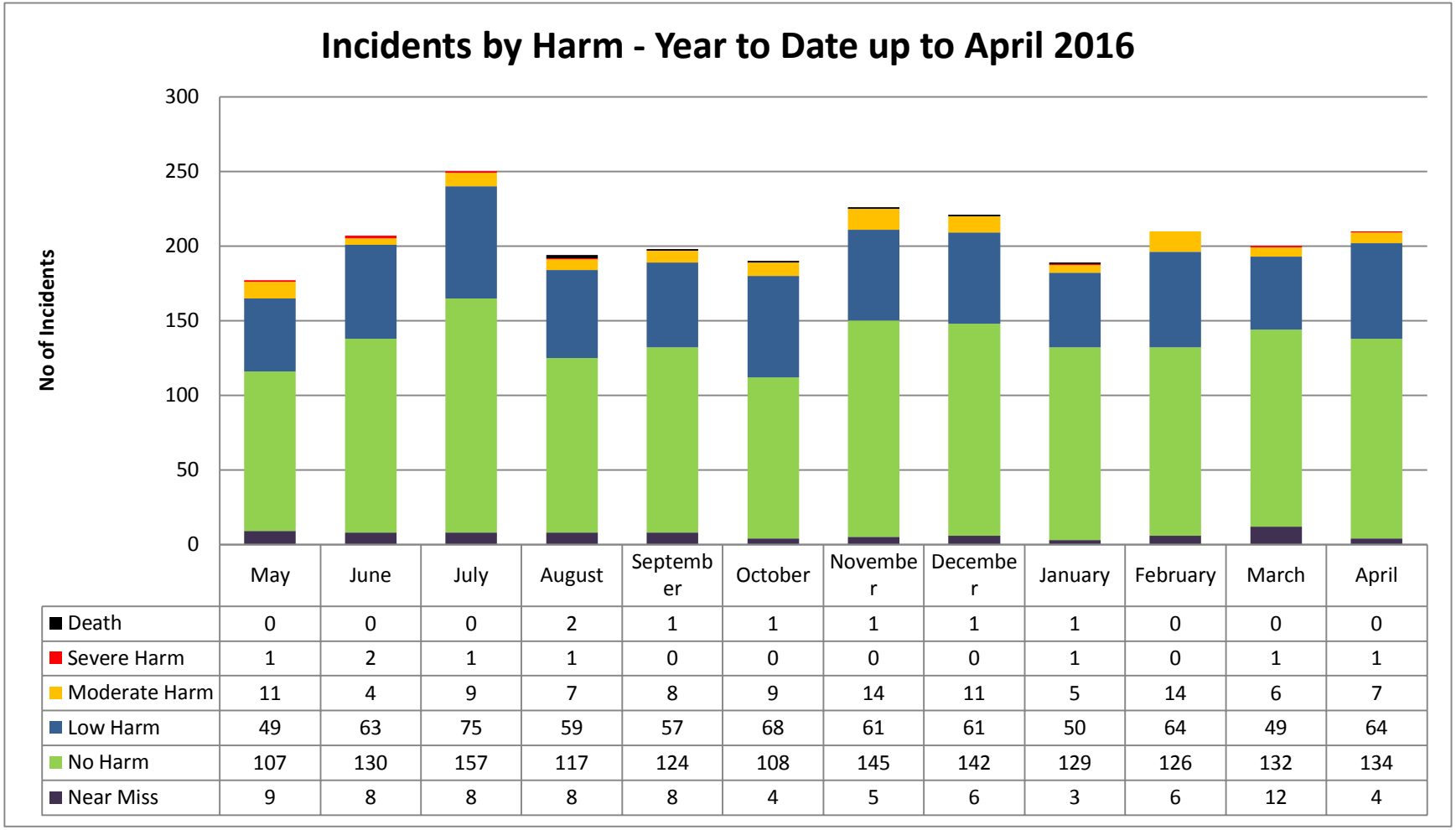
CONTENTS

1. INTRODUCTION

This Quality Report aims to increase accountability and drive quality improvement within The Royal Orthopaedic Hospital NHS Trust (ROH). Through this report, the Governance Department will review performance from the beginning of the financial year to date, identify areas for improvement, and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

This Quality Report is a dynamic document, the data being used has been validated with the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this Quality Report with visually appealing illustration as well as narrative to address queries respective readers may have.

2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff year to date. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.

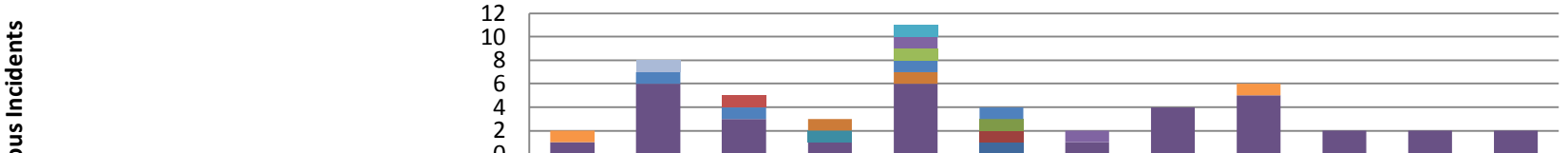


	May	June	July	August	September	October	November	December	January	February	March	April
Death	0	0	0	2	1	1	1	1	1	0	0	0
Severe Harm	1	2	1	1	0	0	0	0	1	0	1	1
Moderate Harm	11	4	9	7	8	9	14	11	5	14	6	7
Low Harm	49	63	75	59	57	68	61	61	50	64	49	64
No Harm	107	130	157	117	124	108	145	142	129	126	132	134
Near Miss	9	8	8	8	8	4	5	6	3	6	12	4

INFORMATION
There were 210 incidents reported in April 2016, including: 1 Severe Harm 7 Moderate Harms 4 Near Misses
ACTIONS FOR IMPROVEMENTS / LEARNING
Training will be delivered to all staff on the Incident Reporting and Duty of Candour process in Quarter 1 and 2. This will include details of how to categorise, grade and complete an incident to maximise its effectiveness.
RISKS / ISSUES
There is delay in the response from managers when a request is made to amend incidents' harm ratings.

3. **Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.**

Serious Incidents - Declared Year to Date up to April 2016



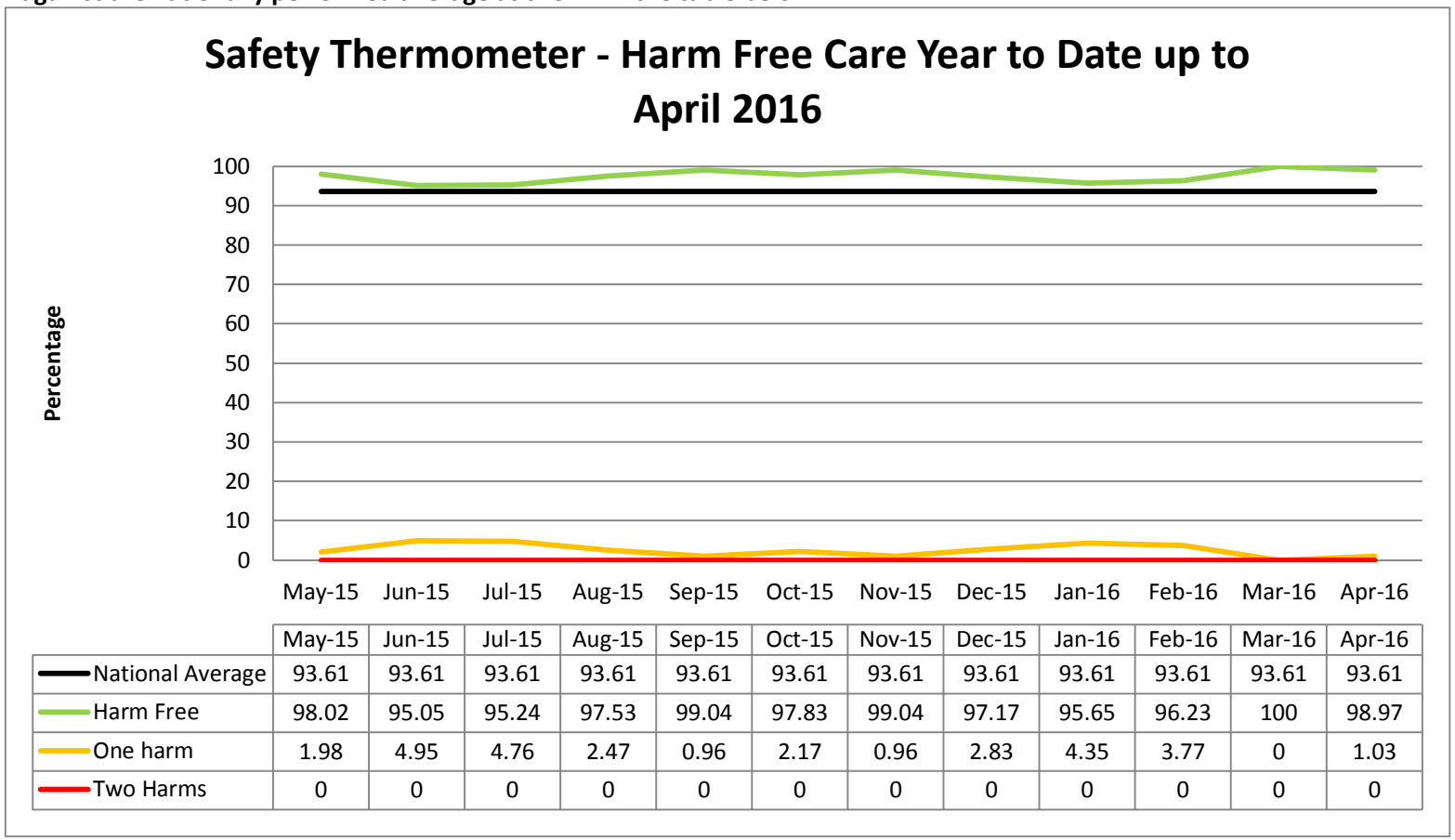
	May	June	July	August	September	October	November	December	January	February	March	April
Commissioning incident		1										
Delayed diagnosis	1								1			
Wrong side injection					1							
Unexpected deaths					1		1					
Staff conduct incidents					1							
Slips, trips & falls			1									
Pressure Ulcers		1	1		1	1						
Emergency transfer out of Trust				1	1							
Appointment delay				1								
VTE meeting SI criteria	1	6	3	1	6		1	4	5	2	2	2
Surgical Invasive procedure incident meeting SI criteria						1						
Emergency transfer to HDU						1						
Failure to act on test results						1						

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

INFORMATION
There were two Serious Incidents (SI) declared in April 2016. These were two VTEs discovered post discharge.
ACTIONS FOR IMPROVEMENTS / LEARNING
5 SIs were submitted to Commissioners in April 2016. 4 VTE SIs; recommendations multifarious but were framed around four key areas: *Individual Level; Interdepartmental Communications; Multi Displinary Team and Growth in Oncology Department & MDT*
RISKS / ISSUES
None identified.

4. **NHS Safety Thermometer - provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month. In February 2016, a revised standard operating procedure for the collection of data was introduced at ROH. It is of note that ROH continues to perform well against the nationally performed average as shown in the table below.**



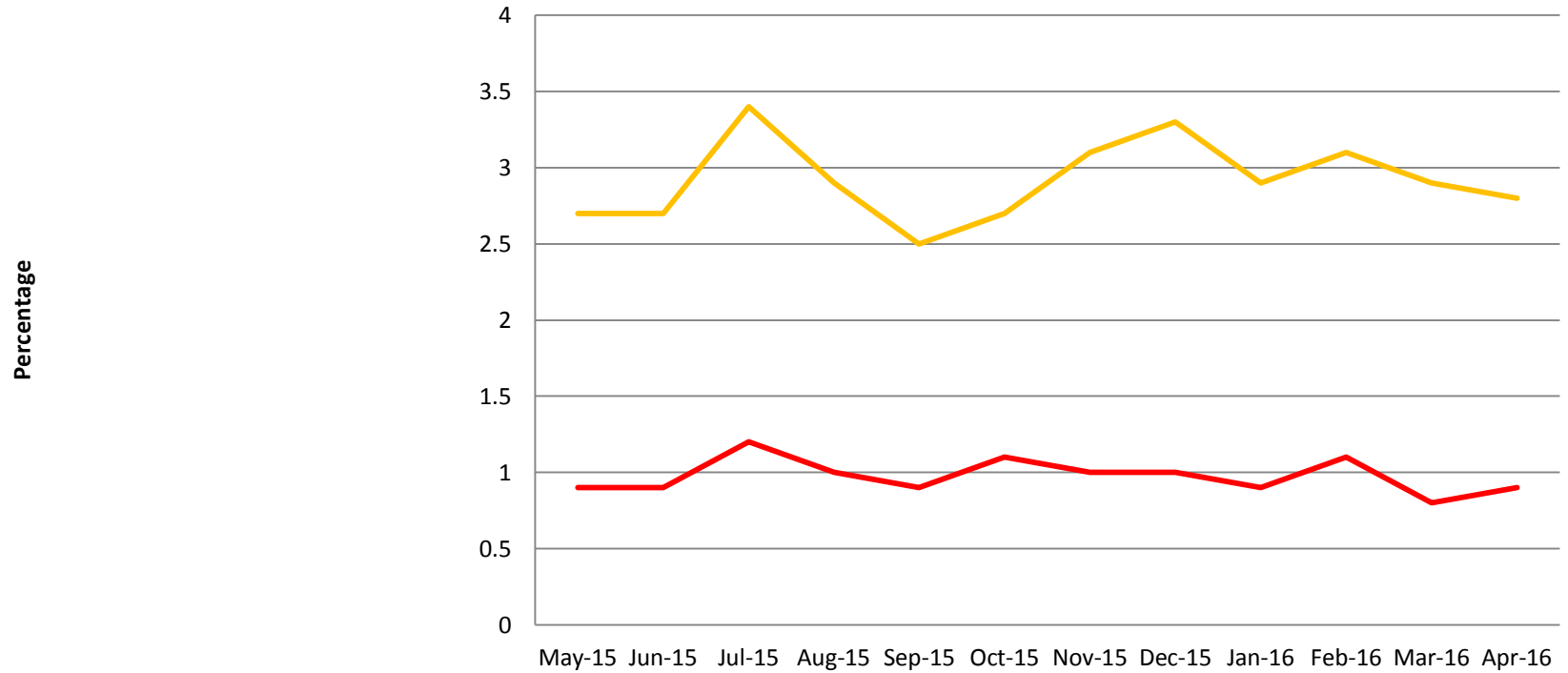
	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
National Average	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61
Harm Free	98.02	95.05	95.24	97.53	99.04	97.83	99.04	97.17	95.65	96.23	100	98.97
One harm	1.98	4.95	4.76	2.47	0.96	2.17	0.96	2.83	4.35	3.77	0	1.03
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

5. **All patient contact and harm – In contrast to the Safety Thermometer which measures the number of harm on one particular day of the month, the following data represents the total number of patient contacts in April 2016 compared to all incidents reported and incidents resulting in harm. Harm includes low harm, moderate harm, severe harm and deaths.**

	Low Harm	Moderate Harm	Severe Harm	Death	Total Incident with Harm	All Incidents Total	Total Patient Contacts
May-15	49	11	1	0	61	177	6541
Jun-15	63	4	2	0	69	207	7657
Jul-15	75	9	1	0	85	250	7378
Aug-15	59	7	1	2	69	194	6651
Sep-15	58	8	0	1	67	195	7700
Oct-15	68	9	0	1	78	190	7082
Nov-15	61	14	0	1	76	226	7251
Dec-15	61	11	0	0	72	220	6714
Jan-16	50	5	1	1	57	189	6627
Feb-16	64	14	0	0	78	210	6768
Mar-16	49	6	1	0	56	200	6862
Apr-16	64	7	1	0	72	210	7636

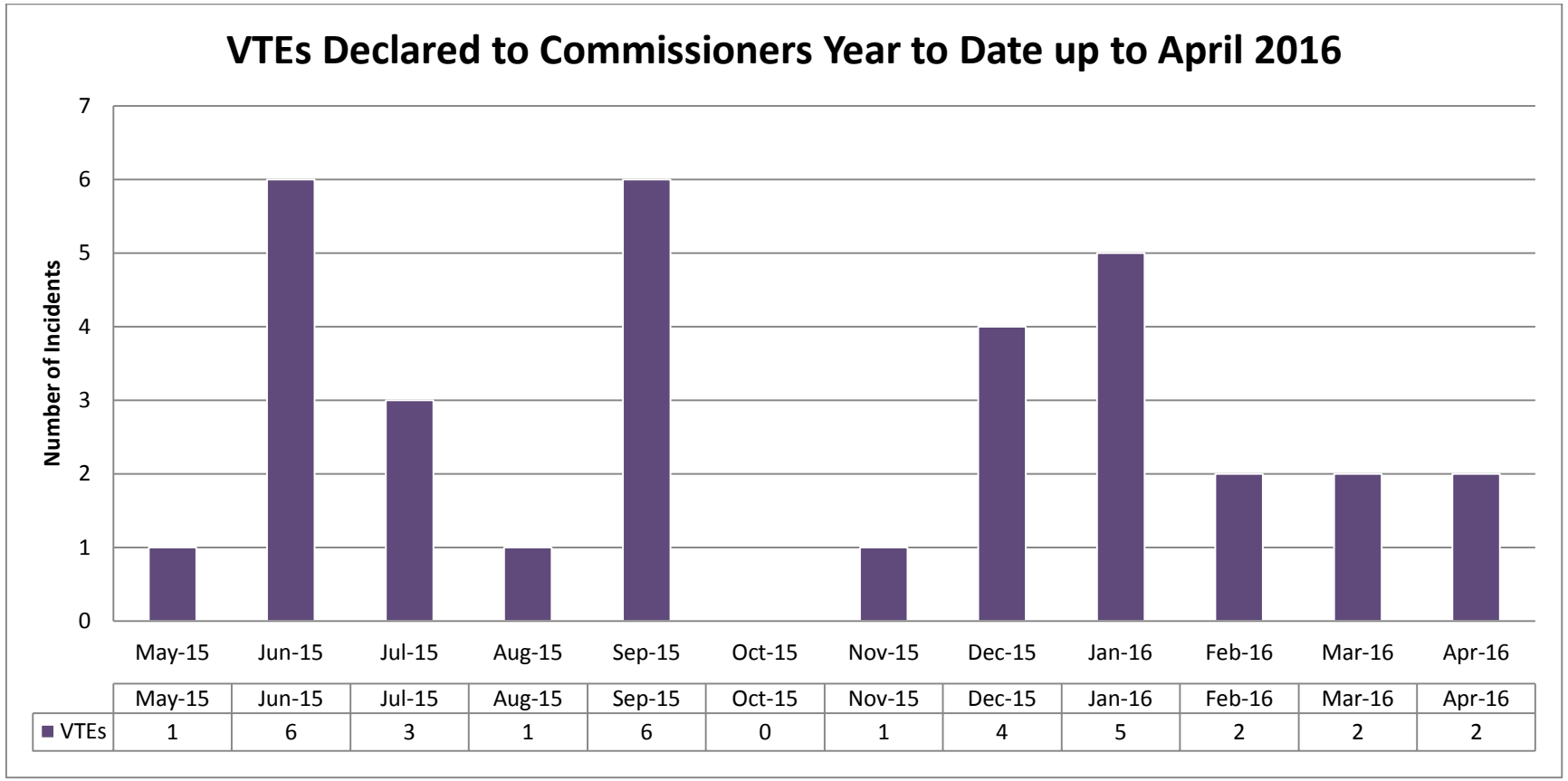
In April 2016, there were a total of 7636 patient contacts. There were 210 incidents reported which is 2.8 percent of the total patient contacts. Of those 210 reported incidents, 72 incidents resulted in harm which is 0.9% of the total patient contact for the month. We are looking into the possibility of benchmarking this data with similar organisations and will include the data as and when it is available.

% of Patient Contact Compared to Number of Incidents and Incidents with Harm Year to Date up to April 2016



	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
% of Patient Contacts with Incidents Causing Harm	0.9	0.9	1.2	1	0.9	1.1	1	1	0.9	1.1	0.8	0.9
% of Patient Contact With All Incidents Reported	2.7	2.7	3.4	2.9	2.5	2.7	3.1	3.3	2.9	3.1	2.9	2.8

6. **VTEs - A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called a venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism).**



	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
VTEs	1	6	3	1	6	0	1	4	5	2	2	2

INFORMATION

There were two VTE incidents in April 2016. These were both declared as SIs.

These were discovered post discharge.

ACTIONS FOR IMPROVEMENTS / LEARNING

4 VTE SIs were submitted in April 2016;

One of the requirements for The Quality Schedule for 2015/16 is an audit of service Users' risk of VTEs and of the percentage of Service Users assessed for VTEs who receive the appropriate prophylaxis, and the Provider must report the results of those audits to the Co-ordinating Commissioner. The target for 2015/16 is 95% compliance

The findings where non-compliance was deemed as none prescription as per guidance **or** there being no documented reason for deviation from Trust guidance. Where the reason was clearly identified by medical staff this was considered as compliance. For example there were a number of documented deviations such as reduced renal function or bleeding risk.
It was noted in Oncology where bleeding risk is an issue, surgeons are documenting that Enoxaparin is to start 24 hours post operatively.

Some patients identified as higher risk whose procedures / risks were not specifically covered within the guidelines were also given Thromboprophylaxis. Requirements in each instance were clear in the Surgeon's operation notes.

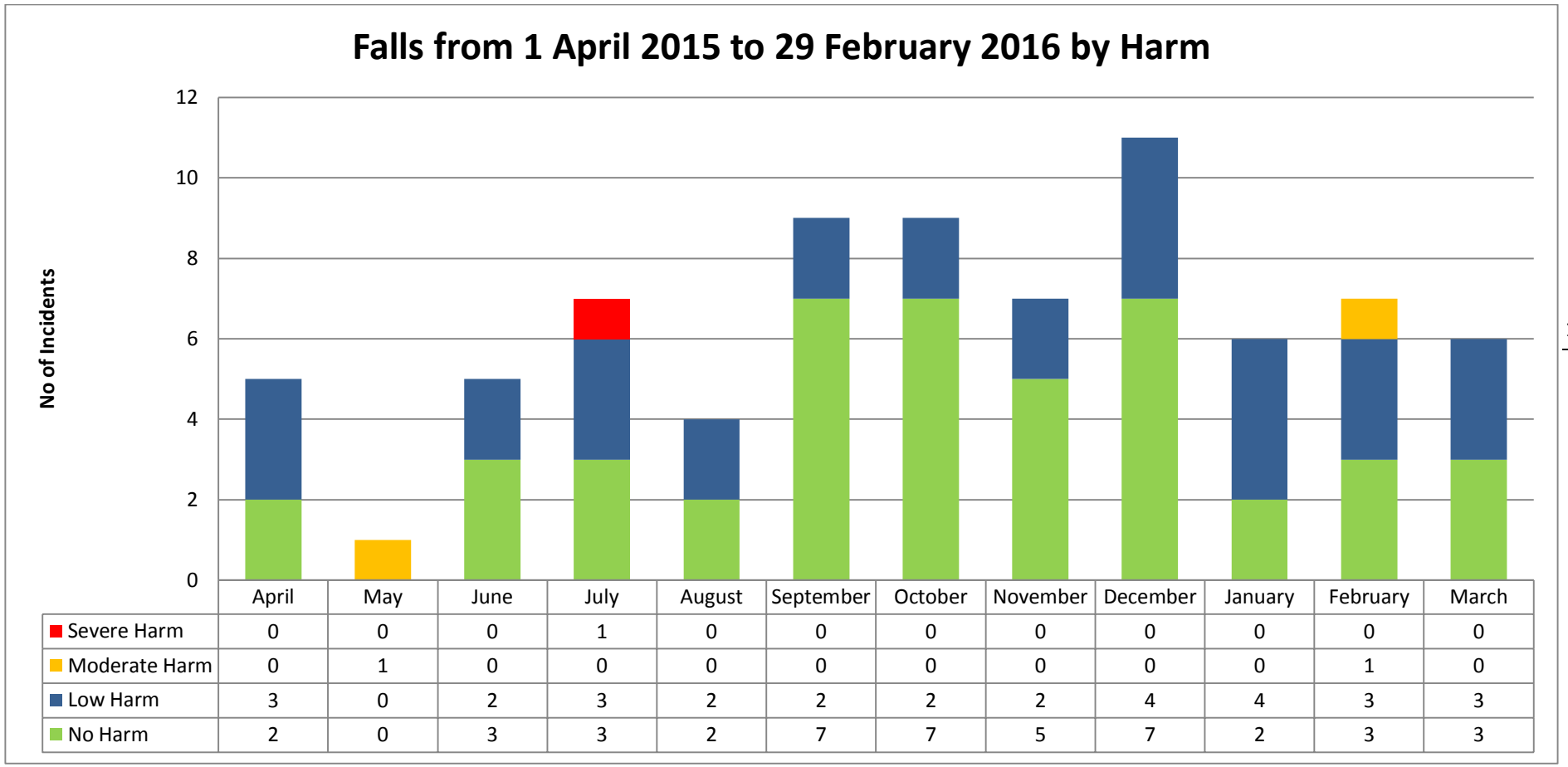
Within the audit the above is considered compliance, as decision had been based on individual risk factors and specifically requested by surgeon.

Of the 30 notes audited **30 (100%)** were deemed compliant with current trust guidance on VTE pharmacological prophylaxis.

RISKS / ISSUES

None identified.

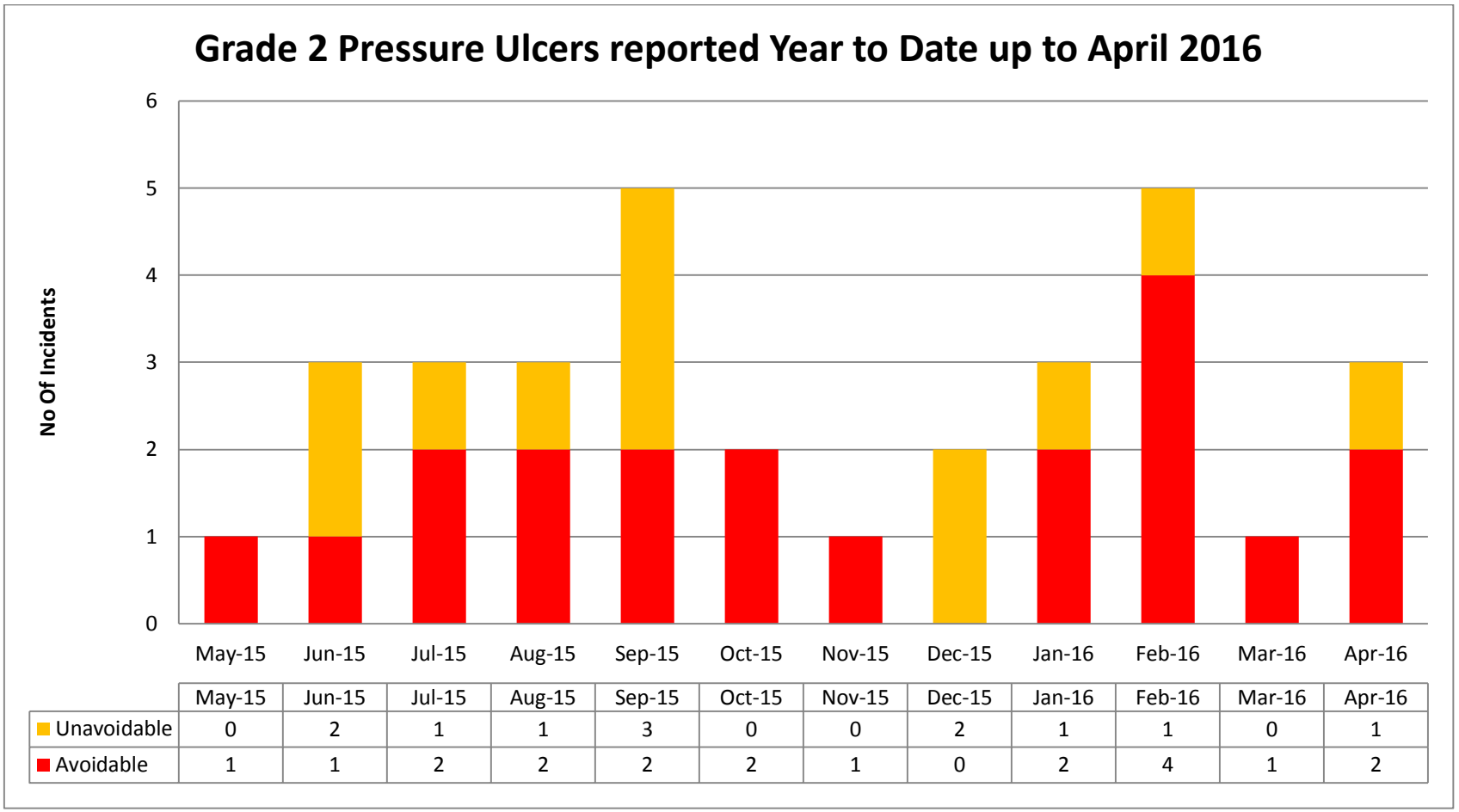
7. **Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident.**



	April	May	June	July	August	September	October	November	December	January	February	March
Severe Harm	0	0	0	1	0	0	0	0	0	0	0	0
Moderate Harm	0	1	0	0	0	0	0	0	0	0	1	0
Low Harm	3	0	2	3	2	2	2	2	4	4	3	3
No Harm	2	0	3	3	2	7	7	5	7	2	3	3

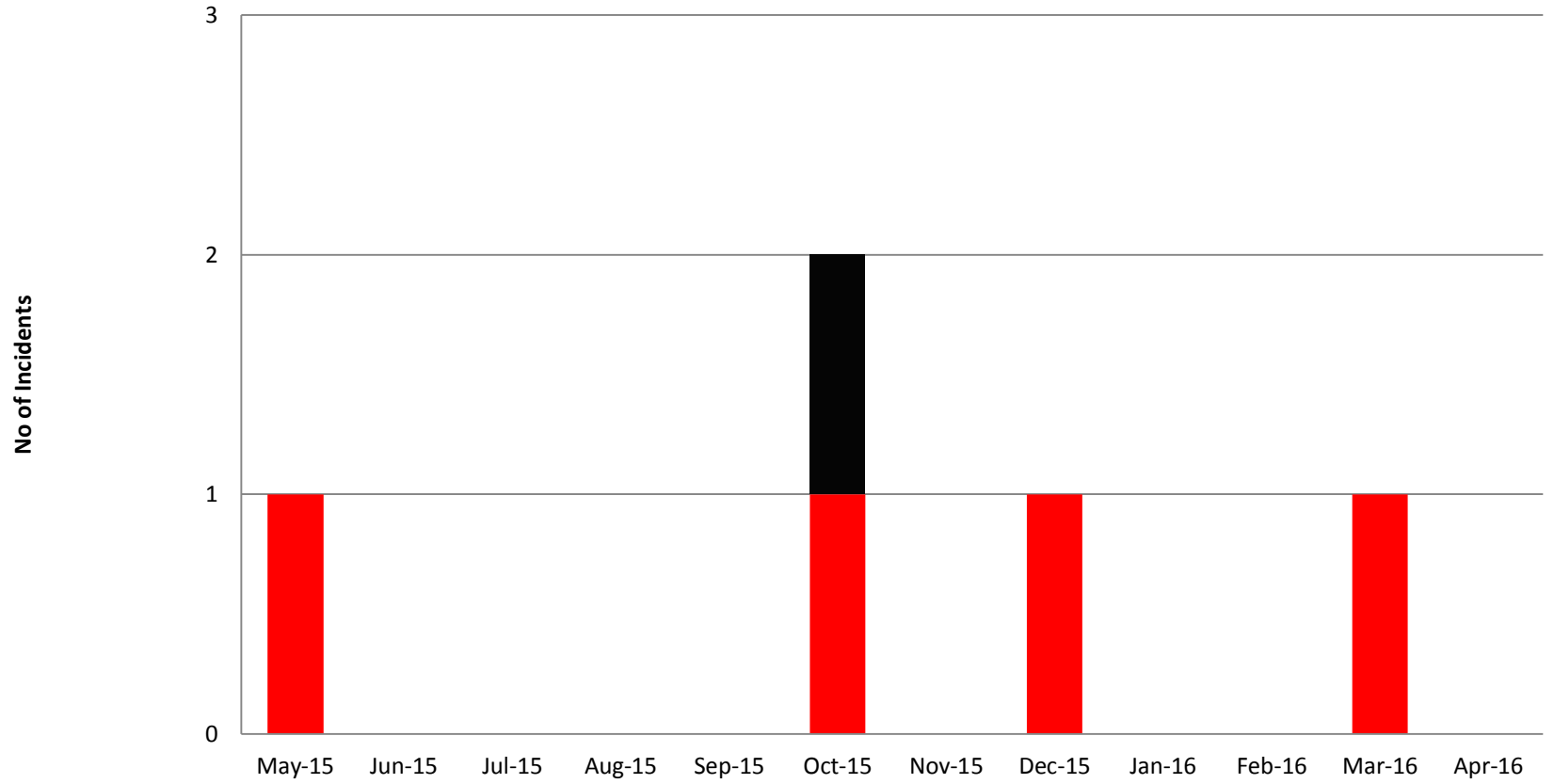
INFORMATION
The responsibility for Falls is currently within the remit of the Deputy Director of Nursing & Clinical Governance while a dedicated falls lead is identified.
ACTIONS FOR IMPROVEMENTS / LEARNING
An update will be provided in next month's report.
RISKS / ISSUES
As above.

8. **Pressure Ulcers - are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.**



	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Unavoidable	0	2	1	1	3	0	0	2	1	1	0	1
Avoidable	1	1	2	2	2	2	1	0	2	4	1	2

Grade 3 & 4 Pressure Ulcers reported Year to Date up to April 2016



	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Grade 4 (Avoidable)						1						
Grade 3 (Avoidable)	1					1		1			1	

INFORMATION

In April there were 3 grade 2 hospital acquired pressure ulcer incidents. Subsequent to further investigation;

2 were deemed avoidable;

1 was deemed unavoidable;

ROH contractual limit for Pressure Ulcers in 2015/16
Grade 2 Avoidable Limit is 15 - at **April 2016 = 2 avoidable**
Grade 3/4 Avoidable Limit is 0 **- at April 2016 = 0 avoidable**

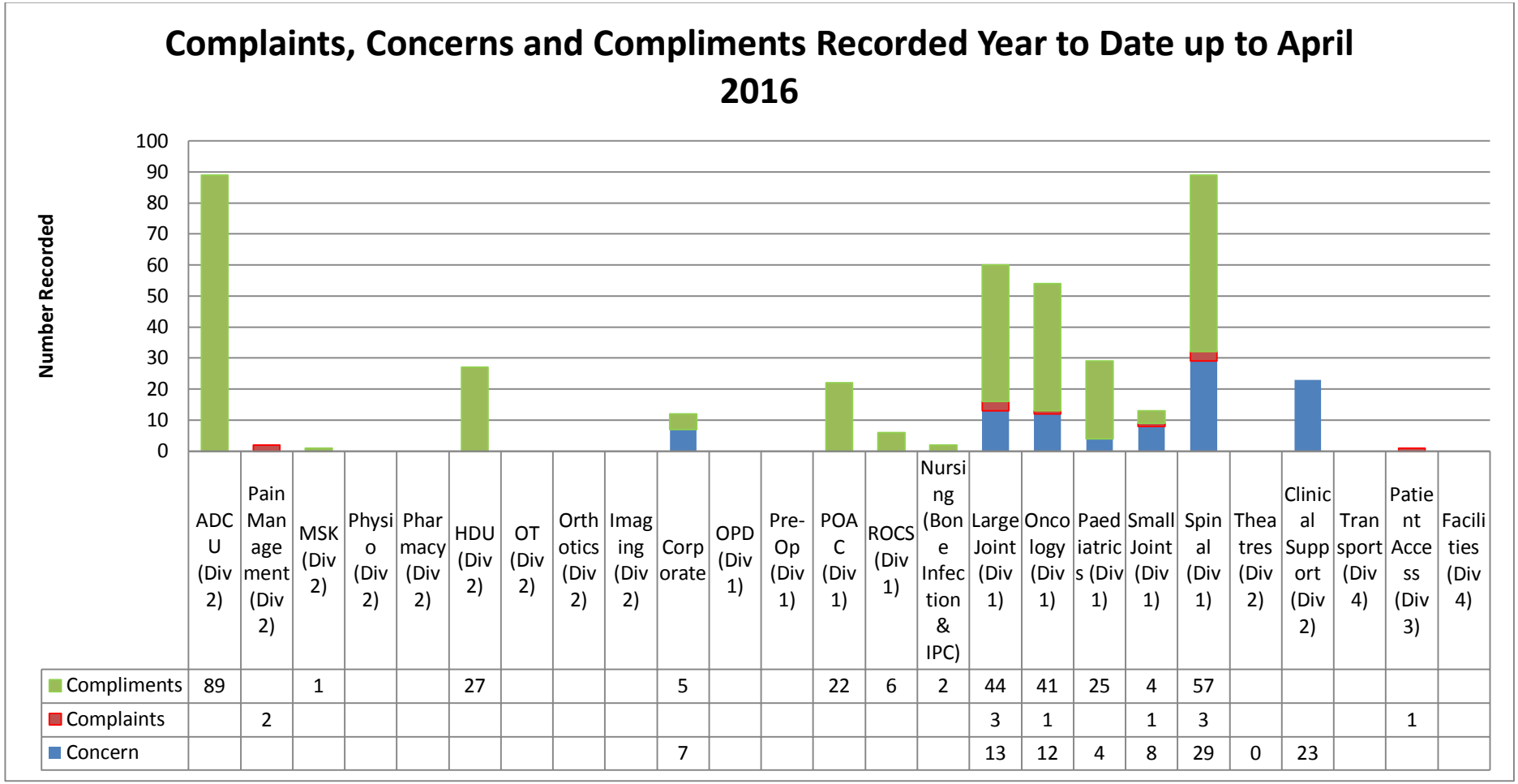
ACTIONS FOR IMPROVEMENTS / LEARNING

A pressure ulcer reduction plan has been developed in order to reduce the number of grade 2 pressure ulcers and eliminate all grade 3 and grade 4 pressure ulcers for 2015/16. There are 10 actions of which all have been commenced and are ongoing.

RISKS / ISSUES

There is a risk of a financial penalty to the Trust by the Commissioners in the event of the exceeding the quota of pressure ulcers as stipulated in the contract.

9. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



	ADCU (Div 2)	Pain Management (Div 2)	MSK (Div 2)	Physio (Div 2)	Pharmacy (Div 2)	HDU (Div 2)	OT (Div 2)	Orthotics (Div 2)	Imaging (Div 2)	Corporate	OPD (Div 1)	Pre-Op (Div 1)	POAC (Div 1)	ROCS (Div 1)	Nursing (Bone Infection & IPC)	Large Joint (Div 1)	Oncology (Div 1)	Paediatrics (Div 1)	Small Joint (Div 1)	Spinal (Div 1)	Theatres (Div 2)	Clinical Support (Div 2)	Transport (Div 4)	Patient Access (Div 3)	Facilities (Div 4)
Compliments	89		1			27				5			22	6	2	44	41	25	4	57					
Complaints		2														3	1		1	3				1	
Concern										7						13	12	4	8	29	0	23			

INFORMATION

In April there were 11 complaints, 96 concerns and 323 compliments received.

The complaints received include;
1. Family of patient experienced poor communication and repeated changes to appointments (Div 1, Spinal)
2. Delays to finding suitable site for surgery as op cannot be performed at ROH due to complex issues (Div 1, Large Joint)
3. Delays to transfer to ROH and whether that affected outcome (Div 1, Oncology)
4. Delays to surgery (Div 1, Spinal)
5. Unacceptable delay to see Pain Management Consultant (Div 2, Pain Management)
6. Query over clinical information given (Div 1, Spinal)
7. Extended waits in OPD for clinic appointments (Div 1, Small Joints)
8. Repeated cancellation of OPD appointments (Div 2, Pain Management)
9. Attitude of Clinician; Discharged unexpectedly (Div 1, Large Joint)
10. Delays in Outpatients (Div 1, Large Joint)
11. Cancellation of appointment, patient not notified (Div 3, Pt Access)

ACTIONS FOR IMPROVEMENTS / LEARNING

19 complaints were closed in April. 10 were upheld, 4 were partially upheld and 5 were not upheld.

Action plans have been developed for all upheld complaints alongside the response which will be monitored through Divisional Team meetings. A copy will also be retained in the complaint file which will be reviewed by the Complaints Manager. Overdue actions will be brought to Clinical Quality Group for review.

Learning identified and actions taken as a result of complaints closed in April 2016 include:

Process for following up additional pre-operative tests is not robust
Action: Review of all pre-op processes underway

PALS phone not always answered
Action: PALS and Complaints staff located in one office for cross-cover

Scheduling of patients for surgery from decision to proceed is not uniform process
Action: Review of operational pathways for listing patients in underway

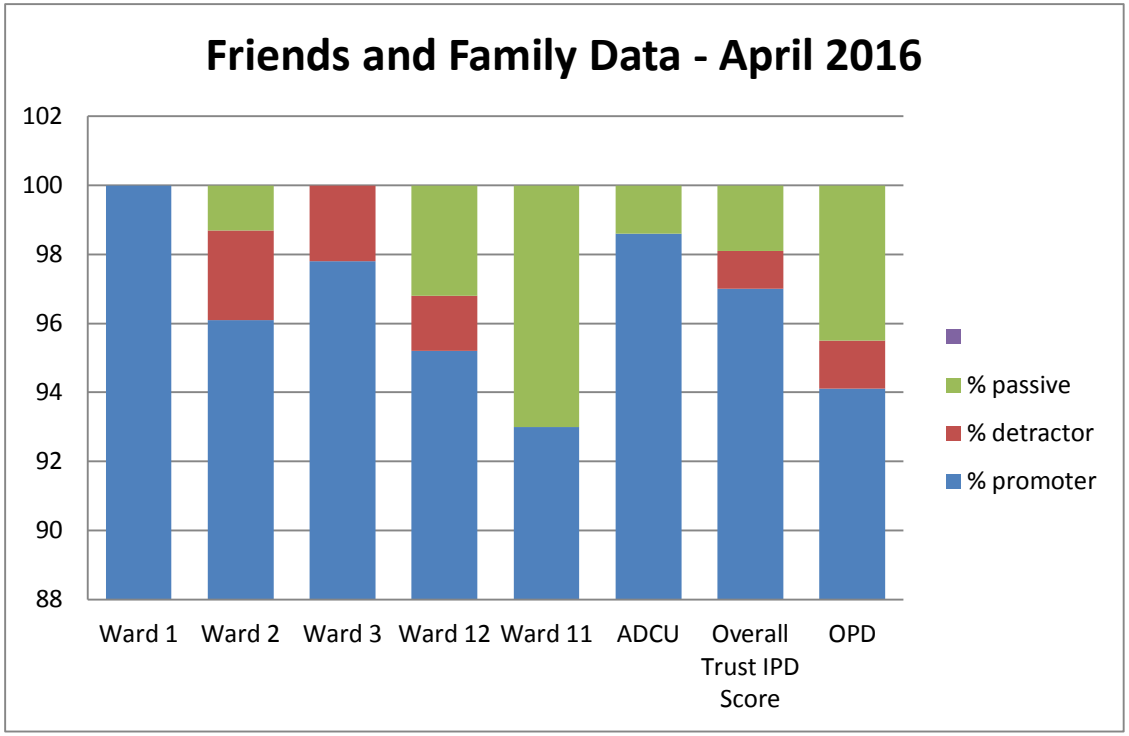
RISKS / ISSUES

Nothing to highlight.

10. Friends and Family Test Results - The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

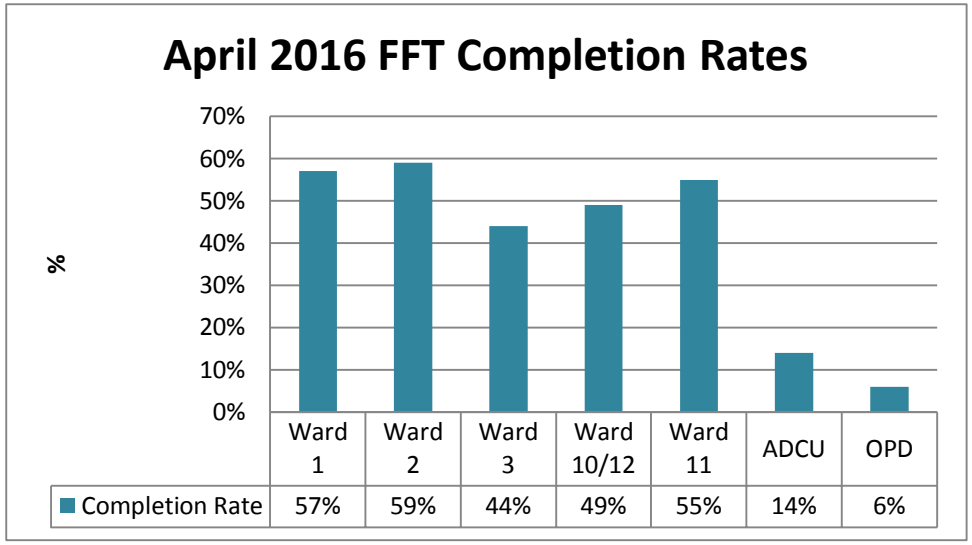
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting patient choice

This is a positive percentage score and it can be seen that almost all patients that we care for would recommend ROH to their family and friends.



The Scores for Friends and Family are now calculated using a straightforward percentage response to the question 'How likely are you to recommend this area to friends or family if they require similar care or treatment?' Any patients answering the question as Extremely Likely / Likely are classified as Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely/Extremely Unlikely are classified as negative.

The percentages for all inpatient activity for April 2016 are 97% of those who responded would promote ROH and 1.1% would not.



There is an improvement plan in place for the Communications Department to increase the level of responses in the OPD and ADCU. Actions include having extra forms available for patients to complete and prompting staff members to ask patients to complete the forms. The possibility of additional software to aid this process is also being explored.

11.Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.

There are currently 10 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20. At present all cases are compliant

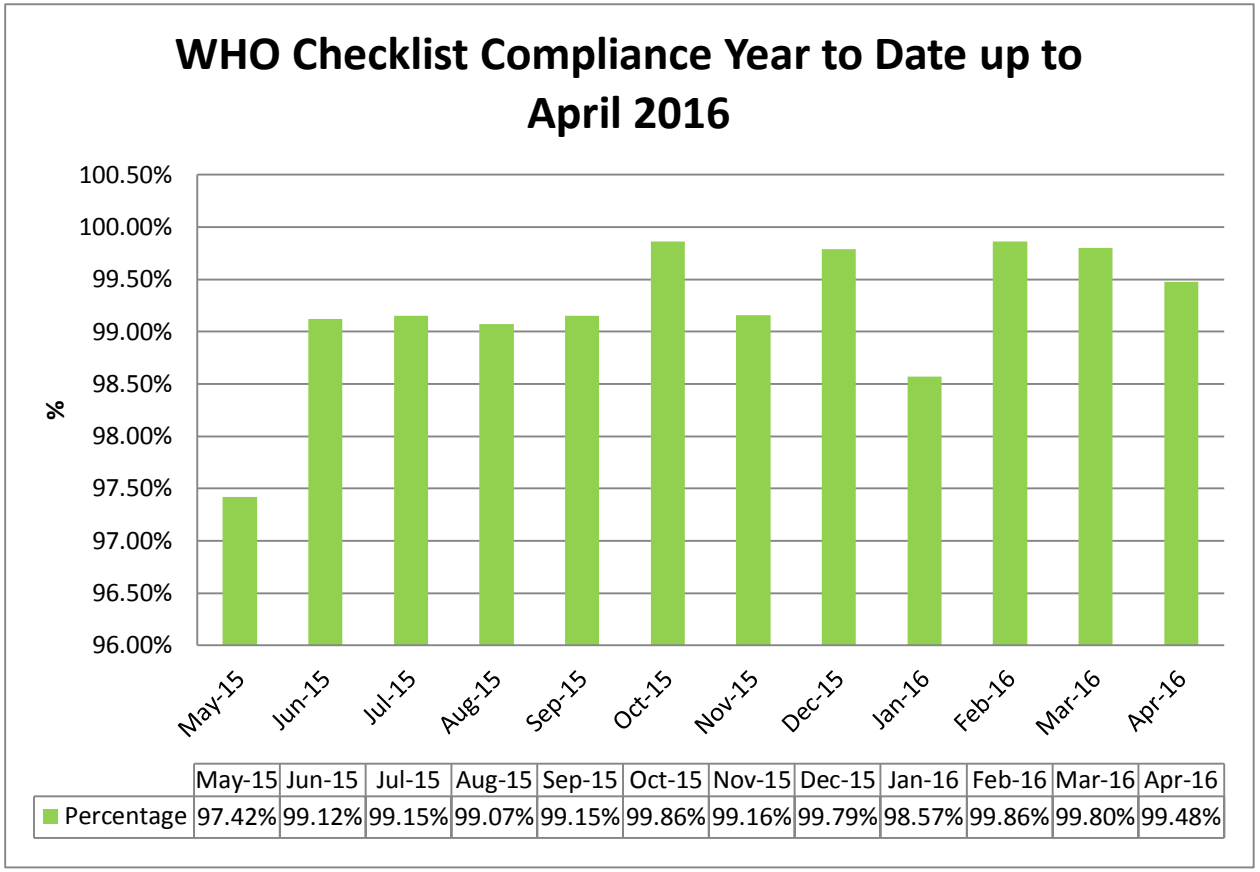
12. Litigation – Current litigation involving ROH

There has been no new litigation cases in April 2016.

There have been 2 case closures.

Although there are various ways in which lessons are shared across the organisation, work is needed to make the triangulation of information between Incidents, Complaints and Litigation more systematic. A project is underway to update the Ulysses risk management tool to mitigate this risk. An update will be provided next month.

13. **WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases of perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**



	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Percentage	97.42%	99.12%	99.15%	99.07%	99.15%	99.86%	99.16%	99.79%	98.57%	99.86%	99.80%	99.48%

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

INFORMATION

Total Cases in April 2016 = 579

Sign Out = 3 Non-Compliance

Total Non-Compliance = 3

Total Compliance = **99.48% Total**

ACTIONS FOR IMPROVEMENTS / LEARNING

The following recommendations are made following the audit collation:

1. Quarterly report to be disseminated to the Medical director, Clinical Directors, Clinical Leads, Consultants and Team Leaders.
2. Directorates with consistent 100% compliance to share best practice.
3. Continue with weekly and monthly reporting to the Medical Director and Director of Nursing & Governance.
4. Monthly reporting to the Commissioners.
5. Non-compliance percentages and incomplete sections and areas of the WHO Patient Safety Checklist to continue to be emailed directly to the Consultant and the staff member involved.

RISKS / ISSUES

None identified.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (6/16) 005

TRUST BOARD

DOCUMENT TITLE:	**Nurse Staffing Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Executive Director of Nursing and Clinical Governance**
AUTHOR:	**Ms Anne Crompton, Deputy Director of Nursing and Clinical Governance**
DATE OF MEETING:	**1st June 2016**

EXECUTIVE SUMMARY:

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. This paper provides the Trust Management Committee with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for April 2016.

REPORT RECOMMENDATION:

The Trust Board is asked to note:

- That the vacancy rate has increased for all ward areas as expected in April 2016 to 13.99 WTE.
- Good progress has been made against the appointment of the paediatric vacancies in HDU with 1 post filled by an internal applicant and the remaining three by students who will qualify in September 2016.
- That fill rates across the Trust are greater than 95% with the exception of fill rates for unregistered staff on Wards 1, 3 and 11.
- From 1 May 2016, all Trusts must report back monthly CHPPD data to NHS Improvement in order to support the development of a single means of recording and reporting staff deployment.
- A recruitment campaign targeted at student nurses (qualify January 2017) is planned for 31 May 2016.
- The Safer Nursing care tool will be rolled out across the Trust in June 2016.
- A review of HCA establishment in in patient areas will be completed in May 2016 and reported to TMC in July 2016 following completion of the Safer Nursing care tool.
- A gap analysis was completed in April 2016 against the RCN Standards for the Care Of Children and Young People which identifies gaps against two of the key standards.
- Agency use is highest in areas of greatest vacancy and there is continued evidence that ward usage is falling as % of total of spend. Agency use will remain high in Theatres due to the high vacancy rate.

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:

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 report will be circulated to all matrons, general managers and ward sisters.

Trust Management Committee on 25 May 2016.

ROHTB (6/16) 005

Nurse Staffing Report

REPORT TO TRUST BOARD: 1 June 2016

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. This paper provides the Trust Board with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for April 2016 with additional information relating to vacancy and plans for recruitment to vacant posts.

2.0 Workforce Information: Trust Overview of Planned Versus Actual Nursing Hours

The overall nurse staffing fill rate for April 2016 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. The actual staffing levels for April 2016 were manually entered into the data collection spreadsheet by the nurse in charge of the shift and verified by the senior sister and matron. Planned staffing hours are based on funded establishment which provides a minimum ratio of 1 to 8 on day shifts for all adult in patient wards. The planned hours are adjusted each month to allow for the number of days in the month and the number of open beds in the ward area.

Table 1 below provides further detail regarding nurse staffing fill rates for April 2016. The Unify Upload for March 2016 is provided in Appendix 1. In the absence of national guidance ROH will RAG rates each ward against a locally agreed framework as follows: Green, where actual available hours are within 5% of planned, amber within 5 and 10%, and red where the difference is greater than 10%.

Table 1: Detailed Ward Breakdown

	Day		Night	
Ward	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
1	95.6	92.2	100.0%	101,7
2	99.3	98.5	98.3	101.7
3	95	86.4	101.7	91.7
12	99.4%	97.2%	97.8%	95.7%
11	98.7	60.8	100	78.4
HDU	100.4%	105.5	101.7%	-

There has been improvement through April 2016 of shift fill rates for all staff in Ward 1 and for registered nurses in Ward 3. It can also be seen that a number of areas through April 2016 did not achieve >95% fill rate. The areas of greatest pressure are:

- Fill rates for non-registered staff on Ward 3 continues to fall below 95% and day time fill rates have reduced since March 2016. The shortfall has been caused by a combination of long term sickness amongst this staff, group and a number of new vacancies, which has reduced the number of staff available to cover shifts and continues to be managed in line with the Trust Sickness/Absence Policy. The acuity and dependency of patients is monitored on every shift to ensure no patient harm occurs. No patient harm has resulted from the reported deficit.
- The fill rate for non-registered staff on Ward 11 is a consequence of the decision to support some night shift with a HCA member of staff to enable adequate break cover and a nurse in charge. Nights on the paediatric ward are unfunded. The ward template has been amended to reflect this and future reports should adjust for this anomaly. In addition the HCA staff have been supporting the ward clerk rota due to the long term absence of this staff member. The member of staff is being managed in line with Trust sickness and absence processes.

2.1 Changes to the reporting of staffing rates from May 2016.

NHS Improvement have issued new guidance following the publication of the Carter Review (2015) which found that there is not a consistent way to record and report staff deployment and recommended that all Trusts start recording care hours per patient day (CHPPD) as a single consistent metric of nursing and healthcare support worker deployment on inpatient wards and units

From 1 May 2016, all Trusts must report back monthly CHPPD data to NHS Improvement in order to support the development of a single means of recording and reporting staff deployment. CHPPD is calculated by adding the hours of registered nurse to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions. The UNIFY CHPPD report will split out registered nurses and health care support workers to ensure that skill mix and care needs are met.

At the Trust we have adapted the database used to collect data to include a new field – Patient Count at Midnight- which will enable automatic calculation by taking the number of hours worked divided by the number of patients on the ward at midnight. The reporting of CHPPD becomes mandatory in June 2016.

2.2 Vacancy and Acuity Data

Band 5 Registered Nurse vacancy rates at ROH have risen as expected to 13.99 WTE this month in line with the rebasing of ward budgets to reflect the uplift for night shifts agreed in the November establishment review. Table 2 below shows the rebased budget at Band 5 and 2 for each of the ward areas with the figures in brackets representing the budget before rebase.

Table 2: Band 5 WTE Vacancy (Based on Figures from Finance April 2016)

Ward	Band 5 Funded Establishment	Band 5 Vacancy	Band 2 Funded Establishment	Band 2 Vacancy
1	13.57 (11.53)	2.52	10.65	2.70
2	13.57 (11.80)	2.54	10.05	0.14
3	14.16 (13.09)	0.96	8.65	2.45
12	21.12 (21.12)	3.59	7.79	(1.92)
11∞	12.00 (13.80)	0.2	0.60	(1.00)
HDU (Includes Band 6 within baseline)	23.32 (22.32)	4.18	1.80	0
Total	97.74 (93.66)	13.99	39.54	2.37

∞: The reduction in Ward 11 is due to rebasing of the budget between clinic and the ward area.

A number of key actions are in place to address recruitment at the Trust and are listed below:

- The Nursing Workforce group has been re-established and met on 21 April 2016. The group will oversee the development of targeted recruitment campaigns and introduce accurate vacancy monitoring across the Trust. Terms of Reference have been agreed and meeting dates set for the remainder of the year. One of the key actions to be completed by end Quarter 1 2016/17 is to develop the internal ability to respond effectively to expressions of interest from nursing staff outside the cycle of planned assessment centres.
- Good progress has been made against the appointment of the paediatric vacancies in HDU with 1 post filled by an internal applicant and the remaining three by students who will qualify in September 2016.
- A student nurse recruitment campaign will commence on 31 May 2016 with an assessment centre planned for 23 June 2016.
- A further recruitment campaign for registered nurses is in progress with an assessment centre on 23 June 2016
- We have increased the number of student nurses who have placements at the Trust from Quarter 1 2016/17 and the number of students who will undertake their final (management) placement at the Trust.
- Overseas recruitment is being further explored by the HR team to enable recruitment of general rather than theatre specific nursing team members. Mediplacements, our recruitment organisation, have very recently engaged a partner organisation based in Brighton to assist in European searches which will enable recruitment of nurses with Level 5 in International English Language Testing System (IELTS) to work as HCAs whilst they study for Level 7 to enable registration within the UK. This step will significantly increase the pool of nurses available for recruitment. Discussion between the Trust and Mediplacements is underway.

Table 3 below shows the recommended staffing levels based on the daily acuity tool by ward for April 2016. Trust Board is asked to note that the Paediatric Ward is not included in this table because the acuity tool used is not appropriate for children and therefore an alternative appropriate tool is being sourced and costed through links with Birmingham Children's Hospital.

Table 3: Acuity by Ward

Ward	Recommended WTE	Actual WTE	Budgeted WTE
1	29.15	28.32	22.92
2	27.90	27.29	23.35
3	31.71	28.44	24.35
12	33.68	38.56	39.1
HDU	19.46	21.58	26.79

It can be seen that whilst most wards staff beyond their funded establishment the acuity tool suggests that staffing requirements were met through April 2016. The areas of greatest disparity (recommended vs actual) are Ward 12, where the ward layout and environment means that a different model of nursing care is delivered to enable safe support and supervision of all patients, and HDU which is a consequence of the flexible staffing model employed.

Trust Board is asked to note that the DDNG has reviewed the tool used to calculate dependency and acuity at ROH and has recommended that before substantial changes are made to the way data is collected, the Shelford Safer Nursing care tool is applied across all wards in June 2016. The tool requires that acuity and dependency measurement must be consistent and that all relevant data are collected during the same period. Data will be collected on every patient on participating wards / units at 1500 hrs, daily Monday to Friday for 20 days as a minimum. Quality control is fundamental to ensuring a robust approach to data collection This will allow nursing staff to understand not only the levels of patients on wards, but also enable this information to be allied to other key data including nurse sensitive care indicators The data gathered through this exercise will enable comparison with that gathered through daily acuity capture and provide a benchmark from which to develop the twice yearly nurse establishment reviews.

A review of HCA establishment will be completed through May 2016 and reported to TMC in July 2016 following completion of the Safer Nursing Care tool.

2.3 Paediatric Nurse staffing at ROH

Work has been undertaken to map current ward staffing and establishments against the Royal College of Nursing (RCN 2013) standards with a paper presented to TMC in April 2015. The Royal College of Nursing (RCN) in 2013 produced 16 standards around Children & Young Person's care. The Director of Nursing has undertaken an initial analysis of these 16 standards in conjunction with the Matron and Interim Senior sister of the Paediatric Ward. The outcome of the analysis is summarised within Table 4 below with each standard being RAG rated.

Table 4: Assessment against RCN Standards

Standard Number	Compliance	Standard Number	Compliance
1		9	
2		10	
3		11	
4		12	
5		13	
6		14	
7		15	
8		16	

Standard 1 requires that the shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff. Standard 14 outlines that where services are provided to children there should be access to a senior children's nurse for advice at all times throughout the 24 hour period. A senior qualified children's nurse is a nurse that holds a children's nursing qualification, also has a master's degree in an appropriate health/social care related subject, with a minimum of five years' full time experience in uninterrupted clinical practice. The expectation is that this post would be at a minimum of Band 8a dependent on the full scope and remit of the position in which case the post may be graded higher where the remit is greater. All post holders of matron positions in children's services must hold a registered children's nursing qualification.

Therefore the key issues to be addressed are the night and weekend Registered Nurses and supernumerary nurse in charge within core hours, in addition to 24/7 access to senior paediatric support. In addition the standards are clear that the Matron for Children's areas must hold a paediatric qualification which is not achieved at the Trust

2.4 Safe Staffing and Efficiency

Caps on agency spend for Registered Nurses, mandated by Monitor, have been in place at ROH since 1 October 2015. The ceiling for ROH has been set at 10% which is a reflection of the relatively high use of agency staff at the Trust. During April 2016 overall nurse agency use at ROH was 11.2 % which is a slight increase in usage since March of 0.5%. Table 5 shows the trend line for total nurse agency use across the Trust.

Table 5: Registered Agency use as a % of total cost (Whole Trust)

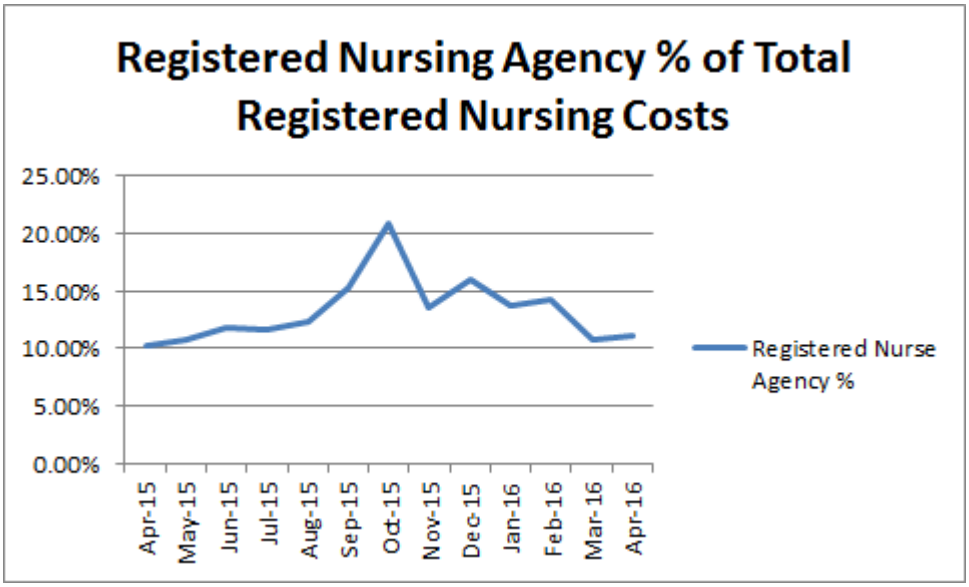
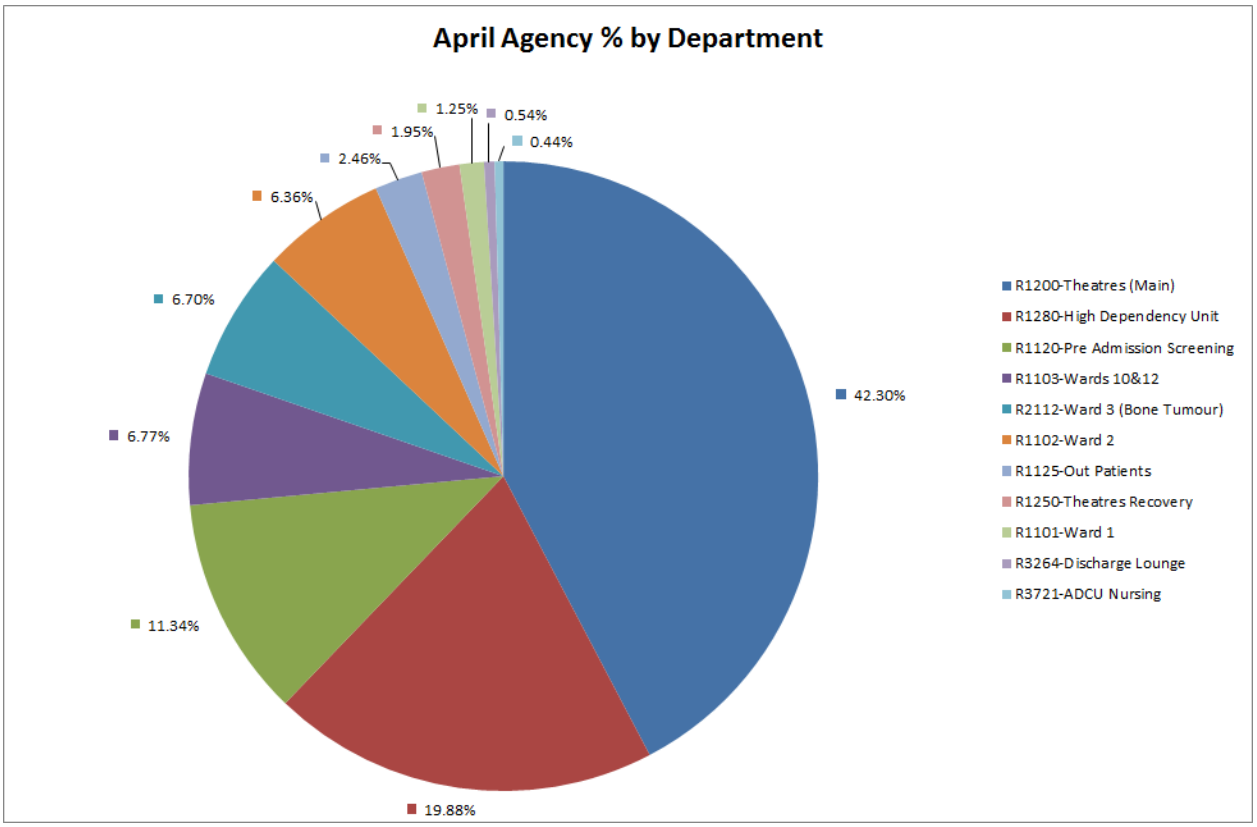


Table 6 presents agency use by area as a total of agency spend across the Trust.

Table 6: Agency use (as a percentage of total spend)



The use of agency staff in Theatre remains high at 42.30 % of total use, however the agency staffed used work regularly at ROH and are familiar with guidelines and processes. The high usage is driven by a high vacancy rate within the Theatre team as reported in previous months. Agency use will remain high in Theatres for the immediate future in order to enable safe delivery of services.

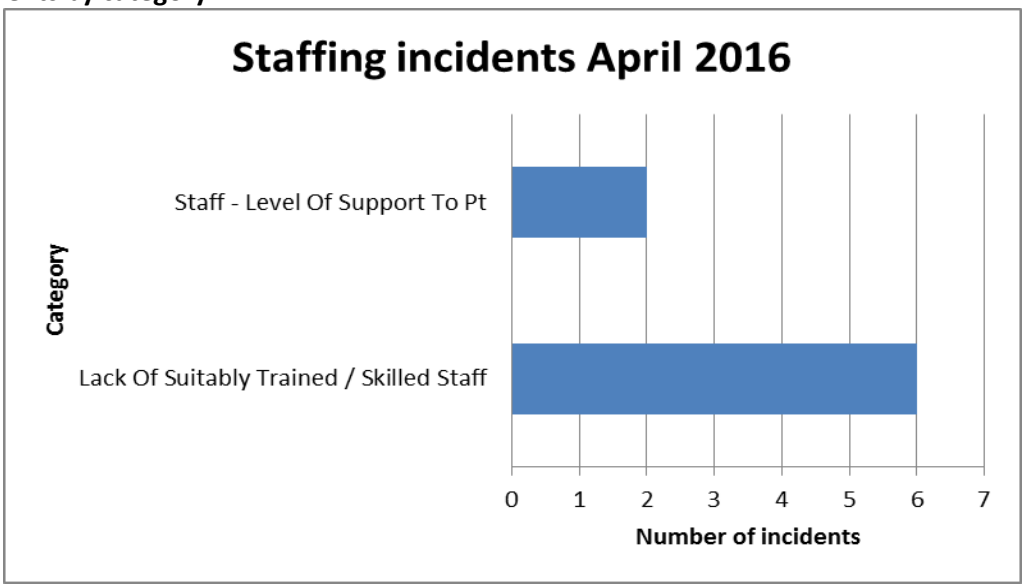
It is however of note that the percentage of total spend used by Theatres has increased over time whilst that of in-patient wards has continued to reduce. All wards, with the exception of HDU are demonstrating agency use of less than 10% of total spend, in line with Monitor requirements. The continuation of the daily 'Safe Staffing' huddle ensures that nurses are moved between wards to cover shortfalls if necessary and that agency use is cancelled if not required. The continued high use of agency staff in HDU is driven by the vacancy factor and by the need to ensure that all shifts are appropriately staffed with Registered Children's Nurses.

3.0 Incident Reporting and Levels of Harm

In addition to the Safer Nurse Staffing tool being used and interpreted, clinical areas are encouraged to report all Safe Staffing incidents. In April 2016, a total of 8 staffing incidents were reported. This compares to a total of 6 reported in March 2016. The number of reported staffing incidents remains low and all ward teams have been reminded of the importance of accurately reporting staffing gaps to enable identification of themes and concerns.

Of the 8 incidents reported, six were categorised as no harm and two as low harm. The low harm incidences both related to a reduction in numbers of nursing staff on the wards resulting in delay in undertaking patient observations and delay in providing pain medication. 3 of the 8 incidents met the criteria for NICE Red flags. It is positive to note that nursing teams are reporting and recording Red Flags as they occur. A detailed breakdown of each incident is provided in Appendix 2. Table 7 below provides a breakdown of incident by category.

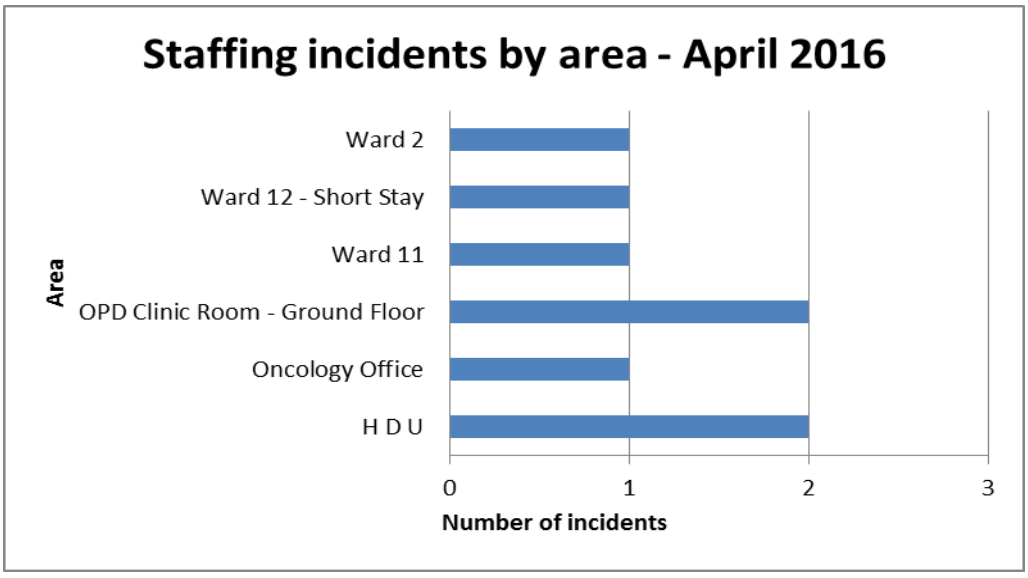
Table 7: Incidents by category



Incidents by area/ward:

Two staffing incidents occurred in OPD and HDU. One staffing incident occurred on Ward 2, Ward 12, Ward 11 and Oncology. Table 8 below identifies the distribution of incidents across all areas.

Table 8: Incidents by ward



Red Flag Shifts April 2016

Three incidents (17547, 17702 and 17559) triggered a NICE 'red flag'. The detail of these incidents is shown in Appendix 2 below.

4.0 Conclusion and Recommendations.

4.1 The Trust Board is asked to note:

- That the vacancy rate has increased for all ward areas as expected in April 2016 to 13.99 WTE.
- Good progress has been made against the appointment of the paediatric vacancies in HDU with 1 post filled by an internal applicant and the remaining three by students who will qualify in September 2016.
- That fill rates across the Trust are greater than 95% with the exception of fill rates for unregistered staff on Wards 1, 3 and 11.
- From 1 May 2016, all Trusts must report back monthly CHPPD data to NHS Improvement in order to support the development of a single means of recording and reporting staff deployment.
- A recruitment campaign targeted at student nurses (qualify January 2017) is planned for 31 May 2016.
- The Safer Nursing care tool will be rolled out across the Trust in June 2016.
- A review of HCA establishment in in patient areas will be completed in May 2016 and reported to TMC in July 2016 following completion of the Safer Nursing care tool.
- A gap analysis was completed in April 2016 against the RCN Standards for the Care Of Children and Young People which identifies gaps against two of the key standards.
- Agency use is highest in areas of greatest vacancy and there is continued evidence that ward usage is falling as % of total of spend. Agency use will remain high in Theatres due to the high vacancy rate.

7.0 Appendix 1: UNIFY upload April 2016

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		1601	1530.5	976.5	900	660	660	660	671	95.6%	92.2%	100.0%	101.7%
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1425.5	1415.5	902.5	889	660	649	660	671	99.3%	98.5%	98.3%	101.7%
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1732.5	1646.5	1125	971.5	600	610	600	550	95.0%	86.4%	101.7%	91.7%
Ward 10 & 12	110 - TRAUMA & ORTHOPAEDICS		1817	1755	1516.5	1441	990	990	990	935	96.6%	95.0%	100.0%	94.4%
Ward 11	110 - TRAUMA & ORTHOPAEDICS		1120	1105.5	304.5	185	660	660	88	69	98.7%	60.8%	100.0%	78.4%
HDU	110 - TRAUMA & ORTHOPAEDICS		1388.8	1442.5	127.5	134.5	1276	1289	0	0	103.9%	105.5%	101.0%	-

Appendix 2: Incident Details April 2016
Please note' NICE RED FLAG INCIDENTS' are shaded red.

Incident Number	Cause Group	Details Of Incident	Area
17547 (no harm)	Lack Of Suitably Trained / Skilled Staff	One staff nurse had to be moved to assist in HDU due to staffing issues whilst ward was very busy (resulting in delay of 30 mins or more in providing pain relief to patients)	Ward 12
17702 (no harm)	Lack Of Suitably Trained / Skilled Staff	Agency nurse did not turn up for night duty (resulting in less than 2 registered nurses present on ward during shift)	Ward 2
17708 (no harm)	Staff – Level of Support to Patient	The department having five vacancies and two vacancies to come; resulting in nursing staff coming in on their days off	Oncology
17640 (no harm)	Lack Of Suitably Trained / Skilled Staff	Staff shortage in clinics due to bank staff not arriving	OPD
17707 (no harm)	Lack Of Suitably Trained / Skilled Staff	Two members of staff off sick	OPD
17559 (low harm)	Staff – Level of Support to Patient	Two trained nurses on shift caring for four patients, two patients became unwell and required continuous nursing care	Ward 11
17624 (low harm)	Lack Of Suitably Trained / Skilled Staff	Member of staff off sick leaving the bleep holder and 3 agency staff to cover	HDU
17627 (no harm)	Lack Of Suitably Trained / Skilled Staff	Ward short staffed leaving bleep holder unable to perform usual tasks. No patient impact recorded.	HDU

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Declaration to NHS Improvement – General Condition 6 – systems for compliance with licence conditions**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive & Yve Buckland, Chairman**
AUTHOR:	**Simon Grainger-Lloyd, Associate director of Governance & Company Secretary**
DATE OF MEETING:	**1 June 2016**

EXECUTIVE SUMMARY:

It is a requirement of the governance condition of the Trust's licence that the Trust submits a Corporate Governance Statement to NHS Improvement within three months of the end of each financial year. The governance condition requires the Trust Board to confirm:

- Compliance with the governance condition at the date of the statement; and
- Forward compliance with the governance condition for the current financial year, specifying (i) risks to compliance and (ii) any actions proposed to manage such risks

Appendix A outlines the rationale and core evidence that the Board can rely on in order to confirm the statements relating to the Corporate Governance statement and other declarations.

NHS Improvement also requires the Board to make declarations regarding:

- Governance systems and processes in place where the Trust is a member of, or considering taking part in a major joint venture or Academic Health Science Centre(AHSC). While the Trust is not a member of an AHSC and is not currently considering becoming part of a major joint venture, it is proposed to answer '**Not applicable**' to this declaration.
- The provision of necessary training to governors, pursuant to Section 151(5) of the Health & Social Care Act 2012. The Board is recommended to make a declaration of '**Confirmed**' in respect of Governor training.

The proposed declarations are attached at Appendix B and C. The required submission date is 30 June.

Foundation trusts are also required to make annual declarations to NHSI regarding their systems for compliance with provider licence conditions (General Condition G6) and availability for resources for the forthcoming year. The Board will remember that it discussed the latter declaration as part of the submission of the Operating plan for 2016/17 at the April meeting. The licence condition declaration was discussed at the May private session on 24 May, but is attached as Appendix D for completeness in public. It was submitted on 31 May in line with the required deadline.

All of these declarations must be made 'having regard to the views of governors'. The Board is asked to note that although the meeting cycle for the Council of Governors has not permitted discussion at a

formal meeting, the proposed declarations have been circulated to the Council of Governors for comment. Any feedback received will be taken into account ahead of the formal submission at the end of June.

REPORT RECOMMENDATION:

The Board is asked to:

- Review the list of evidence available to support the Corporate Governance Statement, AHSC declaration and Governor training
- Approve in principle the declarations proposed, subject to formal agreement of the submission on 30 June by a committee of the Chairman and Chief Executive
- Note the licence conditions declaration which was made on 31 May
- Agree to publish the declarations made once submitted to NHSI

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	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:

Compliance with the NHS Planning Guidance 2016/17 and specifically compliance with the Trust's licence to operate.

PREVIOUS CONSIDERATION:

The licence condition declaration was discussed at the May private session on 24 May

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

NHS IMPROVEMENT ANNUAL STATEMENTS & SELF-CERTIFICATION – EVIDENCE FOR STATEMENT OF COMPLIANCE

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
CORPORATE GOVERNANCE STATEMENT			
The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	None	• **Annual Governance Statement which outlines the key controls in place to ensure that the Trust's governance arrangements are sound and effective.** • **Annual Report contents in 'Accountability Report' summarising how the Trust complies with the Code of Governance.** • **Progress reports on delivery of actions raised in response to the Good Governance Institute review.** • **Quarterly governance submissions to Monitor.** Monitor Corporate Governance ratings for 2015/16: Q1= Green; Q2 = Under Review; Q3 = Under Review; Q4 = Under Review. Q2 – Q4 rating reflects a deterioration in the Trust's deteriorating financial position, which resulted in additional monitoring and information requirements being requested. No formal action was taken in 2015/16. • **Head of Internal Audit Opinion 2015/16** which concludes that 'the organisation has an adequate and effective framework for risk management, governance & internal control. However, our work has identified further enhancements to the framework	ADG&CS

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
		of risk management, governance & internal control to ensure it remains adequate and effective'. • Progress during the year with strengthening the Board Assurance Framework and risk management systems & processes. **Minutes from Audit Committee confirming this.** • Outputs from the Audit Committee workshop in October: **assurance action plan**.	
The Board has regard to such guidance on good corporate governance as may be issued by Monitor from time to time		• **Trust Board paper outlining changes to Risk Assessment Framework.** • **CEO reports to Board highlighting new guidance issued.** • **Board paper outlining plans for the Well Led Framework assessment that is due to commence in June 2016 onwards.** • **Paper to Quality & Safety Committee discussing initial assessment of compliance against the Quality Governance Framework.**	ADG&CS
The Board is satisfied that the Trust implements:	(a) Effective board and committee structures;	• The Committee structure has been reviewed and refined during the year, with the creation of a Finance & Performance Committee for oversight of finance & operational matters. **Paper proposing the establishment of a Finance & Performance Committee considered at the February 2016 Board meeting.** • The **terms of reference for the Committees** have been reviewed and amended during the year and the Quality & Safety Committee has been refocussed onto seeking assurance as distinct from considering operational matters.	ADG&CS

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
		• All Committees report back at each Board meeting on key highlights and matters needing to be escalated via an **assurance report**. • **Annual Governance Statement** 2015/16 outlines the Board & Committee structure. • The Board and Committees have **annual workplans**.	
	(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees;	• The Trust has a **Scheme of Delegation** in place which sets out the matters reserved to the Board. • The **terms of reference for the Committees** have been reviewed and amended during the year and the Finance & Performance Committee was established during 2015/16. **Paper proposing the establishment of a Finance & Performance Committee considered at the February 2016 Board meeting.** • **Organisational charts** have been presented to the Quality & Safety Committee during the year setting out the Groups & Committees that sit within the clinical governance environment. • The **Quality & Safety Committee workplan** includes reports from the clinical governance committees that present by rotation. • The Trust Management Committee (TMC) was refocussed during the year and continues to be the advisory group to the Chief Executive. **Terms of Reference for TMC.**	ADG&CS
	c) Clear reporting lines	• Executive portfolios have been reviewed during the year and in particular the Director of Nursing & Clinical Governance remit has been refocussed to provide	CEO

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
	and accountabilities throughout its organisation.	clearer accountability for clinical rather than corporate governance. **Job description for Director of Nursing & Clinical Governance.** • An Associate Director of Governance & Company Secretary has joined the ROH during the year and takes responsibility for risk management and policy governance as well as more traditional elements of support to the Board & Chairman. **Job description for Associate Director of Governance & Company Secretary.** • A new divisional structure has been implemented during the year to create clearer accountability within the operational areas. **Papers and presentations outlining the divisional structure.** • **Job descriptions, divisional management structure and TMC agendas may be used to evidence compliance with this requirement.**	
The Board is satisfied that the Trust effectively implements systems and/or processes:	(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;	• **Internal and External Audit opinions considered by Audit Committee** • **Going Concern statement in Annual Report and paper to Audit Committee on Going Concern.** • **Finance & Performance Committee meeting papers demonstrating the detail considered to assess efficiency and effectiveness.** • **Trust's response to Monitor's 'Getting a Grip' guidance and the Carter Review.** • **CIP reports** showing good progress having been made during 2015/16.	DOF

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
		• **Activity rectification plan** showing steps being taken to address the deteriorating in finance and activity.	
	(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;	• **Board cycle of business** and the **workplans of the Board Committees** ensure that there is comprehensive oversight of key matters. This has been further strengthened during 2015/16 by the additional of a Finance & Performance Committee. **Paper proposing the establishment of a Finance & Performance Committee considered at the February 2016 Board meeting.**	Ch/ ADG&CS
	(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and	• **CQC:** Assurance is obtained routinely on compliance with CQC registration requirements through Directors and Senior Managers of the Trust having specific responsibilities in respect of CQC standards and more generally in maintaining internal control systems to support those standards. After the CQC inspection in June 2014, the Trust produced a CQC **action plan** which includes strengthened internal controls, systems and responsibilities for quality which continued to be delivered through 2015/16. Likewise, an action plan was developed following the inspection in July 2015 (and subsequent publication in December 2015) which has sought to address any shortfalls identified by the CQC. • **NHS Commissioning Board**: The Trust works in partnership with the Clinical Commissioning Groups and NHS England. Quality Standards are devolved through the Standard Contracts and are agreed at the commencement of each financial year. The Trust evidenced adherence to the quality contract requirements through submission of evidence and are held to account through the monthly contract meetings. Non adherence to agreed standards will lead to increased scrutiny/re-medial action plans and breach of contract notices/fines if non adherence to the	DN&CG

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
	statutory regulators of health care professions;	contracts continues. Assurance of contractual compliance with Quality Standards is measured and gained through the **Patient Safety & Quality Report** scrutinised at Quality & Safety Committee and a **specific monthly report on performance against contract quality requirements considered by TMC**. • **Board and Statutory Regulators of health care professionals**: All registered NHS professionals are bound to their code of conduct and the rules and requirements of their registration therein. Failure to comply with their expected professional standards would lead to disciplinary action via the Trust's disciplinary policy and in some cases removal from their professional register. Assurance is obtained routinely on compliance with professional member registration requirements through Directors and Senior Managers of the Trust having specific responsibilities in respect to members of staff working within their specific areas and more generally in maintaining internal control systems such as annual PDR, and re-validation processes. **Appraisal and revalidation reports.**	
	(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to	• The Trust Board approves the **annual budget and operational plan.** • Budget meetings are held with Divisions and Corporate areas. **Diary invites of these meetings may be used to evidence this.** • Financial performance is discussed and challenged at every Board meeting and in detail by the Finance & Performance Committee. **Minutes of Board & Finance & Performance Committee.** • Quarterly performance meetings are held between Executive and Divisions ensure appropriate challenge and control; these meetings were held monthly between	DOF

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
	ensure the Licensee's ability to continue as a going concern);	Director of Finance, Director of Operations and Divisional representatives for the second half of 2015/16. **Agendas for these meetings may be used to evidence this.** • The Audit Committee considers Going Concern status and recommends statements for the annual report and accounts. **Going Concern paper to Audit Committee.** • The Trust has **Standing Financial Instructions** in place. • Governors are required to approve 'significant transactions' • The Trust uses the services of a Counter Fraud specialist to monitor and investigate any potential fraudulent practice and report back to the Audit Committee. **Updates to Audit Committee.**	
	(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;	• The Board makes every effort to ensure that reports to both the Board and its Committees contain relevant timely and accurate information. • From early 2016, the Board will meet formally on a monthly basis, with board workshops & development sessions being additional to this. **Board minutes.** • The sequencing of Board Committees has been altered such that they meet prior to the Trust Board and can provide appropriate upwards assurance on matters of detail considered. **Meeting schedule.** • **Workplans for the Board & its Board Committees** ensure that there is a forward view of matters needing to be considered several months ahead.	Ch

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
	(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	• **Declaration submitted by 31 May 2016, confirming how the Trust operates to meet the conditions of its licence.** • Material risks are considered through the **Board Assurance Framework** which has been refreshed during the year. • The risk registers previously considered separately by the Quality & Safety Committee and Trust Management Committee have been merged to provide an overarching view of all risks rated red and amber, the most serious of which are included on the Board Assurance Framework. **Corporate Risk Register.**	Ch/ ADG&CS
	(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and	• Trust Board approves the **annual budget and operational plan**. • Performance discussed and challenged at every Board meeting and in detail by the Finance & Performance Committee. **Minutes from Board and Finance & Performance Committee.** • Quarterly performance meetings are held between Executive and Divisions to ensure appropriate challenge and control; these meetings were held monthly between Director of Finance, Director of Operations and Divisional representatives for the second half of 2015/16. **Agendas for these meetings may be used to evidence this.** • Internal Audit review key areas of interest and report findings to Audit Committee. **Internal Audit plan.**	ALL

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
		• Delivery of audit recommendations is monitored at Audit Committee via **recommendation tracking reports.** • The Transformation Committee takes a role in monitoring delivery of the strategic plan. **Transformation Committee minutes, terms of reference and agendas.**	
	(h) To ensure compliance with all applicable legal requirements. "	• The Trust uses the services of an established law firm to provide legal advice on request. • The **Trust's constitution** has been revised within the last two years and sets out the framework in which the Trust is to operate. • The Board is not aware of any other material non- compliance issues, although during the year work was undertaken informed by the CQC review to strengthen the systems and processes for complying with Regulation 20 of the Health & Social Care Act: Duty of Candour. The Trust Executive has maintained a close focus on the process for handling incidents reaching the Duty of Candour threshold and there is confidence now that the improvements are delivering sustained compliance. **Duty of Candour reports.**	ALL
"The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or	(a) That there is sufficient capability at Board level to provide effective organisational leadership on	• The Board keeps the balance of its skills and competencies under review to ensure completeness and appropriateness for the requirements of the Trust. • Both the Board and the Council of Governors considered that there was a need to strengthen clinical governance among the non-executive directors. An additional non-executive director with a clinical background was completed toward the end of 2014/2015. In relation to executives a Director of Strategy and Transformation was appointed in November 2014 - this post was a reconfiguration of posts within the	Ch

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
processes to ensure:	the quality of care provided;	executive team reflecting the need to strengthen the Trust's change capability over the next few years. **Board structure in annual report.** • The Board's composition includes a Medical Director who is a practicing clinician, a registered nurse and two Non Executives with a clinical background. **Board structure in annual report.**	
.	(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	• Every full length public Board includes a Patient Story. **Minutes and agendas of Board meetings.** • The Quality & Safety Committee provides a written update on its work at each Board meeting. **Assurance reports from Quality & Safety Committee.** • Progress with the delivery of the **CQC action plan** is considered by the Board and the Quality & Safety Committee. • CIP schemes are quality impact assessed. **CIP scheme schedule.** • The **Quality Account** includes a set of quality priorities, delivery of which will be monitored by the Quality & Safety Committee on a quarterly basis.	DN&CG
	(c) The collection of accurate, comprehensive, timely and up to date information on	• The Quality & Safety Committee receives a monthly **Patient Safety & Quality report**, the highlights of which are reported up to the Board as part of the assurance report from the Committee. • Detailed reports into specific quality indicators are considered by the Quality & Safety Committee. **Falls update, VTE reports, mortality reports**.	DN&CG

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
	quality of care;	• The Board considers a monthly **Corporate Performance Report**, which includes a set of metrics including key national priority indicators and regulatory requirements in addition to a range of measures covering safety, clinical effectiveness, and patient experience.	
	(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;	• The Quality & Safety Committee receives a monthly **Patient Safety & Quality report,** the highlights of which are reported up to the Board as part of the assurance report from the Committee. • Detailed reports into specific quality indicators are considered by the Quality & Safety Committee. **Falls update, VTE reports, mortality reports**. • The Board considers a monthly Corporate Performance Report, which includes a set of metrics including key national priority indicators and regulatory requirements in addition to a range of measures covering safety, clinical effectiveness, and patient experience.	DN&CG
	(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into	• Data is reported through into the **Patient Safety & Quality Report** which including PALS contacts, friends and family test results, compliments and complaints. • Patient stories are shared at the Board. **Minutes from Board meetings**. • The **Quality Account** is issued to external stakeholders for comment, including Healthwatch • Governors and patient representatives are included on the Patient & Carers Council. **Minutes of Patient & Carers' Council.**	DN&CG

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
	account as appropriate views and information from these sources; and	• A **schedule of walkabouts** is in place, overseen by the Deputy Director of Nursing & Clinical Governance, which involves governors and Non Executive Directors	
	(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate	• As described within the **Annual Governance Statement**; • The Board receives assurance on the Quality of Care through the oversight of the Quality & Safety Committee which is chaired by a NED with a clinical background and attended by the Director of Nursing & Clinical Governance, the Medical Director, the Chief Executive and the Director of Operations. **Terms of Reference for Quality & Safety Committee.** • The Trust has in place a Clinical Quality Committee, chaired by the Deputy Director of Nursing & Clinical Governance which is attended by a range of clinical and non-clinical senior staff from across the Trust. **Agendas and terms of reference for Clinical Quality Committee.** • The Quality & Safety Committee in turn receives more detailed reports from subgroups covering particular aspects of quality, for example drugs and therapeutics. This supports the process of escalation of risk related to quality throughout the Trust. **Quality & Safety Committee workplan.** • Some Board members carry out walkabouts in which they gain first-hand experience regarding the quality of care and the views of patients and staff and others.	DN&CG

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
		• The CEO holds regular briefings with Heads of Department & other senior managers for dissemination to teams. **Team brief.** • The development of the Knowledge Hub has gathered together a number of clinically focused processes, including Outcomes, Effectiveness and Audit. **Material launching the Knowledge Hub.**	
The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.		• The Board keeps the balance of its skills and competencies under review to ensure completeness and appropriateness for the requirements of the Trust. • Both the Board and the Council of Governors considered that there was a need to strengthen clinical governance among the non-executive directors. An additional non-executive director with a clinical background was completed toward the end of 2014/2015. In relation to executives a Director of Strategy and Transformation was appointed in November 2014 - this post was a reconfiguration of posts within the executive team reflecting the need to strengthen the Trust's change capability over the next few years. **Board structure in annual report.** • As per the **declaration to Monitor concerning availability of resources (Continuity of Services Condition 7)**, there remains some risks in relation to sufficient medical and theatre workforce, but these are not believed to be sufficiently serious to impact upon Monitor's licence requirements as arrangements are in place to ensure sufficient safe staffing. Additionally, some staffing considerations for Paediatric care in HDU are being worked through at present, in line with the recommendations from the CQC raised as part of its last visit.	DW&OD
ACADEMIC HEALTH SCIENCES NETWORK OR JOIN VENTURES			
"For NHS	Not applicable		N/A

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
foundation trusts: • that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or • whose Boards are considering entering into either a major Joint Venture or an AHSC."			
GOVERNOR TRAINING			
The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and		New governors receive induction during which any specific training issues are identified and addressed. New governors are offered the opportunity to attend the GovernWell core skills training and subsequently bespoke training is provided in-house each year for all Governors on topics identified by them; the latest session was on holding to account and the Council of Governors has been embedding this responsibility through its meetings in 2015/16 facilitated by Non Executive attendance and presentation. The Council of Governors has also received a presentation by the lead governor from Birmingham & Solihull Mental Health NHS FT describing the work of the governor in another Trust. Further work is planned during 2016/17 to strengthen the offering from Governwell to new governors in particular.	ADG&CS

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
knowledge they need to undertake their role.		**Minutes from Council of Governors meetings. Invitation to attend courses. Accountability training material.**	

KEY:

Abbreviation	Job Title
CEO	Chief Executive
DOF	Director of Finance
DN&CG	Director of Nursing & Clinical Governance
DW&OD	Director of Workforce & OD
ADG&CS	Associate Director of Governance & Company Secretary
Emboldened text indicates evidence available to confirm compliance	

Self-Certification Template

FT Name: The Royal Orthopaedic Hospital NHS Foundation Trust

NHS Foundation Trusts are required to make the following declarations to NHS Improvement:

1 & 2 *Systems for compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*
3 *Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence*
4 *Corporate Governance Statement - in accordance with the Risk Assessment Framework*
5 *Certification on AHSCs and governance - in accordance with Appendix E of the Risk Assessment Framework*
6 *Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act*

Declarations 1 and 2 above are set out in a separate template, which is required to be returned to NHS Improvement by 31 May 2016.
Declaration 3 is included in the APR 2015/16 Final Financial Template, which is required to be returned to NHS Improvement per communications on final operational plan submissions.
Declarations 4, 5 and 6 above are set out in this template, which is required to be returned to NHS Improvement by 30 June 2016.

Templates should be returned via the Trust portal, marked as a Trust Return with the activity type set to Annual Plan Review.

How to use this template

1) Copy this file to your Local Network or Computer.
2) Select the name of your organisation from the drop-down box at the top of this worksheet.
3) In the Corporate Governance Statement and Other Certifications worksheets, enter responses and information into the yellow data-entry cells as appropriate.
4) Once the data has been entered, add signatures to the document, as described below.
5) Use the Save File button at the top of this worksheet to save the file to your Network or Computer - note that the name of the saved file is set automatically - please do not change this name.
6) Copy the saved file to your outbox in your NHS Improvement Portal.

Notes: *NHS Improvement will accept either:*
1) electronic signatures inserted into this worksheet (save signature file locally and use 'Insert - Picture' from the toolbar/ribbon to do this) or
2) hand written signatures on a paper printout of this declaration posted to NHS Improvement to arrive by the submission deadline.

In the event than an NHS foundation trust is unable to fully self certify, it should NOT select 'Confirmed' in the relevant box. It must provide commentary (using the section provided at the end of this declaration) explaining the reasons for the absence of a full self certification and the action it proposes to take to address it.

Worksheet "Corporate Governance Statement"

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

4	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The CQC reinspection in July 2015 highlighted some action needing to be taken to address some shortfall against the standards required to be met to deliver its regulatory activities. This work continues to be monitored by both the Quality & Safety Committee and the Trust Board.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	There are no risks identified to compliance with this statement.
3	The Board is satisfied that the Trust implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The new divisional structure introduced during Autumn 2015 continues to be embedded to ensure that accountability is further clarified.
4	The Board is satisfied that the Trust effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and NHS Improvement delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	During the year, some weakness in control around financial and operational process were identified. The Trust established a Finance & Performance Committee to strengthen oversight and provide assurance to the Board on the measures being taken to address deterioration in financial and activity performance. A rectification plan was requested by and submitted to Monitor which was accepted. During 2016/17, the actions from the plan are bing developed into a more holistic approach to improving the Patient Journey and delivering efficiencies within the organisation. The Trust has accepted a challenging control total for 2016/17. The risks to the delivery of this were outlined as part of the submission of the Operating Plan on 11 April.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Some of the processes in place to effectively escalate risk remain embronic at present and are evolving. The new risk management policy is due to be launched in summer 2016 which will clarify how risks should be managed and escalated. The Trust is planning to conclude its review against the Well Led Framework in 2017, which may highlight some areas of practice which require strengthening.
6	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	There remains a challenge to the organisation with the recruitment of Paediatric nurses for the Trust, however recruitment plans continue to be developed. The Trust is also tasked with reducing its reliance on medical and nursing temporary staffing expenditure in line with the cap on agency spend issued by Monitor during 2015/16. The Trust is currently recruiting into consultant vacancies and has a plan to increase the number of

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature _____ **Signature** _____

Name Yve Buckland **Name** Jo Chambers

The board are unable make one of more of the above confirmations and accordingly declare:

A

B

C

Worksheet "Other declarations"

Certification on AHSCs and governance and training of governors

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

5	**Certification on AHSCs and governance**	**Response**
	For NHS foundation trusts: • that are part of a major Joint Venture or Academic Health Science Centre (AHSC); or • whose Boards are considering entering into either a major Joint Venture or an AHSC.	
	The Board is satisfied it has or continues to: • ensure that the partnership will not inhibit the trust from remaining at all times compliant with the conditions of its licence; • have appropriate governance structures in place to maintain the decision making autonomy of the trust; • conduct an appropriate level of due diligence relating to the partners when required; • consider implications of the partnership on the trust's financial risk rating having taken full account of any contingent liabilities arising and reasonable downside sensitivities; • consider implications of the partnership on the trust's governance processes; • conduct appropriate inquiry about the nature of services provided by the partnership, especially clinical, research and education services, and consider reputational risk; • comply with any consultation requirements; • have in place the organisational and management capacity to deliver the benefits of the partnership; • involve senior clinicians at appropriate levels in the decision-making process and receive assurance from them that there are no material concerns in relation to the partnership, including consideration of any re-configuration of clinical, research or education services; • address any relevant legal and regulatory issues (including any relevant to staff, intellectual property and compliance of the partners with their own regulatory and legal framework); • ensure appropriate commercial risks are reviewed; • maintain the register of interests and no residual material conflicts identified; and • engage the governors of the trust in the development of plans and give them an opportunity to express a view on these plans.	**Confirmed**
6	**Training of Governors**	
	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	**Confirmed**

Signed on behalf of the Board of directors, and having regard to the views of the governors

Signature	Signature
Name Yve Buckland	**Name** Jo Chambers
Capacity Chairman	**Capacity** Chief Executive
Date	**Date**

Where boards are unable to self-certify, they should make an alternative declaration by amending the self-certification as necessary, and including any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance

The Board are unable make one of more of the confirmations on the preceding page and accordingly declare:

A

B

C

Worksheet "Certification G6"

Declarations required by General condition 6 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed
	AND	
2	The board declares that the Licensee continues to meet the criteria for holding a licence.	Confirmed

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature		Signature	
Name	Yve Buckland	**Name**	Jo Chambers
Capacity	Chairman	**Capacity**	Chief Executive
Date	31 May 2016	**Date**	31 May 2016

Further explanatory information should be provided below where the Board has been unable to confirm declarations 1 or 2 above.

A

B

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRANSFORMATION COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	17 May 2016
Guests	None
Presentations received	None
Major agenda items discussed	• Workstreams 1 – 7 updates (by exception) • E-rostering update • GP marketing strategy • IM & T strategy update • Patient Journey deep dive • Perfect Day update
Matters presented for information or noting	• Nothing additional
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The status of Workstream 1 was reported to be 'amber', which reflected some issues with the deployment of the Physician Associates. The Head of Learning & Development was reported to be leaving, however plans were underway to fill the role. • Some areas of concern were highlighted in Workstream 2, relating to some dependencies with the job planning work that was yet to conclude. A delay was reported to concern 'In Touch', in relation to the encryption of messages to and from the server held at Sandwell Hospital. A 'red' rating was reported against the sustained growth element of the workstream, which reflected the request by NHS Improvement to rework the activity trajectorires around Paediatric spinal work. • Some recovery work was underway to address the delays with the ePMA project. • The Committee discussed workstream 5, clinical services development, and agreed that it needed to be redefined by the Executive Team as the focus of the work within this workstream was not now clear. • The e-procurement work as part of Workstream 6, Information for Excellence was reported to be on hold, pending agreement of a procurement strategy. • As the Workstream 7 report was not comprehensive, it was agreed that this needed to be issued in retrospect.
Positive assurances and highlights of note	• In relation to Workstream2, it was reported that good progress had been made on reducing the delays out of

for the Board	HDU and recovery; both metrics were tracked by the Finance & Performance Committee. • The Committee was advised that work was progressing well to improve business intelligence, including the development of the data warehouse feeds. Performance reporting was developing to ensure that robust information was available at an operational level to allow managers to make decisions and manage the business appropriately. • The business case for theatre system replacement had been approved and the project was moving into the implementation phase. • The launch of the Knowledge Hub was noted to have been a success. • Responsibility for the E-rotering project had moved from the Diretcor of Workforce & OD to the Director of Nursing & Clinical Governance. The system had been purchased and interviews for the project manager was planned for the end of May. • A small group had been set up to work through GP marketing and plans were in place to visit a number of GP practices over the next few weeks • The Committee was presented with the draft IM & T strategy, which reflected the change in IT projects, national & local influences and the digital roadmap. It was agreed that the risks, costs and benefits needed to be added into the strategy. • The Committee was appraised of the the Patient Journey project which involved over 100 areas of service change and improvement which would deliver patient benefits.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The outputs of the GP engagement work is to be discussed at the next meeting • The Committee asked that a plan of benefits realisation be developed, linked to the various projects within the Transformation Programme • Clinical leadership in relation to the Patient Journey work is to be discussed at the next meeting • A staff engagement plan is to be developed and discussed 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 1 June 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	25 May 2016
Guests	Dr Bill Rea, Consultant Anaesthetist
Presentations received	Improvements to the Ulysses risk management system
Major agenda items discussed	• Quality Committee update • Drugs & Therapeutics Committee update • Quality & Patient Safety report • Pain management update • Progress with CIP quality impact assessments • Corporate risk register • Update on the operation of the Divisional Governance arrangements
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• As part of the update from the Clinical Quality Committee, it was reported that a gap analysis agiant the requirements for the Friends and Family Test (FFT) had identified that the Trust was not fully compliant; work is underway through the Communications Team to address this as a priority • A risk of non-compliance with the DH guidance 'Positive and Proactive Care': Reducing the need for physical interventions was raised and it was agreed that an update oin the action plan to address this would be considered at the next meeting • Non-compliance with blood fridge monitoring remained a risk and work with University Hospital Birmingham NHSFT is underway to resolve this matter • The ongoing issue concerning the authority of the Physician Associates to act at the ROH was discussed, however discussions are planned to resolve this issue, taking into account the relevant framework of legislation • The detail of the Quality & Patient Safety report was considered which reported that two VTE incidents had been reported in April and two avoidable pressure ulcers had also occurred. Low FFT completion rates were reported for ADCU; a software solution is being developed to make it easier to complete the feedback forms • There was a discussion about triangulation of information

	around complaints, litigation and incidents. It was reported that although there were feedback mechanisms from these cases, there was no systematic way in which lessons learned are shared. Work is underway to improve this, however it was agreed that a briefing would be brought back to a future meeting outlining these plans in more detail. • The Committee was advised that there was further work to do to ensure that pain management was more effective in the organisation and a business case had been approved to invets in an acute pain management service
Positive assurances and highlights of note for the Board	• Good progress was reported to have been made with ensuring that visitors within theatres were clearkly identified, through the use of different coloured 'scrubs'; building work in theatres continued, after which the new 'red line' policy would be implemented. The 'Permit to Work' concept was working effectively in theatres, which had minimised uncessary disruption • Undertaking quality ward-based assessments had been implemented and actions are monitored through divisional teams; there had been some good shared learning as a result of these assessments. • The Committee was pleased to hear that the Paediatric nurse staffing standard would be achieved by September 2016 • The overall improved operation and effectiveness of the Clinical Quality Committee was noted to be pleasing, particularly given that a patient & public representative would join shortly • Good progress was reported to have been made with addressing the backlog of incidents that needed to be closed. A more practical sign off of action plans to prevent the reoccurrence of incidents had been implemented • Divisional Governance Board meetings were reported to be becoming increasingly effective • It was agreed that having guests join the meeting to present specific reports was helpful
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The approach to reinforcing 'Bare Below the Elbow' to be brought back to the next meeting • The Never Events Assurance Plan is to be brought back to the next meeting • Presentation of the minutes of the Clinical Quality Committee would be routine • Update on pressure ulcers to be presented at a future meeting • Inmprovement in terms of pre-operative fasting is to be presented at a future meeting • A report on falls would be presented at the next meeting

	• The systematic approach to dissemination of learning is to be presented in July • The outcome of the quality impact assessment of CIP schemes is to be presented at the next meeting
Decisions made	• It was agreed that the Committee would consider in future the key quality & safety risks through the BAF rather than through the Corporate Riski Register to ensure that there wa focus on those most serious risks

Kathrn Sallah
NON EXECUTIVE DIRECTOR

For the meeting of the Trust Board scheduled for 1 June 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Charitable Funds Meeting held on 17th March 2016
Charitable Funds Committee, 9:00 AM in the Learning and Development Suite

Present
Mrs Frances Kirkham (Chair)
Mr Paul Athey, Director of Finance (left at agenda item 9.f. Bicentenary of ROH)
Ms Stella Noon, Patient Representative
Mr Rod Anthony, Non-Executive Director
Mr Mohammed Qasim, Assistant Financial Accountant
Mr Garry Marsh, Director of Nursing and Governance
Dame Yve Buckland, Chairman
Ms Yvonne Scott, Patient Representative
Ms Elaine Haughton, Financial Accounting Lead and minute taker
Mrs Jane Colley, PA to Chair & Company Secretary (JCo)

Apologies
Mrs Jo Chambers, Chief Executive Officer (JC)
Ms Lin Russell, Oncology Service
Mr Andrew Pearson, Medical Director
Professor Taunton Southwood, Non-Executive Director
Mr Jonathan Lofthouse, Director of Operations
Mr Tim Pile, Non-Executive Director
Mrs Kathryn Sallah, Non-Executive Director

Minute no.	Detail	Actions
170316-01	**Minutes from October 2015** The minutes of the previous meeting were accepted by the committee as an accurate record of the meeting.	
170316-02	**Actions from previous meeting** 11/13/959 - PA reported limited progress, he had found some old files, but nothing giving information on the endowment funds. Conversation with GB required if not possible then a conversation with the lawyers would be needed to understand our options.	

	JL advised new information provided through InTouch kiosks. FK remainder of items that aren't completed will be covered in agenda.	YB to pick up with Anne re patient council.
170316-03	**Review of financial position to 31st December 2015** **Presented by P Athey** PA advised the committee that income received during the period was mainly due to Mr Dubrowsky legacy and further legacy of £25k. PA updated the committee of the actual spend analysis of the major funds and committed/approved bids against these funds to make aware of estimated funds available. SN queried the £25k new legacy and asked whether it was for a specific purpose but PA advised it was not. PA reported on the investment loss but advised it was due to economic factors. He highlighted that the investment portfolio was made up of a number of assets, some of which were held to hedge against stock market volatility. FK queried page 5 Oncology and a report in regards to who attended course and the learning outcome. GM queried how the learning was shared within the Trust. PA mentioned that there was a formal feedback process for bids of over £5,000 as these are approved by the Charitable Funds sub-committee. YB queried if triggers are in place for individuals who do not feedback. GM suggested that the study policy include a requirement for feedback from learning to be shared. FK advised HR should be starting point.	MQ to chase RG for report on conferences YB to speak to HR to establish process of feedback

170316-05	**<u>Cazenove market update and review of investments</u>** PA referred to the detailed report provided by Cazenove, and advised the committee that the investment had fallen by £25k in the period. The report was noted by the committee	
170316-06	**<u>Internal Audit Report</u>** PA advised that Charitable Funds had its first Internal Audit. Generally it was positive as picked up items already being discussed such as having the correct forms in place for donations and advertising. PA highlighted the recommendation relating to the appropriate authorisation of spend, but noted that this related to the completion of bid forms only; each requisition for charitable funds expenditure was still being signed off by the appropriate signatories. PA advised that the SFIs do not include details around the investment of Charitable funds. RA advised that policies and procedures for main trust should not be mixed with CF PA advised that there was a separate section in the SFIs relating the Charitable Funds, and that this had been approved by CF committee. FK questioned whether there is internal audit planned for future. PA advised there is nothing in plan for 16/17 but would be idea to include in 17/18 RA questioned if any of the actions had been followed up but Paul advised that this would be picked up via Audit Committee. FK advised next Audit should be in 2017/18.	1.2 and 1.4 to reviewed by June 2016 by MQ
170316-07	**<u>Mr Dubrowsky Legacy</u>** <u>Cazenove Investment Proposal</u> PA presented the recommendations from Cazenove regarding investment of the Dubrowsky leagacy and	

	noted that the key factors for consideration were risk appetite and the length of time that the funds would be held for. PA described the option of Absolute return- this was felt to be a safer option but had a lower expected return compared to equities. The general advice from Cazenove was that, assuming we were not intending to spend a significant proportion of the money quickly, it would be better to hold the investment in a multi asset fund If we are intending to hold the investment for a shorter period of time, an interest bearing account or absolute return would enable funds can be accessed quickly. General option if planning to invest in research lab in the near future would be to lean towards absolute return. YB questioned the long term outlook for our investments, given the economist view of the down turn and our current portfolio performance over the last quarter. PA highlighted the graph within the Cazenove paper, showing that the target for the portfolio is inflation plus 4% RA advised markets have picked up but also mentioned status of EU so would be against investing until decision made in June PA suggested that a firm decision was delayed until the direction of travel with regards to the research lab was agreed. <u>Research Lab</u> Presented by PA on behalf of PB, LJ and MS PA noted the various options outlined in the papers and advised that the authors recommended that the option involving collaboration between ourselves and the university was felt to be preferred as it expand the opportunities for research. YB queried how the relationship between UOB and	

	ROH would work (who would employee the staff, who would receive accreditation for research etc.) PA advised that any staff working at our on-site lab would be employed by the Trust, and that we would be paying a rental fee to access lab space at the UoB. PA queried why the previous business case had suggested that a number of the cost would be self-financing after an initial start-up period, but this did not seem to be the case in this iteration. The previous case also promised some commercial financing that was no longer referred to. The committee agreed that we needed to reach a position where research would be sustainable over the long term. PA questioned whether support should be given to a separate fundraiser for this fund, or whether this should be part of a wider fundraising platform for the Trust. YB agreed in regards to fundraising and highlighted that we should be looking to raise awareness on an international scale rather than just local. SN queried whether there are already charities undertaking this research, and whether formal links with these charities should be considered. FK advised that the case was currently very inward looking and felt that, due to the nature of cases, there should be an outward looking international scope. She also repeated her firm view that legal advice should be sought to the use of the legacy given the wording of Mr Dubrowsky's will. YB feels a presentation from Lee Jeys and Martyn Snow to Charitable Funds sub-committee would be very helpful to understand the long-term opportunities for the fund and to help to directly answer some of the questions being raised. A brief discussion regarding the potential for a conference to be supported took place. RA feels inviting fellows to attend could possibly be only way	LJ MS PB to provide presentation-soon YB to get some legal advice on legacy.

	of providing strategy of how to expend funds/research lab. YB reiterated the importance of ensuring that the legacy left of Mr Dubrowsky was used to deliver maximum benefit in his memory.	
170316-08	**<u>Fundraising</u>** **<u>Prenseted by Yve and Jane</u>** JCo Legacy Brochures around Trust, buying places in London Marathon. BCH are available to provide further information and strategy. YB advised we should develop fundraising and join association and get them to present. Think about increasing publicity, liaise with Comms team. If fundraising for bigger funds would have to review legality issues, potential requirement for further admin requirements. RA questioned how do we go about creating strategy for fundraising? YB go to BCH and gain advise and ask them to review- pick up strategies from others such as Stanmore. Do as much as we can from existing strategy i.e. publicise. FK mentioned that concerns in regards to the lack of spending so fundraising and not spending wouldn't be ideal. <u>She also pointed out that historically there had been low levels of expenditure of charitable funds. That must change if there is to be an increase in fundraising.</u> Small resource and organisation- questions where is the capacity? Requires someone to spearhead project. Needs persuasion that we actually have resources available. YB advised we have invested a lot in Comms and we can use to assist. Contract basis to raise funds of which salary will be consisted off. RA asked about commercial sponsorship to help	YB and JCo CEO Association of NHS to visit in next meeting

	fundraise. Pick up next CF meeting.	
170316-09	**<u>Bids for funding</u>** The Committee heard bids (Enclosures 8-13).	
	<u>9a Orthotics Accessibility</u> **<u>Presented by Janet Campbell (JCa)</u>** JCa presented a bid designed to increase space and improve access in the Orthotics waiting are. She advised that we had already made some attempts to improve accessibility but they have not had the desired effect. We are unable to get wheelchairs through un-aided and the waiting room is very small, meaning patient experience is not good. YS questioned if there would be anymore storage space created. JC advised that this was not part of the plan as it relates to walk way area and extra storage would reduce space. FK advised <u>that if a blockage was not created then this would improve the area.</u> JCa highlighted that prices were currently draft, and could not be confirmed until we engaged our architects to agree a formal specification. FK agreed in principal to the bid, subject to detailed costs. GM questioned the Health & Safety issues as a store room has been changed to a consulting room and would therefore require a window. PA questioned whether we are agreeing for architects fees to be funded from Charitable Funds? It was agreed in principal that architects fees could be funded from Charitable Funds.	JCa to provide detailed costs Estates to provide support for design issues, particularly around Health & Safety
	<u>9b Quality Mark</u>	

	Presented by Anne Crompton (ACr) ACr presented a bid to support the introduction of a nursing quality mark. She advised that ward sisters and managers would all need to sign up and agree individually to have Royal College support. YS questioned if it would require further training for staff? ACr advised some staff would need to attend training to establish how it works, and that some training would be incorporated through existing routes. For example, when the dementia strategy moves forward, the training for staff will be picked up then. GM feels staff care but that this would provide public confidence in the care that we provide. YB agrees and wants staff involved to feedback on how they can implement the Quality Mark. FK questioned whether this was a one off cost and for how long does it last? ACr advised it is for the duration of the award and process to be reassessed on an interim basis to ensure we can continue having the award. It was agreed to fund £1,200 per ward	
	9c Rose Cottage **Presented by Maurice Adkins (MA)** MA presented a bid to improve the environment in Rose Cottage. GM questioned how we were ensuring that we catered for all religions. He also queried what the £500 for contingencies related to. MA stated that the contingencies were for any necessities that committee may feel are needed and also pointed out to some elements of the bid were only estimates at this point, YB questioned number of deaths in past year. MA advised of around 9 deaths. YS supported the bid and advised it it is lasting	

	memory and should be a more pleasant experience. YB agreed as long as it is on basis of multi faith room. GM suggested that advice from an undertaker should be sought on how to refurb. It was agreed to support the bid of £5350.10	
	9d Gym **Presented by Fraser Pressdee (FP) and Nikki Mason (NM)** FP & NM presented a bid to support improvements to the physical estate and equipment within the physiotherapy gym. The bid provided a range of options at different prices. YB supported the bid, noting her past experiences and discussions with staff members regarding the opportunity to enhance patient service from upgrading equipment. She noted her support for the larger bid. GM also agrees and feels physio is a neglected part of ROH. The supported the larger bid, but possibility without the estates works? PA supported the principle, but urged caution given the commitments to General Funds already made, and the fact that with NHS funding tightening, there were likely to be further bids in 2016/17 for medical equipment that could be accelerated using available charitable funds. FK asked if there were any other funds that could be utilised? PA advised that the League of Friends fund may be an option SN questioned if whether all the expenditure should come from charitable funds NM advised the replacement of equipment has been carried out when required from exchequer funds. This bid was to enhance the offered that could be supported from the usual NHS route.	

	FK suggest that the League of Friends should be asked if thay would be willing to support the larger bid? SN asked whether it should be part of overall review of therapy services. YB advised that it fits with the Birmingham MSK review and also is a key part of the hospital strategy. YS queried annual service costs and NM stated this would need to be funded through their exchequer budget. GM queried whether there were any other suitable funds. PA mentioned that most funds have specific purposes and he was not aware of any other options. SN pointed out that we need to advertise the expenditure from Charitable Funds to increase future donations FK reiterated the need to see if the League of Friends would be willing to support this bid. This could include their branding in some way. We could then make a decision in the next meeting. The bid of £75,000 was agreed in principle subject to clarity around funding routes.	Leagues of Friends (LOF) to be contacted
	9e Learning and Development **<u>Presented by David Richardson (DR) and Pauline Jones (PJ)</u>** DR and PJ presented a bid for further funds to continue to work undertaken by Learning & Development following a previous successful bid for £75,000. It was noted that the Trust has recently won two regional apprenticeship awards. FK questioned how much of the £75,000 has been spent to date.? PJ advised around £62,000. This was	MQ to query totals

	different to the amounts recorded in finance. MQ agreed to look into this. FK asked if it is publicised around Trust. DR confirmed that is was and advised that a lot of people were interested and that demand higher than supply SN asked if we are retaining the individuals we train? DR advised that the L&D policy states that if staff leave within 2 years, then a certain percentage of funding is paid back. PA feels that the previous bid has clearly delivered its aims and so we could be confident of benefit that could be gained from this bid. That said, he again noted the limited funds and questionned whether the Trust would benefit more from the capital purchase of equipment that would benefit a range of patients rather than L&D support for individuals. YB feels that this offers good value and supports the bid but given the reducing nature of the funds available suggest that, as future funding comes in, we should set it aside to supported the bid. FK identifies that this bid supports individuals that did not have opportunity for training and this this therefore helps retain staff and develop our own staff. SN feels that staff retention is important. It was agreed to support £42,810 over 2 years, and that this should be communicated to all relevant staff.	remaining from £75k
	9f Bicentenary of ROH **Presented by Sally Xerri-Brookes (SXB)** SXB presented a bid to support the work planned to celebrate the bicentenary of the ROH. She advised they we attempting to get a Royal visit and feels we have a strong case Part of the bid related to the development of a booklet. FK queried who will be reading the booklet and who will design it? SXB stated it will go directly to patients, members and staff. The communications team can design the booklet – it will be a simple way of summarising the	

	organisation. YB felt this would be a good use of Charitable Funds as we continue to celebrate and help motivate staff. FK feels that this directly relates to staff and therefore can pick up funds from other various funds. She supported the idea to provide a budget for the team to carry out activities. It was agreed to support funding of £10.700	
	9g ANP Nurse Qualification **Presented by Jo Phillips (JP)** JP presented a bid to support ANP training. YB advised that as general funds were running out, we should consider using spinal funds. Mohammed Qasim was to investigate the potential of funding through specific spinal charitable funds, and YB was to advise Alistair Stirling of this.	MQ to look into options for using Spinal funds. YB to advise Alistair Stirling regarding request to use Spinal funds to support bid
170316-10	**Bids approved virtually** Queen's 90th Birthday Already approved and cheque sent for ROH to be included in book.	
170316-11	**Six month updates** Enclosures 11a Dementia Event and 11b R & D Drug Trial. Committee expressed thanks for updates.	MQ to contact SK re Dementia update
170316-12	**Briefing on the role of the Charitable Trustee**	

	Committee acknowledge Trustee documentation and there were no queries.	
170316-13	**<u>Gift Aid Form</u>** Committee acknowledge revised form but may need revising depending on feedback.	MQ to action feedback information
170316-14	**<u>Physiotherapy Fund- purpose amendment</u>** The committee were unable to review this request during the meeting and requested for this to be circulated virtually for approval. FK doesn't feel expanding purpose of fund is deemed appropriate	MQ Find practical solution & to get more details in regards to source of funds and why needs to change
	<u>Any other business</u> YS queried the charitable funds bid that had been approved of for the Falls Prevention beds and whether or not there was a correlation in the reduction of falls since these beds have been purchased. SN queried the Mindfulness Training bid and requested any feedback on the learning outcomes that have been established.	YB to provide information in regards MQ to contact CB to obtain further information.
	<u>Date of future meetings</u> TBC	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 6 July 2016

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 6 July 2016 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.

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** 6 July 2016: 1100h – 1330h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair & Non Executive Director	(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 Paul Athey	Finance Director	(PA)
Mr Garry Marsh	Director of Nursing & Clinical Governance	(GM)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(AC)	
Prof Phil Begg	Director of Strategy & Transformation	(PB)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]
Mr Patrick Thies	Physician Associate	(PT)	[Item 3 only]
Mr Neil Rogers	Divisional General Manager (Division 2)	(NR)	[Item 12.1 only]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies – Mr Andrew Pearson & Mr Jonathan Lofthouse	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	Update from Physician Associate	Presentation	PT/PB
1125h	4	Minutes of Public Board Meeting held on the 1 June 2016 *for approval*	ROHTB (6/16) 012	Chair
1130h	5	Trust Board action points: *for assurance*	ROHTB (6/16) 012 (a)	Chair
1140h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (7/16) 003 ROHTB (7/16) 003 (a)	YB/JC
		MATTERS FOR APPROVAL		
1200h	7	Risk Management policy: *for approval*	ROHTB (7/16) 005 ROHTB (7/16) 005 (a) ROHTB (7/16) 005 (b)	SGL
		QUALITY & PATIENT SAFETY		
1210h	8	Freedom to Speak Up Guardian appointment: *for assurance*	ROHTB (7/16) 004 ROHTB (7/16) 004 (a) - ROHTB (7/16) 004 (c)	AC

1220h	8	Safe Staffing Report: *for assurance*	ROHTB (7/16) 005 ROHTB (7/16) 005 (a)	GM
1230h	9	CQC action plan update: *for assurance*	ROHTB (7/16) 006 ROHTB (7/16) 006 (a)	GM
FINANCE AND PERFORMANCE				
1240h	10	Performance reports: *for assurance*	ROHTB (7/16) 007 ROHTB (7/16) 007 (a) ROHTB (7/16) 007 (b)	PA/GM
COMPLIANCE & RISK MANAGEMENT				
1300h	12	Board Assurance Framework – Quarter 1 2016/17: *for assurance*	ROHTB (7/16) 009 ROHTB (7/16) 009 (a)	SGL
1310h	12.1	Pathology service update: *for assurance*	To follow	NR
ASSURANCE UPDATES FROM THE BOARD COMMITTEES				
1320h	13	Quality & Safety Committee	ROHTB (7/16) 010	KS
	14	Finance & Performance Committee	ROHTB (7/16) 011	RA
	15	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 7th September 2016 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.

MINUTES

Trust Board (Public Session) - DRAFT v0.3

Venue Boardroom, Trust Headquarters **Date** 1 June 2016: 1100h – 1300h

Members present

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair	(TP)
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	Director of Finance	(PA)
Mr Andrew Pearson	Medical Director	(AP)
Mr Garry Marsh	Director of Nursing & Clinical Governance	(GM)

In attendance

Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]
Dr Navina Evans	Observer		

	Paper Reference
1 Apologies	**Verbal**
Apologies for absence were received from Mrs Kathryn Sallah, Anne Cholmondeley and Phil Begg. The Chairman welcomed Navina Evans who was observing the Board meeting in support of her aspiring Chief Executive's course and the planned assistance with the Trust's Well Led Framework review.	
2 Declarations of Interest	**Verbal**
The Director of Operations reiterated the declaration made in the private session that his partner was no longer employed by KPMG LLP.	
3 Patient Story	**Presentation**
The Deputy Director of Nursing & Clinical Governance presented a patient story, which related to a long term patient of the ROH transitioning from care as a Paediatric patient to being treated by adult care services. The story particularly focused on the management of the patient's post discharge treatment, which had been a mix of good and bad patient experience. The story highlighted the need for	

better support for patients transitioning through the care pathway. It was reported that the patient voice would be reflected in the new transitional care policy and this story would be shared as part of the implementation plan for this policy. Pre-operative planning had not been sufficiently robust as it had not picked up on the patient's autism prior to admission. The patient's medication had not always been delivered on time while in the care of the Trust, which had been due to a lack of understanding of the patient's needs rather than a genuine delay in medication. The advice on where to seek advice post discharge had also been confusing. The Chief Executive noted the case highlighted an improvement in the complaints handling process which now focused on meetings to support complaint resolution. However, concern was expressed concerning whether the Trust was undertaking robust pre-operative assessment. This case reflected the absence of a learning disability strategy and learning from the Royal National Orthopaedic Trust was being sought. In terms of medication, adequate pain control was currently an area of focus for the Trust and self-administration was being considered. NHS England was undertaking a programme on customer care training. It was suggested this might need to be developed through Workstream 1 of the Transformation Programme across the organisation to cover all types of staff including reception staff. The Chairman suggested peer reviews would assist with reflective learning. Clarity was needed on non-compliance on the learning disability standards, in light of the quarterly declarations to Monitor around this as a key target. The Board was informed that at present the selection of patient stories to come to the Board was random. Some further through would be given to how this could be more systematised.	
ACTION: Investigate compliance with the learning disability national standard in the context of the quarterly declarations to Monitor **ACTION: Develop a forward plan of patient stories to the Board**	
4 Minutes of the Public Board 4 May 2016	**ROHTB (5/16) 014**
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 (5/16) 014(a)**
The action log was received and noted. The Associate Director of Governance & Company Secretary provided an update on those actions outstanding.	
6 Chairman's and Chief Executive's update	**ROHTB (6/16) 002** **ROHTB (6/16) 002 (a)**
The Chief Executive presented an update on national and local developments since the last meeting.	

Board members were encouraged to attend the Patient Safety Conference planned for 6 June 2016. The policies approved and risks identified by discussions at The Trust Management Committee were noted. The Chairman made a number of points: • The ROHBTS ball on 13 May at Hogarths Hotel, Dorridge had been a terrific success • The Harrison lectures had been launched on 12 May 2016; the dates for the forthcoming lectures would be circulated • She had visited Birmingham Children's Hospital NHSFT to see how fundraising was undertaken elsewhere. This would be a real challenge for ROH but was an exciting opportunity • The National Nurses Day celebration had been a very positive success and was a really upbeat event • She had joined part of the Staff League at the invitation of Stella Noon, former governor to update the League on developments at the ROH • Some time had been spent in theatres shadowing Mr Pearson and she continued to spend time with patients and families across the Trust • An advert for NED recruitment would be issued shortly. It had been decided to organise the recruitment internally and a date at the end of July had been fixed for making appointments. Two NEDs were being sought, one with a background in commercial/partnership working and another with an academic/clinical background.	
7 Performance reports	**ROHTB (6/16) 004** **ROHTB (6/16) 004 (a)** **ROHTB (6/16) 004 (b)**
The Director of Finance explained the finance and performance report had been redesigned in line with the Quality & Patient Safety report which was considered by the Quality & Safety Committee. The financial position was largely in line with plan. Overall, income was at the same level as expected. From a Monitor risk rating perspective, the Trust remained at '2'. A profitable position was expected for Month 3, although income associated with outpatient procedures was below plan. Regarding the pain management service, there was underperformance relating to the retirement of one specific consultant who would need to be replaced by two consultants to manage cases in a different way. The triage service needed to be used more effectively and the Musculo-Skeletal (MSK) service would be accessed for support. Commissioners were considering pain management commissioning in its wider sense and it was agreed	

a more forward looking view was required to identify areas where consultants were coming up for retirement to avoid a break in service provision. In the meantime, access to an individual working in the pain clinic at University Hospital Birmingham NHSFT was being investigated. Communication with commissioners was underway to discuss the position. Theatre pay and ward pay had reduced in line with expectations to meet the agency cap set by NHS Improvement. An assumption had been made that the stock position was being carried over from the position reported in the annual report and accounts. The service line reporting profitability position would be presented to the Finance & Performance Committee in June which would enable a peer to peer review and decisions concerning provision of future services. Peer pressure would assist with demonstrating how individuals impacted on the overall position and should facilitate improved holding to account. Efficiency could be driven out by standardising implants used by individuals. At present a number of CIP schemes were behind schedule. Medium and high risk schemes were being given due focus. It was agreed that the names of the divisions needed to be clarified in the report. An internal audit on CIP processes had been undertaken. A drop in activity had been seen in May and efforts were being directed to resolve this. The Director of Operations confirmed the position would be reversed, advising there was a move to being more forward looking and agile to ensure theatre occupancy is maintained by filling fallow tables where these occur. The information available was now more informative and showed where activity needed to be shifted around. Consultant holidays plans needed to be set early enough to make operational plans more definitive. It was agreed that these decisions needed to be robust and it was suggested that approval of holidays needed to be in the interest of the service. The Chief Executive advised policies were in places, which were currently being reviewed, to ensure a better approach. It was agreed that this should be considered at Finance & Performance Committee. The Patient Journey work will deliver an improved position in terms of activity and performance. It was agreed that closed theatres needed to be differentiated in the information concerning theatre utilisation. The Board was reminded that the operational plan for 2016/17 had been signed off with no headroom for slippage and there were risks around the work to address the recommendations of the Royal College of Paediatric and Child Health (RCPCH) review. The practical implementation of the elements of the workplan to deliver a step change needed to be clarified. It was reported that the job planning process would unlock some potential headroom by reorganising supporting professional	

activities (SPA) time and would also deliver a change to some of the traditional working patterns. The Chairman reported that as from July, Tim Pile would chair the Finance & Performance Committee. The Quality & Patient Safety report was considered. The Board was advised that mandatory training had been revised to reflect the new Duty of Candour process and incident reporting. The CCG representative, who had been present at the Quality & Safety Committee meeting, had confirmed that Root Cause Analyses had improved and a return rate to the Trust was zero for the past few rates. A falls report would be presented at the June Quality & Safety Committee. It had been agreed to invite the ward managers to present their plans to eliminate all avoidable pressure ulcers. An in depth report to the Quality & Safety Committee on the Trust's compliance with the requirements of the Friends and Family Test was planned. Work was also planned to demonstrate systematic learning of lessons from incidents, claims and litigation. A ward health check had been developed, which picked out areas of clinical concern. This would now be considered at the ward managers forum. Ward 1 had been a concern previously, however it was now the best performing across a range of indicators which was pleasing. The detail of the serious harm incident was questioned, which it was agreed would be provided outside of the meeting. It was suggested that the compliments needed to be clarified as they did not appear realistic.	
ACTION: **The process for approval of consultant leave to be considered at the Finance & Performance Committee** **ACTION:** **Provide the detail of the serious harm incident outside of the meeting** **ACTION:** **Clarify the position in terms of compliments**	
8 Safe staffing report	**ROHTB (6/16) 005** **ROHTB (6/16) 005 (a)**
The Director of Nursing & Clinical Governance advised that the report had been considered previously by the Trust Management Committee and he was pleased to report the Paediatric nurse vacancies had been filled. An assessment against the Royal College nurse staffing standards in relation to HDU had been undertaken and full compliance would be achieved by September. There were some challenges with fill rates for healthcare assistants and an establishment review was planned. Overall there was a slight increase in nurse vacancies, however a range of	

recruitment steps were underway. Recruitment into positions within theatres was underway and a piece on theatre recruitment in theatres would feature in the in next edition of 'ROH Life', the Trust's in-house magazine. Agency usage was static. The Director of Nursing & Clinical Governance was due to meet with the nurses that had recently joined from overseas. Interviews for e-roster project lead had taken place and a successful candidate appointed. There were some suggested amendments to the report: • In the appendix listing reported nurse staffing incidents, detail of mitigation to be added. • The difference between budgeted and actual staff usage accounted for by use of bank staff needed to be more clearly reflected in future reports.	
ACTION: Amend nurse staffing report in line with suggestions	
9 NHS Improvement annual declarations 2015/16	**ROHTB (6/16) 006** **ROHTB (6/16) 006 (a)** **ROHTB (6/16) 006 (b)**
The Associate Director of Governance & Company Secretary advised that there was a requirement to make a set of declarations to NHS Improvement on an annual basis. The declaration confirming compliance with the terms of its licence to operate as a Foundation Trust had already been submitted as agreed at the last meeting. The next set of declarations needed to be submitted by 30 June and were: • Confirmation that sound corporate governance arrangements had been in place during 2015/16 and were in place for the forthcoming year. The proposed response was '**confirmed**' to all statements within this declaration. • Confirmation that the Trust had, during 2015/16, trained the Governors sufficiently to enable them to undertake their role effectively. The proposed response was '**confirmed**' to this statement. • Confirmation that should the organisation be part of a Joint Venture or Academic Health Science Centre, appropriate requirements had been met. It was noted that as the Trust was neither part of a Joint Venture nor was an Academic Health Science Centre, this declaration should be answered as '**not applicable**'	

The evidence available to support the declarations was set out in a paper which the Board reviewed. It was agreed that final sign off of the declarations be delegated to a Committee of the Chairman and Chief Executive for submission on 30 June 2016.	
10 Audit Committee	**Verbal**
The Chair of the Audit Committee advised that at the May meeting, the Committee reviewed the Annual Governance Statement and annual report & accounts, and had recommended their approval and adoption to the Board. These had been submitted by the required deadline of on 27 May 2016.	
11 Transformation Committee	**ROHTB (6/16) 007**
The Board received and noted the assurance report.	
12 Quality & Safety Committee	**ROHTB (6/16) 008**
HH Frances Kirkham reported that at the last meeting of the Quality & Safety Committee, the presentation by Dr Rea on the work of the Drugs and Therapeutics Committee had been well received. A concern had been raised in connection with blood fridge monitoring and this was being addressed. The scope of the authority of the Physicians Associates to prescribe had been discussed and this would be reported back at a future meeting.	
13 Council of Governors	**Verbal**
The Chairman reported that at the last Council of Governors meeting, the following had been discussed: • Annual report & accounts in draft, including an explanation of the deterioration in the financial position • An update from Tauny Southwood on the latest staff survey results and actions planned to address the areas where improvement was needed • An update from Tim Pile on the work of the Finance & Performance Committee including the development of a new suite of assurance reports • The plans for the introduction of the Board walkabouts, in which governors would be involved Since the meeting, a public governor election process had been held, which saw the re-election of longstanding governors Rob Talboys and Jean Rookes and the election of a new public governor Brian Toner. A new stakeholder governor had also joined the team, Councillor Peter Griffiths. A staff governor election was due to start which would see elections concluding over the summer.	
14 Charitable Funds Committee (minutes)	**ROHTB (6/16) 009**
HH Frances Kirkham reported that a meeting of the Charitable Funds Committee	

had been held on 27 May. In terms of the Dubrovsky legacy, legal advice had been taken to agree how the funds could be used and further discussions were planned to take this forward. A presentation by Prof Davies had been received on joint inflammation and a request made to support a post-doctoral research fellow. Funding had been agreed as a 'pump priming' project but there was a need to protect the Trust's Intellectual Property. In response to some concerns around the robustness of the process to support the work, the Chief Executive advised that the research to be supported had not yet generated mainstream funding routes. Confirmation of the Due Diligence process would be provided by Prof Begg and usual research governance requirements would be applied internally. Some methods for prioritising funding requests would be considered at a forthcoming meeting. The Committee had received a helpful report from the Trust Chairman as to how fundraising could be taken forward and the funding of an internal post with responsibility for fundraising had been agreed.	
14 Any Other Business	
All were encouraged to join the Patient Safety Conference on 6 June. Further details would follow.	
Details of next meeting	**Verbal**
The next meeting would be held on 6th July 2016 at 1100h, Board Room, Trust Headquarters	

PUBLIC SESSION

Next Meeting: 7 September 2016, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

1 June 2016, Boardroom @ Trust Headquarters

Members present: Yve Buckland (YB), Tim Pile (TP), Rod Anthony (RJA), Tauny Southwood (TS), Frances Kirkham (FK), Jo Chambers (JC), Jonathan Lofthouse (JL), Paul Athey (PA), Garry Marsh (GM), Andy Pearson (AP)

In Attendance: Navina Evans

Apologies: Kathryn Sallah (KS), Anne Cholmondeley (AC), Phil Begg (PB)

Secretariat: Simon Grainger-Lloyd (SGL)

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
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	~~03/02/2016~~ 6-July-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. Further development work currently underway. Names of individuals suggested to trial the system have been put forward. Further update in July 2016.	
ROHTBACT. 018	Annual inclusion report	ROHTB (5/16) 008 ROHTB (5/16) 008 (a)	04/05/2016	Review the scoring for Domain 3 of the EDS assessment	AC	~~01/06/2016~~ 6-July-16	Verbal update on outcome at meeting	
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~~ ~~03-Feb-16~~ ~~06-Apr-16~~ Jun-16	Work underway to develop the material presented to the Finance & Performance Committee into a revised version of the Corporate Performance Report	

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 ~~6-Apr-16~~ Jun-16	Will be built into the new CPR or equivalent	
ROHTBACT. 014	Patient Case – an illustration of the work we do	Presentation	06/04/2016	Quality & Safety Committee to consider the future plans for screening dementia patients	SGL	25-May-16	Deferred to July meeting	
ROHTBACT. 015	One year operational plan and budget sign-off	ROHTB (4/16) 005 ROHTB (4/16) 005 (a)	06/04/2016	Case studies from the material considered by the Finance & Performance Committee to be presented to the Trust Board	SGL	01-Jun-16	Deferred to meeting in autumn when Finance & Performance Committee is operating as 'business as usual'	
ROHTBACT. 020	Board Assurance Framework	ROHTB (5/16) 009 ROHTB (5/16) 009 (a)	04/05/2016	Update the BAF to include risks to the sustainability of the organisation agreed at the Board strategy day	SGL	~~06/07/2016~~ 1/10/2016	Will be updated once the strategy refresh is complete.	
ROHTBACT.02	Patient Story	Presentation	01/06/2016	Develop a forward plan of patient stories to the Board	GM	01-Sep-16	ACTION NOT YET DUE	
ROHTBACT.03	Performance reports	ROHTB (6/16) 004 ROHTB (6/16) 004(a) ROHTB (6/16) 004(b)	01/06/2016	The process for approval of consultant leave to be considered at the F&P committee	JL	19-Jul-16	ACTION NOT YET DUE	

ROHTBACT.01	Patient Story	Presentation	01/06/2016	Investigate compliance with the learning disability national standard in the context of the quarterly declarations to Monitor	SGL	06-Jul-16	Indications suggest that Trust is not compliant with the learning disability national standard. Commentary to be included in the quarterly governance report to Monitor.	
ROHTBACT.04	Performance reports	ROHTB (6/16) 004 ROHTB (6/16) 004(a) ROHTB (6/16) 004(b)	01/06/2016	Detail of the serious harm incident to be provided outside of the meeting	GM	06-Jul-16	Detail circulated.	
ROHTBACT.05	Performance reports	ROHTB (6/16) 004 ROHTB (6/16) 004(a) ROHTB (6/16) 004(b)	01/06/2016	The position in terms of compliments to be clarified	GM	06-Jul-16	Detail to be provided at the July meeting	
ROHTBACT.06	Safe staffing report	ROHTB (6/16) 005 ROHTB (6/16) 005(a)	01/06/2016	The nurse staffing report to be amended in line with suggestions discussed at the meeting	GM	06-Jul-16	Amended as requested	

KEY:

	Verbal update at meeting
	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

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:	**6 July 2016**

EXECUTIVE SUMMARY:

This report provides an update to board members on the national context and key local activities not covered elsewhere on the agenda.

The report also provides a summary of key discussions and decisions taken by the Trust Management Committee since the Board last met.

REPORT RECOMMENDATION:

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

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:

The contents discuss a number of developments which have the potential to impact on the delivery of a number of the Trust's strategic ambitions

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 6 July 2016

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 NHS finances continue to be a major focus at a national level, with Jim Mackey publically announcing in the last month that he expected the NHS provider sector to overspend by £500m in 2016/17, despite the injection of the £1.8b sustainability fund.

2.2 The importance of steadying the ship and delivering in 2016/17 was a key cornerstone of presentations from national leaders at the NHS confederation conference on 15th-17th June. Simon Stevens was clear that NHS England are out of their strategy phase now, and are focussed on implementation. Significant emphasis was placed on the STPs as a vehicle for delivering change at pace, however both Simon Stevens and Jeremy Hunt were clear that the STPs needed to be solving the real underlying problems, with solutions backed by robust data. They are not just a vehicle for bidding for money.

2.3 Results from the BMA's referendum on the new junior doctor's contract are expected to be announced in early July. At this point, we will know whether the contract is formally accepted. All NHS employers have been asked to cease work on implementation of the contract until the outcome of the referendum is known, except for appointment of the Guardian of Safe Working. We have sought expressions of interest in this role with a closing date of Wednesday 29th June.

2.4 Following the result of the EU referendum, NHS Employers are running a campaign aimed at recognising the valuable contribution of all staff including those who originate from the wider EU. The ROH has signed up to supporting this campaign through communications shared with our workforce.

3 Local Context

3.1 At the time of writing, the Birmingham and Solihull Sustainability and Transformation Plan (STP) is due for submission on 30th June 2016. Discussions have taken place between STP leaders and both NHS England and NHS Improvement where progress

towards a final plan has been positively noted. It is acknowledged that the Birmingham and Solihull STP footprint does not have a longstanding history of formal joint-working, and as such has a different start-point to some of the other local systems. It is therefore accepted that a further final plan submission is likely to be required in the autumn to build upon the information being submitted on 30th June.

3.2 The order officially creating the West Midlands Combined Authority (WMCA) came into force on 17th June 2016. The WMCA comprises 7 consistent authorities, 5 non-constituent authorities and 3 Local Enterprise Partnerships. The WMCA is the first step towards devolution in the West Midlands and, whilst these devolution arrangements do not include health services at this stage, there continues to be a link into the various STP footprints. I also represent West Midlands healthcare providers on the West Midlands Public Service Committee, which ensures that the Royal Orthopaedic Hospital has a presence within developments at the WMCA level.

4 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

4.1 In addition to routine business meetings with partners, other key stakeholder and partnership engagement activities over the period include:

- Meeting with Sarah-Jane Marsh, Birmingham Children's Hospital
- Birmingham and Solihull STP System Board meeting
- NHS Provider Chairs and Chief Executives Network Event
- West Midlands CEO meeting
- Attended NHS Confederation Conference, a three day conference held in Manchester with key note speeches from Simon Stevens

5 ROH PATIENT SAFETY CONFERENCE – JUNE 2016

5.1 The Trust's first ever Patient Safety Conference was held at the Midland Arts Centre on Wednesday 8th June 2016. The conference was attended by over 100 leaders from across the Trust, and was an opportunity to discuss and reflect upon the individual and collective contribution we all make towards patient safety. Our keynote speaker, Professor Michael West, spoke with real passion and enthusiasm as to how we need to 'listen with fascination' to each other, and take action to ensure that we are always working together to deliver excellent care for our patients. Workshops ran throughout the day, giving attendees a chance to reflect upon their own leadership and values, and feedback from staff was very positive about the stimulating content of these sessions.

5.2 Feedback from the conference will be shared across the Trust and actions arising will be incorporated into our revitalised staff engagement work, led by our HR & OD team.

6 UPDATE FROM TRUST MANAGEMENT COMMITTEE

6.1 Since the last meeting of the Board on 1 June 2016, the Trust Management Committee (TMC) was held on 22 June 2016.

6.2 **22 June 2016**

TMC considered the following items to be of note to the Board:

- Following discussion, it was agreed that an update report on progress against the Patient Journey II programme would be reported to TMC as a standing item on a monthly basis, given the implications that the improvement & efficiency schemes have for the achievement of the Trust's activity and financial targets.
- A revised Business Case for additional Anaesthetic staff was presented and approved on the basis of:
    - Discussion & engagement with the surgeon body
    - Update on additional staffing to Theatre User Group
    - Further analysis of costings within the case to ensure staff / middle grades costed correctly
    - Phased recruitment approach
    - Follow up report presented back to TMC in July
- A Business Case for theatre staff was presented to TMC. The case was challenged on both its financial accuracy and levels of professional engagement, therefore it was agreed that additional discussions would take place with the Director of Finance and Director of Nursing & Clinical Governance, before returning to TMC in July. Vacant posts are already out to recruitment, and it was agreed that recruitment should continue whilst this case is finalised.
- TMC approved the recommendation that the Trust returns to its status as a 'dropped instrument facility' by October 2016 following a review of the Decontamination Service, where it has been identified that the Trust
- A high level Procurement Strategy was reviewed by TMC and support was given for the enhancement of the Trust's existing procurement function, and a commitment to agree the level of 'invest to save' resource required. A Business Case will be presented to TMC at a later date.
- TMC endorsed the recommendation for a new Data Quality Committee to be established, with clinical engagement from Divisions required.

6.3 The following policies were reviewed by TMC and recommended for approval:

- Non-Medical Prescribing Policy
- Safe Surgery Policy
- Appraisal and Revalidation Policy
- Responding to Concerns Policy
- Transitional Care Policy (with agreed action for Division 1 to prepare an operational policy for the management of patients between 16-18 years old)

6.4 TMC acknowledged that a number of risks had presented themselves throughout the meeting which would need to be captured on the Corporate Risk Register, including:

- Sickness absence levels in the unregistered nursing workforce and the potential linkage to staff satisfaction
- Delay to the improvements planned to the Pre-Operative Assessment Centre processes
- Risks posed by the recommendations within the report from the review by the Royal College of Paediatric and Child Health

7 RECOMMENDATION(S)

7.1 The Board is asked to discuss the contents of the report, and

7.2 Note the contents of the report.

Jo Chambers
Chief Executive
29 June 2016

ROHTB (7/16) 005

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

POLICY TITLE:	Risk Management Policy
ACCOUNTABLE EXECUTIVE LEAD:	Jo Chambers, Chief Executive
POLICY AUTHOR:	Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary
DATE OF MEETING:	6 July 2016

POLICY STATUS: *[add X to the relevant box]*

NEW POLICY		**AMENDED EXISTING POLICY**	**x**

SUMMARY OF KEY POINTS/CHANGES:

The Risk Management Policy is presented for approval.

The key changes to the policy are:

- The Policy has undergone a full rewrite
- Clarification of the risk assessment and escalation process
- Introduces requirement for the risks proposed for addition to the Corporate Risk Register and BAF to be considered by the Trust Management Committee and propose to the Trust Board whether these should be added and how they should be treated
- The Trust Board will receive the Corporate Risk Register monthly and BAF quarterly

The Trust Board is requested to approve the policy, together with the proposed implementation plan.

The length of the policy is 19 pages.

CONSULTATION:

An early draft of this policy was presented to the Trust Management Committee for initial comment and then circulated to the key managers across the Trust for formal consultation afterwards for a period of a calendar month. The Clinical Quality Committee has also considered and supported the policy. The outcome of this consultation is reflected in this policy.

EQUALITY IMPACT ASSESSMENT:

The development of the policy has involved an equality impact assessment and an initial impact assessment has been completed and approved by the Associate Director of Governance & Company Secretary.

ROHTB (7/16) 005 (a)

The Royal Orthopaedic Hospital
NHS Foundation Trust

RISK MANAGEMENT POLICY

Policy author(s)	Associate Director of Governance and Company Secretary
Accountable Executive Lead	Chief Executive
Approving body	Trust Board
Policy reference	ROH/ORG/0XX

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:
1 – All staff

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:
1 – All staff

POLICY APPROVAL DATE:
July 2016

POLICY IMPLEMENTATION DATE:
August 2016

DATE POLICY TO BE REVIEWED:
June 2019

ROHTB (7/16) 005 (a)

DOCUMENT CONTROL AND HISTORY

Version No	**Date Approved**	**Date of implementation**	**Next Review Date**	**Reason for change** (e.g. full rewrite, amendment to reflect new legislation, updated flowchart, etc.)
1.0	July 2016	August 2016	June 2019	Full rewrite to clarify process of identifying, assessing and reporting a risk

RISK MANAGEMENT POLICY

KEY POINTS

1. Risk assessment is key to management of risk in the Trust

2. Staff and managers at all levels have a role to play in ensuring risks are managed effectively. Responsibilities are set out at section 5.

3. The procedure for risk assessment and management is set out in section 6

4. Additional risk controls are formed into Risk Treatment Plans

5. A summary of risk assessment findings is transferred into a Risk Register and progress against actions monitored by an appropriate level of management/body (e.g. committee)

6. Effective management of risk benefits patient, staff and others. It also ensures legal compliance and compliance with other standards (e.g. CQC fundamental standards)

PLEASE NOTE THAT THIS LIST IS DESIGNED TO ACT AS A QUICK REFERENCE GUIDE ONLY AND IS NOT INTENDED TO REPLACE THE NEED TO READ THE FULL POLICY

RISK MANAGEMENT POLICY

CONTENTS

APPENDICES:

1. INTRODUCTION

1.1. Risk management is both a statutory requirement and an indispensable element of good management at the Royal Orthopedic Hospital NHS Foundation Trust. It is a fundamental part of the total approach to quality, corporate and clinical governance and is essential to the Trust's ability to discharge its functions as a partner in the local health economy, as a provider of safe and high quality health services to the public and as a responsible employer of significant numbers of staff. It is expected that all risk management activities in the Trust will follow the procedure and principles described within the policy to ensure a common approach to risk management.

1.2. The Trust accepts its humane, economic and legal responsibilities in connection with this policy and is committed to fulfilling those responsibilities and improving standards where possible.

1.3. The Trust accepts that some of its activities may create risk to patients, staff and others and will take all reasonably practicable measures to control these risks to an acceptable level.

2. OTHER POLICIES TO WHICH THIS POLICY RELATES

- Health & Safety
- Fire Safety
- Incident Reporting

3. GLOSSARY AND DEFINITIONS

3.1. *Hazard:* means anything which has the potential to cause harm, damage or loss

3.2. *Risk:* means the "probability of something happening that will have an adverse impact upon people, plant, equipment, financials, property or the environment and the severity of the impact." *(ASNZA 4360 1999)*

3.3. *Clinical Risk:* means any risk arising from the clinical care that might harm one or more persons receiving NHS-funded care

3.4. *Non-Clinical Risk*: means any risk that may arise other than from clinical care.

3.5. *Risk Assessment:* means the systematic examination of the effect the Trust's undertaking may have on patients, staff and others as a result of its activities. The system enables the Trust to identify measures needed to control risks to acceptable levels.

3.6. *Risk Rating:* means the overall rating applied to a risk. This rating is arrived at by considering likelihood that a risk may result in harm/damage/loss together with the expected severity of the impact it might have on an individual and/or the Trust. Risk ratings and their calculations are defined by use of a risk assessment matrix.

3.7. *Risk Documents:* means risk assessments and risk registers

3.8. *Controlled Residual Risk:* means the risk remaining after controls have been put in place.

3.9. *Risk Treatment Plan:* means action required to implement additional controls.

3.10. *Target Risk Score:* means the level of risk remaining that is acceptable to the risk owner once all additional controls are implemented and effective so as to sufficiently control and/or prevent the realisation of negative impact, as far as practicable.

4. PRINCIPLES

4.1. This policy provides a continual, systematic approach to the assessment of all types of risks across the Trust. The same process is used to identify clinical, non-clinical, organisational, strategic, financial and reputation risks, analyse the risk and identify treatment plans to remove or minimise the identified risk.

4.2. An overriding principle behind robust risk management is the provision of a safe environment and sound working practices for treating our patients and to provide safe place in which staff can work. The Management of Health & Safety at Work Regulations, along with other statutory requirements, make explicit the legal duty placed on the Trust to ensure risks are systematically assessed and effectively controlled. The risk assessment process enables the Trust to fulfil this duty and comprises the following principles:

- Identification of hazards
- Deciding who/what might be harmed/damaged/lost
- Evaluation of risks and development of controls
- Recording of findings and implementation of controls
- Reviewing and updating of assessments

5. ROLES AND RESPONSIBILITIES

5.1. Trust Board

- Accountable and responsible for ensuring that the Trust has a programme in place for managing all types of risk at all levels
- Consider assurance reports from the Board's committees to verify that risks are being managed appropriately and that the Trust can deliver its objectives
- Receive the Board Assurance Framework quarterly to challenge and confirm that treatment plans for the key risks to the delivery of the Trust's strategic objectives are being effectively managed and gaps in control & assurance are being addressed
- Receive a monthly report on the Corporate Risk Register, noting the changes recommended by the Trust Management Committee (through the delegated authority of the Chief Executive)

5.2 Audit Committee

- Seek assurance on behalf of the Board that the Trust's risk management systems are effectively identifying and managing corporate and strategic risks

5.3 Other Board Committees

- Review quarterly the red risks on the Corporate Risk Register/BAF and confirm and challenge the adequacy of the treatment plans for those that are within the natural remit of the Committee

5.4 Trust Management Committee

- Receive a monthly update on all risks on the Corporate Risk Register and monitor progress against Risk Treatment plans
- Receive proposed additions to the Corporate Risk Register proposed by the Divisions/Project Boards/equivalent corporate groups
- Recommend to the Trust Board whether a new risk should be treated, tolerated, terminated or transferred or where appropriate the proposal to de-escalate or close a risk
- Confirm the validity of the risk scores of each risk on the Corporate Risk Register

5.6 Chief Executive

- Lead management commitment to the principles of this policy and enable effective implementation of its requirements.

5.7 Associate Director of Governance & Company Secretary

- Accountable for the development of an effective risk management framework within the Trust.
- Responsible for the process by which the Corporate Risk Register and Board Assurance Framework are updated and presented to the relevant Committee or Trust Board
- Ensures that decisions and feedback from the consideration of the Corporate Risk Register and Board Assurance Framework are communicated back to relevant staff

5.8 Executive Directors

- Ensure effective implementation of these standards and encourage improvement in their area of responsibility.

5.9 Divisional General Managers/equivalent including Heads of Service

- Ensure effective implementation of these standards and encourage improvement in their area of responsibility
- Ensure local and divisional risk registers are developed, monitored and maintained
- Ensure that risk registers monitored at the Executive or Board level appropriately reflect any changes or controls to the risks evident at Divisional or Corporate area level
- Ensure review of divisional risk registers and approve scores and risk treatment plans prior to inclusion in the Corporate Risk Register or Board Assurance Framework
- Co-ordinate actions required for their division or Corporate area to address all risk management issues.
- Monitor progress against local Risk Treatment Plans
- Monitor quality of local risk documents and facilitate continuous improvement

5.10 Divisional Governance Boards/Project Boards/Corporate & Clinical Committees

- Receive and consider risk assessments raised within the Division/Project/Corporate area
- Monitor the Divisional/Project/Corporate area risk register and progress with Risk Treatment Plans
- Propose to the Trust Management Board the addition of risks to the Corporate Risk Register
- Where appropriate propose de-escalation or closure of a risk from the Corporate Risk

Register

- Re-assign a risk to an alternative Committee/Group if needed, gaining agreement from the appropriate Committee/Group chair

5.11 Ward & Department Managers

- Ensure effective implementation of these standards and encourage improvement in their area of responsibility
- Ensure all risks are subject to the risk assessment process
- Involve staff in the risk assessment process
- Ensure staff are aware of the risks and controls affecting their health and safety
- Ensure risk documents are made available to staff
- Ensure controls are implemented and maintained. Request divisional assistance where appropriate
- Ensure risk documents are maintained and reviewed as appropriate

5.12 All staff

- Take reasonable care for the health and safety of themselves/ others (patients, visitors & other staff) who may be affected by what they do or fail to do
- Co-operate with all aspects of this policy, reporting defects and deficiencies promptly and appropriately
- Contribute to the risk assessment process
- Become and remain aware of risks and controls associated with their activities
- Co-operate with safe systems of work

6. RISK MANAGEMENT PROCEDURE

6.1 There are five steps to the risk management process which form a continuous cycle:

6.2 Risk Identification and recording

6.2.1 Staff should initially consider what their main areas of work are and how these relate to the local objectives and the objectives of the Trust. Every work area that has a significant hazard should be assessed for risk. A well-structured systematic approach is critical, because a potential risk not identified at this stage will be excluded from further analysis. Risk may be identified

from a number of internal and external sources including:

- Walking around your workplace and looking afresh at what could reasonably be expected to cause harm (e.g. change in practice, new equipment, new way of undertaking a procedure, workplace layout)
- Incidents, including trends of incidents
- Work-related sickness absence
- Business and service delivery plans
- Delivery plans for the achievement of the Trust's strategic objectives
- Complaints and claims
- External audits and regulatory frameworks (CQC, NHSLA, Internal audit, peer accreditation)
- Guidance issued by professional bodies, such as Royal Colleges
- Local inspection findings
- Equipment handbooks, material safety data sheets/product packaging
- Recommendations from national confidential enquiries or service frameworks
- Whistleblowing notifications
- Root cause analyses
- Safety alerts

6.2.2 When identifying a risk, consideration should be given to what could pose a potential threat (or opportunity) to the achievement of objectives within the context of the Trust. For example, whether the risk is strategic, programme or operational.

6.2.3 Key to understanding the true meaning of a risk is the risk description. As a rule, the following convention should be used to formulate a risk statement:

THERE IS A RISK THAT _____ **CAUSED BY** _____ **WHICH MAY RESULT IN** _____

For example: ***<u>There is a risk that</u> the new purchasing system cannot be acquired, <u>caused by</u> the need to reprioritise the capital expenditure plan, <u>which may result in</u> continued expenditure on agency staff to support the existing paper-based system***

6.2.4 Individual risks, when identified, should be recorded <u>as soon as possible</u> on a **risk assessment proforma** (Appendix 3), and forms the basis of a new entry on the Ulysses risk module. A summary of the risk assessment should be then included on a risk register. The standard template for a risk register is attached at Appendix 4.

6.3. Assessing and scoring

6.3.1 It is vital that all risks are assessed in an objective and consistent manner if they are to be managed and to guide operational, project planning and resource allocation.

6.3.2 Risks are firstly assessed on **likelihood** (probability of the risk materialising) and secondly on **severity** (degree of harm or impact caused by the risk materialising).

6.3.3 When assessing how likely it is that a risk would occur, take into account the current environment. The likelihood of harm etc. occurring will be influenced, for example, by the number of times a procedure/task is required to be completed, the number of people involved in the activity, the amount of particular hazardous substance involved in the procedure. The degree of likelihood will form part of the risk rating judgement.

6.3.4 The impact will be determined by the expected effect upon individuals and or the Trust and its capabilities or reputation.

6.3.5 In order to standardise these judgements, the **Risk Assessment Matrix** (Appendix 1) has been developed and should be used to assist in this process. Numerical values for likelihood and impact are multiplied in order to achieve an overall risk rating. Determination of likelihood and severity scores will be influenced by the controls already in place.

Overall risk ratings are categorised as follows:

Rating	Definition	Value
Green	Low	1-3
Yellow	Moderate	4-8
Amber	Medium	9-12
Red	High	15-25

6.4. Planning

6.4.1 When planning to address the risk it will be necessary to identify those controls that already exist and have a beneficial effect on either likelihood or severity or both. All controls (existing and additional) should be considered in order of effectiveness. For example, ceasing an unnecessary procedure/activity will eliminate risk and allow vital resources to be applied to necessary activities. Limiting the amount of a hazardous substance used in a procedure will reduce the likelihood of harm. Isolating the procedure from those at risk will prevent harm occurring to certain individuals/groups. Applying written procedures and training to achieve conformity with safe systems will further reduce the chances of harm occurring and the provision of personal protective equipment (e.g. gloves) will provide that final degree of protection should other controls fail. The order in which controls should be considered is:

- Elimination
- Reduction
- Isolation
- Conformity
- Protection

A safe system will feature all or some of these types of controls.

The risk rating following the application of these existing controls is known as the **Controlled Residual Risk**.

6.4.2 Where there are gaps in current controls or controls that are in development prior to maturity, then risk owners should develop an action plan to address these shortfalls, otherwise known as a **Risk Treatment Plan**. The most important thing to consider when writing a Risk Treatment Plan is whether your actions are proportionate to the level of the risk. In considering actions ask yourself whether you have done all the things that you may be required to do by law, regulation, national guidance, best practice (consult the relevant policy). Your aim is to eliminate the risk, however it is recognised that this is not always possible, so it is essential that actions will reduce the risk to the lowest level (So far as is reasonably practicable).This level of risk, taking all actions into account, is known as the **Target Residual Risk**.

When formulating the Risk Treatment Plan the following must be included as a minimum:

Actions must always be SMART

- **S**pecific
- **M**easurable
- **A**chievable
- **R**ealistic
- **T**imely

6.4.3 The Risk Treatment Plan is a critical element of the risk assessment and as the actions are completed, the risk assessment should be updated.

6.5 Monitoring and closure

6.5.1 The implementation of the Risk Treatment Plan and level of risk are to be kept under review to ensure that actions are delivered by the required date. Responsibility for this will be principally through the Divisional Governance Boards/Project Boards/Corporate areas, with oversight of delivery or issues related to delivery being reported through to the Trust Management Committee for those escalated for inclusion on the **Corporate Risk Register**.

6.6 Report and Escalation

6.6.1 The Trust has in place a Corporate Risk Register, which is an integral part of the system of internal control and defines the highest priority risks which may impact on the ROH's ability to deliver its objectives. The Corporate Risk Register enables the Trust to be assured of the adequacy of the management of these risks.

6.6.2 The Trust Management Board has oversight of the management of these risks on behalf of the Trust Board.

6.6.3 The escalation flowchart (Appendix 2) includes the process for putting forward risks for escalation onto the Corporate Risk Register or the Board Assurance Framework (BAF) and Appendix 3 shows the hierarchy of risk scrutiny within the Trust.

6.6.4 If actions to mitigate a risk can be managed at local level and the risk to service delivery or safety is not likely to be realised then there is no requirement to escalate a risk to the next level of management. However, all Amber and Red risks must be escalated to divisional level to ensure that there is appropriate management knowledge. In turn, Red risks may be proposed for inclusion onto the Corporate Risk Register from any of the following:

- Within divisions, which will have an effect on safety, the capability or reputation of the Trust if realised or which cannot be managed at that level
- By Trustwide governance committees and are a corporate issue
- From Trust projects or programmes, which cannot be managed at that level or may have an adverse effect on the strategic direction of the Trust

6.6.5 Any risks being proposed for inclusion onto the Corporate Risk Register will be presented to the Trust Management Committee who will challenge the robustness of actions and grading of the risk assessment. If agreed, the Trust Board will be asked to consider the recommendation from

the Trust Management Committee. Likewise, the Committee will consider any proposals for de-escalation from the Corporate Risk Register based on the successful completion of the Risk Treatment Plan or a change in circumstances that means that the risk no longer exists.

6.6.6 The Trust Board will receive a report at each meeting detailing proposed new risks for inclusion onto the Corporate Risk Register, any risks that have been mitigated and any that have had their grading revised.

6.6.7 The Trust Board will be required to decide what action will be taken regarding the proposed risk and mitigating actions and this will be communicated back to the risk owner.

Based on recommendations from the Trust Management Committee, the Trust Board will need to decide one of the following for each risk presented:

Terminate	**Cease the activity likely to generate the risk**
Treat	**Reduce the likelihood or severity of the risk by putting appropriate controls in place**
Tolerate	**Accept the risk and monitor**
Transfer	**Redefine the responsibility for managing the risk (e.g. by contracting out a particular activity.)**

7 BOARD ASSURANCE FRAMEWORK

7.1 The Trust has in place a **Board Assurance Framework** (BAF) which exists to monitor the risks to the delivery of the Trust's strategic objectives. The BAF identifies the key controls to manage these risks and details the assurances available to the Board that these controls are in place and are working effectively. Gaps in controls and assurances are highlighted in the BAF, together with the actions planned to address these gaps.

7.2 As part of the risk escalation process, proposals may be put forward to the Trust Board from the Trust Management Committee to add a risk to the Board Assurance Framework if it is agreed that due to the nature or severity of the risk that there is possibility that the delivery of one or more of the Trust's strategic objectives may be compromised.

7.3 The adequacy of the Board Assurance Framework informs the year end Head of Internal Audit Opinion and the Annual Governance Statement.

8 CONSULTATION

8.1 An early draft of this policy was presented to the Trust Management Committee for initial comment and then circulated to the key managers across the Trust for formal consultation afterwards for a period of a calendar month. The outcome of this consultation is reflected in this policy.

9 AUDITABLE STANDARDS/PROCESS FOR MONITORING EFFECTIVENESS

9.1 In order to monitor compliance with this policy the Associate Director of Governance & Company Secretary will use the following set of indicators

- Risk assessments are comprehensively completed
- Ulysses is updated as new risks arise and are closed
- Agendas & minutes from Divisional Management Boards and equivalent, TMC and Trust Board include risk register discussions
- Risk registers show progress against actions in treatment plans
- Risk scores are appropriate and show movement as treatment plans are delivered
- The Board Assurance Framework includes only entries that have the possibility of impacting on the delivery of the Trust's strategic objectives
- Risk reports propose risks for de-escalation as well as escalation

10 TRAINING AND AWARENESS

10.1 Training is provided in line with the Trust Risk Assessment Training Needs Analysis and Matrix in accordance with the Mandatory Training Policy.

10.2 Bespoke training will be provided by the Governance Team.

10.3 Awareness of this policy is achieved via corporate publicity (e.g. electronic communications) and the line management and governance structures.

11 EQUALITY AND DIVERSITY

11.1 The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals (staff, patients and visitors) are treated fairly, with dignity and appropriately to their need. The Trust recognises that equality impacts on all aspects of its day-to-day operations and has produced and Equality Policy Statement to reflect this. All policies are assessed in accordance with the ROH Equality Impact Assessment Toolkit.

12 REVIEW

12.1 This policy will be reviewed in three years' time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation/standards.

13 REFERENCE DOCUMENTS AND BIBLIOGRAPHY

Best practice examples of other NHS organisations' risk policies have been used to inform the development of this policy.

14 FURTHER ENQUIRIES

14.1 Further information regarding this policy is available from the Governance Team (roh-tr.governance@nhs.net) and the Associate Director of Governance & Company Secretary (0121 685 4353 or s.grainger-lloyd@nhs.net).

Appendices

Appendix 1 – Risk Assessment Matrix

Appendix 2 – Risk Assessment & Risk Register Process

Appendix 3 – Risk Management hierarchy

Appendix 4 – Risk Assessment Proforma

Appendix 5 – Risk Register Template

Appendix 1

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 not expected to happen but may occur in some circumstances
3	Possible	The event may occur occasionally
4	Likely	The event is likely to occur, but is not a persistent issue
5	Almost Certain	The event will probably occur on many occasions and is a persistent issue

2. **SEVERITY:** What is the highest potential consequence of this risk? *(If there is more than one level, choose the highest score)*

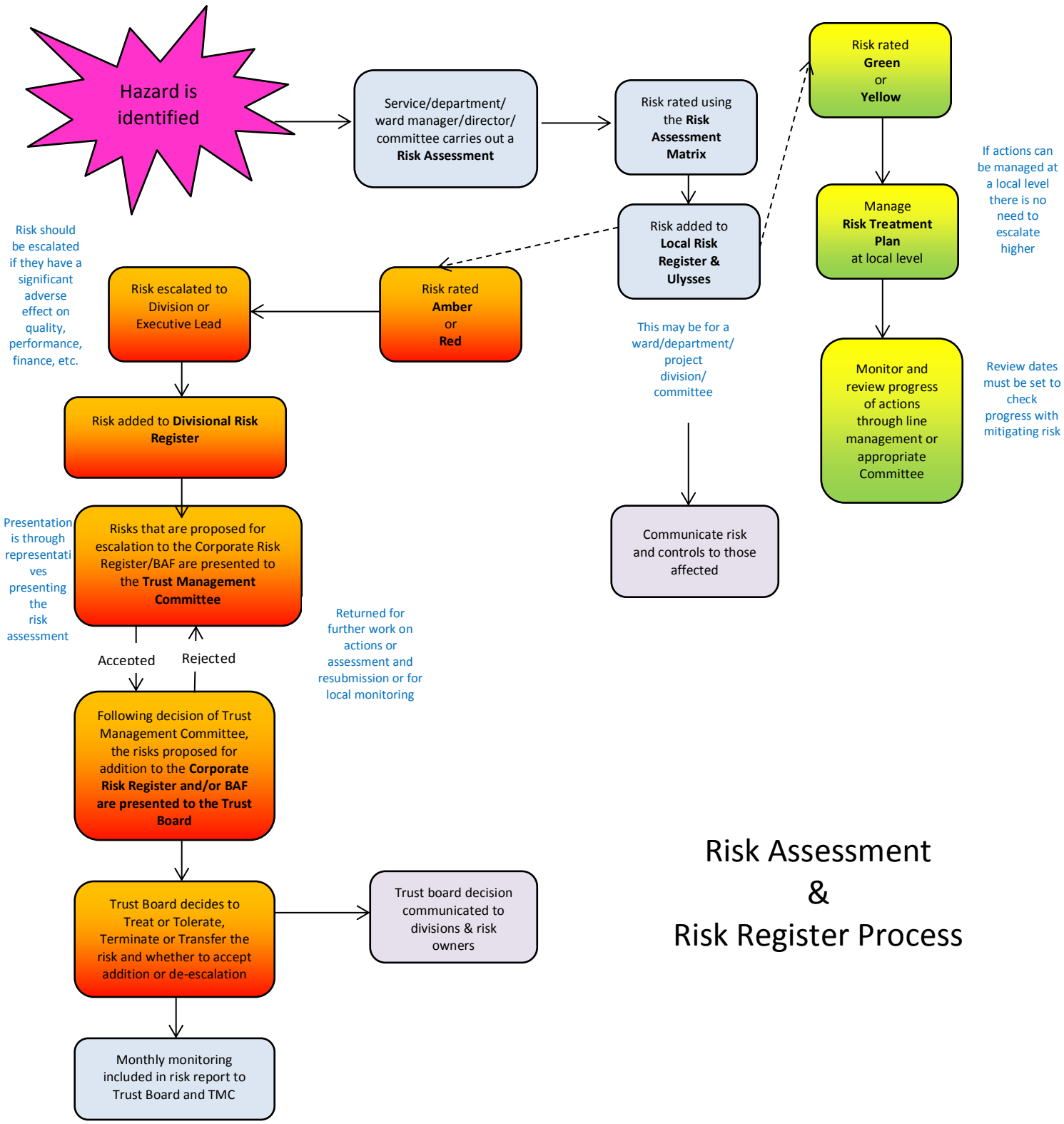
Descriptor	Patient Experience	Potential Impact on Organisation	Cost of control	The Potential for complaint/ Litigation
Insignificant 1	Reduced quality of patient experience/clinical outcomes not directly related to delivery of clinical care	No risk at all to organisation	£0 - £50K	Unlikely to cause complaint \ litigation
Minor 2	Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable	Minimal risk to organisation	£50K - £500K	Complaint possible Litigation unlikely
Moderate 3	Unsatisfactory patient experience/clinical outcomes with short term effects – expect recovery <1wk	Some disruption in service with unacceptable impact on patient Short term sickness	£500K - £2M	High potential for complaint Litigation possible but not certain. .
Major 4	Unsatisfactory patient experience/clinical outcomes with long term effects – expect recovery >1wk	Long term sickness Service closure Service/department external accreditation at risk	£2M - £4M	Litigation expected/certain Multiple justified complaints
Catastrophic 5	Unsatisfactory patient experience/clinical outcomes – continued long term effects	National adverse publicity External enforcement body investigation Trust external accreditation at risk	£4M & Above	Multiple claims or a single major claim

3. RISK RATING: Use 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

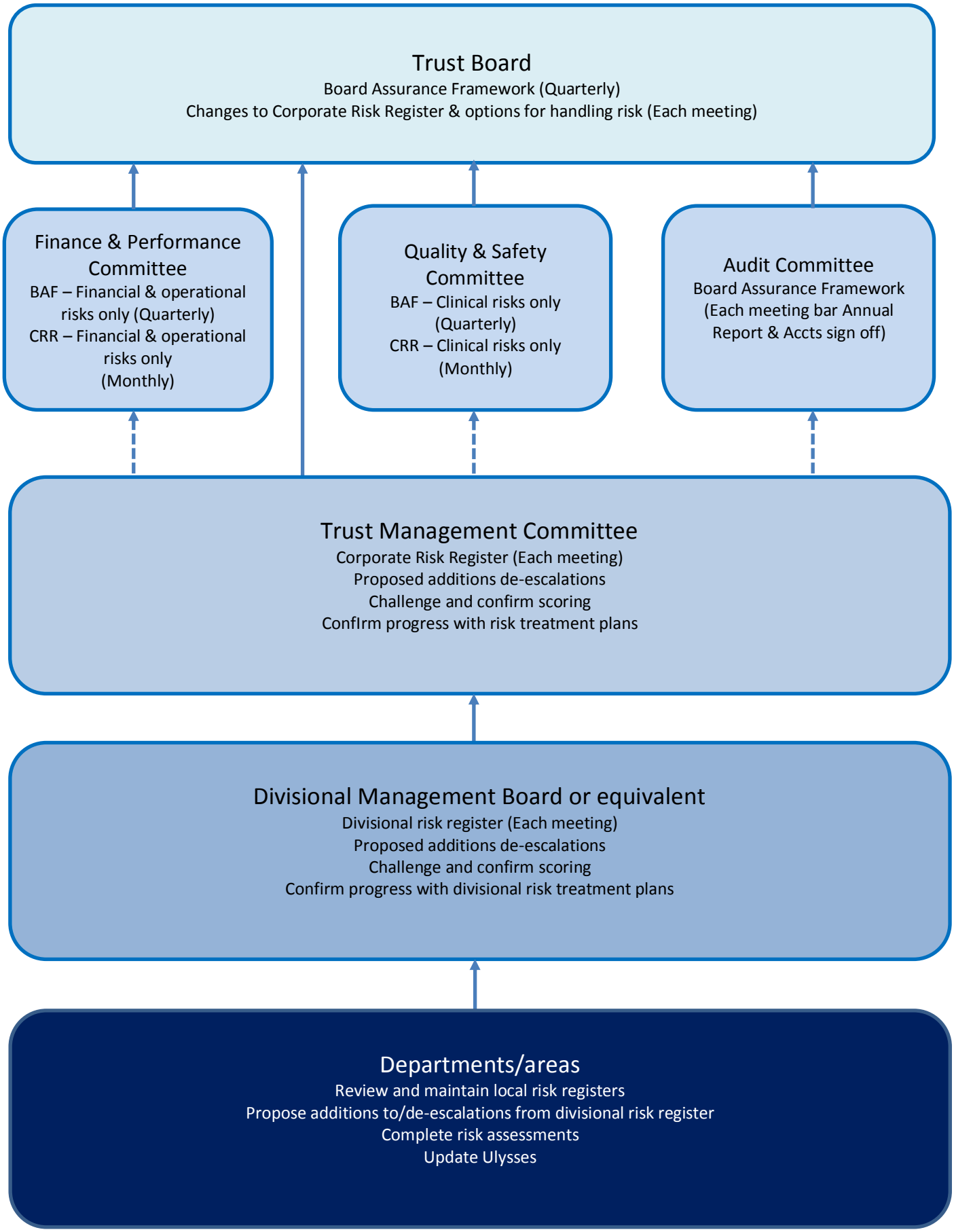
Green = LOW risk **Yellow = MODERATE risk** **Amber = MEDIUM risk** **Red = HIGH risk**

Appendix 2



Risk Assessment & Risk Register Process

Appendix 3 – Risk Management Hierarchy



Appendix 4

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Risk Assessment Proforma

Name of Assessor:	**Date of Assessment:**

Risk Owner (Name and Title):

Description of Risk

There is a risk that . . .

Causes	**Consequences**

Source of risk – please choose one

Strategic☐ Financial☐ Operational☐ Clinical☐ Other:
Reputational☐ Contract☐ Compliance☐ Audit☐

Which area did this risk originate in?
e.g. ward, department

Link to strategic objective – please choose one

1 exceptional patient experience & outcomes ☐ | 2 developing services ☐ | 3 cutting edge knowledge, research, education and innovation ☐ | 4 safe & efficient processes☐ | 5 highly motivated & skilled staff ☐

Risk Type– please choose one

Local / departmental☐ Project☐ Divisional☐ Trust-wide☐ Strategic☐ BAF☐

Risk rating

Current risk rating score = Target risk rating score = * *level of risk remaining after all controls (actions) in place*

RISK SCORE: Risk Rating = consequence x likelihood

Likelihood	Consequence				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
5: Certain	5	10	15	20	25
4: Highly Likely	4	8	12	16	20
3: Likely	3	6	9	12	15
2: Possible	2	4	6	8	10
1:Remote/None	1	2	3	4	5

Current controls/mitigations

Internal	External

Risk Treatment Plan – please choose one

1 Terminate☐ *cease the 'risky' activity* | 2 Transfer ☐ *move elsewhere e.g. contract out* | 3 Tolerate ☐ *accept and monitor the risk* | 4 Treat☐ *reduce the risk by putting in controls*

Resource Implications *(e.g. include money, people, equipment, space)*

Actions required to manage risk

Details	**Person responsible**	**Expected completion date**

Monitoring Committee/Group	**Frequency of Review** – please choose one
	Monthly☐ Quarterly☐
	6-monthly☐ Annual☐

APPENDIX 5 – RISK REGISTER TEMPLATE

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Risk Reference	Risk owner	Division/Department/Corporate area	Risk Statement (There is a risk that…caused by…which may result in…)	Initial risk score			Summary of Risk Controls and Treatment Plan	Controlled residual risk score			Risk movement since last reviewed	Risk controls scheduled / not in place and associated actions	Completion date for Actions (one date per action)	Target risk score			Date of risk closure or de-escalation
				Likelihood	Severity	Risk Rating (LxS)		Likelihood	Severity	Residual risk rating (L x S)				Likelihood	Severity	Residual risk rating (L x S)	

Each risk assessment must have a unique identifier which will be used on all documentation related to it. The unique identifier is the reference number in the above and will be made up of characters as follows:

- Year assessment was carried out (last two digits of the year, so for 2016 = 16)
- Month assessment was carried out (two digits, so for March = 03)
- Ward/department identified (three letters, so for Ward 1 = WA1 for instance)
- Sequential number (two digits, so for the eleventh risk identified = 11)

The Royal Orthopaedic Hospital NHS
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POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Risk Management Policy
ACCOUNTABLE EXECUTIVE LEAD:	Chief Executive
POLICY AUTHOR:	Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary
APPROVED BY:	
DATE OF APPROVAL:	

An implementation plan must be developed for all policies. This will ensure that a systematic approach is taken to the introduction of policies in order to secure effective working practices.

The following template provides a list of activities to consider as a starting point for thinking about implementation in a systematic manner.

ROHTB (7/16) 005 (b)

IMPLEMENTATION PLAN OWNER: Simon Grainger-Lloyd

REFERENCE	ACTION	RESPONSIBLE	COMPLETED? (YES/NO)	IF NO, PLANNED COMPLETION DATE	EVIDENCE	STATUS
1	*Communications and engagement*					
a	Policy consultation	SGL	Yes		E-mail circulation	
b	Policy cascade via staff communications and divisional governance meetings	SGL	No	Mid July 2016	Staff communications; minutes of Divisional meetings	
c	Inclusion in ROH life	SGL/SXB	No	August 2016	ROH Life copy	
2	*Training*					
a	Creation of training package summarising process	SGL/Corporate Governance Officer	No	Autumn	Training package	
b	Risk management to be included in staff induction	SGL/Corporate Governance Officer/SR	No	Autumn	Training package	
3	*Resources*					
a	Corporate Governance Officer to be recruited	SGL	No	July 2016	Job advert; outcome of selection process	
b	Ulysses to be amended to map to new committee and group structure	SGL/FR	No	August 2016	Ulysses screenshots	
c	New risk assessment template to be loaded into Ulysses	SGL/FR	No	August 2016	Ulysses screenshots	
4	*Monitoring Effectiveness & Evaluation*					
a	Risk registers & BAF more accurately reflect current and future risks for Divisions, areas and the Trust	SGL	No	Autumn	Risk registers and BAF	

Final date when plan is expected to be fully implemented: Autumn 2016

Status key:

Green	Fully on target	**Amber**	Some slippage but expected to meet timescale	**Red**	Significantly off target date or failed to complete	**Blue**	Completed

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	Freedom to Speak Up Guardian appointment
SPONSOR (EXECUTIVE DIRECTOR):	Anne Cholmondeley, Director of Workforce and OD
AUTHOR:	Anne Cholmondeley, Director of Workforce and OD
DATE OF MEETING:	6 July 2016

EXECUTIVE SUMMARY:

This report contains detail about how The Trust intends to implement the mandatory role of the Freedom to Speak up Guardian. It also includes the requirement for ensuring the Guardian role in ROH is recruited effectively, well embedded and successful in its remit.

The risk register from the staff survey highlights the need to improve staff belief that speaking out makes a difference to patients. Such belief is a key engagement driver.

REPORT RECOMMENDATION:

The Trust Board is asked to:

1. Note the obligation on the Trust to appoint a FTSU Guardian
2. Support the arrangements to appoint to the role on a part time basis, embedded within Clinical Governance

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		Equality and Diversity	x	Workforce	x

Comments:

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

The report detailing the Guardian role at ROH contributes to the Trust's strategic intentions relating to **Safe and Efficient processes**, **Exceptional Patient Experience, Every Step of the Way** and **Fully engaged patients and staff**

Progress will be monitored through the ROH incident reporting system

PREVIOUS CONSIDERATION:

None

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Freedom to Speak up Guardian role

REPORT TO THE TRUST BOARD – 6 JULY 2016

Background

When Sir Robert Francis conducted his Freedom to Speak Up (FTSU) review throughout the summer of 2014, he sought a wide range of views from across the NHS. This included first hand experiences from staff who had raised a concern (and reported that they had suffered some form of detriment as a result of doing so), employers, professional and system regulators, and other professional bodies.

In February 2015, Sir Robert Francis published his final report which made a number of key recommendations under five overarching themes with actions for NHS organisations and professional and system regulators to help foster a culture of safety and learning in which all staff feel safe to raise a concern. Two key elements include the appointment of a local FTSU Guardian in each trust and a national Guardian to support the scheme across all trusts. The NHS contract mandates Trusts to ensure the local Guardian role is in place by **1st October 2016**.

Policy alignment

The Guardian will need to align to the Freedom to Speak Up (FTSU) policy which is currently being reviewed by the Executive Team and Board. There will also be national guidelines, support and advice available through the National Guardian office and the CQC.

The formal FTSU policy will go to the TMC in July.

Scope of FTSU Guardian role

The FTSU guardian will have a key ambassador role in helping to promote the profile of raising concerns about patient safety matters at the ROH. They will also provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled. They will also work alongside the Trust leadership teams to support the organisation in becoming a more open and transparent place to work.

The Guardian should not get involved in investigations or complaints, but help to facilitate the process where needed, ensuring organisational policies are followed correctly.

The National Guardian Office has published guidance for employers on how to establish the role locally, including the key skills and attributes.

Please note: To date thirty seven Trusts have appointed Guardians (with five recruiting multiple guardians).

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Implementation at Royal Orthopaedic Hospital

Alongside the FTSU policy (written by the Learning, Development and Equalities Manager), activity continues towards recruiting the right person at ROH.

From national guidelines, a role specification and key characteristics document has been developed for ROH – See **Role specification** document and **Purpose** document (see attachments).

Along with recruiting in line with the national role specification, it is recommended that the person in the role is part time (circa 2 days per week) and that the appointee is from a clinical background. It is envisaged the role will:

- Raise visibility across the Trust of the value of Speaking Out and deal rapidly with perceived initial low volume of formal concerns
- Work closely with the existing Contact Officers whose role is to focus on supporting staff with bullying and harassment concerns
- Reinvigorate the existing Speak Out champions
- Be based within the Governance team and have overall accountability to the CEO

Financial provision has been made for this role for two days a week. The post will be advertised to ensure open competition, with encouragement from the Executive team of those individuals who have already shown aptitude for such a role.

Support

The Guardian will automatically become part of a national network and join colleagues from other Trusts across the NHS in the ongoing implementation of the Guardian initiative.

The National Guardian office has committed to providing training, support and networking opportunities for Guardians around the country.

In additional, the Trust will ensure there is a coach (if requested) assigned to the Guardian to provide advice and support particularly with complex issues.

The Guardian will also be encouraged to attend both internal and external training programmes to develop their skill set. Areas of development could include mediation, report writing, listening skills and presentation skills.

Reporting

Reporting is recommended on a monthly basis through a robust reporting tool (ROH incident system) along with regular updates with the Director of Nursing, Clinical Governance, Medical Director and the CEO. Progress should monitored against a number of measures including staff survey results (e.g. Question 19), spot questionnaires and feedback from events.

The National Guardian office also has a website with a variety of information links to NHS organisations that have already set up their Guardian programme. These sites have started to provide the impact and positive effects of its implementation.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Communications

The Guardian will be expected to work closely with the Communications team. There will be a variety of communications channels including ROH Life, Team Brief, press releases, intranet space design, posters, leaflet drops, presentations, promotional events, attending meetings at all levels and FAQs sheets with focus initially on raising awareness of the role and its function.

The critical elements that will ensure this role is successful are:

Recommendations

The Trust Board is asked to:

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

1. Note the requirements to appoint a FTSU Guardian
2. Support the arrangements to appoint to the role on a part time basis, embedded within Clinical Governance

Freedom to Speak Up Guardians – Purpose and key principles of the role

Purpose
The Freedom to Speak Up Guardian will work alongside trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

Key principles	…what this means
Independent	… in the advice they give to staff and trust's senior leaders, and free to prioritise their actions to create the greatest impact on speaking up culture … and able to hold trusts to account for: creating a culture of speaking up; putting in place processes to support speaking up; taking action to make improvements where needed; and displaying behaviours that encourage speaking up
Impartial	… and able to review fairly how cases where staff have spoken up are handled
Empowered	… to take a leading role in supporting staff to speak up safely and to independently report on progress on behalf of a local network of 'champions' or as the single role holder
Visible	… to all staff, particularly those on the frontline, and approachable by all, irrespective of discipline or grade
Influential	… with direct and regular access to members of trust boards and other senior leaders
Knowledgeable	…in Freedom to Speak Up matters and local issues, and able to advise staff appropriately about speaking up
Inclusive	… and willing and able to support people who may struggle to have their voices heard
Credible	… with experience that resonates with frontline staff
Empathetic	… to people who wish to speak up, especially those who may be encountering difficulties … and able to listen well, facilitate constructive conversations, and mediate to help resolve issues satisfactorily at the earliest stage possible
Trusted	… by all to handle issues fairly, take action as necessary, act with integrity and maintain confidentiality as appropriate
Resilient	… and able to handle difficult situations professionally, setting boundaries and seeking support where needed
Forward thinking	… and able to make recommendations and take action to improve the handling of cases where staff have spoken up, and freedom to speak up culture more generally
Supported	… with sufficient designated time to carry out their role, participate in external Freedom to Speak Up activities, and take part in staff training, induction and other relevant activities … with access to advice and training, and appropriate administrative and other support
Effective	… monitoring the handling and resolution of concerns and ensuring clear action, learning, follow up and feedback

Role specification for the Freedom to Speak Up Guardian

Acting in a genuinely independent capacity, the Freedom to Speak Up Guardian will be appointed by the Board, working alongside them and members of the executive team to help support the organisation to become a more open, transparent place to work.

In particular the Freedom to Speak Up Guardian will:

- Work with the chief executive and Board to help create an open culture which is based on listening and learning and not blaming.

- Develop, alongside the Board, chief executive and executive team a range of mechanisms, in addition to the formal processes, which empower and encourage staff to speak up safely.

- Ensure that staff with disabilities and those from black and other minority ethnic backgrounds are encouraged to speak out and are not disadvantaged by doing so.

- Participate in the organisation's educational programme for all staff so that they understand how they can raise concerns and for managers about how they respond to concerns and supporting the member of staff appropriately.

- Be entirely independent of the executive team, so they are able to challenge senior members of staff, reporting to the Board or externally as required.

- Be a highly visible individual, who spends the majority of their time with 'front line' staff, providing expertise in developing a safe culture which supports and encourages staff to speak up using the local procedures and if necessary advising them on how to raise concerns, including externally.

- Act in an independent and impartial capacity, listening to staff and supporting them to raise concerns they may have by using the available structures and policies, both within the organisation and outside.

- Independently review any complaints from members of staff about the way they have been treated as a result of raising a concern and report back to the individual and, with their agreement, to their manager, the chief executive and the director of human resources.

- Ensure members of staff who speak up are treated fairly through the investigation, inquiry and or review and that there is effective and open communication during this time.

- Ensure that information about those who speak up is kept confidential at all times, subject to requirements around safeguarding and illegality.

- Meet quarterly with the chief executive to feedback themes from the concerns raised and to share positive and negative experiences and outcomes.

- Report at least every six months to the Board and the organisation as a whole.

- Participate in the national network for the guardians, sharing and helping to develop excellent practice in supporting members of staff who speak up.

Those appointed as Freedom to Speak Up Guardian should have these characteristics:

- Understand the trust, its values and key priorities and challenges.

- Have a track record of supporting and listening to staff and in demonstrating the values of the trust and the NHS constitution in their daily working lives.

- Be able to facilitate a conversation between members of staff and their managers.

- Have a good understanding of how to raise concerns and the barriers that can exist for those who speak up.

- Be an approachable, trusted, non-judgemental individual, who is comfortable with talking with ‘front line’ staff from all disciplines and all grades and can build a rapport which demonstrates compassion and understanding.

- Have the ability to set boundaries, be concise, synthesise and present information and be able to write reports for the chief executive and the Board.

- Have an understanding of mediation and managing confidential matters; this includes an understanding of managing and keeping confidential records of cases.

- Be responsive and resilient.

- Have an ability to work with a range of stakeholders, especially those responsible for patient safety and patient and staff experience, to ensure that lessons are learnt, themes identified and necessary changes are made.

- Confident in speaking at internal and external events.

March 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (7/16) 005

TRUST BOARD

DOCUMENT TITLE:	**Nurse Staffing Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Nursing and Clinical Governance**
AUTHOR:	**Ms Anne Crompton, Deputy Director of Nursing and Clinical Governance**
DATE OF MEETING:	**6 July 2016**

EXECUTIVE SUMMARY:

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. This paper provides the Trust Management Committee with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for May 2016.

REPORT RECOMMENDATION:

The Trust Board is asked to note:

- That Care Hours Per Patient Day (CHPPD) will replace fill rates as the principle measure of Registered Nurse and Health Care Support Worker deployment from May 2017.
- That the Safer Nursing Care Tool will be rolled out across the Trust in June 2016 with a preliminary report to TMC in July 2016.
- That a suitable nurse acuity tool for use in Children's areas will be identified, sourced by the Corporate Nursing Team with recommendations to the Divisional Board in July 2016.
- That the vacancy rate has increased as expected in May 2016 for both registered and unregistered staff.
- That good progress has been made in recruitment of Children's nurses to HDU with full planned establishment achieved by end September 2016.
- That ROH has received a very positive response to its student nurse recruitment campaign with 18 applicants being taken forward to an assessment centre on 25 June 2016.
- That the implementation plan for roll out of E- Rostering is in development with a planned start date of September 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		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

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 Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (7/16) 005

The report will be circulated to all matrons, general managers and ward sisters. Trust Board receives a monthly report on safe staffing. Considered by Trust Management Committee on 22 June 2016.

Nurse Staffing Report
REPORT TO TRUST BOARD: June 2016

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. For the first time this month this report provides details of Care hours Per Patient Day (CHPPD) which has become the principle measure of nurse deployment in line with NHS I (2016) requirements.

The paper provides the Trust Board with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for May 2016 with additional information relating to vacancy and plans for recruitment to vacant posts.

2.0 Workforce Information: Trust Overview of Planned Versus Actual Nursing Hours

The overall nurse staffing fill rate for May 2016 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. The actual staffing levels for May 2016 were manually entered into the data collection spreadsheet by the nurse in charge of the shift and subsequently verified by the senior sister and matron. Planned staffing hours are based on funded establishment which provides a minimum ratio of 1 to 8 on day shifts for all adult in patient wards. The planned hours are adjusted each month to allow for the number of days in the month.

Table 1 below provides further detail regarding nurse staffing fill rates for May 2016. The Unify Upload for May 2016 is provided in Appendix 1. In the absence of national guidance, ROH will RAG rates each ward against a locally agreed framework as follows: Green, where actual available hours are within 5% of planned, amber within 5 and 10%, and red where the difference is greater than 10

Table 1: Detailed Ward Breakdown

	Day		Night	
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
1	95.1%	102.2%	90.2	93.5%
2	98.6%	97.7%	101.6%	96.7%
3	96.7%	75.4%	101.6%	88.3%
12	97.7%	96.7%	99.0%	95.8%
11	104.6%	77.8%	106.7%	83.3%
HDU	100.5%	53.1%	100.0%	-

- The improvement in fill rates for Registered Nurses seen on Ward 3 in April 2016 has been sustained into May 2016 although the fill rate for care workers has reduced over this period. The ward continues to manage a high level of sickness in this staff group. Further investigation has identified that the finding identified above is an anomaly caused by a planned reduction in bank and agency care staff over the bank holiday periods during May when activity was reduced. The ward team has been reminded of the importance of changing the staffing template to reflect planned changes to staffing numbers should this event recur.
- The fill rate for non-registered staff on Ward 11 is a consequence of the decision to support some night shifts with a HCA member of staff to enable adequate break cover and a nurse in charge. Nights on the paediatric ward are unfunded for HCA staff. The budgets have been rebased in Month 2 to enable an uplift of Registered Nursing staff to 3 at night and future reports should adjust for this anomaly. In addition the HCA staff have been supporting the ward clerk rota due to the long term absence of this staff member. The member of staff is being managed in line with Trust sickness and absence processes.
- The low fill rate for care staff on HDU is reflective of the long term sickness. The model of nursing care on HDU is currently under review and these posts will be reviewed as part of that work. An update on progress against this action will be provided in the July report to Trust Board.

2.1 Care Hours Per Patient Day (CHPPD)

Following the publication of the Carter Review (2016**)** NHS Improvement have issued new guidance which requires all Trusts to report Care Hours Per Patient Day. From May 2016 CHPPD will become the principle measure of nursing and care support deployment. CHPPD provides a single consistent metric of nursing and healthcare support worker deployment on inpatient wards and units

CHPPD is calculated by dividing the number of actual nursing (both registered and unregistered) hours by the number of patients on the ward at midnight. It therefore represents the number of nursing hours that are available to each patient. Care Hours per Patient Day (CHPPD) is a way of representing staffing data that puts the nursing hours in the context of the patient activity and has been chosen as a measure because it is an easy to understand figure. CHPPD provides

- A single figure that represents both staffing levels and patient requirements, unlike actual hours alone, and
- A method of comparisons between wards/units. As CHPPD has been divided by the number of patients, the value doesn't increase due to the size of the unit therefore allowing comparisons between different units of different sizes.

During May CHPPD were calculated by ward as detailed in Table 2 below:

WARD	Table 2: Care Hours Per Patient Day (CHPPD)			
	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
1	532	4.2	3.0	7.1
2	591	3.6	2.6	6.2
3	610	3.9	2.3	6.2
12	630	4.6	3.3	7.9
11	202	9.0	1.4	10.4
HDU	130	20.7	1.1	21.8

Given that this is the first month this measure has been reported nationally, there is no benchmarking data available. It will be possible to report comparisons in future staffing papers to TMC as this measure will be reported nationally via UNIFY.

2.2 Vacancy and Acuity Data

During Month 2 (May 2016), further work was undertaken to rebase ward budgets to reflect the uplift for registered nurses on night shifts from 2 to 3 as agreed in the November 2015 establishment review. This has meant that the proportion of ward budget assigned to bank staff has been incorporated into the total ward budget and has resulted in an expected increase in the number of substantive nursing vacancies across all ward areas. Table 3 below shows the rebased ward budgets at Band 5 and 2 for each of the ward areas with the figures in brackets representing the budget before rebase.

Table 3 Band 5 WTE Vacancy (Based on Revised Figures from Finance May 2016)

Ward	Band 5 Funded Establishment	Band 5 Vacancy	Band 2 Funded Establishment	Band 2 Vacancy
1	13.57 (11.53)	2.62	10.32	2.6
2	13.57 (11.80)	1.9	9.05	0.55
3	14.16 (13.09)	1.16	7.65	1.45
12	18.61 (18.61)	1.08	13.91	4.16
11	15.96 (13.80)	3.16	1.8	0.2
HDU (Includes Band 6 within baseline)	23.32 (22.32)	4.18	1.8	0
Total	99.19 (93.66)	14.1	44.57	9.76

In addition Ward 2 has a Band 6 vacancy taking the total number of Registered Nurse ward vacancies at the Trust to 15.1 WTE which represents a vacancy factor of 10% across all ward areas. Of significance is the increase in the number of paediatric nurse vacancies on Ward 11 which is a direct result of an uplift to 3 Registered nurses on duty at night in line with Royal College of Nursing Guidance.

A number of key actions are in place to address recruitment at the Trust and are listed below:

- The Nursing Workforce group has been re-established and a work plan agreed. The group will oversee the development of targeted recruitment campaigns and introduce accurate vacancy monitoring across the Trust. Terms of Reference have been agreed and meeting dates set for the remainder of the year. One of the key actions to be completed by end Quarter 1 2016/17 is to develop the internal ability to respond effectively to expressions of interest from nursing staff outside the cycle of planned assessment centres.
- Band 2 and Band 5 Job descriptions have been reviewed and a generic ROH JD produced. This enables responsive recruitment to take place and benefits patients by having a consistent skill set in the workforce.
- Good progress has been made against the appointment of the paediatric vacancies in HDU with 1 post filled by an internal applicant and the remaining three by students who will qualify in September 2016.
- The Band 5 vacancies on Wards 2 and 3 have been appointed to together with 1 of the vacancies on Ward 11.
- A student nurse recruitment campaign commenced on 31st May 2016 which resulted in 23 applications. An assessment centre is planned for 25th June 2016.
- A recruitment campaign for experienced registered nurses has resulted in 7 applicants with an assessment centre on 25th June 2016
- A HCA recruitment campaign will commence w/c 13th June 2016 to enable recruitment to the Care Certificate Programme in September 2016.
- Targeted Children and Young People (CYP) nurse recruitment will take place commencing 20th June 2016.
- A new 8a Ward Matron post has been developed which will incorporate the role of Ward 11 ward sister with responsibility for providing professional leadership across all services where care is delivered to CYP (advertised 14th June 2016).

Table 4 below shows the recommended staffing levels based on the daily acuity tool by ward for April 2016. Trust Board are asked to note that the Paediatric Ward is not included in this table because the acuity tool used is not appropriate for children and therefore an alternative appropriate tool has been identified (PANDA). Progress against acquisition of PANDA or equivalent tool is dependent on the approval of a Divisional level business case and updates against progress will be provided in future reports.

Table 4: Acuity by Ward

Ward	Recommended WTE	Actual WTE	Budgeted WTE
1	29.97	27.61	28.01
2	26.40	26.57	23.35
3	32.34	27.59	24.35
12	28.45	36.08	39.1
HDU	18.67	20.63	26.79

It can be seen that whilst most wards staff beyond their budgeted funded establishment the acuity tool suggests that staffing requirements were met through May 2016. All wards have an additional bank budget which enables them to staff up to their requirements (ring-in). It is of note that the budgeted establishment shown in Table 4 above does not include the 'ring-in' budget allocated to each ward area. The areas of greatest disparity (recommended vs actual) are Ward 12, where the ward layout and environment means that a different model of nursing care is delivered to enable safe support and supervision of all patients, and HDU which is a consequence of the flexible staffing model employed.

2.2.1 Safer Nursing Care Tool

Trust Board are asked to note that the DDNG has reviewed the tool used to calculate dependency and acuity at ROH and has recommended that the Safer Nursing Care tool is applied across all wards in June 2016. The Safer Nursing care tool is nationally applied and its use at ROH will enable benchmarking to take place effectively. The tool requires that acuity and dependency measurement is consistent and that all relevant data are collected during the same period. Data will be collected on every patient on participating wards / units at 1500 hrs, daily Monday to Friday for 20 days as a minimum. Initially the introduction of the tool was planned w/c 6th June 2016 but the loss of activity during this week and subsequent impact on ward activity means that the commencement of the tool has been delayed until 13th June 2016.

Once applied and analysed data gathered via the Safer Nursing Care tool will allow nursing staff to understand not only the acuity levels of patients on wards, but also enable this information to be allied to other key data including nurse sensitive care indicators such as falls and pressure ulcer incidence. The data gathered through this exercise will enable comparison with that gathered through daily acuity capture and provide a benchmark from which to develop the twice yearly nurse establishment reviews.

A review of HCA establishment will be completed through May and June 2016 and reported to TMC in July 2016 following completion of the Safer Nursing Care tool. We will continue to use bank HCA staff during the period of this review.

2.3 Safe Staffing and Efficiency

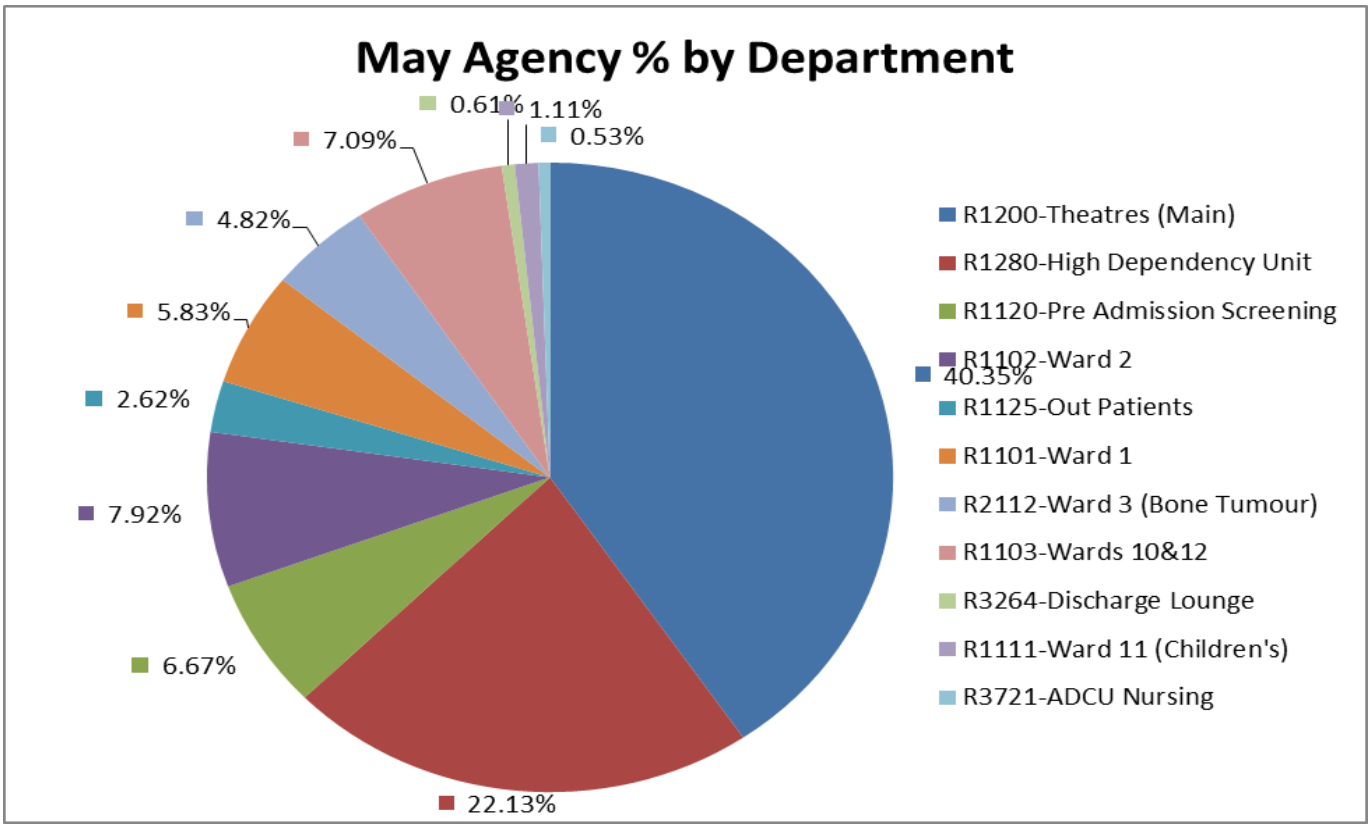
Caps on agency spend for Registered Nurses, mandated by NHS Improvement , have been in place at ROH since 1st October 2015. The ceiling for ROH has been set at 10% which is a reflection of the relatively high use of agency staff at the Trust. During May 2016 overall nurse agency use at ROH was 10.9% which is a slight decrease in usage since April of 0.3%. Table 5 shows total nurse agency use across the Trust since April 2015. It can be seen that the trend is downwards.

Table 5: Registered Agency use as a % of total cost (Whole Trust)

April 15	May 15	June 15	July 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	April 16	May 16
10.2 %	10.8 %	11.8 %	11.6 %	12.3 %	15.3 %	20.9 %	13.5 %	15.9 %	13.7 %	14.2 %	10.7 %	11.2 %	10.9 %

Table 6 presents agency use by area as a total of agency spend across the Trust.

Table 6: Agency use (as a percentage of total spend)



The use of agency staff in Theatre remains high at 40.35 % of total use, however the agency staffed used work regularly at ROH and are familiar with guidelines and processes. The high usage is driven by a high vacancy rate within the theatre team as reported in previous months. Agency use will remain high in theatres for the immediate future in order to enable safe delivery of services.

It is however of note that the percentage of total spend used by theatres has increased over time whilst that of in-patient wards has continued to reduce. All wards, with the exception of HDU are demonstrating agency use of less than 10% of total spend, in line with Monitor requirements. The continuation of the daily 'Safe Staffing' huddle ensures that nurses are moved between wards to cover shortfalls if necessary and that agency use is cancelled if not required. The continued high use of agency staff in HDU is driven by the vacancy factor and by the need to ensure that all shifts are appropriately staffed with Registered Children's Nurses. Work is currently underway to review the staffing model in use in HDU with an update report expected to Divisional Board in July 2016.

2.3.1 Agency and bank use as a percentage of ward totals.

Table 7 below shows the proportion of agency and bank staff use against that of permanent staff.

Table 7: Agency and Bank Staff usage

Ward	Registered Nurses			HCAs		
	Permanent	Bank	Agency	Permanent	Bank	Agency
1	75.7%	14.7%	9.6%	62.9%	31.9%	5.1%
2	80.1%	7.8%	12.1%	68.7%	22.2%	9.0%
3	84.4%	9.0%	6.6%	53.0%	39.5%	7.5%
11	84.7%	14.2%	1.1%	71.7%	20.3%	8.0%
12	77.4%	13.4%	9.3%	56.8%	33.0%	10.2%
HDU	72.8%	8.6%	18.6%	100.0%	0.0%	0.0%

It demonstrates a high reliance on bank and agency Heath Care Assistants (HCA) across all ward areas. The HCA establishment review that is planned for completion by the end July 2016 will identify where there are gaps in establishments to enable this anomaly to be addressed.

2.3.2 Introduction of E–Rostering at ROH

E-rostering systems enable managers to improve the way their most valuable resource is managed – their people. Managers design their rosters, by taking account of the needs of the service first. A good e-rostering system will allow staff to request the times they prefer to work, whilst ensuring that working and time off rules are followed. A key benefit of e-rostering is supporting managers to match the right people skills to meet patient demand. Managers have better control to end over-staffed wards when there is minimal demand, and to avoid under-staffed and unsafe wards when patient demand is high. It's also easier for managers to arrange cross cover across wards or healthcare teams.

E-rostering systems make it easier for employees to request when they would like to work their contracted hours. Managers are more empowered to use their workforce more effectively in terms of controlling costs and improving the quality of patient care and the experience of patients. The ability of e-rostering to support flexible working can result in increased attendance rates and a reduction in short-term sickness. It can also help reduce staff turnover. By retaining talented staff, recruitment and induction costs are therefore minimised, as are demands for temporary staffing cover. Better staff management is well recognised as having a direct effect on the delivery of good patient care.

E rostering will be rolled out across ROH using Allocate software. A number of key actions have been completed in preparation for this:

- A Band 7 Project manager has been appointed to post
- A start date of September 2016 has been agreed
- A detailed implementation plan is in development with the first draft being available for review by end June 2016.
- A communication plan will be developed over the next month to ensure optimal levels of staff engagement and involvement.

3.0 Incident Reporting and Levels of Harm

In addition to the Safer Nurse Staffing tool being used and interpreted, clinical areas are encouraged to report all Safe Staffing incidents. In May 2016, a total of 7 staffing incidents were reported. This compares to a total of 7 reported in April and 6 reported in March 2016. The number of reported staffing incidents remains low and all ward teams have been reminded of the importance of accurately reporting staffing gaps to enable identification of themes and concerns.

Of the 7 incidents reported 1 was graded as 'low harm' with the remaining 6 staffing incidents graded as 'no harm'. The low harm incident related to a reduced numbers of HCAS on duty for a short period of time (2hrs). 4 of the 8 incidents meet the criteria for NICE Red flags. It is however disappointing to note that these were not recognised as such by the nursing teams and ward sisters/charge nurses have been reminded of the need to ensure that all staffing incidents are reviewed against the red flag criteria before sign off. A detailed breakdown of each incident is provided in Appendix 2. Table 8 below provides a breakdown of incident by category.

Table 8 Incident Categories

Of the 7 incidents reported, 5 were categorised as 'level of support to patient' and 2 were categorised as 'lack of suitably trained/skilled staff'.

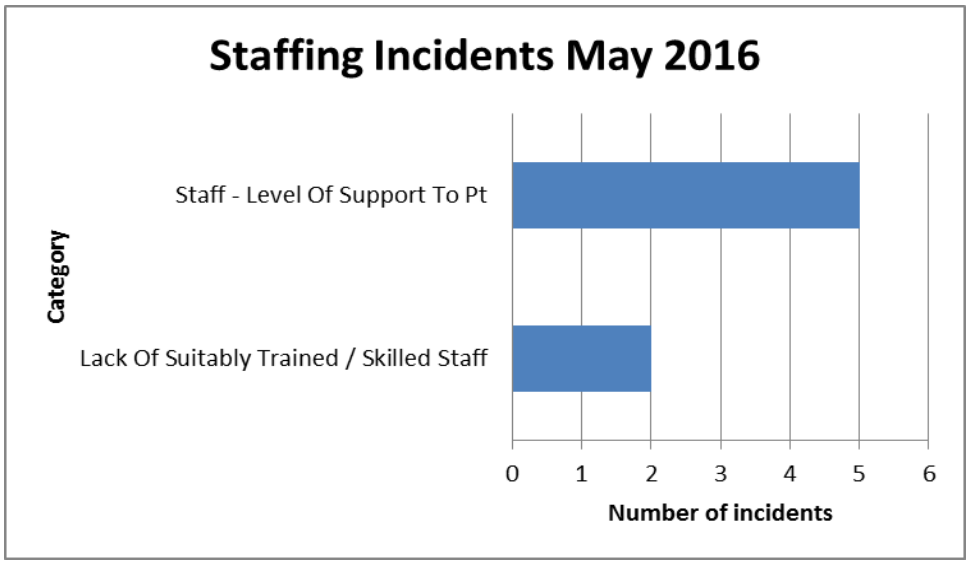
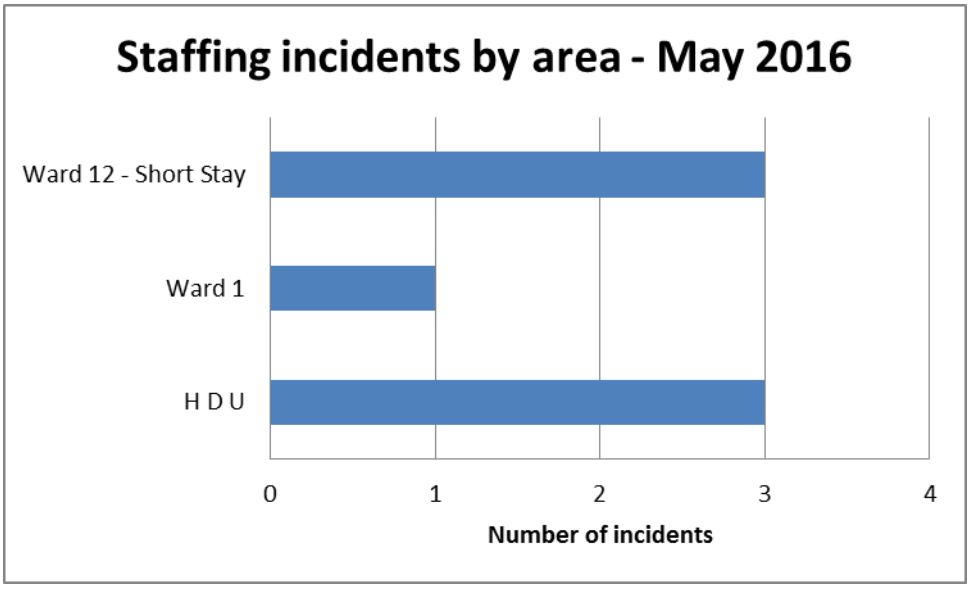


Table 8: Incidents by area/ward:

Three staffing incidents occurred on Ward 12 and HDU. One staffing incident occurred on Ward 1.



Red Flag Shifts May 2016

It is disappointing to note that none of the reported staffing incidents prompted completion of a NICE Red Flag alert. Further investigation of these incidents has confirmed that 3 met the criteria for NICE Red Flags. The detail of these incidents is shown in Appendix 2. Ward sisters and Charge Nurses have been reminded of the need to review each staffing incident against NICE red flag criteria before final sign off.

4.0 Conclusion and Recommendations.

The Trust Board is asked to note:

- That Care Hours Per Patient Day (CHPPD) will replace fill rates as the principle measure of Registered Nurse and Health Care Support Worker deployment from May 2017.
- That the Safer Nursing Care Tool will be rolled out across the Trust in June 2016 with a preliminary report to TMC in July 2016.
- That a suitable nurse acuity tool for use in Children's areas will be identified, sourced by the Corporate Nursing Team with recommendations to the Divisional Board in July 2016.
- That the vacancy rate has increased as expected in May 2016 for both registered and unregistered staff.
- That good progress has been made in recruitment of Children's nurses to HDU with full planned establishment achieved by end September 2016.
- That ROH has received a very positive response to its student nurse recruitment campaign with 18 applicants being taken forward to an assessment centre on 25 June 2016.
- That the implementation plan for roll out of E- Rostering is in development with a planned start date of September 2016.

7.0 Appendix 1: UNIFY upload May 2016

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		1605.5	1532.5	905.5	925.5	756	682	682	649	95.5%	102.2%	90.2%	95.2%
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1427	1407	919	898	682	693	671	649	98.6%	97.7%	101.6%	96.7%
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1792.5	1732.5	1162.5	877	620	630	620	547.5	96.7%	75.4%	101.6%	88.3%
Ward 10 & 12	110 - TRAUMA & ORTHOPAEDICS		1778	1737	1336	1292	1155	1144	814	780	97.7%	96.7%	99.0%	95.8%
Ward 11	110 - TRAUMA & ORTHOPAEDICS		1069.5	1118.5	297	231	660	704	66	55	104.6%	77.8%	106.7%	83.3%
HDU	110 - TRAUMA & ORTHOPAEDICS		1384	1391	270	144	1297	1297	0	0	100.5%	53.1%	100.0%	-

Appendix 2: Incident Details May 2016
Please note' NICE RED FLAG INCIDENTS' are shaded red.

Incident Number	Cause Group	Details Of Incident	Area	Outcome
17797	Staff – Level of Support to	Patient found in bed by HCA with 2 pillows over body		Bed rail bumpers added and pillows were removed.

(no harm)	Patient	and head caught between bed rails	Ward 12	Matron requested that parents must be reminded that if the patient is left without supervision this must be communicated to the ward to ensure a nurse is present. No harm was caused to patient; parents provided 24 hour support to patient. All staff now aware of inappropriate use of pillows as bumpers, correct bumpers borrowed from ward 11. Staff aware of bedrails policy and documentation for risk assessment. Incident occurred during handover period, parents had been present throughout the day but had not informed nurses when they left so additional monitoring not arranged..
17803 **(no harm)**	Staff – Level of Support to Patient	4 RN and 2 HCA for entire ward, no afternoon co-ordinator	Ward 12	Assured that shifts were put out to Nurse Bank. Agency have apologised for giving nursing staff the wrong information. Staffing levels have changed on the late shift to take into account the number of late post-op patients.
17860 **(low harm)**	Staff – Level of Support to Patient	Between 13:00 and 15:00 only one HCA on ward caring for 27 patients.	Ward 12	Considering staggering early shift bank/agency shift times to close the gap between early and late shift. Matron will discuss matter with Ward Manager.
17847 **(no harm)**	Lack Of Suitably Trained / Skilled Staff	Agency nurse moved to another ward to provide cover; leaving another ward with only 4 RN and 3 HCA	Ward 1	Manager undertaking recruitment to help stabilise staffing issues.
17774 **(no harm)**	Lack Of Suitably Trained / Skilled Staff	4 out of 6 staff were agency, bleep holder leadership skills were felt to be poor	HDU	Manager has assured matron that the area is trying to ensure that substantive staff are spread evenly in an attempt to avoid the substantive:agency ratio like the one in this incident.The rota is being reviewd to ensure no repeat of this incident Staff have been reporting when there is a high number of agency staff being used on any given shift and the management team are aware of the staffing vacancies

				currently on HDU.
17828 **(no harm)**	Staff – Level of Support to Patient	Agency staff didn't turn up for a night shift Summary of outcome:	HDU	Ward Manager has contacted agency but has not yet received a response from agency in relation to issues raised. In relation to an agency staff member not turning up this impacts on the supernumerary coordinator who also carries the hospital bleep at night – this therefore means that the bleep holder can only provide support in the event of an emergency as they have to care for patients also
17829 **(no harm)**	Staff – Level of Support to Patient	Agency staff for night shift did not arrive. Team support contacted but no response.	HDU	Ward Manager has contacted agency but has not yet received a response from agency in relation to issues raised. As mentioned above, agency staff not turning up impacts on the supernumerary coordinator who also carries the hospital bleep at night – this therefore means that the bleep holder can only provide support in the event of an emergency as they have to care for patients also. No incidents occurred as a result of this event.

ROHTB (7/16) 006

TRUST BOARD

DOCUMENT TITLE:	**CQC Action Plan update**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Nursing and Clinical Governance**
AUTHOR:	**Ms Anne Crompton, Deputy Director of Nursing and Clinical Governance**
DATE OF MEETING:	**6 July 2016**

EXECUTIVE SUMMARY:

This report presents an update on all actions which required completion by the end of May 2016 in line with the timescales outlined within the CQC Action Plan of January 2016.

Trust Board is asked to note the progress that has been made against delivery of the actions due by May 2016. There has been some slippage on actions as detailed below. Details of the actions which are not yet complete are provided below:

REQUIREMENT NOTICE ACTIONS (6/11 off track)

- Revised timescales for completion of actions relating to block booking have been noted previously and a programme to enable compliance is in progress.
- We had had difficulty in recruiting to paediatric posts in HDU resulting in difficulty in meeting the RCN recommendations for paediatric staffing on the unit. However it should be noted that good progress has been made in recruiting to these posts and the reason that it remains amber is that we are awaiting start dates for new recruits. Recruitment continues with two further Children's nurses invited for interview on 25th June 2016.
- Dates have not yet been agreed for commencement of works in HDU and this limits compliance with two of the six requirement notices.
- The HDU new starter revised preceptorship programme is in progress but not yet complete.

MUST DO ACTION (1/5 off track)

- The off track action relates to audit of staff in OPD to ensure that learning from investigations has been shared and understood by staff. The audit has been delayed by amendments made to the SI process at May Clinical Quality Group and the tool will be presented to the June TMC meeting with a plan to audit compliance in July 2016.

SHOULD DO ACTIONS (5/7 of track).

- The off track recommendation relating to learning disabilities has been reviewed by the Director of Nursing and Clinical Governance with a view to developing a strategy that meets local need and is in line with that of the local CCG by end September 2016.
- The Divisional team have commenced review of clinic templates. However, evidence that block booking has been reduced in line with the trajectory described is not yet available.
- The SOP relating to the booking of diagnostic tests has been written but is not yet in practice.
- The creation of additional storage facilities in HDU has not yet commenced

REPORT RECOMMENDATION:

- To note the progress that has been made against delivery of the actions due by end May 2016, in particular the progress that has been made to recruit and professionally develop Children's Nurses in HDU.
- To note that there has been slippage on actions in each of the categories as detailed above.
- To note that a recovery plan is in place where timescales have slipped.

To note the amendments to the timescales to enable the CQC Master action plan to be updated.

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		Equality and Diversity		Workforce	X

Comments: [*elaborate on the impact suggested above*]

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Provision of high quality care and patient experience

Reputational Risk

PREVIOUS CONSIDERATION:

Trust Management Committee on 22 June 2016.

ROHTB (7/16) 006

CQC Action Plan Update

REPORT TO THE TRUST BOARD – 6 JULY 2016

1.0 Introduction

Following publication of the Care Quality Commission Report in December 2015, a detailed Action Plan was developed to respond to the recommendations detailed within. This report provides an update on progress against the actions due for completion by the end of May 2016 and seeks to provide assurance that the monitoring process in use is both robust and thorough. A repository of evidence supporting compliance with the actions required is held by the governance team @ P:\governance\0. LIVE WORKING DOCUMENTS\CQC Action Plan. It is divided into sections in line with the CQC Action Plan template for ease of reference.

2.0 RAG Key

Colour	Meaning
	Off track and no plan to address
	Off track but plan in place to address issues
	Complete

3.0 Requirement Notices

The Trust received a total of 6 Requirement Notices and updates against all actions due by end May 2016 are provided below. A RAG rating is provided against each action.

Action No	Requirement Notice No	Key Measures	Action Required	Progress	RAG rating
1	1	Waiting times for clinic less than 60 minutes by May 2016 Waiting times for clinic less than 30 minutes by November 2016	Implementation of 'In touch' system in OPD by April 2016.	In touch system implemented in OPD. Go-live in Radiology happened on 13th June 2016 after technical issues resolved	**Green**
2	1	Waiting times for clinic less than 60 minutes by May 2016 Waiting times for clinic less	Audit of compliance with waiting time SOP to be reported to	Minutes from Divisional Board detail evidence of discussion about waiting tomes and this is now monitored on a monthly	**Green**

		than 30 minutes by November 2016	Divisional Clinical Governance Board by end April	basis	
3	1	No clinics will be block booked. Block booking of clinics to stop in line with timescale below:	End April 2016: no more than 40% of clinics using block booking End June 2016 No more than 30% of clinics using block booking End September 2016: no clinics will use block booking as a clinic template.	There is a need to completely revise the timescales for this action. Due to the complexity, number of clinics and the need to tie this action in with job planning there will be a delay in the delivery. Job planning will be completed end June 2016 and without including this into the delivery would risk the loss in activity / capacity End July 2016: no more than 40% of clinics using block booking End Sept 2016 No more than 20% of clinics using block booking End November 2016: no clinics will use block booking.	Amber
4	3	There will be a distinct Paediatric facility on HDU which meets national and best practice standards.	Appoint architect by Jan 2016. Design development complete by end March 2016	Appropriate professional and clinical input in to the new design. The design has been developed to incorporate two Paediatric en-suite bedrooms and associated accommodation together with links to the Theatre Store. The drawings and specification are in the final stages with a view to obtaining a cost for the works by end April 2016 with a start on site date	Amber

				scheduled for May 2016. **Update May 2016:** Awaiting final decision on start dates. **Update June 2016**. The Divisional General Manager, Division 2, established an implementation board that has been meeting fortnightly since April to ensure the delivery of this scheme. However, the award of contract is currently being held pending the Trust's response to the Royal College report.	
5	4	Separate toilet and bathroom facilities will be available for male and female patients on HDU.	Develop business plan and secure funding.	As above and funding secured. **Update May 2016:** Awaiting final decision on start dates **Update June 2016** – as above, final decision awaited, linked to Royal College report.	**Amber**

Action No	Requirement Notice No	Key Measures	Action Required	Progress	RAG rating
6	5	All Children will be cared for a by a Registered Children's Nurse.	Undertake further recruitment of Registered Children's Nurses following unsuccessful recruitment on 11.12.2015.	Three recruitment campaigns have been undertaken including rotational posts between Ward 11 and HDU, HDU only. A national journal was used in addition to NHS Jobs. The latest campaign resulted in 2 candidates and interviews took place on 17.03.2016. Recruitment is challenging but posts are advertised on NHS jobs and another national advert was posted in April 2016.	**Amber**

				Recent recruitment has identified two student Children's nurses who have accepted posts at ROH and will graduate the programme in September 2016. In addition discussion re the model of delivery of Children's Services is taking place with BCH including the possibility of developing a BCH @ROH model of care. Discussions are underway with BCH to enable development of a SLA to use their bank staff to support Ward 11 and HDU as required with good progress and likely start date late June 2016 May 16-4 posts advertised, interviewed and appointed. 1 internal commencing 1/6/16. Further 3 commencing September as currently students. Remains amber because staff currently not in post but good progress has been made against this objective. Recruitment continues with two further Children's nurses invited for interview on 25th June 2016.	

6	5	All Children will be cared for a by a Registered Children's Nurse.	Implement a revised preceptorship programme for all new starters to HDU	A new PDN has been appointed in HDU. The revised preceptorship programme is in progress with completion expected in	Amber
7	5	All Children will be cared for a by a Registered Children's Nurse.	Complete 'Children's Critical Care Assess adult nurses against the passport competencies in line with trajectory agreed at TMC in December 2015. All adult nurses will have completed the 'Children's Passport' competencies by end March 2016	May 16- all eligible staff have completed their paediatric competency document. 1 member of staff has had no exposure to paediatrics and will go to BCH in September. Out of 17 staff 15 have completed and 2 are in the process. A further SN is still in preceptorship and a plan is in place to send to BCH to complete competencies in Sept 2016.	Green
8	5	All Children will be cared for a by a Registered Children's Nurse.	Review and Approve Transitional Care Policy by end March 2016	The policy has been reviewed and is currently out to consultation with a plan to submit to TMC on 27th April 2016. Update April 2016: Policy has been written but feedback from CQG required that greater consultation and detailed implementation plan be develop. Timescale adjusted to enable this to take place. For final sign off June 2016.	Amber

				The Transitional Care Policy is due for submission to TMC in June 2016.	
9	5	All Children will be cared for a by a Registered Children's Nurse.	Rotational programme between Ward 11 and HDU fully implemented	The rotational programme has been fully implemented and staff are rotating between Ward 11 and HDU	**Green**
10	5		Develop roll out programme for competency based training with BCH	RAPT course scheduled for 10/8/16 delivered in house aimed at both nursing and medical staff). Staff to be identified to attend. 4 staff has attended the deteriorating child 1 day course at BCH and 2 staff are booked to attend airway management course in June. An ongoing programme of rotation to BCH and access to shared education programmes will be developed by the PDN for submission to Divisional Board in July 2016.	**Green**
11	6	Completion of RCPCH review.	Completion of a review by RCPCH by end March 2016 to include: Review of current arrangements for medical advice, nursing support and management. Review of the processes for risk assessing children	Terms of reference for the review agreed in December 2015. Review took place on 21st/ 22nd March.	**Green**

			prior to admission. Review of processes for management of the deteriorating child and the safety of arrangements for transfer through the Critical Care Network		

Of the 11 recommendations due for completion at end May 2016, 6 are off track but all have plans in place to enable recovery. Specifically:

- Revised timescales for completion of actions relating to block booking have been noted previously and a programme to enable compliance is in progress.
- There has been difficulty in recruiting to paediatric posts in HDU resulting in difficulty in meeting the RCN recommendations for paediatric staffing on the unit. However it should be noted that good progress has been made in recruiting to these posts and the reason that it remains amber is that we are awaiting start dates for new recruits. Recruitment continues with two further Children's nurses invited for interview on 25th June 2016.
- Dates have not yet been agreed for commencement of works in HDU and this limits compliance with two of the six requirement notices.
- The HDU new starter revised preceptorship programme is in progress but not yet complete.

4.0 Must do Recommendations.

Action Number	Must do No	Key Measures	Action Required	Progress	RAG rating
1	9	*Upload of monthly data to ICNARC website.* *Enable benchmarking against other Critical Care Units.*	Begin upload to IGNARC by end March 2016	The Trust is prepared for next quarterly data upload and data collection is underway. June 2016 – this remains on track	**Green**
2	10	*The arrangements*	Implement revised mandatory	Mandatory training	**Green**

		for the trust to discharge its Duty of Candour, although understood by staff, were not thorough.	training programme by end March 2016. Audit of compliance with DoC to be presented to QSC by end April 2016	programme revised and will be delivered from April 2016. DoC awareness added to induction training in February 2016 CCG audit showing 100% compliance with DoC presented to QSC in March 2016	
3	11	*Sickness levels among staff had risen to almost twice the Trust target in June 2015.*	Monthly monitoring of sickness rates at Divisional Governance Board.	Sickness rates are reported monthly at Divisional Governance Board	**Green**
4	12	*The compliance rate for mandatory training was falling short of the trust target by a significant amount.*	Develop schedule of training to ensure staff are meeting mandatory training.	Monitoring of compliance with mandatory training now takes place at all Divisional Boards.	**Green**
5	13	*OPD staff could not tell us if Governance put explanations and findings from investigations into writing to the patient as there had been no severe harm incidents in the OPD to test the procedure.*	Audit of staff within OPD against principles outlined in SI Policy. Publication of audit findings and evidence of discussion at Divisional Governance Board	The revised SI process was presented to CQG in May 2016 and amends suggested. The revised process together with an audit tool with be presented and signed off at the June CQG meeting. Audit of staff in OPD will be led by the Head of Governance in July 2016	**Amber**

Of the 5 actions due for completion at the end May 2016, 4 are on target. The off track action relates to audit of staff in OPD to ensure that learning from investigations has been shared and understood by staff. The audit has been delayed by amendments made to the SI process at May Clinical Quality Group and the tool will be presented to the June meeting with a plan to audit compliance in July 2016.

5.0 Section 3: Should do Actions

Action No	Should Do Notice No	Key Measures	Action Required	Progress	RAG rating
1	18	*100% of patients with a Learning Disability will be supported to have full access to all Trust Services.*	Develop and launch a revised LD Strategy across the Trust.	A new Strategy is not yet in place. However action has been taken to move this forward including: Identification of the existing process and gap analysis completed. The Trust has a Nurse Lead for LD and she will be engaged in delivering next steps. The DNG has met with the local CCG Chief Nurse and requested support and advice on the development of a strategy that corresponds to local Health drivers and reflects best practice and delivery. Timescales have been revised to enable delivery of a strategy by end Q2 2016/17	Amber

2	19	*No clinics will be block booked. Block booking of clinics to stop in line with timescale below:* *End March 2016: no more than 40% of clinics using block booking* *End June 2016 No more than 20% of clinics using block booking* *End August 2016: no clinics will use block booking.*	Commence review of all Consultant clinic templates in order to develop a standardised clinic template for use across all services. End March 2016 no more than 40% clinics will be block booked	This action is off track as detailed in the Must do action section above.	**Amber**
3	20	*No clinics will be block booked. Block booking of clinics to stop in line with timescale below:* *End March 2016: no more than 40% of clinics using block booking* *End June 2016 No more than 20% of clinics using block booking* *End August 2016: no clinics will use block booking.*	Development of a SOP for booking diagnostic tests prior to OPD appointment.	Completed SOP – to share with Div 2 and 3 to start implementation process.. April 2016 update: SOP not yet in use May 2016 update: The Divisional team have commenced review of clinic templates. However, evidence that block booking has been reduced in line with the trajectory described is not yet available. It is anticipated that evidence to support delivery will be available by end July 2016 in line with the timescales detailed in MUST Do Action	**Amber**
4	20	*Evidence that improved management practice has been applied to all clinics held in OPD by end October 2016 by*	Implement SOP for clinic waits across all PODS and services within OPD.	SOP in place in OPD but does need reviewing to include the InTouch system new time scale described above.	**Green**

		compliance with the following metrics: *Waiting times for clinic less than 60 minutes by May 2016.* *Waiting times for clinic less than 30 minutes by November 2016.*		**May 2016 Update**: Wait times are being routinely published and the first report of compliance is due to the Divisional Governance Board in July 2016.	
5	15	*There was very limited storage space.*	Scoping of additional storage creation within estates plan to be completed. Identification of additional storage facilities	This action will be completed as part of HDU refurbishment . Start date not yet agreed	**Amber**
6	16	*Ward rounds were generally not multi-disciplinary. However, the nurse allocated to that patient was present for all professional reviews. Multidisciplinary working can improve patient outcomes and provide effective patient care*	Implementation of revised ward round to ensure compliance with NHS England seven day services standard around MDT working by end April 2016.	Good progress has been made against delivery of MDT ward rounds with a physiotherapist and Pharmacist joining the team	**Green**
7	17	*The Trust had a high new to follow up ratio of 1:4.73*	Develop reporting tool to capture new to follow up ratio at patient, speciality and consultant level	**May 2016 update** Reporting tool is now available for clinical services managers. Next steps to benchmark each consultant and develop and agree a plan of reducing new to follow up ratios by consultant	**Amber**

Of the 7 *should do* actions due for completion at end of May 2016, 5 are off track. Specifically:

- The off track recommendation relating to learning disabilities will be reviewed by the Director of Nursing and Governance with a view to developing a strategy that meets local need and is in line with that of the local CCG by end September 2016.
- The Divisional team have commenced review of clinic templates. However, evidence that block booking has been reduced in line with the trajectory described is not yet available.
- The SOP relating to the booking of diagnostic tests has been written but is not yet in practice.
- The creation of additional storage facilities in HDU has not yet commenced.

6.0 Conclusion.

Trust Board is asked:

- To note the progress that has been made against delivery of the actions due by end May 2016, in particular the progress that has been made to recruit and professionally develop Children's Nurses in HDU.
- To note that there has been slippage on actions in each of the categories.
- To note that a recovery plan is in place where timescales have slipped.
- To approve the amendments to the timescales to enable the CQC Master action plan to be updated.

Garry Marsh
Director of Nursing & Clinical Governance

1 July 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Finance & Performance Report – May 2016**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Director of Finance**
AUTHOR:	**Various**
DATE OF MEETING:	**5th July 2016**

EXECUTIVE SUMMARY:

This paper, alongside the Quality report, replaces the old Corporate Performance report as the mechanism for reporting performance against the Trust's key targets and performance metrics. It is intended that this structure will provide a consistent reporting style from Board level down to Divisional reporting. The report covers the main performance metrics related to finance, activity, operational efficiency and operational workforce.

The majority of financial indictors remain reasonably stable against plan, with a slight under-performance in May offsetting the equivalent over-performance in April. Agency spend increased in May linked to expenditure on junior doctor locums, whilst CIP performance is currently behind plan, particularly in the two main operational divisions (1 and 2).

Activity levels mirror the overall financial picture, with a slight underperformance in admitted patient care work in May. This corresponds with under delivery of the targeted theatre sessional usage, although in-session utilisation was above plan.

Theatre cancellations have reduced in the first 2 months of 2016/17, as have delays in discharge from recovery. This information is displayed in more detail in Section 11, which also highlights the continued issue with patients being admitted on the day before surgery.

There was a slight increase in RTT backlog numbers in May, however the Trust continues to achieve its 92% target. The number of patients waiting over 52 weeks for treatment dropped in May, as the Trust feels the benefit of the fire-break in waiters created by the Q4 Cromwell work.

The majority of workforce indicators remain on track, with PDR/appraisal numbers increasing towards the 85% target.

REPORT RECOMMENDATION:

Trust Board is asked to note this report and discuss actions to be taken with regards to the issues outlined in the 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	X	Environmental	X	Communications & Media	
Business and market share	X	Legal & Policy	X	Patient Experience	
Clinical	X	Equality and Diversity		Workforce	X
Comments:					
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
The Finance & Performance Report, alongside the Quality Report, demonstrates performance against a number of key metrics linked to the delivery of the Trust objectives.					
PREVIOUS CONSIDERATION:					
This report was considered by Finance & Performance committee and TMC in June 2016.					

FINANCE & PERFORMANCE REPORT

MAY 2016

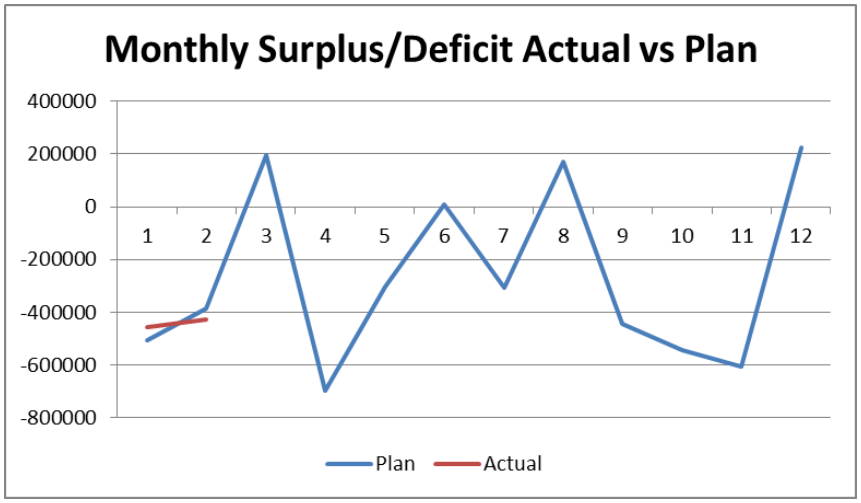
CONTENTS

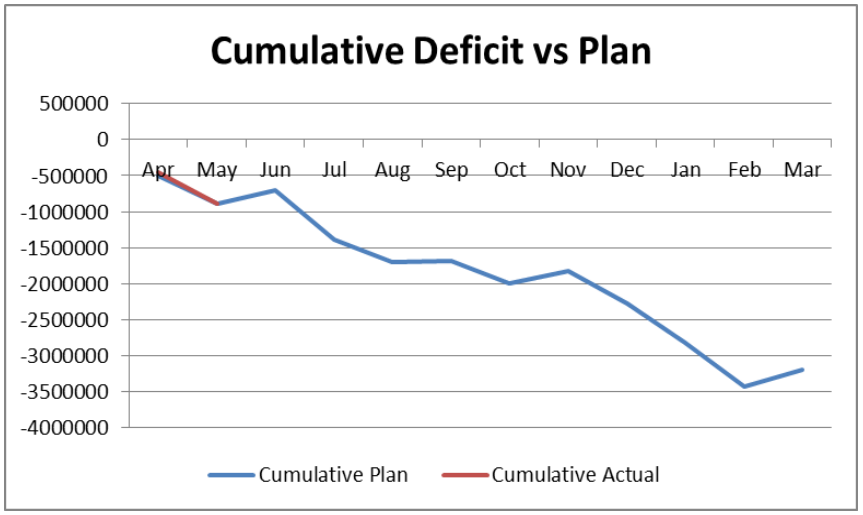
INTRODUCTION

The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

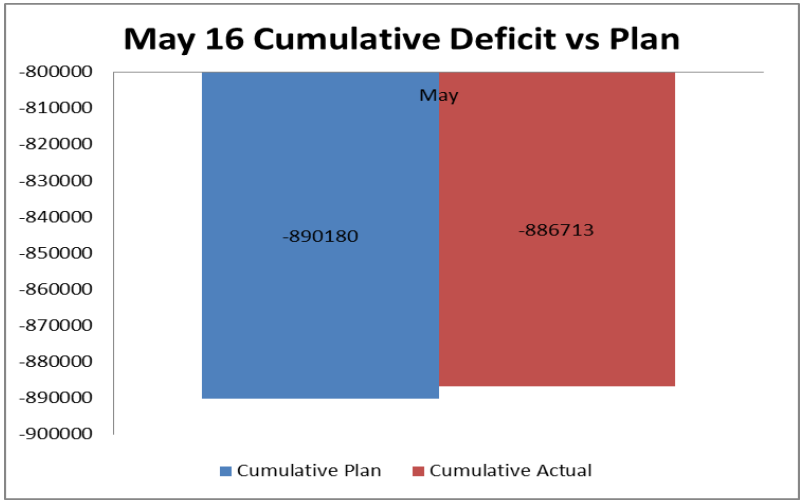
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Financial Sustainability Risk Rating (FSRR)





NHSI Financial Sustainability Risk Rating (FSRR)		
	Plan	**Actual**
Capital Service Cover	1	1
Liquidity	4	4
I&E Margin	1	1
I&E Margin – Variance against plan	2	4
Overall FSRR	2	2



INFORMATION

The Trust has delivered a cumulative deficit of £887,000 as at the end of May against a planned deficit of £890,000. Overall income and expenditure positions have remained fairly static against plan, with a slight over-performance in April offset by a slight underperformance in May. Further detail on the key drivers of the financial position is provided in the income and expenditure sections below.

CIP performance is behind plan for Month 2, however this was offset by underspends in other areas.

The deficit position results in the Trust achieving ratings of 1 for both our Capital Service Cover and I&E Margin metrics as part of the NHSI Financial Sustainability Risk Rating. The achievement of a 1 in any metric caps the overall performance level for the Trust at a maximum rating of 2, despite receiving the highest available rating for liquidity and performance against plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

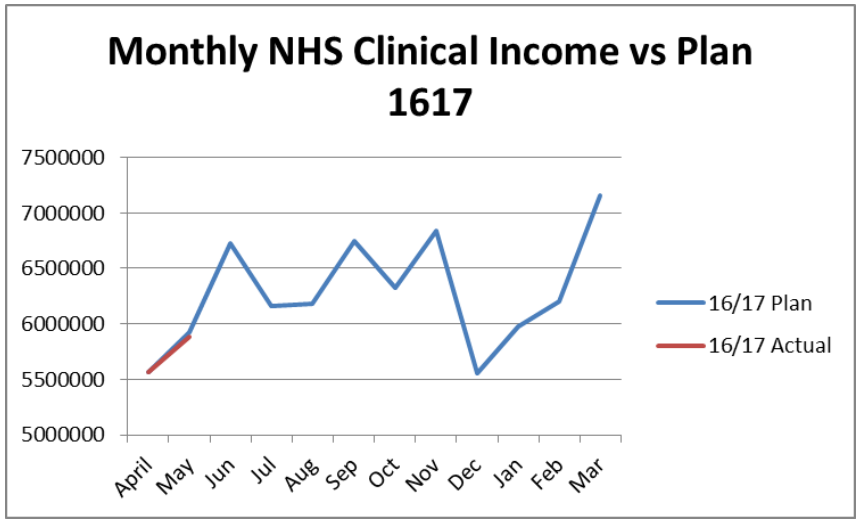
See income & expenditure sections for more details

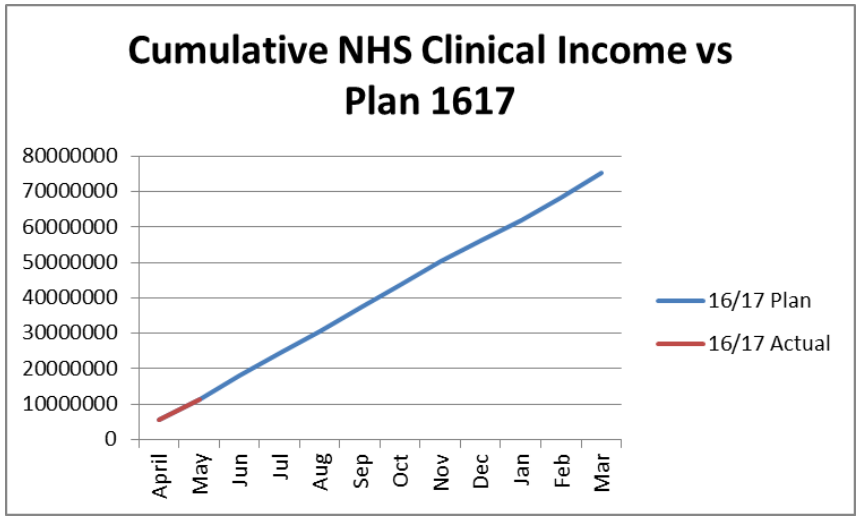
RISKS / ISSUES

Achievement against the overall financial target for the Trust remains a challenging ask, and it is vital that the combination of activity delivery, cost control and efficiency improvements are all achieved to enable the target to be hit.

June was planned to deliver an in-month surplus of £194,000, leaving a planned Q1 deficit of £697,000. It is highly unlikely that this position will now be delivered following the closedown of all theatres for the week commencing 6th June. This could potentially impact on the receipt of the Trust's sustainability funding for Q1.

2. **Income – This illustrates the total income generated by the Trust in 2016/17, including the split of income by category**





NHS Clinical Income – May 2016			
	Plan	**Actual**	**Variance**
Inpatients (inc XBDs)	3,026	2,945	(81)
Day Cases	681	667	(14)
Outpatients	691	609	(82)
Critical Care	218	266	48
Therapies	247	317	70
Pass-through income	200	197	(3)
Other variable income	352	352	0
Block income	506	531	25
TOTAL	5,922	5,884	(38)

NHS Clinical Income – YTD 2016			
	Plan	**Actual**	**Variance**
Inpatients (inc XBDs)	5,787	5,744	(43)
Day Cases	1,316	1,347	31
Outpatients	1,368	1,265	(103)
Critical Care	416	446	30
Therapies	457	530	73
Pass-through income	400	380	(20)
Other variable income	732	716	(16)
Block income	1,013	1,054	41
TOTAL	11,489	11,482	(7)

INFORMATION

NHS Clinical income under-performed by 0.6% in May, having over-performed by 0.5% in May. Admitted patient care performance was largely driven by under-delivery of discharged activity in both inpatients (23 spells) and day cases (27 spells), again largely mirroring similar levels of over-performance in April. Case-mix returned to usual levels in May, but remains slightly low for the year to date.

Outpatients continued to under-perform from an income point of view, driven by a significant reduction in the number of outpatient procedures undertaken in month. This largely relates to the retirement of a pain management consultant, and the difficulties in recruiting to a full time locum post to cover. A proportion of his workload has been transferred to other services including therapies, which partly explains the over-performance in that service in the year to date.

ACTIONS FOR IMPROVEMENTS / LEARNING

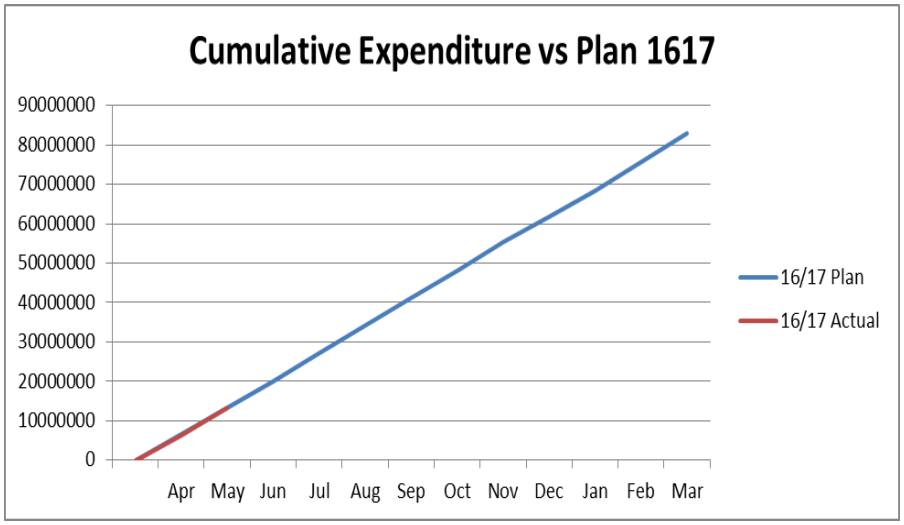
Division 2 continue to explore alternative operating models to cover the pain management service whilst substantive recruitment to the consultant vacancy is completed.

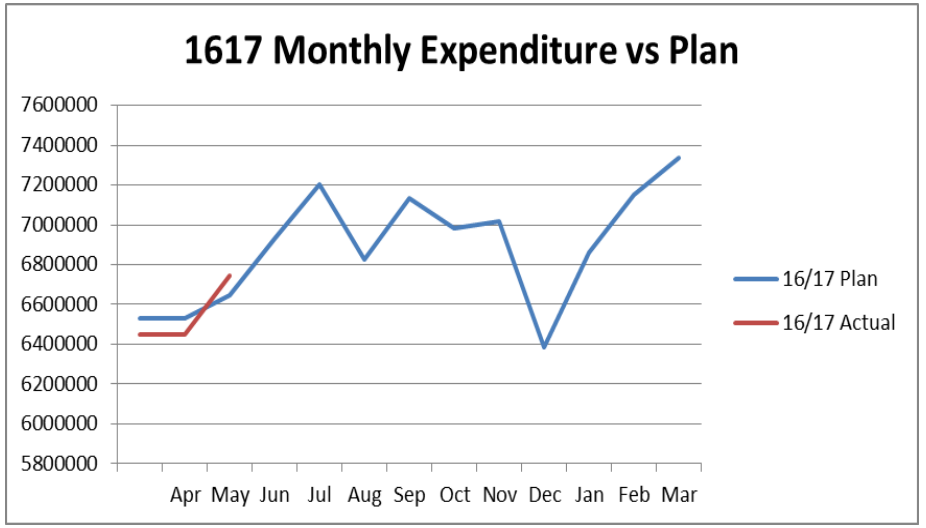
Continued daily focus is taking place to ensure inpatient activity is maximised, whilst work is completed on the Patient Journey II project to ensure capacity can reach required levels.

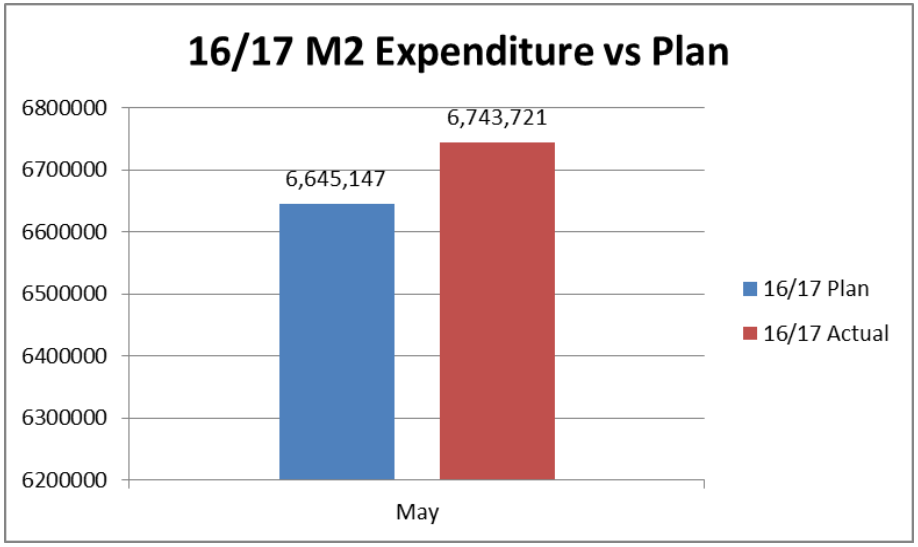
RISKS / ISSUES

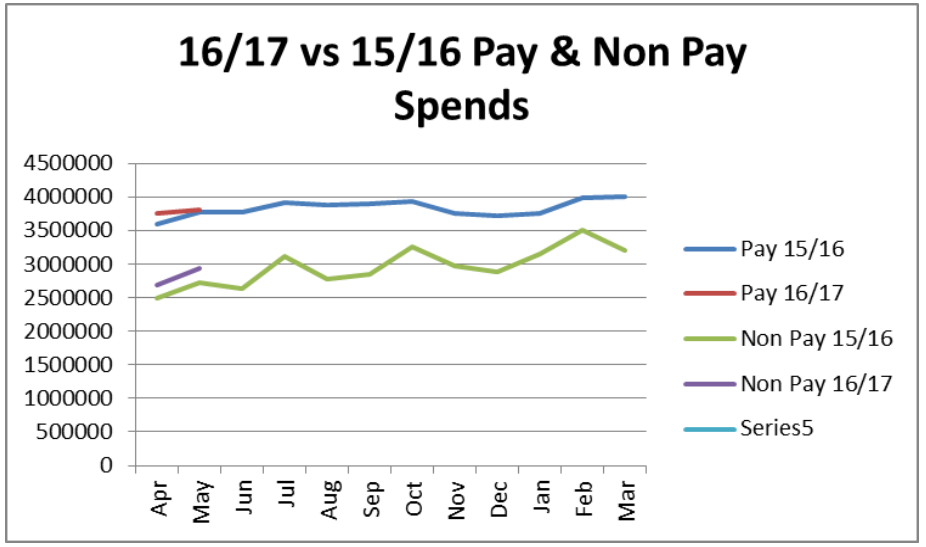
The closure of all theatres for 1 week from 6th June 2016 will have a significant effect on both June's income position, but also on the ability of the Trust to clawback that activity in later months of the year when stretch targets are already in place. The Operations team are developing a plan for how this can be achieved.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2016/17, compared to historic trends









INFORMATION

Expenditure levels increased in May, with an overspend of £98,000 against planned levels. A number of the material variances are still being investigated, but they included:

- An increase in prosthesis expenditure, with £844,000 of spend recognised as compared to £699,000 in April. This continues to be analysed to understand any links between activity and theatre stock processes. A credit note of £45,000 was received in April that related to expenditure at the Cromwell and was incorrectly allocated to prosthesis, this reduced the spend in April to the £699,000 and contributes to the variance of prosthesis expenditure from April to May.
- A £52,000 increase in junior doctor expenditure, largely linked to increased locum usage. Three additional locums were used by the Trust in May compared to April, following a decision to increase medical locums in POAC to clear patients quickly. Commissioning invoices were also received in May in the amount of £36,000, these had not been accounted for in the April position.
- A £40,000 increase in expenditure at BCH linked to spinal deformity services
- A £45,000 year to date overspend on estates maintenance costs.

Due to the increase in medical locum spend, the overall agency spend increased by £54,000 as compared to April's position, taking us above the NHSI agency cap.

Non Pay expenditure remains circa 8% above the level of spend seen in the comparable months of 2015-16, however income has increased by circa £10% against the same comparator. Pay expenditure has increased only 2% against the 15-16 comparator, which would largely relate to pay awards, incremental drift and NI changes.

ACTIONS FOR IMPROVEMENTS / LEARNING

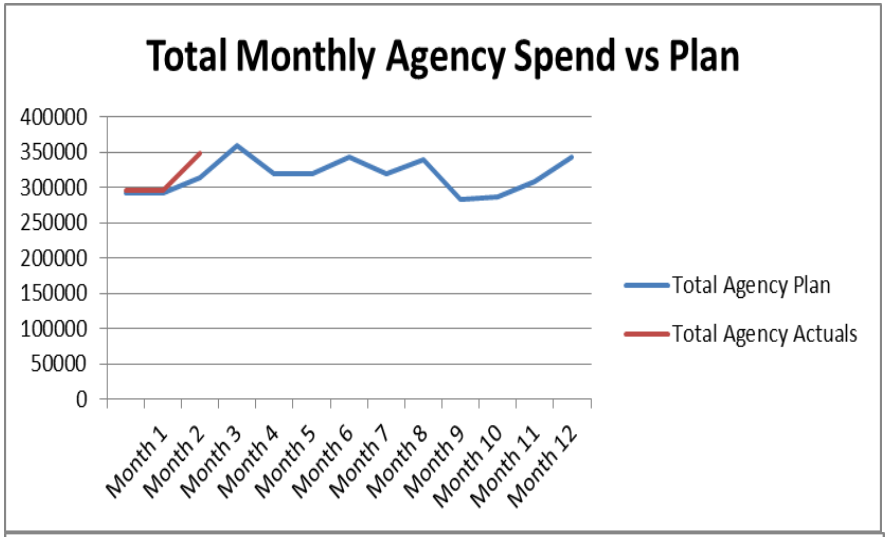
Divisions 1's (Patient services) financial position has shown a deterioration in Month 2, largely linked prosthesis and junior medical staffing. These issues will be picked up within Divisional Performance meetings. Division 4 (Estates & Facilities) is also overspending as a result of building maintenance costs, and a review will be undertaken to understand whether this is simply linked to the timing of projects.

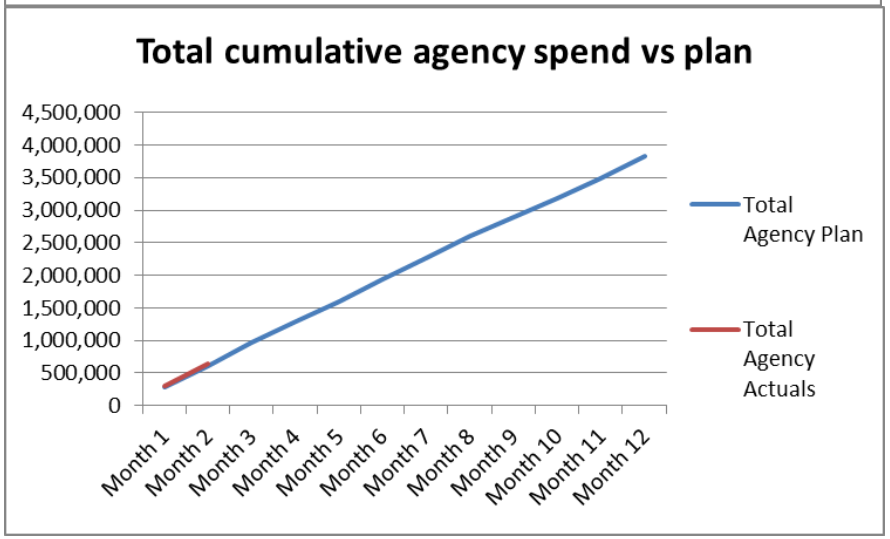
All other Divisions are broadly breakeven at the end of Month 2.

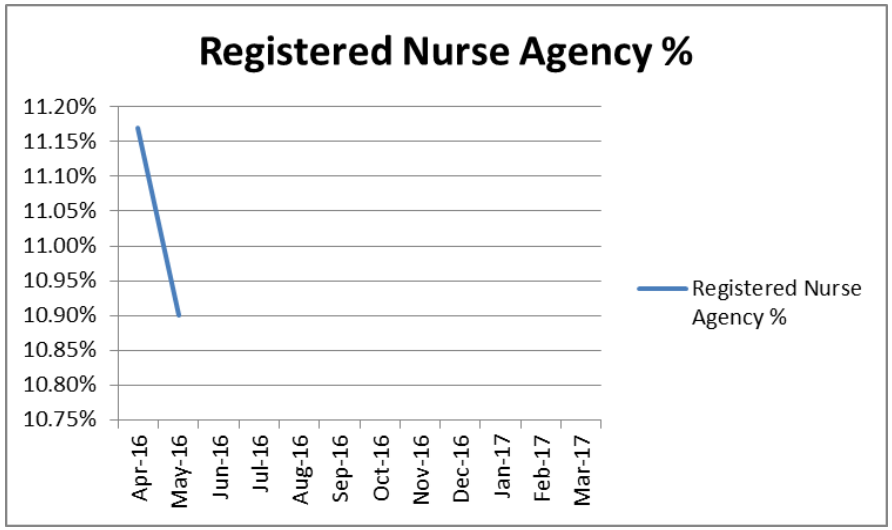
RISKS / ISSUES

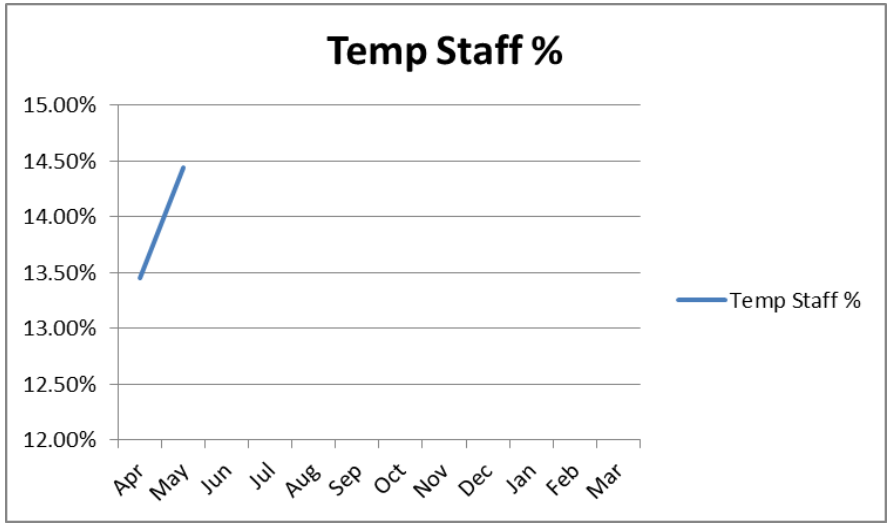
Further work is required to implement the full recommendations of the review into theatre stock control and processes, as there remains a risk that without these improvements, full reliance cannot be placed on non-pay expenditure.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2016/17, and performance against the NHSI agency requirements









INFORMATION

Agency expenditure increased by £54,000 in May, largely driven by a £52,000 increase in locum junior doctor expenditure. This increased the percentage of the pay bill relating to temporary staffing from 13.5% to 14.5%.

The Trust is currently £39,000 above the NHSI agency cap trajectory at the end of Month 2. Further investigation is being undertaken into the driver for this increase.

Agency nursing spend remained static in month, with a minor reduction in the proportion of registered nursing spend relating to agency costs.

ACTIONS FOR IMPROVEMENTS / LEARNING

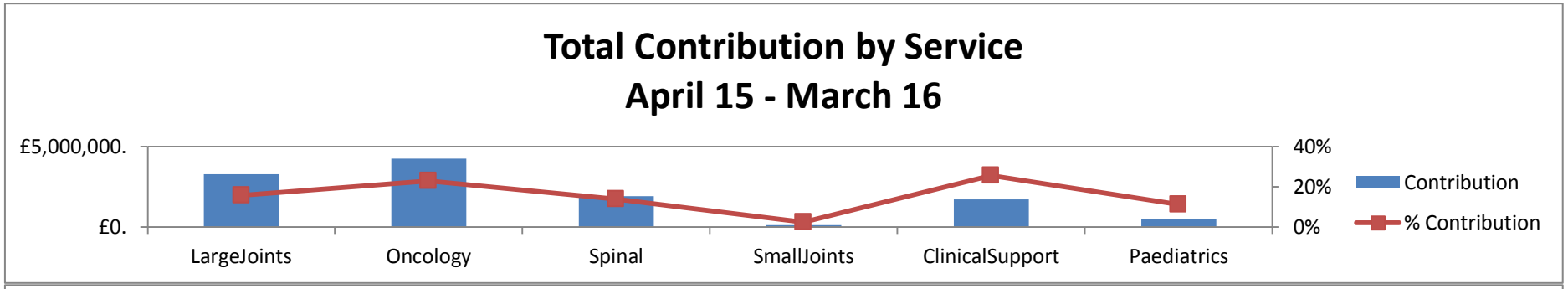
May's expenditure on junior doctors is currently being reviewed to understand the drivers, and to determine whether controls are working appropriately and whether these costs are likely to continue.

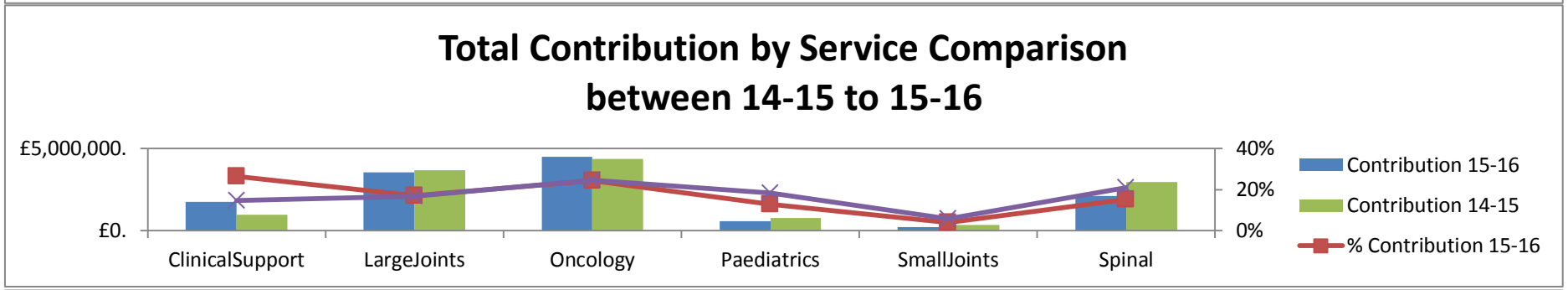
Further work is still required to ensure that the new Physicians Associates are having the maximum impact on displacing existing locum costs.

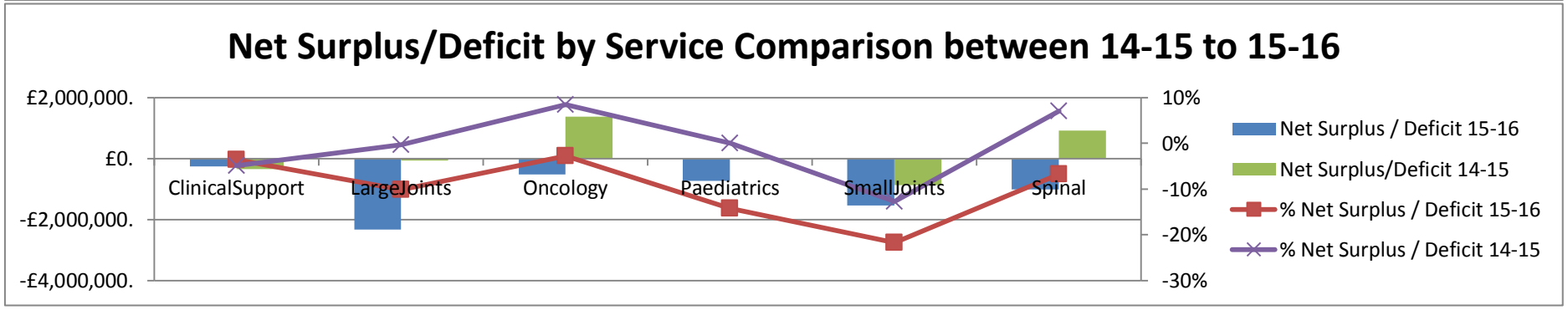
RISKS / ISSUES

Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls. The Trust will need to take all necessary steps to bring expenditure back in line with the capped trajectory.

5. Service Line Reporting – This represents the profitability of service units, in terms of both consultant and HRG groupings







INFORMATION

The graphs above, and the associated narrative, relate to the financial year 2015-16 and a comparison to previous financial year 2014-15.

The first graph is showing the contribution each service is generating, currently the Trust target is set at <20%. It can be seen that only Oncology and Clinical Support services achieved and exceeded the Trust's target of 20%. All other services generated less than 20% with Small Joints providing the lowest contribution of £136k, outlining that their direct costs are close to matching the income generated before applying any Trust overheads. This is mainly due to Tariff configuration and service provision.

The second graph is comparing the total contribution each service made towards the trust's position in the financial year 15-16 and 14-15. It can be seen that Large Joints and Oncology have been consistent over the two year's as both their contributions to income generated have remained at 17% and 25% respectively. Clinical Support is the only service line that has improved its contribution in 15-16 and exceeded the 20% contribution target.

The graphs show that once the finance department accounts for overheads, depreciation and interest, all service lines are running at a net loss, this is reflected in the overall Trust positions reported £6.37m deficit in 2015-16.

Large Joints are currently creating the highest gross loss, due to theatre utilisation, case mix and increased direct costs in relation to HRG tariff funding.

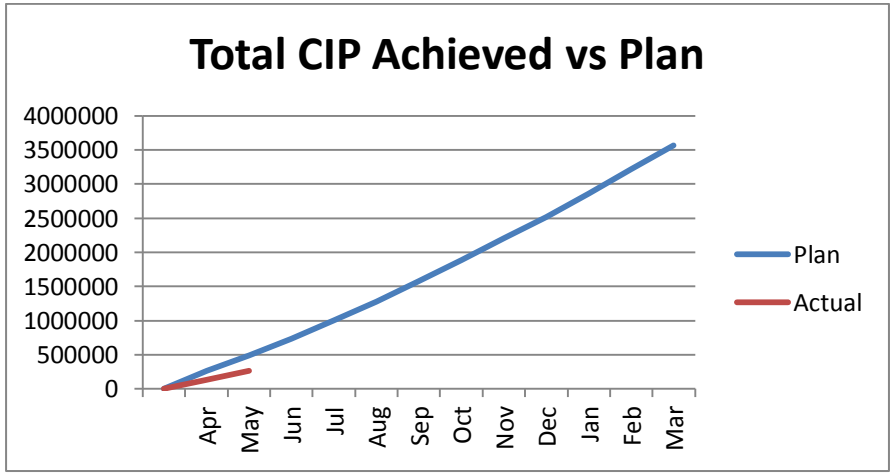
It should be noted that the two service lines Oncology and Spinal that had generated a net surplus in 14-15 have now in 15-16 generated net deficits. It can be seen that majority of the services except Clinical Support have produced greater deficits in 15-16 compared to 14-15.

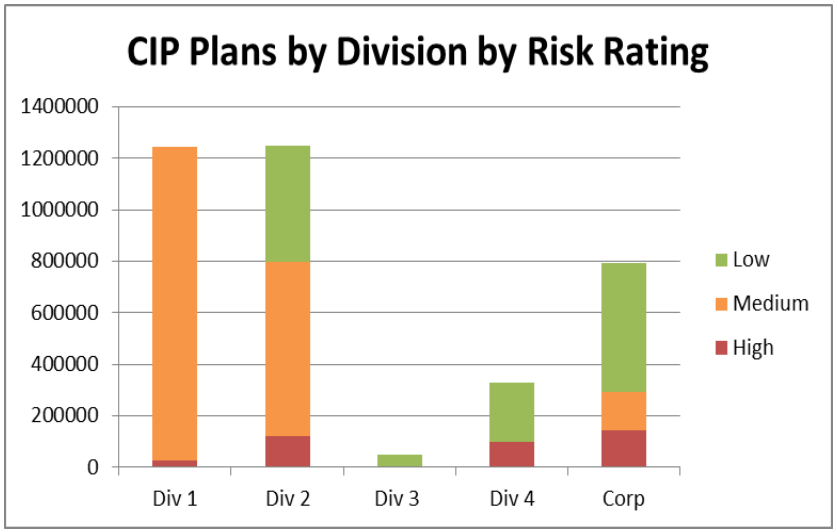
ACTIONS FOR IMPROVEMENTS / LEARNING

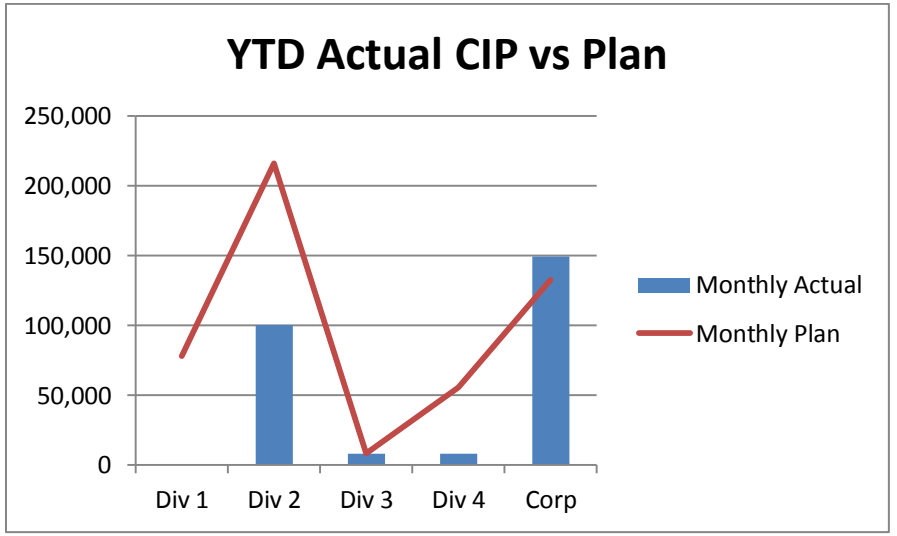
It is important that the use of SLR is embedded into the Trust, as this information provides the vehicle to challenge clinical and price variation at all levels. SLR reporting will form part of the divisional reporting moving forwards, and will be challenged at monthly performance meetings.

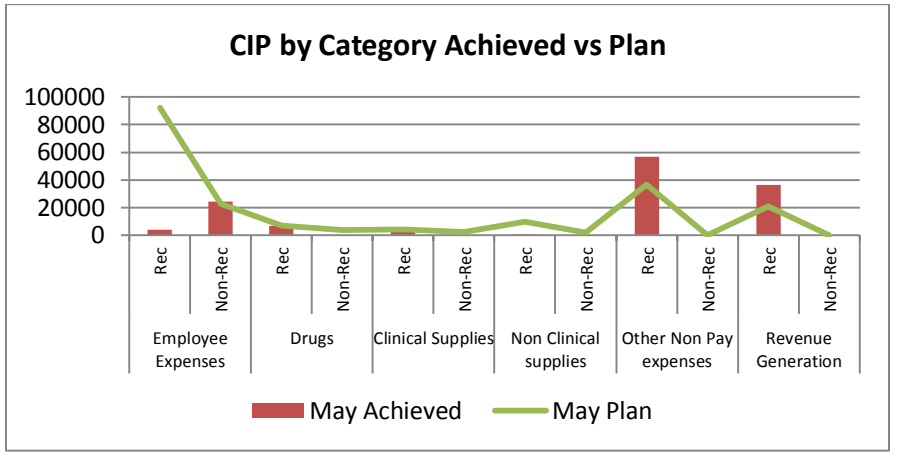
RISKS / ISSUES

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2016/17









INFORMATION

As at the end of Month 2, the Trust has recognised £265k of savings, against a plan of £490k. £43k (16%) of savings to date are non-recurrent. The in month savings recognised were £133k against a May target of £223k.

£92k of the CIP achieved in month relates to the Corporate Division achieving 138% of their target set for May, with the majority of the CIP relating to coding improvements and depreciation savings. £34k relates to CIP savings achieved by Division 2. The balance relates to smaller savings in Divisions 3 and 4. No savings have yet been released in Division 1.

The majority of CIP schemes are still rated as medium or high risk in terms of likely delivery. Further work is required by CIP leads to ensure that these schemes are delivered, and that additional mitigation schemes are developed to cover any future slippage.

The majority of Quality Impact Assessments for in year CIP schemes have been developed and the process of review by the Director of Nursing & Governance and the Medical Director for formal sign off is ongoing. These will then be monitored through the Quality Committee. The use of the Quality Committee as an assurance route for QIAs will ensure a more timely process of review during 2016-17.

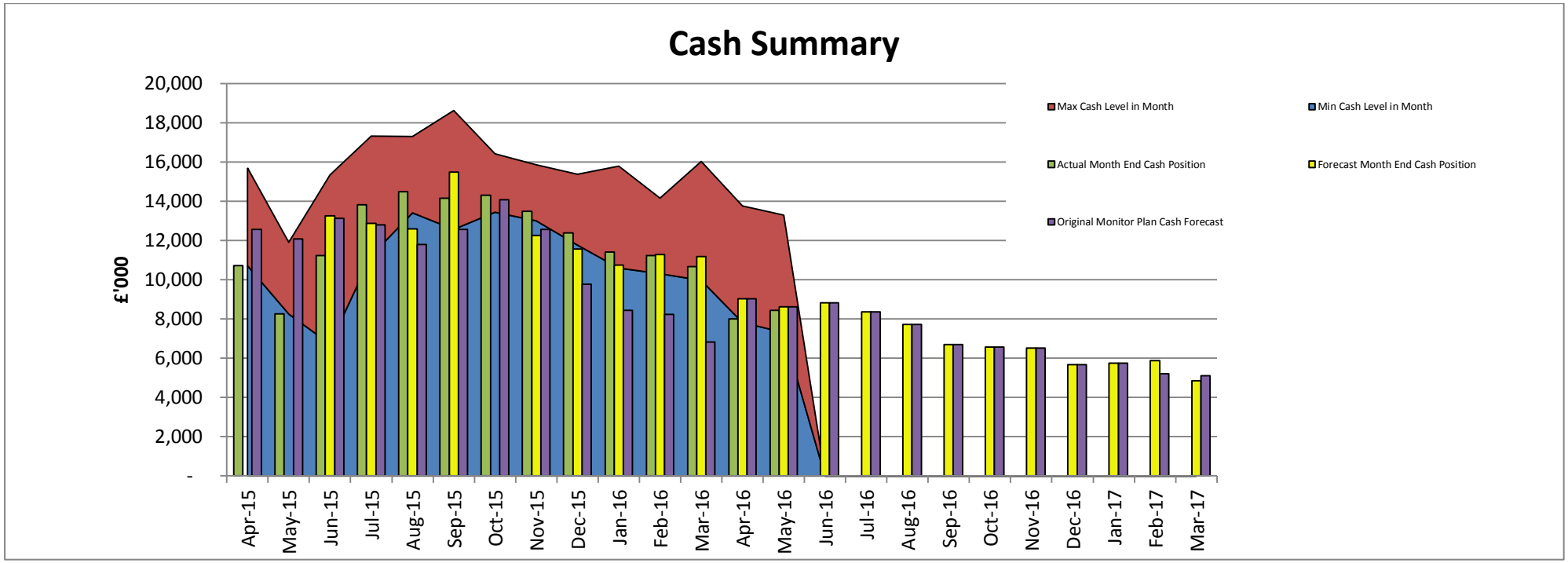
ACTIONS FOR IMPROVEMENTS / LEARNING

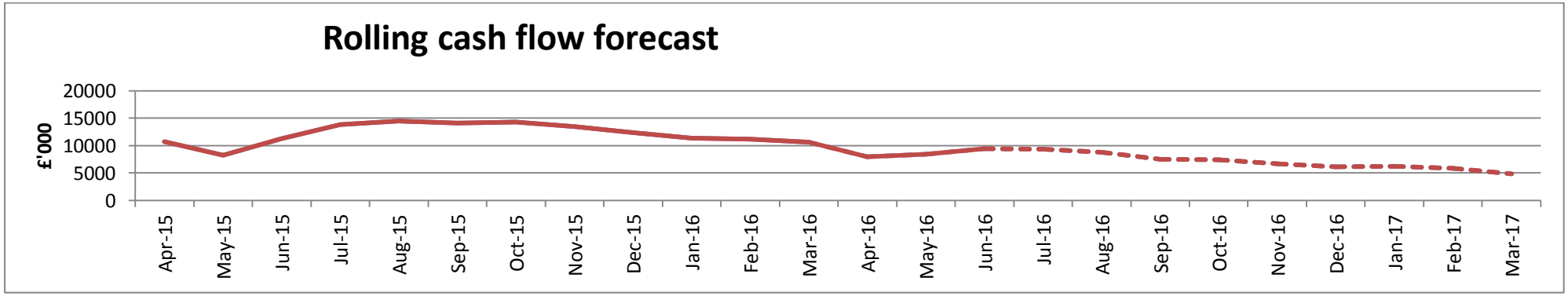
There are still gaps in some areas with regards to the required CIP documentation, largely relating to implementation plans and QIAs. Leads are reminded that all schemes require an outline description for approval, followed by an implementation plan, benefits realisation review and QIA, prior to the initiation of the scheme.

RISKS / ISSUES

The CIP target of £3.67m represents a significant challenge to the Trust. It is vital that we remain on target in the early months as it will not be possible to make significant clawbacks against this level of savings target later in the year.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet





INFORMATION

Cash levels remain in line with planned levels at the end of May 2016. The Trust is forecasting an end of year cash balance of circa £5m, which relies upon the delivery of our deficit plan and the control of capital spend within the budget that has been set.

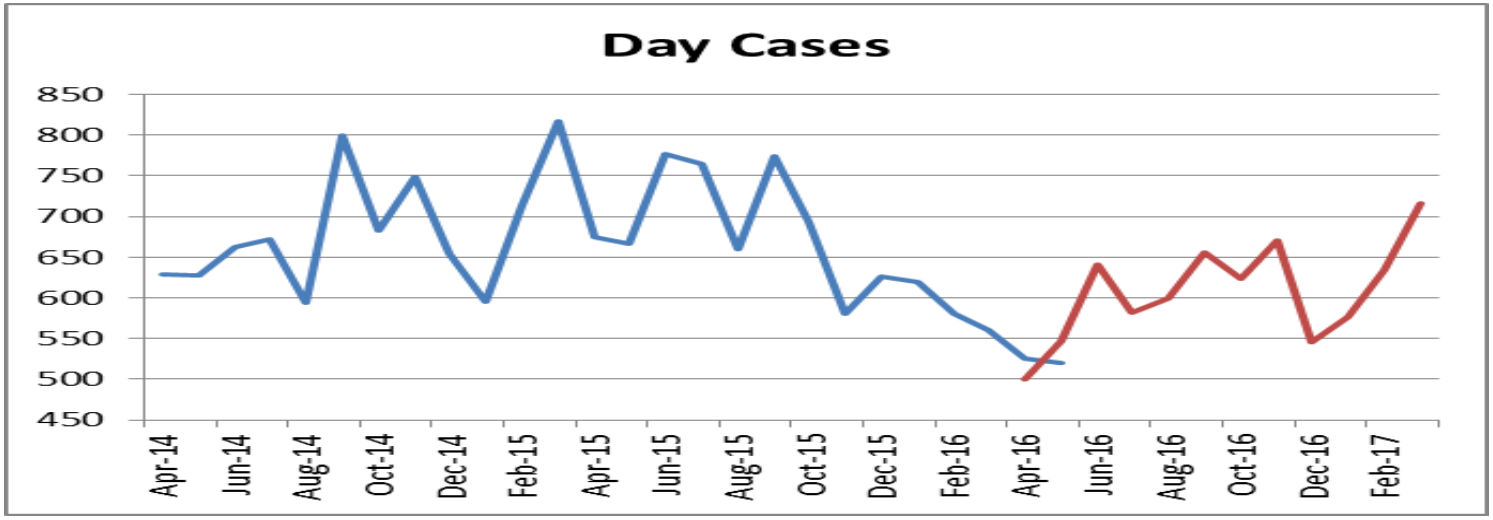
ACTIONS FOR IMPROVEMENTS / LEARNING

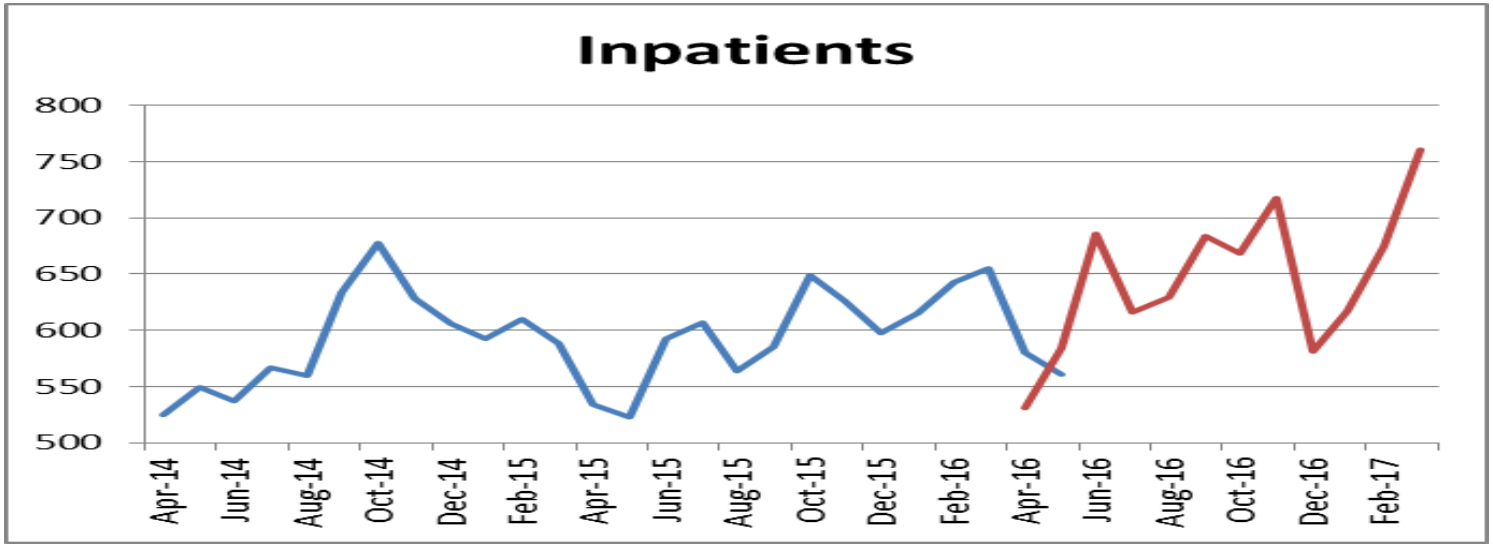
The Financial accounting team are continuing to review opportunities to improve the monitoring and projection of working capital movements, particularly in relation to early warnings around stock purchases and issuing.

RISKS / ISSUES

Given the in-month fluctuation of the cash position, which can potentially hit levels £1m-£2m below month end figures before mandate payments are received, it is vital that financial projections are met to ensure that cash can be comfortably managed within safe tolerances.

8. Activity: Admitted Patient Care – This illustrates the number of inpatient and day case discharges in the month, and year to date





INFORMATION

The activity levels for both day case and inpatient activity have been slightly below the profiled plan for May.

ACTIONS FOR IMPROVEMENTS / LEARNING

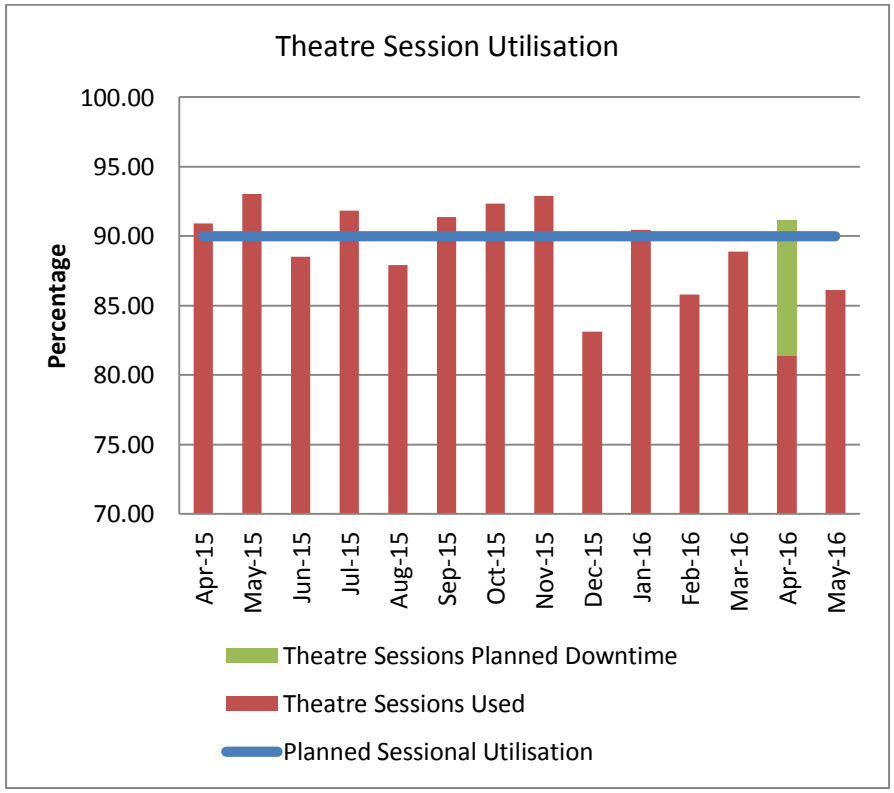
Work continues as part of the "6,4,2" planning process to achieve optimal utilisation of lists, to backfill lists that would otherwise be unused due to surgeon leave, to understand the reasons when patients DNA or cancel, to improve pre-operative assessment processes and robust list order / lock down process.

Longer term, there is work as part of team service objectives linked to the 2016-17 job planning round to achieve improved list uptake, in order to deliver the planned level of activity as it is profiled through the year.

RISKS / ISSUES

The events of week commencing 6th June, leading to a week of cancelled elective operating, clearly present a risk in terms of the catch up of this activity, which is currently being worked through by the clinical and operational teams.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

86.11% of planned sessions utilised, against a plan of 90%

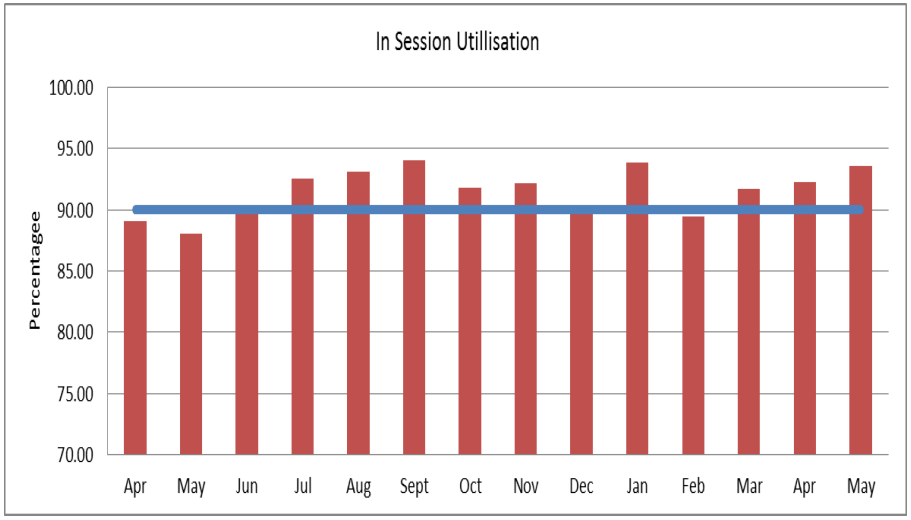
ACTIONS FOR IMPROVEMENTS / LEARNING

Due to annual leave / study leave, we can typically expect surgeons to cover a 42 week year. Timetables are based on a 52 week year. Discussions take place proactively as part of the "6,4,2" process to ensure that other surgeons pick up lists that would otherwise be fallow. A more robust approach to job planning to build in buddy arrangements and prospective cover, as well as recruitment to specialities where there are vacancies or that are under pressure from an activity / RTT / 52 week perspective, will improve this position.

RISKS / ISSUES

Engagement in the job planning process.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



Add graph showing theatre in-session usage by month (cutting & gasing time only) – may need to wait for Theatreman for this

INFORMATION

Utilisation against this measure remains consistently above the target 90%

ACTIONS FOR IMPROVEMENTS / LEARNING

There are a range of actions being undertaken as part of the Patient Journey 2 project to ensure continual improvement in theatre in session utilisation, focussing on start time, turnaround, optimal list composition and the eradication of unplanned overruns.

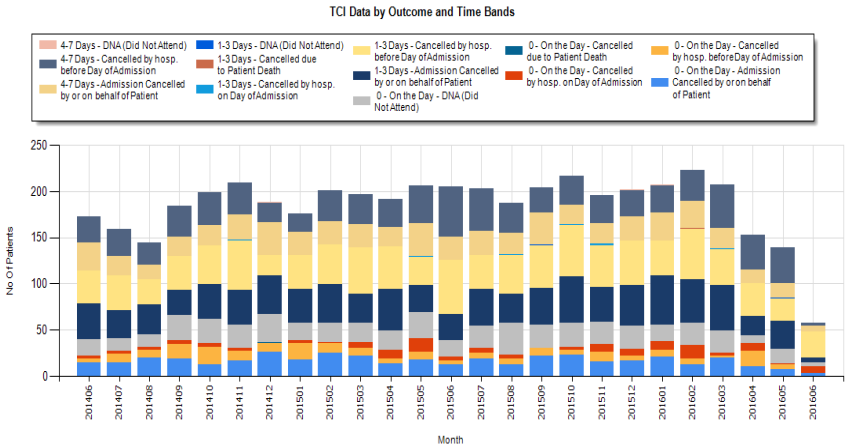
The implementation of the new Theatre Management System (Theatreman) in October will be a further vehicle to ensure that lists are optimally booked based on the available time.

RISKS / ISSUES

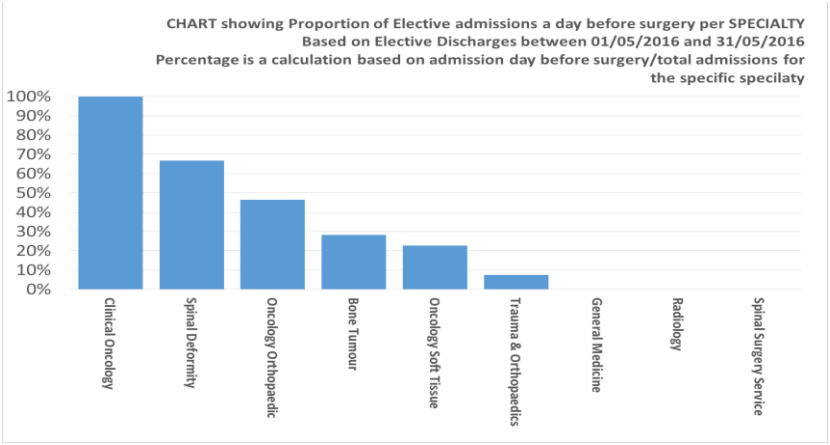
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (eg experience in spinal scrub) to ensure the best possible efficiency.

11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

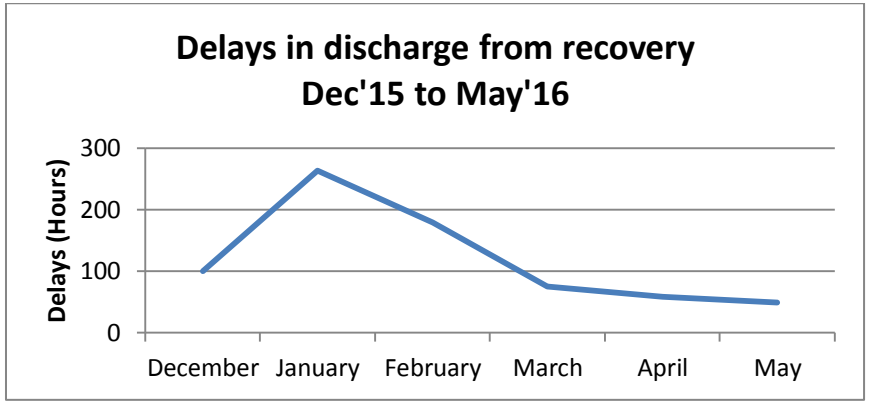
Cancellations by patient / hospital



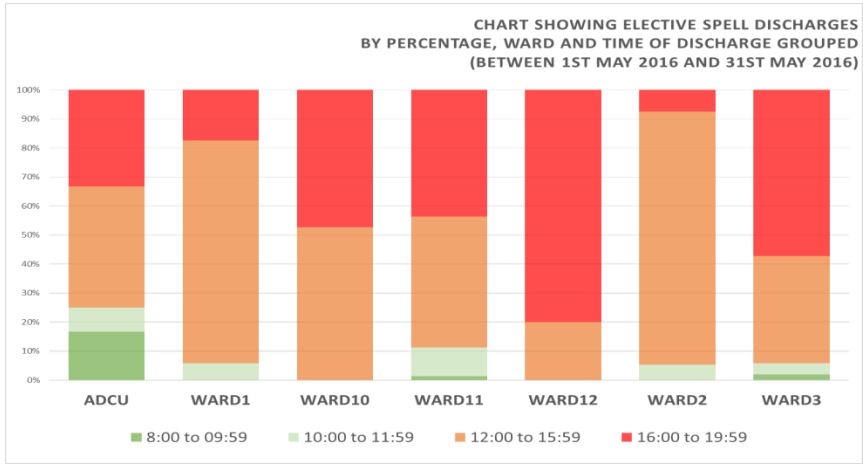
Admission the day before surgery



Delays out of recovery



Time of day patients discharged



INFORMATION

There continues to be a high proportion of patients who are self-cancelling before the day of surgery, which will be addressed as part of Patient Journey 2. There is some root cause analysis work that is ongoing, linked to the daily operational huddles, about the effectiveness of the pre-operative assessment process. It is not clear whether the 72 hour reminder call is assisting in the reduction of patient cancellations, and it is recommended that further work is done on setting our expectations with patients at the time they are listed for surgery. Work is ongoing to understand whether there are any specific specialties/consultants where this occurs more frequently, to be able to focus action.

ACTIONS FOR IMPROVEMENTS / LEARNING

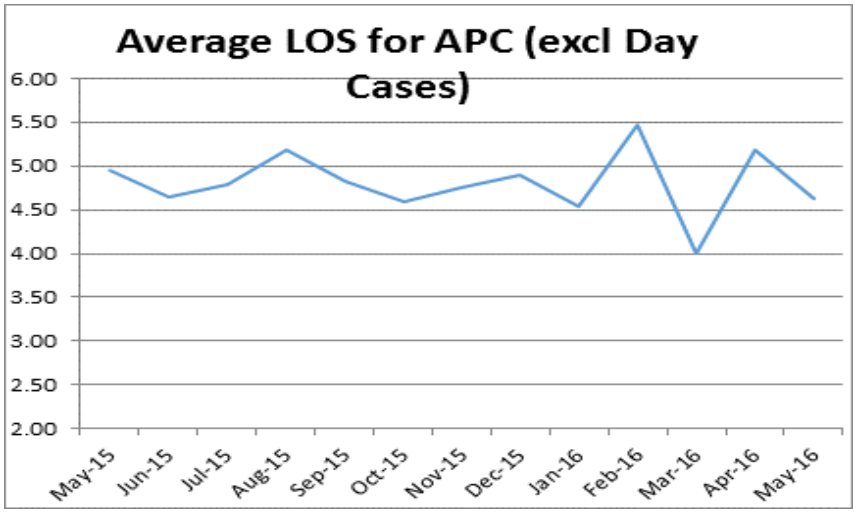
Continued work is required to ensure that all specialties have a pool of patients who are pre-op'd and available to be called in at short notice to fill cancellation slots. The concept of pooling of appropriate patients between consultants also needs to be undertaken to maximise efficiency.

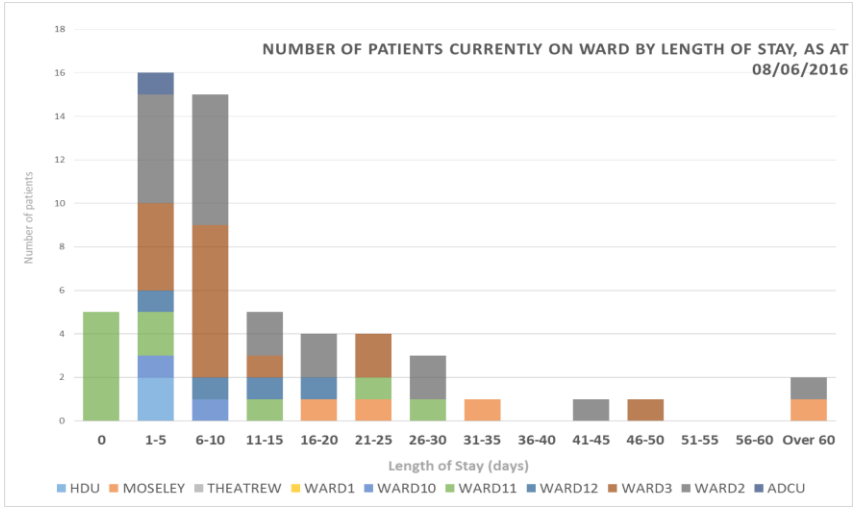
Work is required to draft and agree criteria for admission night before – clinical and social (ie if someone is coming from a long way) for agreement with consultants. Spinal deformity currently insist on all patients being admitted the night before.

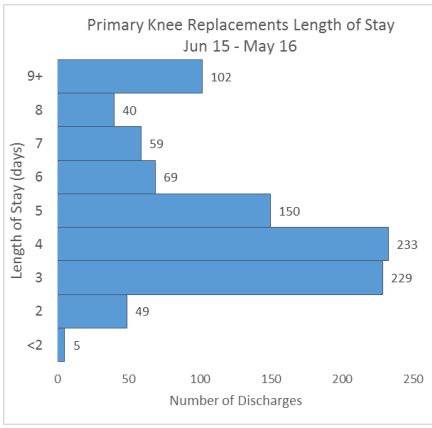
RISKS / ISSUES

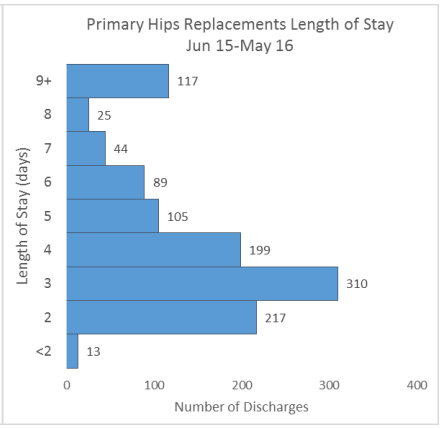
As activity increases in line with the profiled plan, it will become increasingly difficult to sustain admission before the day of surgery, and necessary to achieve a higher level of discharges before midday. This is covered within Patient Journey 2.

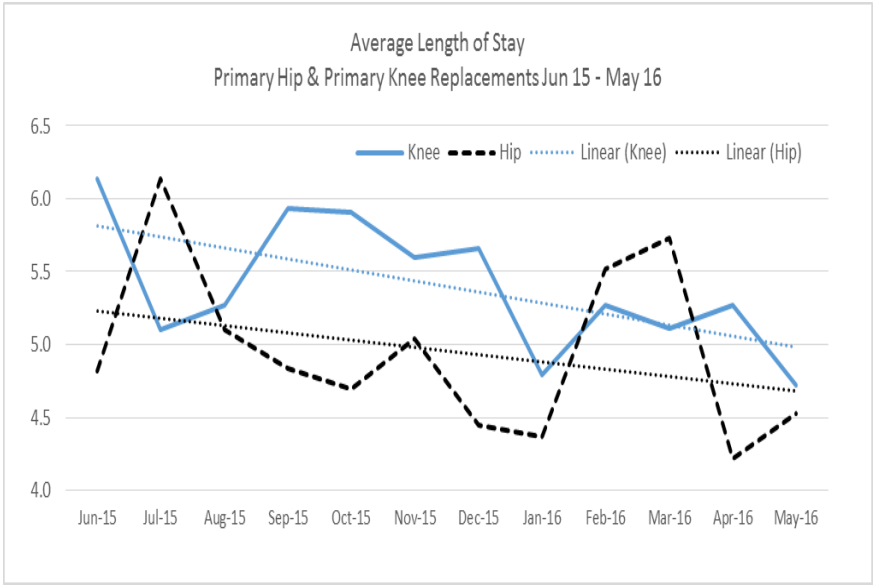
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Length of stay of current inpatients is well controlled. The length of stay for primary hips and knees has reduced steadily over time.

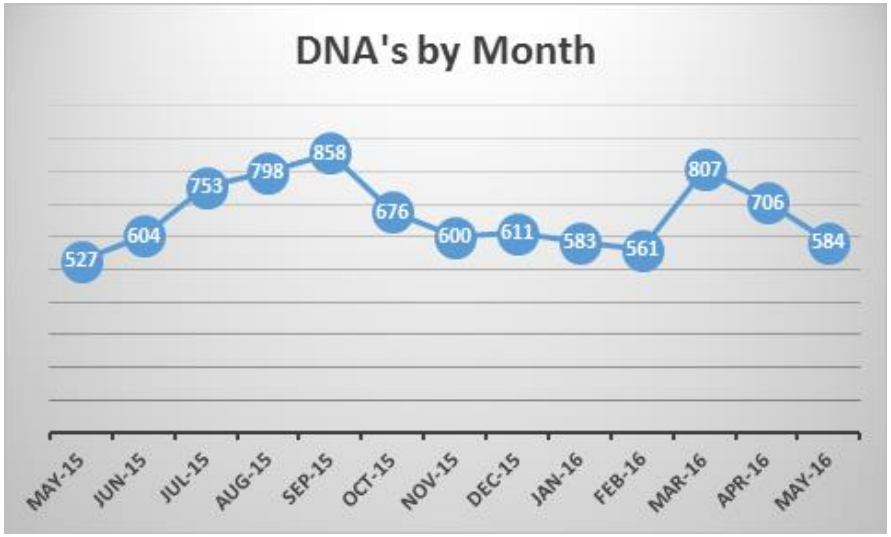
ACTIONS FOR IMPROVEMENTS / LEARNING

Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.
Previous worked on Enhanced Recovery After Surgery will also be evaluated, and where it is seen to be working this will be rolled out where this can be done in a cost neutral way.
More formalised ward reviews should be part of consultant job planning discussions, which will be helpful in speeding up decision making and therefore shaving days off individual patient length of stay, or bringing discharge earlier in the day so that the bed can be recycled for incoming patients.

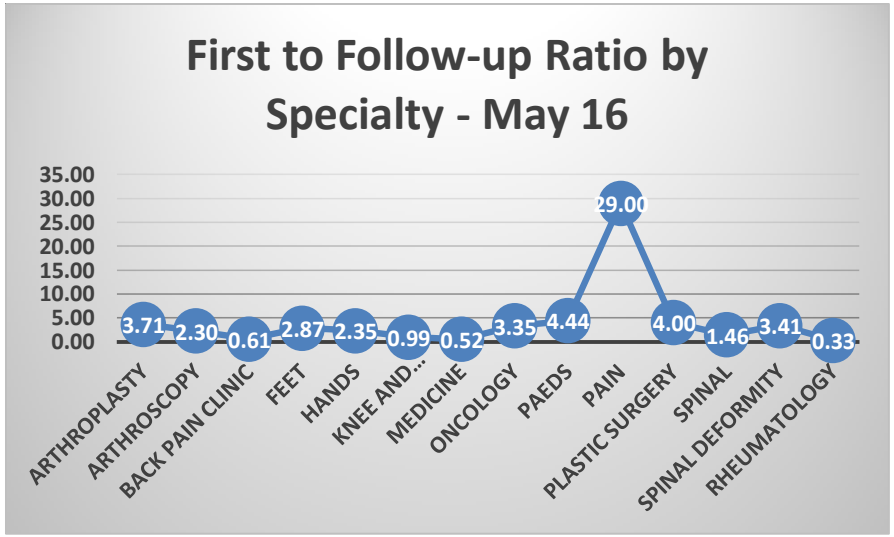
RISKS / ISSUES

With a defined bed stock, these changes need to happen at pace in order to deliver the commissioned level of activity.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients



Graph showing average waiting time in outpatients by month under development



Graph showing under / overbooking of clinic by specialty under development

INFORMATION

Outpatient DNAs remain stubbornly high. The first to follow up ratios at consultant level remain variable, relating to individual clinical practice. The figure for pain is spurious, in that the current consultant cover in the service is diminished following a recent consultant retirement, with the post not back filled during May. Follow up patients continued to be seen, hence skewing the ratio, whilst new patients were seen by the MSK team.

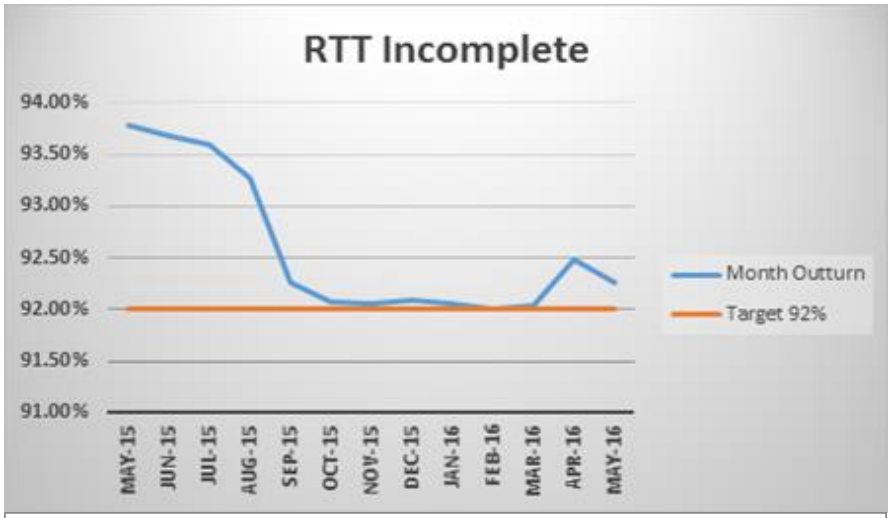
ACTIONS FOR IMPROVEMENTS / LEARNING

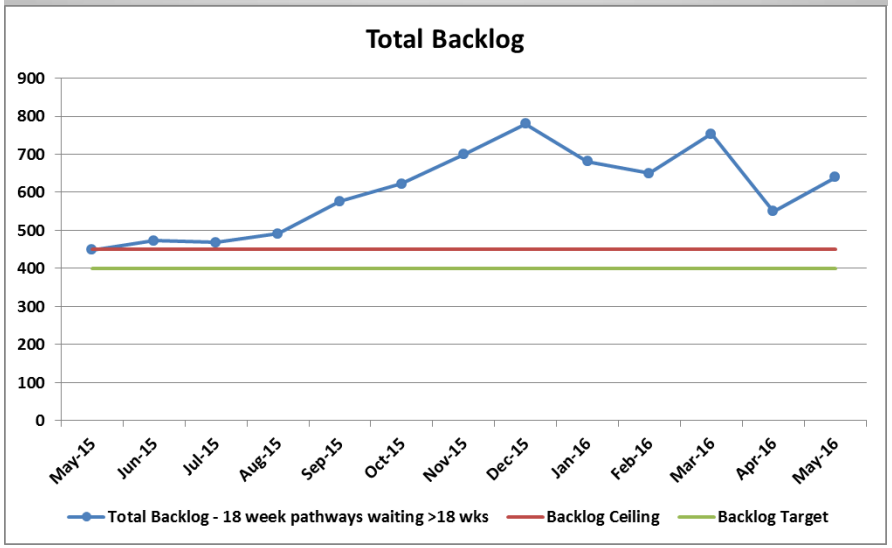
There are a range of actions as part of Patient Journey 2, and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

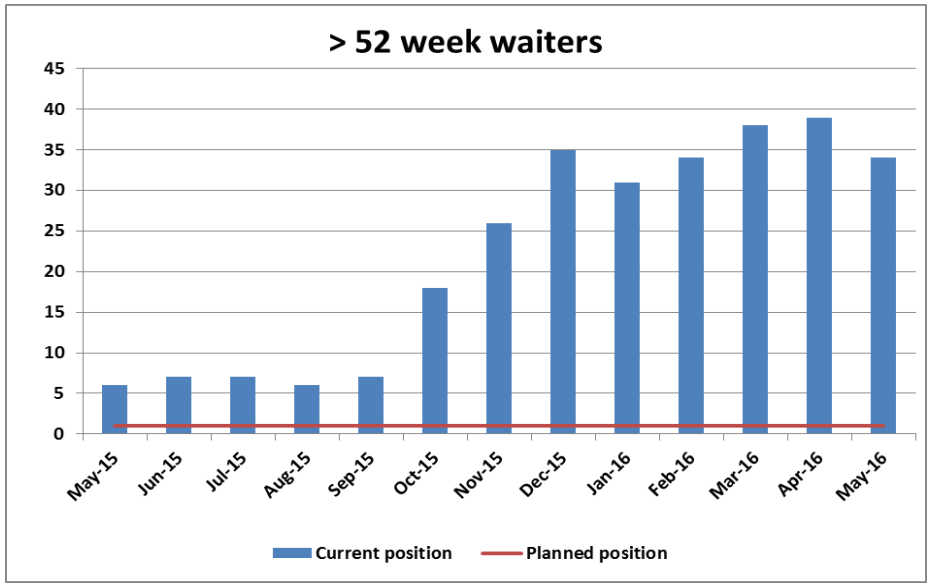
RISKS / ISSUES

Clinical engagement in the redesign of patient pathways.

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets	Target / Trajectory	Actual (May)	Actual (YTD)
52 week waiters	40	34	
18 week RTT	92%	92%	
Cancer (2 week wait)	93%	100%	100%
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	100%
Cancer (31 days for 2nd or subsequent treatment)	94%	94%	95%
Cancer (62 days)	85%		

INFORMATION

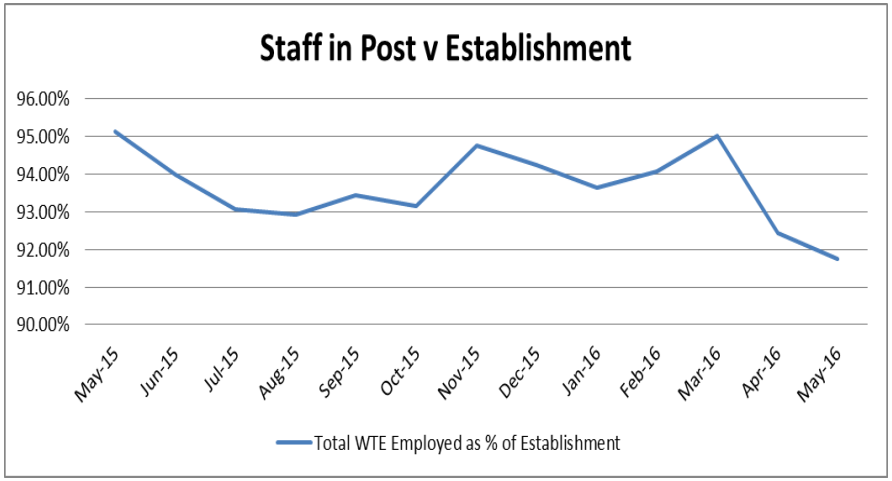
As part of the contact round discussion the Trust has been required to sign up to deliver against a number of performance trajectories, namely against the 92% Incomplete Standard and in respect to 52 Week Breaches.

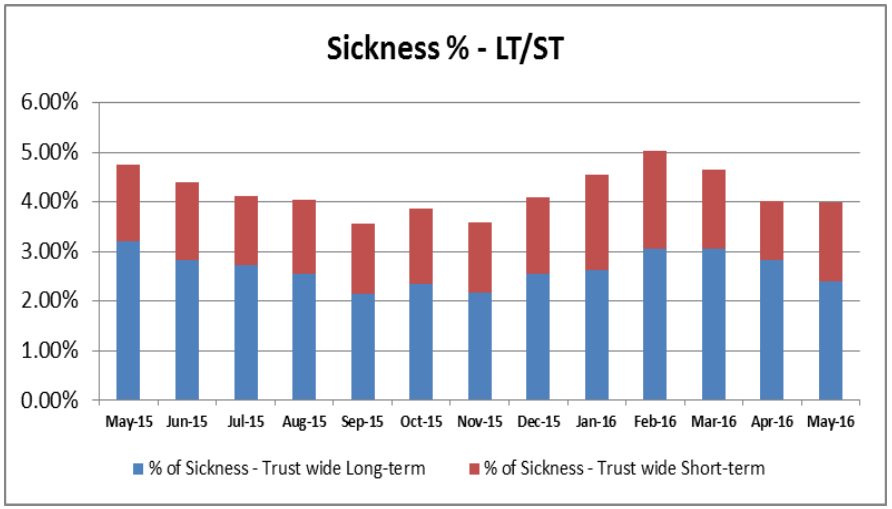
ACTIONS FOR IMPROVEMENTS / LEARNING

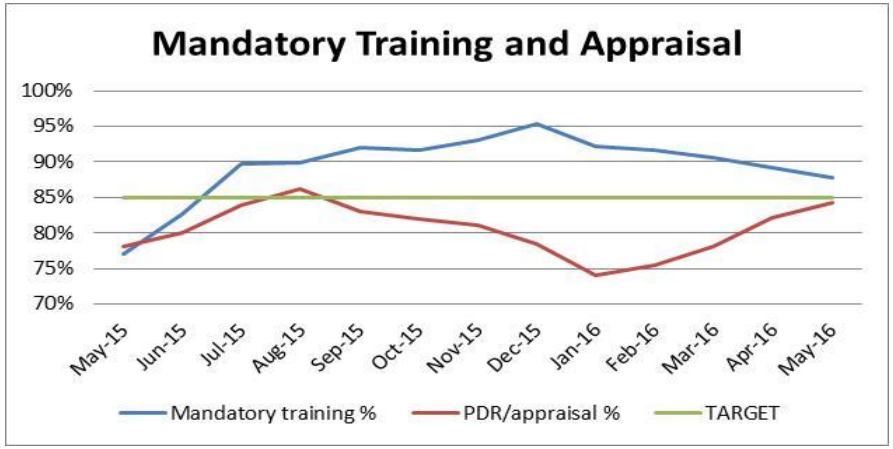
Effective use of additional operating lists at BCH, with potential requirement to treat further 52 weeks breaches in an alternative setting.

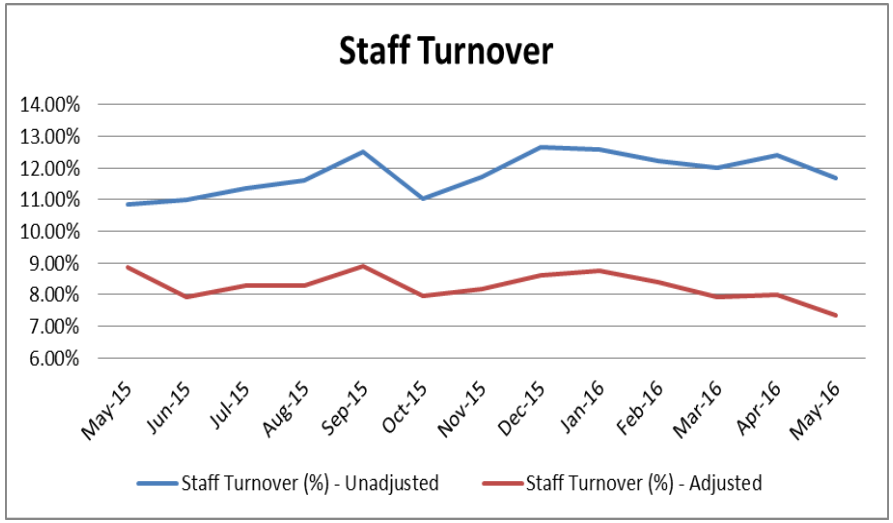
RISKS / ISSUES

15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training









INFORMATION

Sickness absence has decreased again this month. May's figure was the lowest level of sickness absence since December 15. The 12 month average figure has decreased and the position is now green for the first time since July 2011.

The vacancy position taken from the ledger has declined slightly this month, but still remains amber. A combination of an increase in the nursing baseline and vacancy panels holding a small number of corporate/ clerical vacancies are important to note.

The unadjusted turnover figure (all leavers minus junior medical staff and excluding employees who retire and return to work,) has reduced again this month.

The mandatory training position has marginally decreased again this month: we believe this is due to managers concentrating on completing PDRs. The unscheduled theatre down time in June has been used to offer additional mandatory training slots.

The appraisal position is continuing a steady increase and has received increased operational attention. The drive to increase this to green continues via Divisional Boards.

ACTIONS FOR IMPROVEMENTS / LEARNING

Statutory and Mandatory training and appraisals have been discussed at Divisional Boards in May to seek to maintain progress on appraisal, whilst not worsening the position on mandatory training.

RISKS / ISSUES

GOVERNANCE DEPARTMENT

QUALITY REPORT

June 2016

EXECUTIVE DIRECTOR: Garry Marsh — *Director of Nursing and Governance*
DEPUTY DIRECTOR: Anne Crompton — *Deputy Director of Nursing and Governance*
AUTHOR: Faye Rafferty — *Governance Manager*

CONTENTS

1. INTRODUCTION

This Quality Report aims to increase accountability and drive quality improvement within The Royal Orthopaedic Hospital NHS Trust (ROH). Through this report, the Governance Department will review performance, identify areas for improvement, and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

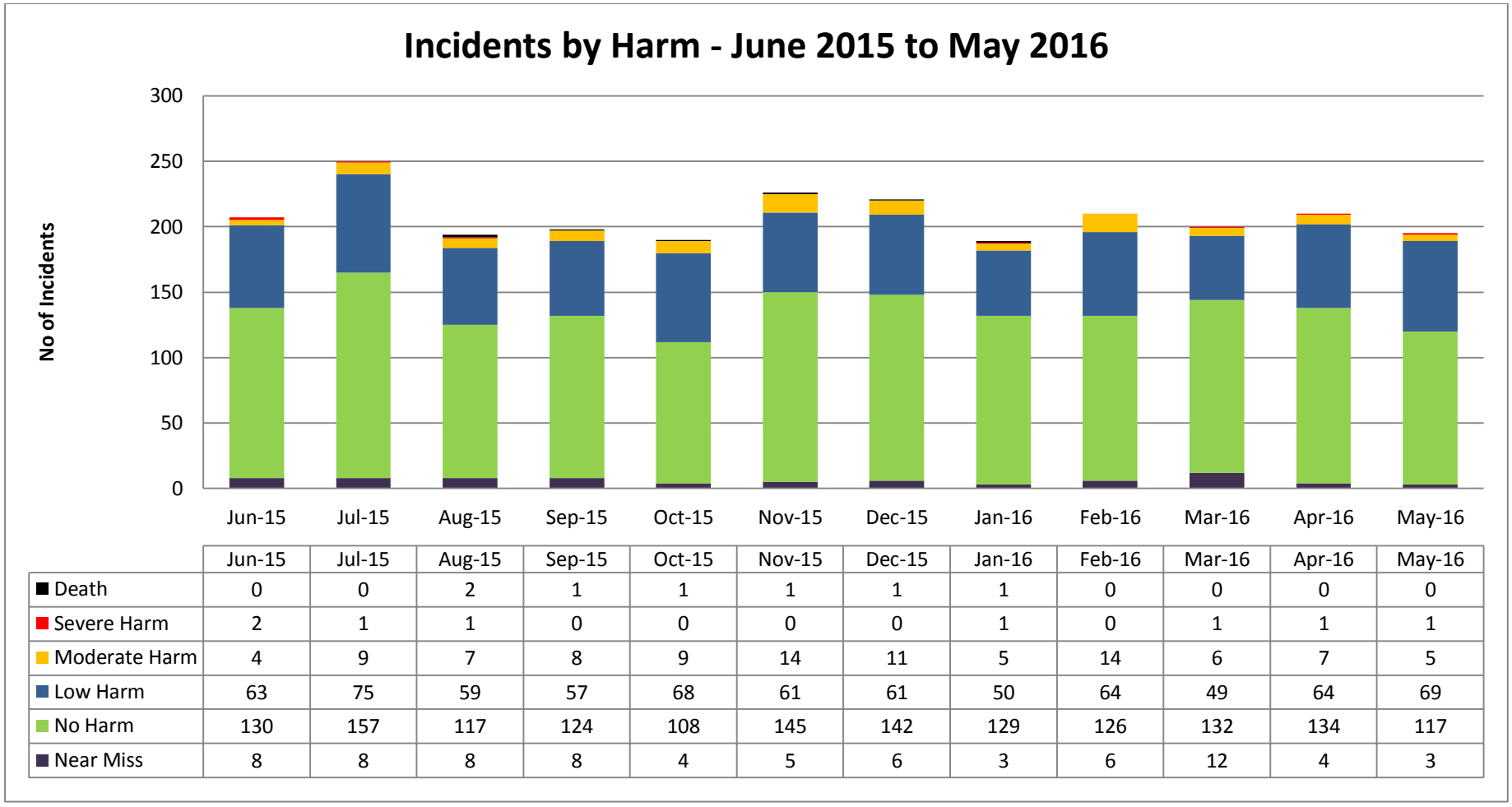
This Quality Report is a dynamic document, the data being used has been validated with the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this Quality Report with visually appealing illustration as well as narrative to address queries respective readers may have.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department;

Email: **roh-tr.governance@nhs.net**

Tel: 0121 685 4000 (ext. 55641)

2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.



	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Death	0	0	2	1	1	1	1	1	0	0	0	0
Severe Harm	2	1	1	0	0	0	0	1	0	1	1	1
Moderate Harm	4	9	7	8	9	14	11	5	14	6	7	5
Low Harm	63	75	59	57	68	61	61	50	64	49	64	69
No Harm	130	157	117	124	108	145	142	129	126	132	134	117
Near Miss	8	8	8	8	4	5	6	3	6	12	4	3

INFORMATION

There were 195 incidents reported during May 2016;

- 1 Severe Harm
- 5 Moderate Harms
- 3 Near Misses

ACTIONS FOR IMPROVEMENTS / LEARNING

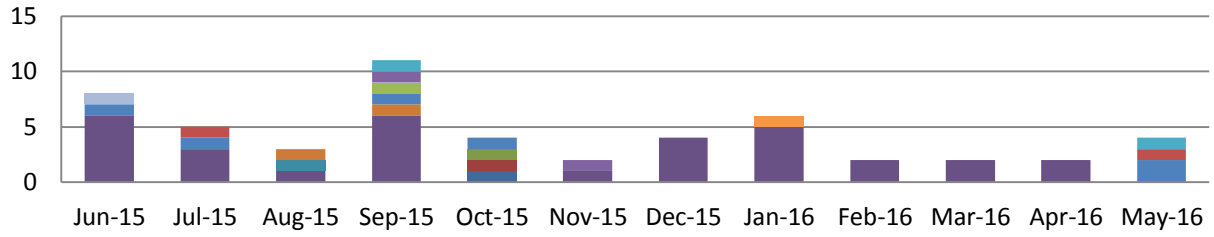
The mandatory training presentation for governance that is delivered to all staff annually has been updated to include details of how to report an incident and the Duty of Candour process. An SOP has also been developed to be included in the Trust's SI policy that describes the process for identification, reporting and closure of serious incidents.

RISKS / ISSUES

There can be a significant delay in the response from incident managers when a request is made to review and amend incidents' harm ratings. This is to be raised at Divisional Governance Meetings and Divisional Management Boards

3. **Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.**

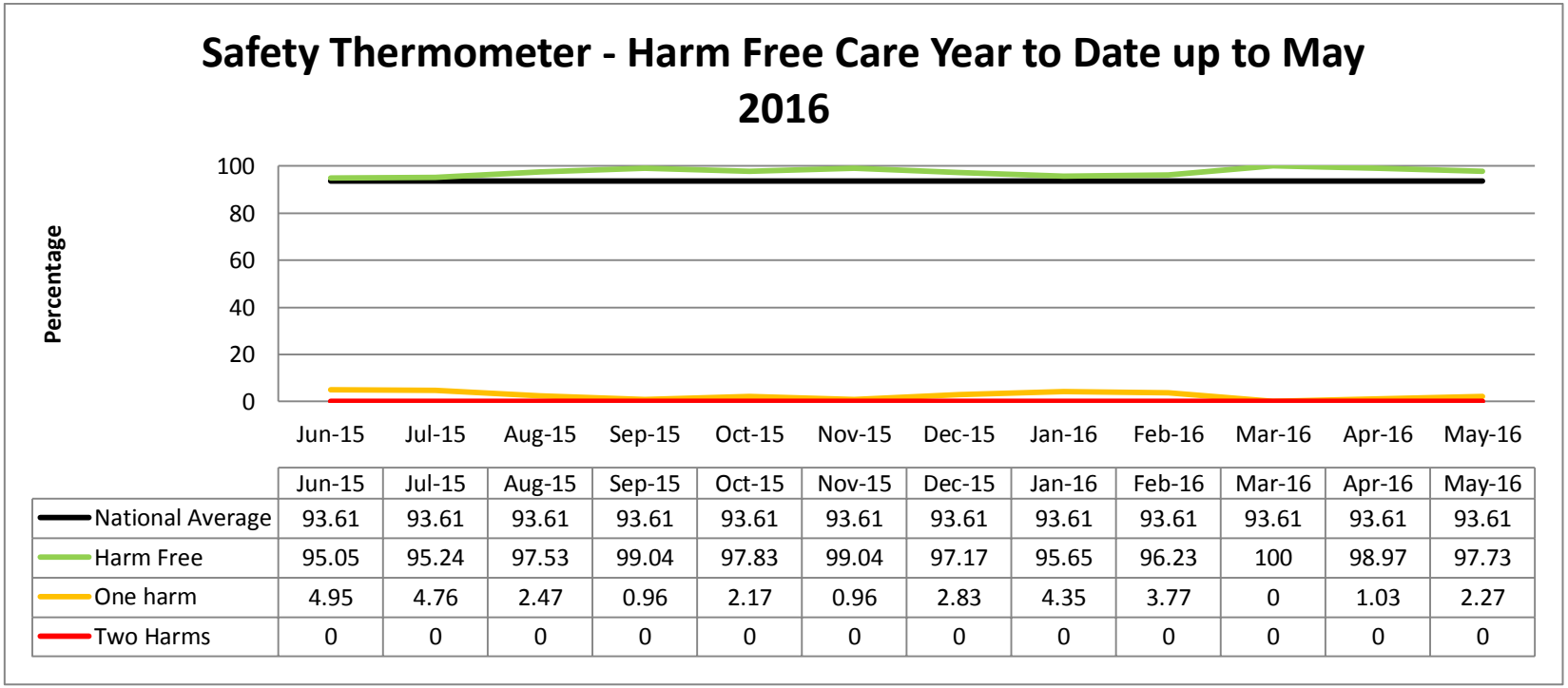
Serious Incidents - Declared June 15 - May 16



	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Commissioning incident	1											
Delayed diagnosis								1				
Wrong side injection				1								1
Unexpected deaths				1		1						
Staff conduct incidents				1								
Slips, trips & falls		1										1
Pressure Ulcers	1	1		1	1							2
Emergency transfer out of Trust			1	1								
Appointment delay			1									
VTE meeting SI criteria	6	3	1	6		1	4	5	2	2	2	
Surgical Invasive procedure incident meeting SI criteria					1							
Emergency transfer to HDU					1							
Failure to act on test results					1							

INFORMATION
There were 4 Serious Incidents (SI) declared in May 2016.
ACTIONS FOR IMPROVEMENTS / LEARNING
2 SIs were submitted for closure to Commissioners in May 2016. Both reports were in response to VTEs details of recommendations are provided in the VTE section below
RISKS / ISSUES
None identified.

4. **NHS Safety Thermometer - provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month. In February 2016, a revised standard operating procedure for the collection of data was introduced at ROH. It is of note that ROH continues to perform well against the national average as shown in the table below.**



	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
National Average	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61
Harm Free	95.05	95.24	97.53	99.04	97.83	99.04	97.17	95.65	96.23	100	98.97	97.73
One harm	4.95	4.76	2.47	0.96	2.17	0.96	2.83	4.35	3.77	0	1.03	2.27
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

The harms that have been reported during May all relate to pre-existing pressure ulcers that have been inherited that have not been caused by the Trust.

Children and Young Person's Safety Thermometer

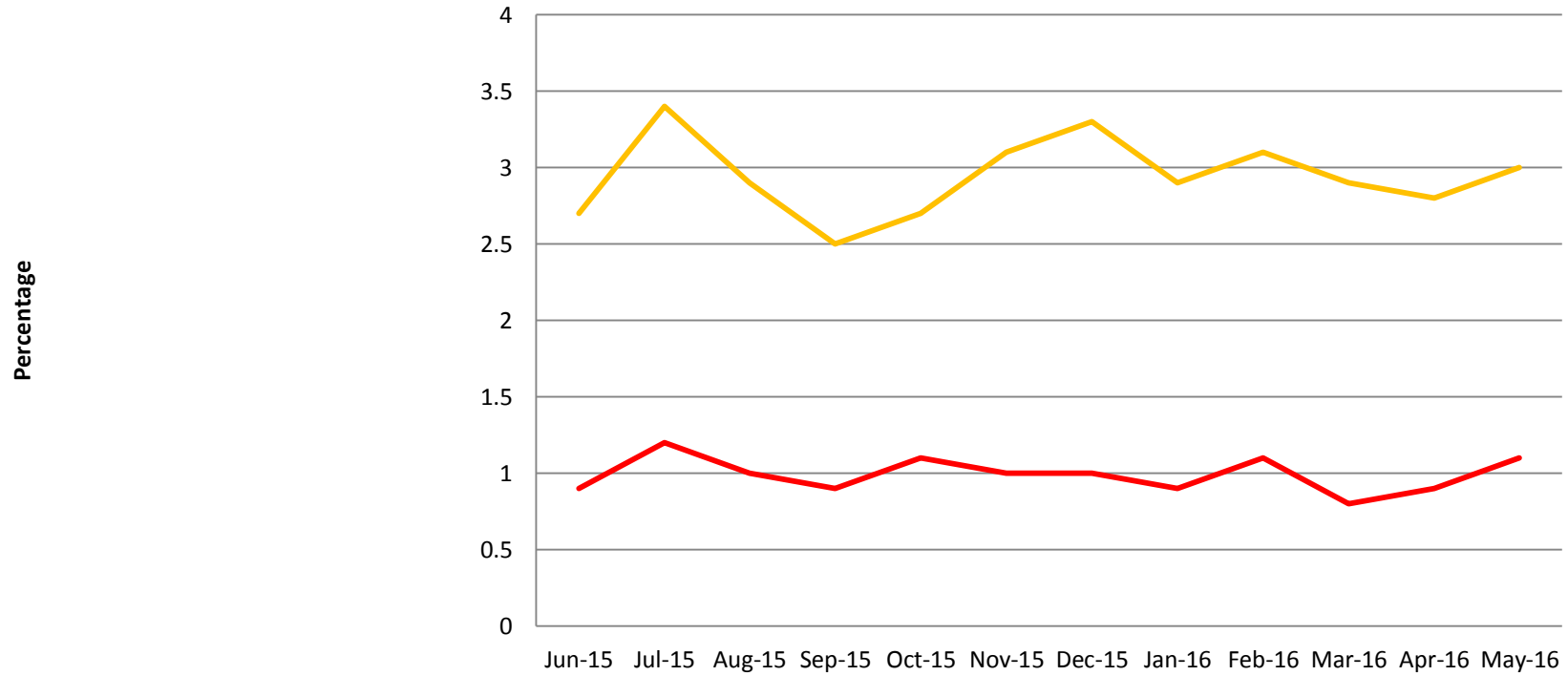
The Trust has started to submit data to the Children and Young Person's Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. Due to the limited number of data points submitted graphical representation of the data is not yet available from the national tool. This report will include information form the tool once available.

5. **All patient contact and harm – In contrast to the Safety Thermometer which measures the number of harm on one particular day of the month, the following data represents the total number of patient contacts in May 2016 compared to all incidents reported and incidents resulting in harm. Harm includes low harm, moderate harm, severe harm and deaths.**

	Low Harm	Moderate Harm	Severe Harm	Death	Total Incident with Harm	All Incidents Total	Total Patient Contacts
Jun-15	63	4	2	0	69	207	7657
Jul-15	75	9	1	0	85	250	7378
Aug-15	59	7	1	2	69	194	6651
Sep-15	58	8	0	1	67	195	7700
Oct-15	68	9	0	1	78	190	7082
Nov-15	61	14	0	1	76	226	7251
Dec-15	61	11	0	0	72	220	6714
Jan-16	50	5	1	1	57	189	6627
Feb-16	64	14	0	0	78	210	6768
Mar-16	49	6	1	0	56	200	6862
Apr-16	64	7	1	0	72	210	7636
May 16	69	5	1	0	75	195	6528

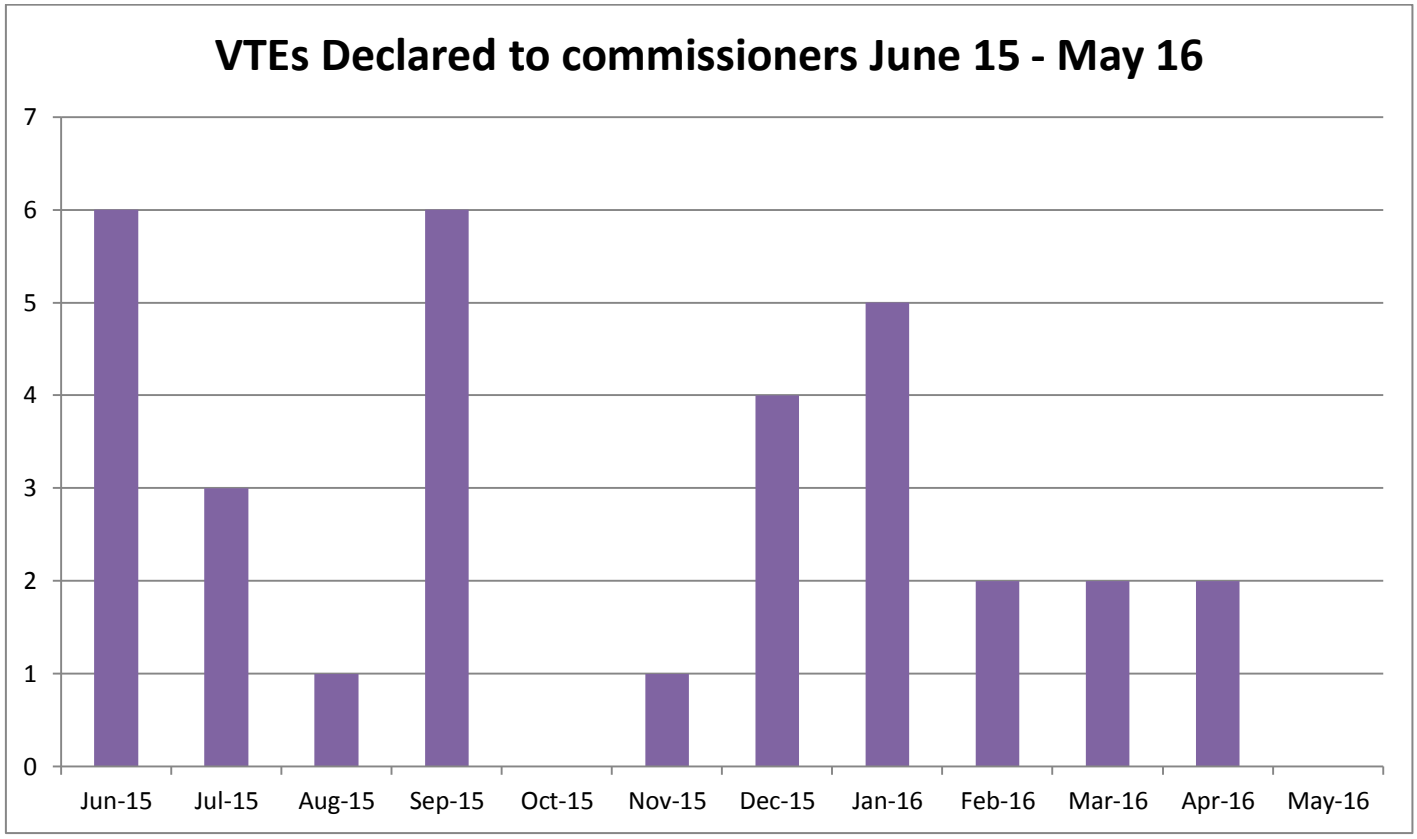
In May 2016, there were a total of 6528 patient contacts. There were 195 incidents reported which is 3.0 percent of the total patient contacts. Of those 195 reported incidents, 75 incidents resulted in harm which is 1.1% of the total patient contact for the month. The Trust is currently reviewing the possibility of benchmarking this data with similar organisations and will include the data as and when it is available.

% of Patient Contact Compared to Number of Incidents and Incidents with Harm Year to Date up to May 2016



	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
% of Patient Contacts with Incidents Causing Harm	0.9	1.2	1	0.9	1.1	1	1	0.9	1.1	0.8	0.9	1.1
% of Patient Contact With All Incidents Reported	2.7	3.4	2.9	2.5	2.7	3.1	3.3	2.9	3.1	2.9	2.8	3

6. **VTEs - A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called a venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism).**



RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION
First choice for orthopaedic care

INFORMATION

There were no VTE incidents reported to Commissioners during May

ACTIONS FOR IMPROVEMENTS / LEARNING

2 final investigation reports were submitted to Commissioners during May 2016.

1. One VTE was deemed avoidable. Recommendations include ensuring pre-op fasting guidelines are followed and that advice to patients is clear regarding fasting, to ensure that anti-embolism stockings are prescribed on the drug chart as well as indicating left, right or both legs.

2. The second VTE was deemed avoidable. Recommendations include ensuring perioperative VTE risk assessments are completed fully, to ensure that ward staff are aware of the importance of competing the VTE care plan fully to include clinical reasons why TED stockings are only applied to 1 leg.

Following investigation of VTEs a trend has been identified relating to documentation which can sometimes result in potentially unavoidable VTEs being deemed as avoidable particularly around compliance with 24 hour post admission/readmission requirements. Education relating to documentation continues within the Trust.

The VTE Committee has received interest from several surgical consultants who are interested in attending the Trust's committee.

A themed review was jointly undertaken between the Trust and Birmingham Cross City Clinical Commissioning Group on 9th March 2016 focussing on Venous Thromboembolism. An action plan was developed in response to this review. An update on these actions is to be submitted to the June Clinical Quality Meeting confirming that 4 of the actions have been completed. The actions that remain open are

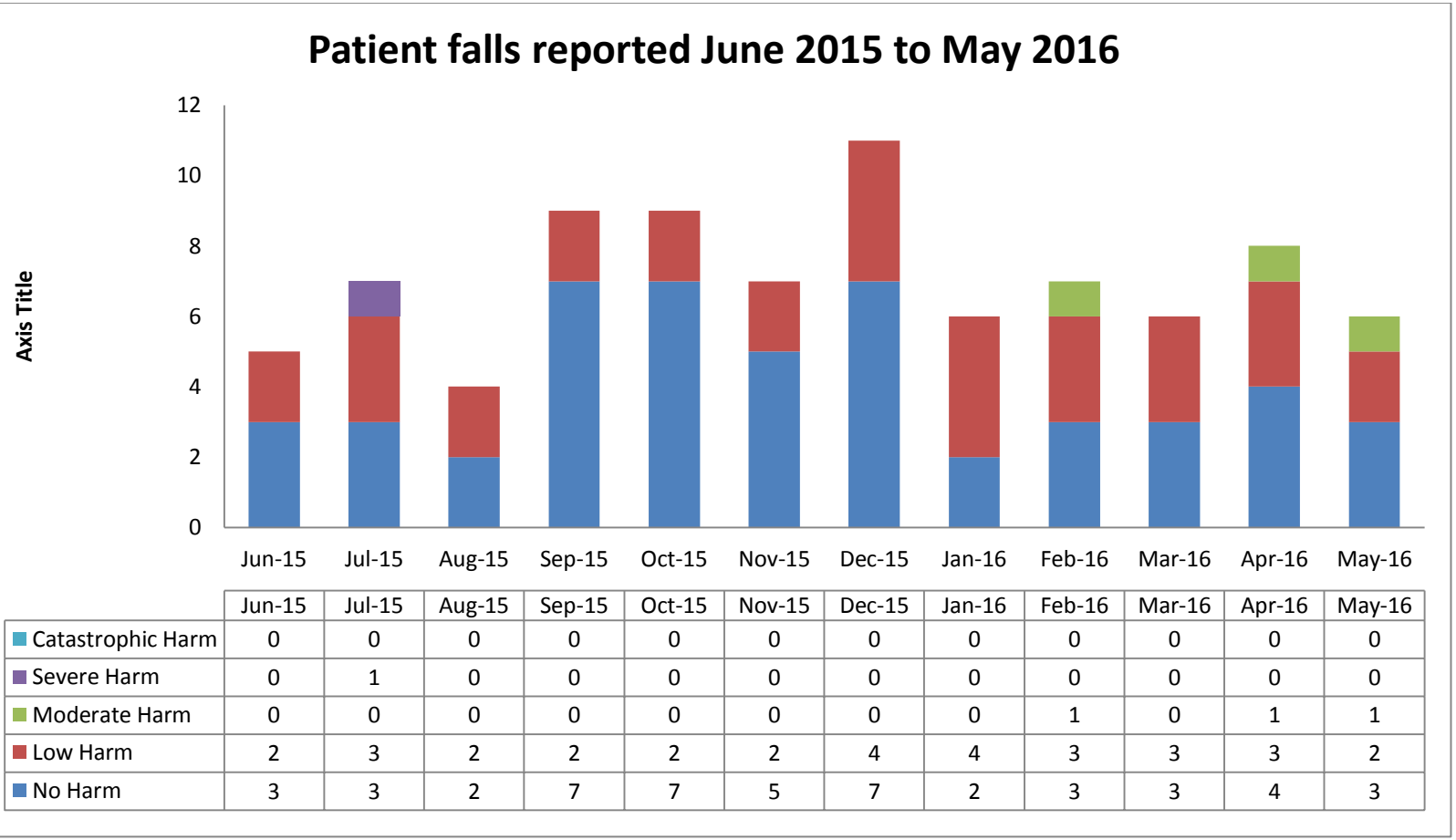
1. The VTE committee have identified that best practice would ensure they are given the authority to request justification for any prescribing that is outside of the current national guidance
   Update: An agreed updated version of the VTE care plan is on the Clinical Quality Committee agenda for approval 24th June 2016
2. Review VTE care planning documentation, to include more comprehensive use of when SCD/ anti embolic stockings are removed/ reapplied and the rationale;
   Update: An agreed updated version of the VTE care plan is on the Clinical Quality Committee agenda for approval 24th June 2016

3. Recognition for the significant work undertaken by ROH to date, regarding VTE. To include feedback from patients post- discharge via the ROCs team and their SSI telephone helpline and questionnaire;
   Update: No action required, process on-going and will be enhanced as part of the 2016/17 requirement

RISKS / ISSUES

None identified.

7. Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident.



	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Catastrophic Harm	0	0	0	0	0	0	0	0	0	0	0	0
Severe Harm	0	1	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	0	0	0	1	0	1	1
Low Harm	2	3	2	2	2	2	4	4	3	3	3	2
No Harm	3	3	2	7	7	5	7	2	3	3	4	3

INFORMATION

During April 2016, there were 8 patient falls at ROH. 5 of these falls have been found to be unavoidable the remaining 3 incidents have been reviewed and have been categorised as avoidable. The reason for these falls being deemed as avoidable is due to the delayed completion of the falls risks assessment.

Falls incidents that occurred during May are currently under review.

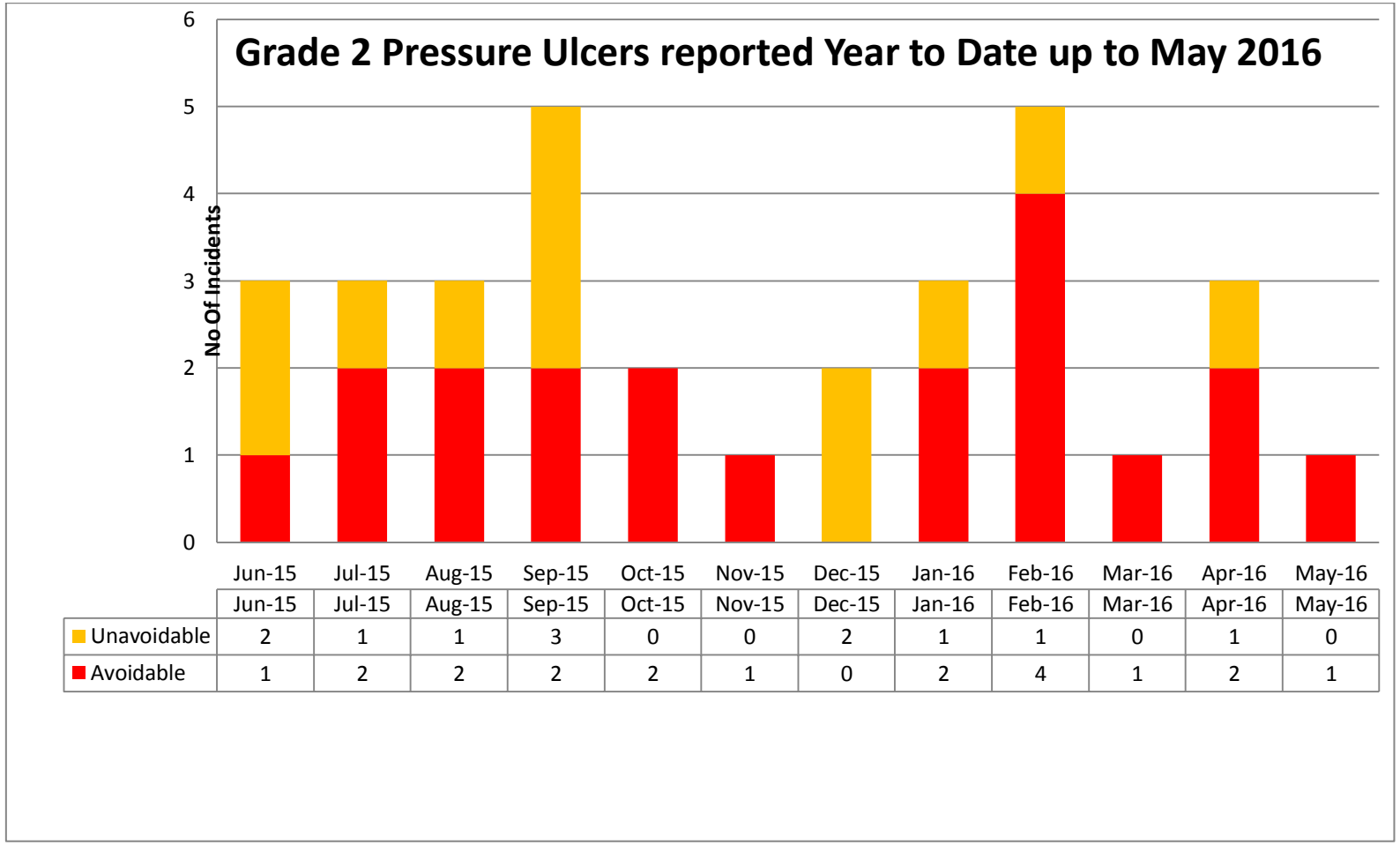
ACTIONS FOR IMPROVEMENTS / LEARNING

- Accurate completion of documentation in respect of falls assessment continues to indicate non -compliance.
- Some clinical areas still require staff training on the use of the Hoverjack. This is now in circulation (based on ward 1) and is ready to be used by the critical mass of nursing and therapy staff who have been trained (including bleep holders). Derby manual handling trainers will continue to provide refresher training for staff at annual updates.
- A comprehensive medical "checklist" is currently under development to improve medical management of the inpatient faller. It is envisaged that this will provide a more stream lined approach to medical management and prevent inconsistencies in care. Review of this work has been extended and this will be ready for consideration by the falls prevention and reduction committee in July 2016.

RISKS / ISSUES

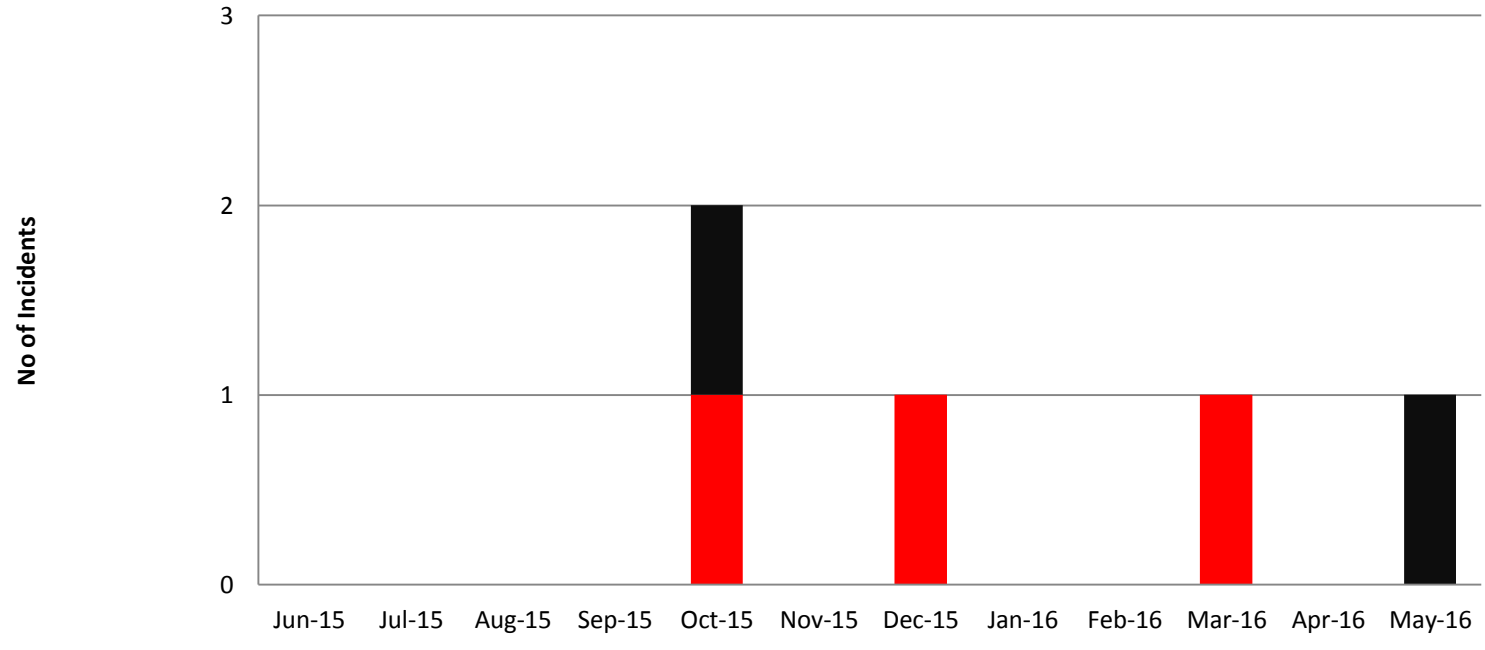
As above.

8. **Pressure Ulcers - are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.**



	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Unavoidable	2	1	1	3	0	0	2	1	1	0	1	0
Avoidable	1	2	2	2	2	1	0	2	4	1	2	1

Grade 3 & 4 Pressure Ulcers reported Year to Date up to May 2016



	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Grade 4 (Avoidable)					1							1
Grade 3 (Avoidable)					1		1			1		

INFORMATION

In May there was 1 avoidable grade 2 pressure ulcer reported on Ward 2

A grade 4 hospital acquired pressure ulcer that has been deemed avoidable was reported in May 2016 on Ward 3

ROH contractual limit for Pressure Ulcers in 2016/17
Grade 2 Avoidable Limit is 15 - at **May 2016 = 3 avoidable**
Grade 3/4 Avoidable Limit is 0 **- at May 2016 = 1 avoidable**

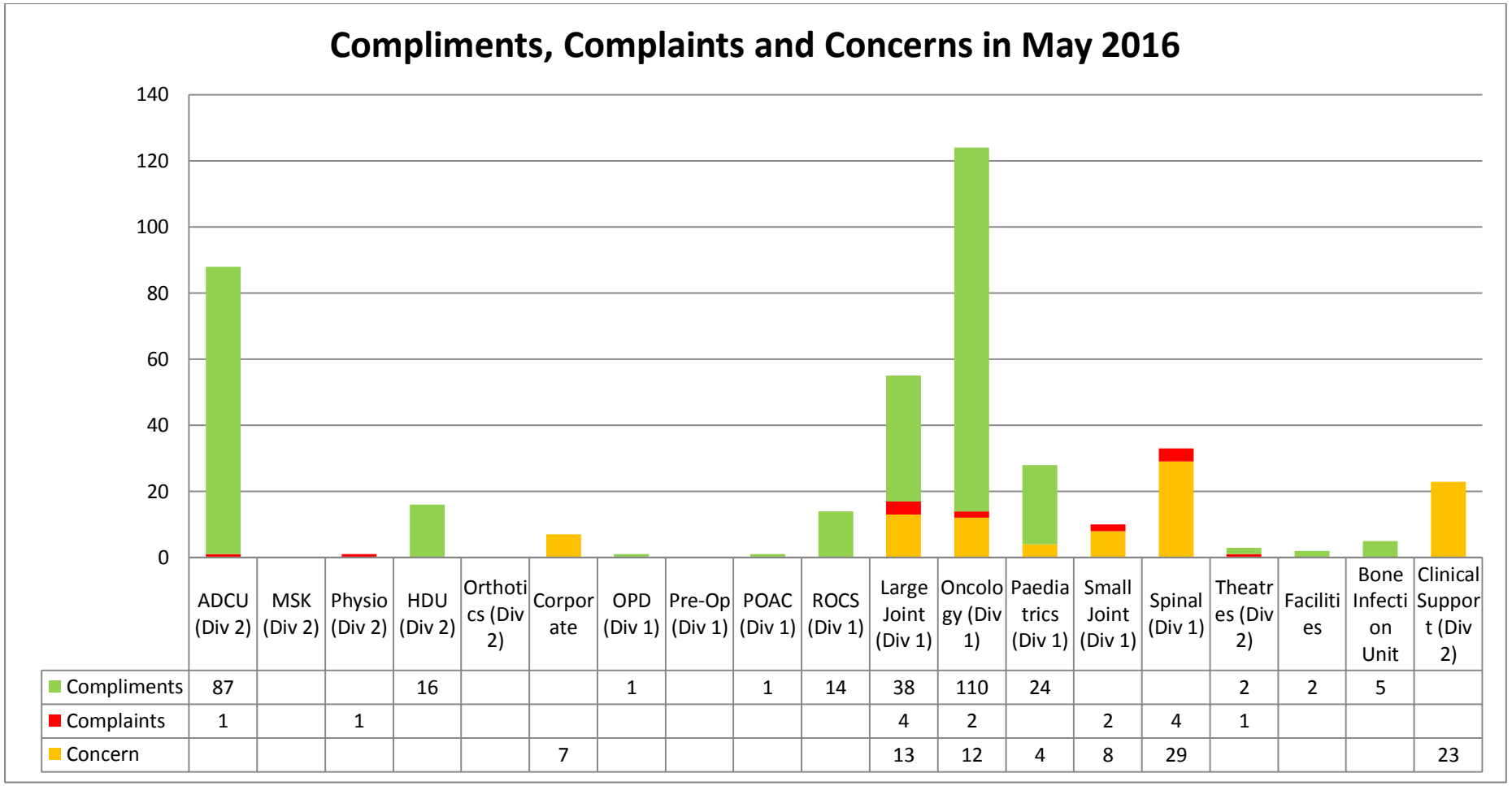
ACTIONS FOR IMPROVEMENTS / LEARNING

A pressure ulcer reduction plan has been developed in order to reduce the number of grade 2 pressure ulcers and eliminate all grade 3 and grade 4 pressure ulcers for 2016/16. There are 10 actions of which all have been commenced and are ongoing.

RISKS / ISSUES

There is a risk of a financial penalty to the Trust by the Commissioners in the event of the exceeding the maximum permissible level of pressure ulcers as stipulated in the contract.

9. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



	ADCU (Div 2)	MSK (Div 2)	Physio (Div 2)	HDU (Div 2)	Orthotics (Div 2)	Corporate	OPD (Div 1)	Pre-Op (Div 1)	POAC (Div 1)	ROCS (Div 1)	Large Joint (Div 1)	Oncology (Div 1)	Paediatrics (Div 1)	Small Joint (Div 1)	Spinal (Div 1)	Theatres (Div 2)	Facilities	Bone Infection Unit	Clinical Support (Div 2)
Compliments	87			16			1		1	14	38	110	24			2	2	5	
Complaints	1		1								4	2		2	4	1			
Concern						7					13	12	4	8	29				23

INFORMATION

In May there were 15 complaints, 96 concerns and 300 compliments received.

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 9 complaints closed in May 2016, all of which were closed within the agreed timescales. This gives a 100% completion within agreed timescales for the month and meets the agreed KPI.

Of the 9 complaints closed in May 2016:

- 4 were upheld
- 3 were partially upheld
- 2 were not upheld

Action plans have been developed for all upheld complaints alongside the response which will be monitored through Divisional Team meetings. A copy will also be retained in the complaint file which will be reviewed by the Complaints Manager. Overdue actions will be brought to Clinical Quality Group for review.

Learning identified and actions taken as a result of complaints closed in May 2016 include:

- Patients are not always given clear information when new conditions are identified

  Action: Review of communication in pre-operative clinic

- Communication between doctors and outpatients not always clear

  Action: OPD review of the process of passing information about delays being undertaken with new system

- Information about changes to services either not received or not sent (Pain Management)

Action: Review of actions taken with a view to changes process in future

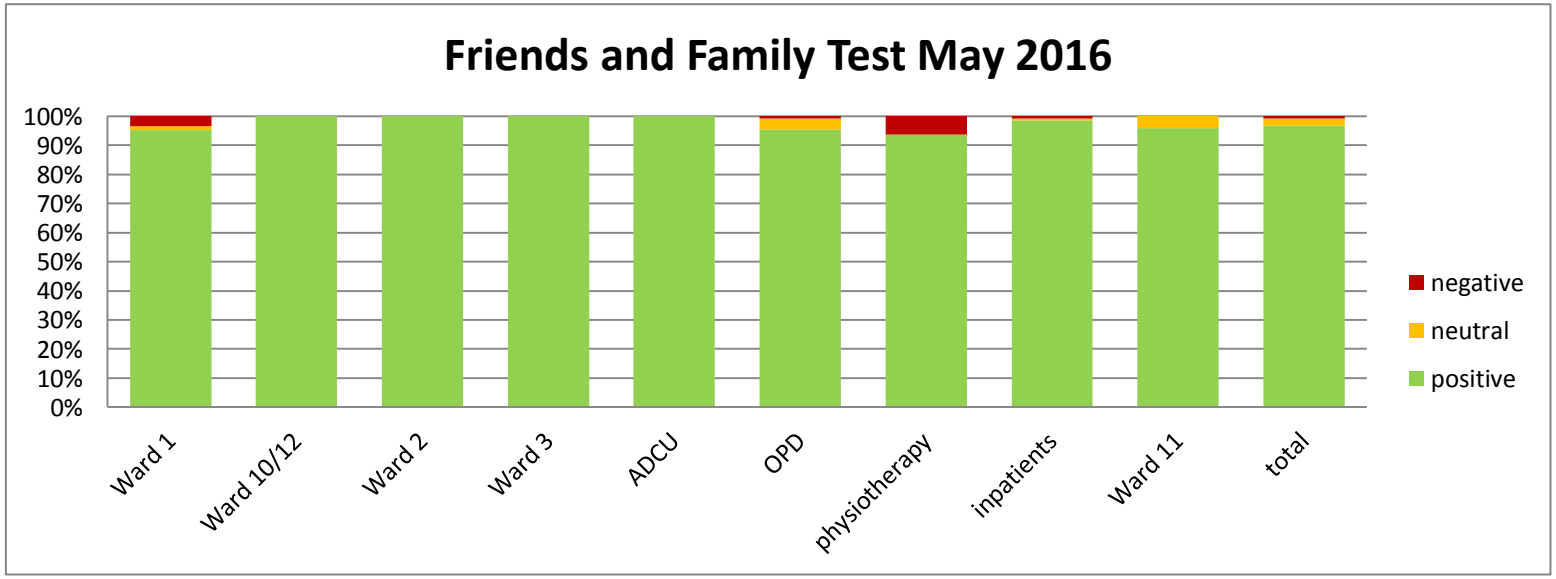
RISKS / ISSUES

None Identified

10. Friends and Family Test Results - The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

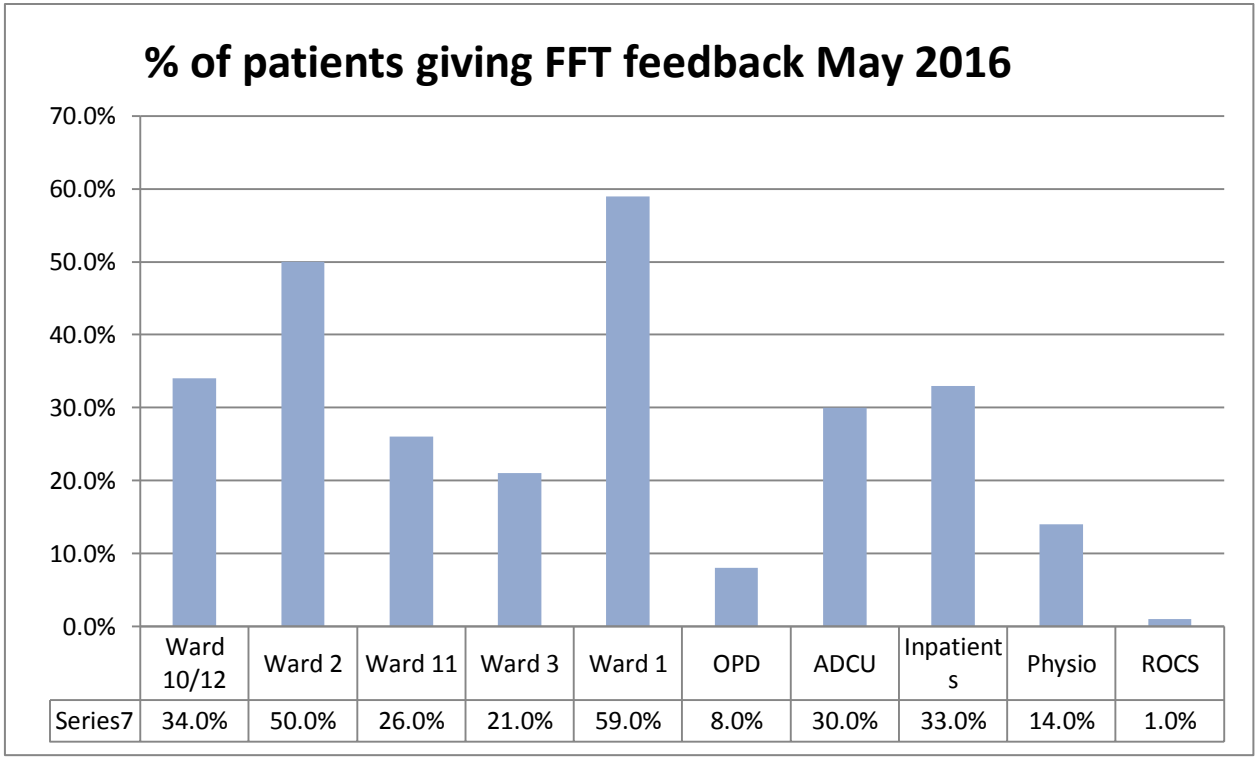
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting patient choice

This is a positive percentage score and it can be seen that almost all patients that we care for would recommend ROH to their family and friends.



The Scores for Friends and Family are now calculated using a straightforward percentage response to the question 'How likely are you to recommend this area to friends or family if they require similar care or treatment?' Any patients answering the question as Extremely Likely / Likely are classified as Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely/Extremely Unlikely are classified as negative.

The percentages for all inpatient activity for May 2016 are 97% of those who responded would promote ROH.



There is an improvement plan in place for the Communications Department to increase the level of responses in the OPD and ADCU. Actions include having extra forms available for patients to complete and prompting staff members to ask patients to complete the forms. The possibility of implementing additional software to aid this process is also being explored.

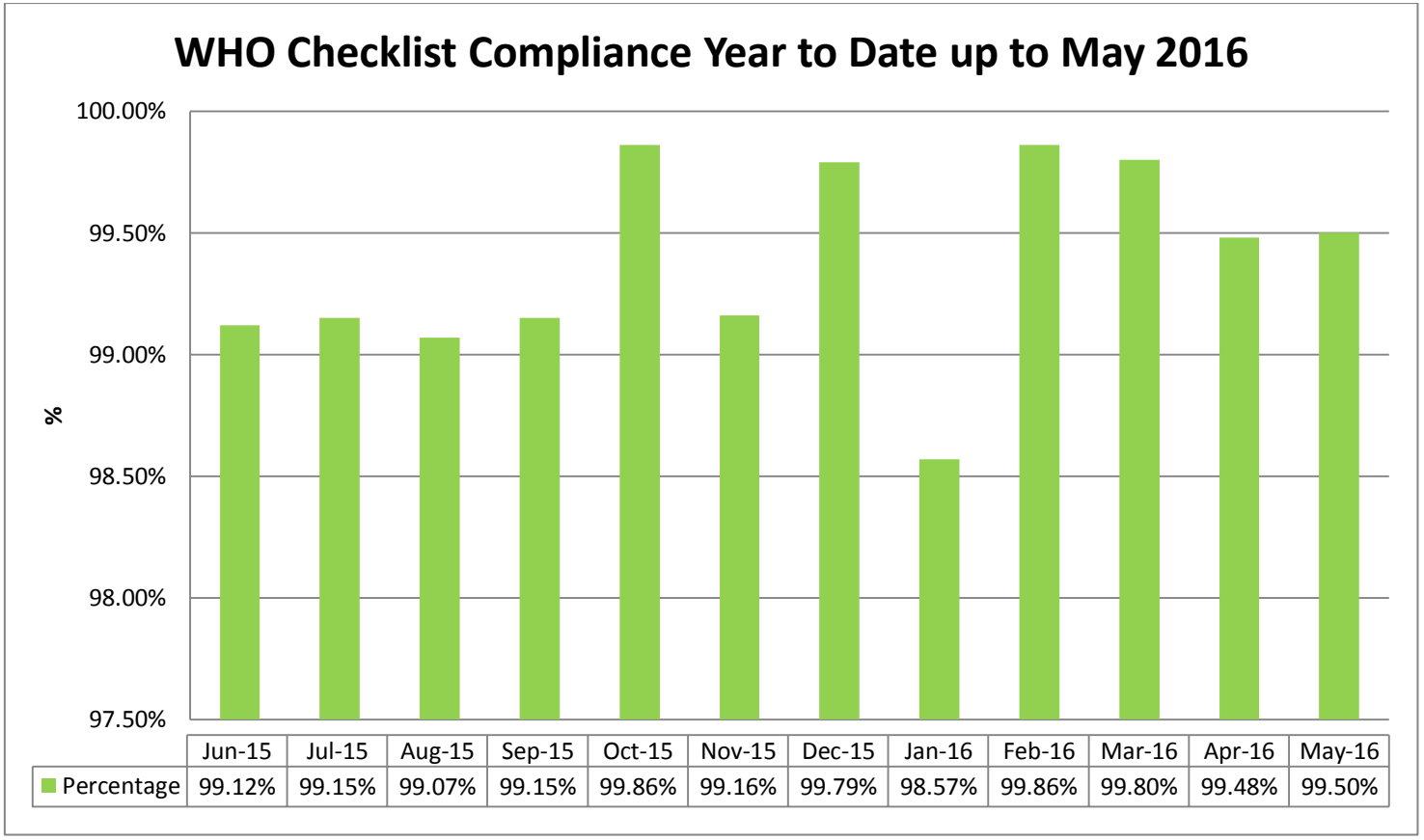
11.Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.

There are currently 12 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20. At present all cases are compliant and there are no risks to continued compliance.

12. Litigation – Current litigation involving ROH

There has been one new litigation case opened in May 2016.

13. WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases of perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.



	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Percentage	99.12%	99.15%	99.07%	99.15%	99.86%	99.16%	99.79%	98.57%	99.86%	99.80%	99.48%	99.50%

INFORMATION

Total Cases in May 2016 = 602

Sign Out = 3 Non-Compliance

Total Non-Compliance = 3

Total Compliance = **99.50% Total**

ACTIONS FOR IMPROVEMENTS / LEARNING

The following recommendations are made following the audit collation:

1. Quarterly report to be disseminated to the Medical director, Clinical Directors, Clinical Leads, Consultants and Team Leaders.
2. Directorates with consistent 100% compliance to share best practice.
3. Continue with weekly and monthly reporting to the Medical Director and Director of Nursing & Governance.
4. Monthly reporting to the Commissioners.
5. Non-compliance percentages and incomplete sections and areas of the WHO Patient Safety Checklist to continue to be emailed directly to the Consultant and the staff member involved.

RISKS / ISSUES

None identified.

ROHTB (7/16) 009

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Quarter 1 2016/17 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**6th July 2016**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at April 2016.

On the attached Board Assurance Framework, risks are grouped into two categories:

- Strategic risks – those that are most likely to impact on the delivery of the Trust's strategic objectives. These are entries shaded in blue on the attached.

- Escalated risks – those risks featuring on the Corporate Risk Register (an amalgamation of formerly two separate registers for the Trust Management Committee and Quality & Safety Committee) that have been added to the Board Assurance Framework on the basis that their pre-mitigated risk scores are sufficiently high to suggest that they could impact on the delivery of the Trust's business and its strategic plans

- The risks agreed for removal by the Board when it last reviewed the BAF have been archived.

- Additional mitigating actions and plans to close any gaps in control and/or assurance have been updated.

- It is proposed that risks 798 and S797 are merged as it is felt that this is the same risk in essence.

- There have been three new risks added to the BAF, which have been discussed by the Trust Management Committee, which agreed that they should be added to the BAF as new risks:

  Risk 1028 – Network bandwidth

  Risk 1030 – Equipment replacement

  Risk 1031 – Electronic Inventory Management System

- There has been movement in the post mitigation scores of the following risks:

Risk 798 – Mitigating score has reduced from 15 to 12

Risk 27 – Mitigating score has reduced from 16 to 9

Risk 770 – Mitigating score has increased from 12 to 16

REPORT RECOMMENDATION:

Trust Board is asked to:

- review the Board Assurance Framework
- confirm and challenge that the controls and assurances listed to mitigate the risks are adequate
- approve the proposed changes to the 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	X

KEY AREAS OF IMPACT ***(Indicate with 'x' all those that apply):***

Financial		Environmental		Communications & Media	x
Business and market share		Legal & Policy	x	Patient Experience	
Clinical		Equality and Diversity		Workforce	x

Comments: Pages within the report refer in some manner to all of the key areas highlighted above.

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:

Trust Board in May 2016

BOARD ASSURANCE FRAMEWORK Q1 2016/17

Risk Ref	Department	Executive Lead	Risk Statement	Strategic Objective	Primary Assurance Body	Initial risk			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Target risk		
						Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
803	Fin	Paul Athey	Risk to financial viability through the inability to manage internal costs, deliver key programmes or respond to tariff deductions which could lead to concerns over the Going Concern status of the Trust	Safe and efficient processes that are patient-centred	F & PC	4	5	20	**June 2016** **The Patient Journey II project in in place to provide the platform for the changes needed in 2016/17.** Formal programme structure is in place. Detailed financial plan produced for 2016/17. Check and challenge of financial performance at all levels of the Trust. Finance & Performance Committee of the Board has been established to provide additional oversight on financial and operational position.	**F&P Report; Monthly Performance Reviews; Transformation Board Reports; Audit Committee – Review of contract risk; Weekly activity / income reports at Exec Business Meeting** CPR; Monthly Performance Reviews; Transformation Board Reports; Audit Committee – Review of contract risk; CIP Board reports	4	4	16	↔	The Trust continues to pursue transformation efficiency gains through its Transformation Programme. A Patient Journey plan has been developed jointly between Operations and Transformation which will provide the platform for the changes needed in 2016/17	Ongoing	2	5	10
582	WFOD	Anne Cholmondeley	Risk of non-delivery of strategic objectives associated with leaders' ability to lead change, including cultural change.	Highly motivated, skilled and inspiring colleagues	Transformation Cttee	4	4	16	**June 2016** **Realignment of the Learning and OD and Medical education Team to create a transactional Eduction and Training team based within the knowledge hub, and a Head of OD and inclusion to focus on the deliery of leadership, engagement and OD.** **January 2016:** The Transformation Committee received a presentation on Leadership and leadership development at its meeting in January. Further work is underway to prepare a People Strategy which will be considered by the Board in Quarter 4 2015/16 or Quarter 1 on 2016/17. **December 2015:** Initial discussion ref Leadership at TC in October and further presentation requested for December. Work ongoing with small group of consultants to shape medical engagement approaches. Conversations with consultants continue, aiming to integrate 'paired learning' approach. Leadership strategy in final stages of development. **September 2015:** 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. Kings Fund reported to Board on 3rd June and due to go to medical workforce at end of	Presentation to Transformation Committee; RF report working group workstation 1 of TP, notes from Workforce & OD Committee	3	4	12	↔	People strategy to be developed and the subject of the Transformation Committee at a future meeting and the Trust Board subsequent to this. Leadership Strategy going to Board September.	~~Q1~~ Q2 2016/17	2	4	8

798	WFOD	Anne Cholmondeley	The Board and organisation does not have adequate capacity or capability to change or does not organise its resources to change effectively, which could lead to the organisation being slow to respond to changing internal or external influences	Highly motivated, skilled and inspiring colleagues	Transformation Cttee	3	5	15	**June 2016 Existing work engaging staff in strategy development and communication.** Previous update: 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.	3	4	12	↓	People strategy (Engagement & Leadership with detailed action plan).	Q1-Q2 2016/17	2	4	8
804	Fin	Paul Athey	There is a risk that Information and Business Intelligence is insufficient in quantity, usefulness or reliability to inform key operational decisions and to manage the business on a day to day basis or to help improve services.	Safe, efficient processes that are patient-centred	F & PC	4	5	20	**June 2016 BI Project underway to address all aspects of BI data improvement. Improved Data Warehouse in place, driving all SUS/SLAM submissions** **Manual interrogation and verification of data, triangulating key clinical indicator information.** **Data Quality reports are starting to be shared with Ops managers, addressing areas such as PAS attendnances not closed etc.** **Manual daily huddle to validate previous day's performance and assure the current day's performance through theatres.** **Deep dive and granular analysis & actions to improve performance on matters such as cancellations and delays out of recovery and length of stay.** **IM&T Strategy developed and being implemented;** **Upgrade of Informatics infrastructure to SQL 2012 to provide platform for future Informatics developments;** **January 2016:** Robust rigorous manual interrogation and verification of data. Triangulating key clinical indicator information. Manual daily huddle to validate pervious day's performance and assure the current day's	Daily huddle outputs and ACTION; Weekly 6-4-2 and list review by Director of Operations and review by Executive of weekly activity tracker and governance trackers for complaints, SIs and Duty of Candour incidents; monthly corporate performance report; safe staffing report; Internal Audit reports; Transformation Committee Reports; CQC report & action plan; IM&T Programme Board minutes; ad hoc report through Serious Incident and Root Cause Analysis/Lessons learned communications to staff	3	5	15	↔	**Data Quality strategy to be reviewed by TMC in June 2016 with a view to setting up a data quality review group to take this work forward.** **Data Quality Group to be set up** Developing an enhanced suite of measures to provide assurance of ongoing recovery plan and planning for future years. Embracing key performance measures to reduce waste waiting and performance variation and improve flow of patients from referral to follow up.	Q2 2016/17	2	4	8
801	CEO	Jo Chambers	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.	Delivering exceptional patient experience and world class outcomes	Trust Board	4	3	12	**June 2016** **The Trust is part of a national Vanguard model, which will provide opportunities to develop a quality improvement process and a set of quality indicators.** **The Trust engages in the wider NHS nationally and locally to stay on top of changing context and regulatory requirements. Ensure the organisation 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.	3	3	9	↔	Vanguard model will be used to influence the wider Health Economy as it develops and embraces a new way of working collaboratively. Existing controls are being developed through the appointments to the new organisational 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.	Ongoing	2	3	6

S797	WFOD	Anne Cholmondeley	The Board and organisation 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	Highly motivated, skilled and inspiring colleagues	Trust Board	4	4	16	**June 2016** **People strategy (Engagement & Leadership) with detailed action plan).** **Action ongoing to improve engagement - improved communication, staff involvement in improvement activity and increased learning opportunities for whole workforce 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	3	4	12	↔	People strategy (Engagement & Leadership with detailed action plan). Freedom to Speak up Guardian role to be implemented to encourage staff to speak up to enable learning and to coach managers in response to safety incidents. Other actions as detailed in Transformation Programme work stream 1	Q2 2016/17	1	4	4
S799	Strat	Phil Begg	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	Highly motivated, skilled and inspiring colleagues	Trust Board	4	3	12	**June 2016** **A refresh of the Trust's 5-year strategy is underway and will reinforce our commitment to and provide clarify on our objectives for all stakeholders. The 'Our People' section of the strategy will confirm our approach to staff engagement and provide details of the leadership strategy currently in development.** 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	3	3	9	↔	**The Director of Strategy & Transformation has visits planned to review other Trust's successful change and engagement programmes.** Development of the leadership strategy and People Strategy due to be considered by the Transformation Committee and Trust Board in ~~Q1~~ Q2 2016/17	~~Q1~~ Q2 2016/17	2	3	6
S802	CEO	Jo Chambers	There is a risk that the Trust's operational model is unsustainable as a result of tariff changes, year on year efficiency requirement and the need to meet the requirements of an increasingly burdensome regulatory environment.	Developing services to meet changing needs, through partnership where appropriate	Trust Board	3	4	12	**June 2016** **Effort is directed into continuing 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 embedding of the new organisational structure which brings new skills into the Trust**.	Viable business plan. Key milestones met – growth, expenditure, CIPs, transformation initiatives. Evidence of alignment with commissioner intentions.	3	3	9	↔	Refresh of the Trust's strategic plan and seek new opportunities for collaboration as part of the new Vanguard model. Further engagement of the work with NHSI on optimisation and efficiencies (The Perfect Day)	Q2 2016/17	2	3	6
S270	FIN	Paul Athey	National tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist	Developing services to meet changing needs, through partnership where appropriate	F & PC	4	4	16	**June 2016** **Completion of reference costs & patient level costing returns.** **Work as a roadmap partner for NHSI in developing costing standards** Monitor 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 given the issues faced with the current year tariff and the first version of next year's tariff which has been seen. 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.	**Reference costs submissions** **Audit report on costing process** 2016/17 NHS contracts 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 technical working group to influence tariff development	3	4	12	↔	**SOA writing to Jim Mackay to ask for support on resolving the long standing problems with the orthopaedic chapter** January 2016: Delay to the publication of the new national tariff, which will allow some stability for the current year.	Mar-17	1	4	4

S800	CoSec/DNG	Simon Grainger/Lloyd/Garry Marsh	Governance structure and processes are poorly understood with a result that they become a barrier rather than a tool for delivery	Safe, efficient processes that are patient-centred	QSC	3	3	9	**June 2016** **Mandatory Training has been reviewed to incorporate DOC and Incident reporting. Divisions now monitor weekly trackers due to heightened compliance and escalate risk to executive team.** Governance team structure is now fully filled; clarity over separation of responsibilities between Director of Nursing & Clinical Governance and the Associate Director of Governance & Company Secretary; refinement of processes around incident reporting, policy governance, compliance with CQC Regulation 20 and complaints handling has made the processes more fit for purpose.	Structure chart; TOR; Awareness, understanding application of organisational structure and processes at sub Board level; effectiveness of the new structure; new complaints and Duty of Candour policies; new Policy on Policies; weekly trackers reviewed by Exec Team; Patient Safety & Quality report	2	3	6	↔	**Continue to embed the new governance structures, including those at Divisional Level. Training to be created for key processes and responsibilities. Audit effectiveness of new clinical governance policies.** **Maternity leave in governance team with effect from July 2016 to be filled.**	Sep-16	1	3	3
S832	Ops	Jonathan Lofthouse	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	Developing services to meet changing needs, through partnership where appropriate	Trust Board	3	3	9	**June 2016** **Membership of unit of planning meetings; Membership of SOA; Membership of academic health science network; Membership of regional chief operating officers group, Membership of SDP unit and National Orthopaedic Vanguard.**	Transformation Committee meetings and regular reports to board; Quarterly Commissioner review meetings; Activity Review Group; Business Planning Group	2	3	6	↔	Continue maintaining strategic focus and exploit opportunity for collaborative working and driving quality improvements at a national level through the Vanguard	Ongoing	2	3	6
S796	DNG	Garry Marsh	The Board and organisation loses its focus on patient care so the ROH is no longer a patient-centric organisation	Delivering exceptional patient experience and world class outcomes	Trust Board	3	3	9	**June 2016** *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/TMC. Board members visiting wards and departments speaking directly to patients and staff.*	Representation from the CCG at Q&S Committee. Patient quality report to QS every month. Patient Quality Report; CPR; Patient & Carer Council; Quality Meeting; Patient Harm Reviews; FFT feedback; Complaints & PALS review; Patient Stories.	2	3	6	↔	Governor representative to routinely observe Quality & safety Committee meetings; continued patient stories at Trust Board; improved membership engagement and plans to redevelop the membership & governor engagement plan.	Sep-16	1	3	3
S986	DNG	Garry Marsh	There is a risk that the Paediatric nurse staffing on HDU is insufficient to meet the needs of Paediatric patients that the Trust cares for	Delivering exceptional patient experience and world class outcomes	QSC	3	4	12	**June 2016 1 successful applicant has started in HDU and is currently on supernumrary period. Two paed nurses will be interviewed on Monday 13th June who have extensive paediatric experience. Arrangements for the one nurse due to start in September to be finalised.** All four Paediatric nurses working on HDU have completed a two week rotation to BCH critical care unit to allow uplift and refresh of skills. New SOPs for admission of elective and emergency patients to HDU have been developed.	2 WTE paed nurses have been recruited. CQC action plan; SOPs; critical care passport evidence portfolio; presentation for CQC Quality Summit.	3	3	9	↔	Actions contained within the CQC action plan around recruitment events for Paediatrics staffing and liaising with Birmingham Children's Hospital to develop a programme to access competency based training for all HDU staff. Developing a programme to assess adult nurses against the Paediatric passport and a rotational programme between Ward 11 & HDU by end of Feb 16. Further actions planned to be completed by September 2016.	Q2 2016/17	2	2	4

269	Fin	Jonathan Lofthouse	There is a risk that the Trust may fail to deliver the activity targets set out in the Trust's annual operational plan, leading to a shortfall against the agreed Financial Outturn position for the year and potential poor patient experience	Safe, efficient processes that are patient-centred	F & PC	4	4	16	**January 2016:** Fines removed for waits in excess of 18 week RTT. Activity rectification plan has been developed and approved by Monitor. Will meet activity rectification plan and anticipate will slight overachieve against it. The plan has been accepted by Monitor, however the action plan will take several months to embed. **November 2015:** 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. 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	Activity rectification plan; minutes of Trust Board & Finance & Performance Committee; Corporate Performance Report; outputs from daily huddles and ACTION;	3	4	12	↔	A Patient Journey plan has been developed jointly between Operations and Transformation which will provide the platform for the changes needed in 2016/17 to deliver its activity and financial targets. Turnaround and improvement framework to be further developed.	~~Ongoing~~ Q2 2016/17	2	4	8
7	OPS	Jonathan Lofthouse	Long waiting times for spinal deformity. Impact of BCH capacity on ROH's waiting list potentially causing delays and poor patient experience & outcomes. This risk has a significant potential financial impact year to date.	Delivering exceptional patient experience and world class outcomes	F & PC	5	4	20	**June 2016 Year 16/17 financial threat significantly less. Q&E risk still significant with patients waiting 18 months. BCH have increased tables from 48 to 72. BCH & ROH are working closely together to improve access ability. BCH have implemented new systems processes in PICU. January 2016:** Further meeting with BCH and have requested additional triumvirate meetings with NHSE and BCH. Also scoping the potential to move a cohort of children at Nuffield. **December 2015:** Currently 11 patients over 52 weeks on the IP WL the majority of whom require treatment at BCH. Currently 31 patient suitable and families confirmed for Cromwell half of which are 30 plus weeks. Timetable planning during Jan to March 2016 to utilise as many ROH lists as possible. Weekly PTL being sent to NHS England plus fortnightly update on plan. Meeting with the team to produce trajectory for spinal def as per request of NHS England this week	Activity reports to the Board on a monthly basis from October 2015; correspondence with NHS England and BCH. Minutes from NED steering group on activity & finance.	4	4	16	↔	Appointment of 2 additional spinal deformity consultants Active management of waiting list Sourcing additional capacity as required. 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	~~01/06/2016~~ Jul-16	3	3	9

27	WFOD	Anne Cholmondeley	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.	Delivered by highly motivated, skilled and inspiring colleagues	F & PC	5	4	20	**June 2016** **The 2 PAs were continuing to embed their services within oncology and arthroplasty.** **A review was taking place of the levels of service provided by the Fellows.** **The ATRs for the additional junior and senior fellows were nearing completion - FR was awaiting feedback regarding the updated job description and personal specifications.** **Further consideration was being given to recruit ANPs to work within POAC to replace junior doctors. There will shortly be a junior doctor recruitment drive to replace the 8 locums currently being used.** **Expediture on management of agency staff likely to increase due to vacancies. Medical staff expenditure likely to increase due to traiining vacancies.** **A further PA was expected to be appointed during Q2 2016.** **No additional PAs would join the Trust during the following year.** **January 2016:** Four US PAs remain to join the Trust, with our first having joined the Trust on 18 January 2016. Our second is due to join us in mid March 2016, with the third expected at the start of May. Our fourth candidate is still to confirm a start date due to	Updates to Transformation Committee on delivery of work stream 1. Minutes from Workforce & OD Committee. Agency staffing presentation to Trust Board workshop on 13 January. Agency staffing cost position as outlined in the CPR received by the Board on a monthly basis.	3	3	12	↓	**MD Agency group fortnightly to address detailed actions regarding reduction. Revised medical model consultantion. Divisional 1 recruitment plan neeeded for junior fellows. Nurse Group to review recruitment next steps.** 5 physicians associates have now been offered employment but are yet to all start. Working group now formed to develop working practices of PAs/ANPs/junior doctors; 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 definitive plan and start date.	Q4 15/16 - ~~Q1~~ 2 16/17	2	4	8
275	DNG	Garry Marsh	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.	Delivering exceptional patient experience and world class outcomes	QSC	4	4	16	**June 2016** **Paper to be presented at Trust's Clinical Quality Meeting describing the process for reviewing and monitoring action plans to closure. The Trust Quality Report includes information relating to actions identified for improvement and learning in response to incidents, claims and complaints. This report is presented at the Trust's Quality and Safety Committee and disseminated to divisions via Divisional Management Boards.** **No change to risk status until process is embedded and consistent across all divisions.** **April 2016** An action plan has been drafted and the Governance Department are currently arranging the allocation of resources to undertake the actions. March 2016 The Ulysses system has now been reviewed by both Ulysses and the Governance Department. An action plan is currently being drafted with oversight from Ulysses to ensure viability. Learning and actions from SIs will be disseminated at Divisional Board Meetings by the Governance facilitators in the mean **January 2016:** Mitigations described in December 2015 are in place and are operational however recommend no change	Patient Safety & Quality Report presented monthly to TMC and Board Clinical Audit meeting shared events/claims/SIRIs/Incidents Directorate Governance meetings	3	4	12	↔	Trust Business and Learning days to continue to provide a platform for sharing lessons learned. Quality & Patient Safety report continues to evolve to encompass assurances over lessons learned from incidents, complaints and claims. Additional communication channels to be identified to share lessons learned and disseminate good practice to other areas of the organisation. Update on dissemination of lessons learned planned for July 2016 to Quality & Safety Committee.	~~01/06/2016~~ Q3 2016/17	2	2	4

414	MD	Andrew Pearson	There is a risk that the Trust may suffer reputational damage owing to its low position for significantly below average for the oxford knee score and index for revision knees	Delivering exceptional patient experience and world class outcomes	QSC	4	4	16	**June 2016 Latest PROMS report (Apr-Dec 2015) shows ROH for primary THR and TKR is above the England average and better than comparator SOA hospitals (RJAH, RNOH and Wrightington).** **Revision TKR report shows insufficient data numbers to calculate an adjusted score. For revision THR the ROH is significantly above the England average.** **January 2016:** PROMS report presented to QSC in January 2016, which reported that the Trust's PROMs scores for Total Knee Replacements was an outlier against the national average position. **September 2015:** Update on PROMS to be presented to CGC in October or November 2015. Latest PROMS figures have been published and are undergoing analysis. ROH remains an outlier for TKR and revision TKR (as do 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.	Report to QSC; national comparative data; PROMs scores by consultant	3	3	9	↓	Additional set of metrics identified which will improve PROMS scores, including physiotherapy, enhanced recovery, improved pain management on wards, patient education, review of surgeon techniques & their individual results and organisation wide focus on supporting PROMs work. A further meeting is due to be given in the late Spring on theories regarding measures required to improve the PROMs figures.	~~01/05/2016~~ Q2 2016/17	2	3	6
770	Ops	Jonathan Lofthouse	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure,	Safe and efficient processes that are patient-centred	QSC	4	4	16	**June 2016** **Motor has been replaced with another motor on standby. Continued enhanced maintainence and scheduling service continuing.** March 2016 Annual Maintenance Programme continues but this issue can not be fully mitigated without full rebuild due to building design air plant. January 2016: Two two-week blocks of maintenance each year. Further estates work planned for the future. December 2015: No update of this risk from theatre manager. There are plans to generally improve the theatre environment but this will not allow this plant to be replaced. In order to do this there would have to be a shut down of theatres which is currently not acceptable for service delivery. There is consideration within the Trust to build a new theatre block which would resolve this issue.	Estates maintenance schedule	4	4	16	↑	Identification of plan for theatre maintenance	~~Q1 2015/16~~ Q2 2016/17	2	2	4
1028	Fin	Tony Eardley	**New**! There is a risk that the network bandwidth is insufficient to support all essential network traffic, including access to clinical systems as well as administrative tools	Developing services to meet changing needs	IM&T Programme Board	4	4	16	**June 2016 Request submitted to upgrade network bandwidth of NHS net connection but funding not currently approved. Request submitted to implement network monitoring software so that network traffic can be analysed and limited in a managed way, funding not currently approved.**	IM & T Programme Board minutes	4	4	16	NEW	None identified	TBC	2	4	8
1030	Ops	Neil Rogers	**New!** Extremely limited capital funding available for 2016/17 to replace equipment that is beyond its useful life meaning that there is a risk that patient care might be compromised.	Safe and efficient processes that are patient-centred	TMC	4	5	20	**Request for funding for capital bids has been submitted for consideration. Capital bids have previously been prioritised by Division 2 senior leadership team and submitted at the end of March 216. Feedback received during May is that none of the equipment bids have currently been funded.**	Funding requests. TMC minutes.	4	4	16	NEW	None identified	TBC	2	2	4

1031	Ops	Neil Rogers	**New!** There is a risk that the Trust does not currently have an electronic inventory management system. Whilst there are now plans in place to procure one, the implementation will not commence until September 2016. This means that the financial risks associated with the control of stock in Theatres that were identified as part of the 2015-16 year and stock take and the risks to day to day effficient operational delivery and care to patients due to not having the correct implants or other consumable items, will persists part way into 2016/17.	Safe and efficient processes that are patient-centred	TMC	4	4	16	**June 2016** **Engagement of experienced Interim Logistics Manager. Regular liaison with NHS Supply Chain ahead of on site implementation commencing on 5th September 2016,**		3	4	12	NEW			2	2	4

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	29 June 2016
Guests	Sarah Mimmack, Nurse Lead for Infection Prevention & Cleanliness
Presentations received	None
Major agenda items discussed	• Quality Committee update • Infection Control Committee update • Quality & Patient Safety report • Falls update • Patient Satisfaction survey and action plan • Progress with CIP quality impact assessments • Policy governance update • Corporate risk register • Update on the operation of the Divisional Governance arrangements
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The Committee discussed some difficulties with integrating Physician Associates within the Trust. It was noted that the Executive was debating the model. • A risk around training appropriate staff in physical restraint has been identified by the Clinical Quality Committee, although a plan is in place to train porters and junior doctors as a priority • The continued delay with securing an Associate Medical Director for Division 1 was highlighted, although the Medical Director was optimistic that plans were in place to recruit into the vacancy and to fill the Clinical Service Lead positions shortly • The risk to the CQUIN that concerned 'flu vaccination was discussed, given that it was challenging to persuade staff to be vaccinated • It was reported that a Grade 4 pressure ulcer had been reported • An in depth update on falls was received, which highlighted an increase in the number of avoidable falls during 2015/16, many linked to poor documentation • It was noted that discussions were needed to agree where workforce information and its impact on quality & safety

	should be presented • The Director of Operations suggested that the Committee needed to be cognisant over the quality & safety risks associated with insufficient capital funding to purchase replacement medical equipment
Positive assurances and highlights of note for the Board	• The Never Events assurance action plan has been completed, following the recent approval of the Safe Surgery policy • Good work to define the barriers within theatres and enforce the Permit to Work practice has been undertaken. This will be enhanced further when the estates work in theatres is concluded. • The operation of the Clinical Quality Committee was reported to have improved further, with a set of standards for the Committee having been set – no late papers are accepted, cover sheets are to be used for all papers and the minutes of the meetings are to be provided routinely to the Quality & Safety Committee • Support by the governance team to the divisions is now much more robust and some divisions are holding governance workshops • The recent pre-operative fasting audit showed an improved position in terms of the time that patients ceased drinking pre-operatively • The Committee received an update on the rise in Surgical Site Infections and the linked theatres closure; the lessons learned were being shared with the wider NHS which was noted to be positive • The national patient survey published in June presented a positive picture and any actions would be built into divisional action plans • An improving position in terms of addressing those policies which had exceeded their review date was reported, although further work was noted to be needed in HR and estates • An improved position on PROMS was reported, however an action plan to sustain this improvement is needed
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The Board to discuss the Physician Associates positon in terms of its impact on quality & safety • The timeframe for the estates work in theatres to address infection control concerns is to be presented at the next meeting • The outcome report from the theatres closure review is to be presented at the next meeting • Pressure ulcers to be discussed at the next meeting • Some refinement to the Patient Safety & Quality report was suggested • Further update on PROMS to be considered at the July

	meeting
Decisions made	• The Committee supported the proposal to eliminate paper based reporting in favour of using Amplitude

Kathryn Sallah
NON EXECUTIVE DIRECTOR

For the meeting of the Trust Board scheduled for 6 July 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	14 June 2016
Guests	None
Presentations received and discussed	None
Major agenda items discussed	• Standardisation of prostheses • Finance & Performance Overview • Prospective order book • Financial implications of long stay patients • Turnaround programme and performance framework • Job planning update • Procurement strategy
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• Of principle concern was the continued absence of an overarching reporting framework to provide a prospective view of activity & finance performance and to articulate the turnaround steps planned, alongside the improvements anticipated • It was reported that although the Trust was largely on plan in terms of income, the position in outpatients was behind expectations • The break in the pain management service as a result of the retirement of a single consultant was discussed; more robust succession planning for forthcoming retirements is needed • Although much work had been undertaken, further action is needed to make the controls around stock management tight • Further work is needed to understand how the Physician Associated model is to be operationalised • CIP performance is behind plan at present • The activity positon was reported to be behind plan at present and the recent theatre close down would impact on the position further. The impact of annual leave in May had also not been helpful; work is underway to reframe the annual leave policy to ensure that there is clear guidance on ensuring that there is sufficient resource to support the activity plan evenly throughout the year

	• The prospective order book was circulated, which reported that including additional opportunities, 15,264 cases could be treated. This would ensure that the £3.2m control total was met. It was agreed that there should be a real focus on driving through the improvements needed to achieve the step change in activity required • Income associated with long stay patients was noted to not be being recovered at present
Positive assurances and highlights of note for the Board	• Good work was described to address variation in prostheses used and possible support from the Vanguard was discussed in this respect. The potential cost savings as a result of this were noted to be significant. • The position concerning delays out of HDU was reported to have improved • Good work was reported to be underway to develop an improvement & turnaround programme and a set of assurances that the committee could draw upon would be delivered out of this work • The significant cost saving in terms of SPA time was noted to be associated with the Job Planning work; job planning software was implemented in May • Options around the provision of procurement services were reported to be being considered. This would be presented to the Trust Board in due course.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• In terms of the prospective order book, it was agreed that a more ambitious target should be set and the clawback to address the underperformance year to date needed to be reflected • The risks associated with the delivery of the order book needed to be set out clearly as a priority
Decisions made	• None specifically

Dame Yve Buckland

CHAIRMAN AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 6 July 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 7 September 2016

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 7 September 2016 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.

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** 7 September 2016: 1100h – 1300h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair & Non Executive Director	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Rod Anthony	Non Executive Director	(RA)
Mrs Jo Chambers	Chief Executive	(JC)
Mr Andrew Pearson	Medical Director	(AP)
Mr Paul Athey	Finance Director	(PA)
Mr Garry Marsh	Director of Operations, Nursing & Clinical Governance	(GM)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(AC)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies – HH Frances Kirkham, Professor Tauny Southwood and Professor Phil Begg	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	3	Patient story	Presentation	GM
1125h	4	Minutes of Public Board Meeting held on the 6 July 2016 *for approval*	ROHTB (7/16) 020	Chair
1130h	5	Trust Board action points: *for assurance*	ROHTB (7/16) 020 (a)	Chair
1135h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (9/16) 002 ROHTB (9/16) 002 (a)	YB/JC
QUALITY & PATIENT SAFETY				
1150h	7	Safe Staffing Report: *for assurance*	ROHTB (9/16) 003 ROHTB (9/16) 003 (a)	GM
1200h	8	CQC action plan update: *for assurance*	ROHTB (9/16) 004 ROHTB (9/16) 004 (a) ROHTB (9/16) 004 (b)	GM

FINANCE AND PERFORMANCE				
1215h	9	Performance reports: *for assurance*	ROHTB (9/16) 005 ROHTB (9/16) 005 (a) ROHTB (9/16) 005 (b)	PA/GM
COMPLIANCE & RISK MANAGEMENT				
1230h	10	Quarter 1 2016/17 – NHS Improvement governance submission *for information*	ROHTB (9/16) 006 ROHTB (9/16) 006 (a) ROHTB (9/16) 006 (b)	JC
ASSURANCE UPDATES FROM THE BOARD COMMITTEES				
1240h	11	Quality & Safety Committee	ROHTB (9/16) 007	KS
	12	Finance & Performance Committee	ROHTB (9/16) 008	TP
	13	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 5th October 2016 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.

MINUTES

Trust Board (Public Session) - DRAFT v0.3

Venue Boardroom, Trust Headquarters **Date** 6 July 2016: 1100h – 1300h

Members present

Dame Yve Buckland	Chairman	(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 Paul Athey	Director of Finance	(PA)
Mr Garry Marsh	Director of Nursing & Clinical Governance	(GM)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(AC)
Prof Phil Begg	Director of Strategy & Transformation	(PB)
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL [Secretariat]
Mr Neil Rogers	Divisional General Manager (Division 2)	(NR)

	Paper Reference
1 Apologies	**Verbal**
Apologies for absence were received from Mr Andrew Pearson and Mr Jonathan Lofthouse. Neil Rogers was introduced who would be representing Operations in the absence of Mr Lofthouse.	
2 Declarations of Interest	**Verbal**
The Chairman advised that she had been appointed as part of a panel advising on the merger and shape of Further Education colleges. Her register of interests would be updated accordingly	
3 Update from Physician Associate	**Presentation**
The Director of Strategy & Transformation delivered a presentation summarising the role of the Physician Associate. The presentation summarised how the role had evolved and where PAs were	

employed regionally at present. It was reported that there was a move to recruit more PAs from overseas. The way in which PAs could be successfully integrated within organisations was discussed, which included close working relationships with Junior Doctors and more generally, there was benefit in the individuals sharing responsibilities and contributing to the learning of an organisation. The challenges with PAs was also discussed, which related predominately to some of the legal limitations of their roles, in that currently they are not able to undertake non-medical prescribing duties, cannot request tests covered by IRMER regulations and had limited authority within the Pathology remit. The cost improvement target associated with the PAs at the ROH was highlighted to be c. £235, this being linked to reduction in agency staff as a result. The Director of Strategy & Transformation was thanked for his informative presentation.	
4 Minutes of the Public Board 1 June 2016	**ROHTB (6/16) 012**
The minutes of the public meeting held on 1 June 2016 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 (6/16) 012(a)**
The action log was received and noted. The Associate Director of Governance & Company Secretary provided an update on those actions outstanding.	
6 Chairman's and Chief Executive's update	**ROHTB (7/16) 003** **ROHTB (7/16) 003 (a)**
The Chief Executive provided a routine update on strategic and local matters. It was noted that the Patient Safety Conference held in June had been a successful event. The formal evaluation was yet to be assimilated and a proposal for the follow up would be prepared by the Director of Workforce & OD. It was noted that the national contract for Junior Doctors had not been accepted and the implications of this for the ROH was being worked through at present. In terms of the revised business case for anaesthetic staff that had been considered by the Trust Management Committee on 22 June, it was suggested that lessons learned from the development of this business case needed to be harnessed and applied to the development of similar business cases. The development of a procurement strategy was discussed. This related to the procurement function set up and would also take into account the wider system procurement considerations with the STP and Vanguard. Collective procurement was encouraged as a standalone function did not appear to be suitable for the organisation.	

The Chairman asked the Board to note the National Orthopaedic Alliance briefing for Vanguard Chairs which had been provided. The Chairman also advised that: • A STP workshop had been attended and she drew the Board's attention to the presentation on 'Creating a 'civic ambition' for health and care in Birmingham and Solihull' which had been delivered at the workshop. • A STP Leaders and Chairs' away day had been attended on 2 June and the key themes and agreed actions was presented for information. • A number of further events had been attended since the last meeting, including the Patient Safety Conference on 8 June; NHS Providers Chairs & CEO's event on 9 June; and a PWC event – 'Learning from Failure - Turnaround to Transformation' on 30 June which she had attended with the Vice Chair. • In terms of Non Executive Director recruitment, the closing date for applications was 8 July, with interviews on 22 July. Some good candidates had put themselves forward.	
7 Risk Management Policy	**ROHTB (7/16) 005** **ROHTB (7/16) 005 (a)** **ROHTB (7/16) 005 (b)**
The Associate Director of Governance & Company Secretary presented a revised risk management policy for approval. He advised that: • The policy was part of ongoing work to strengthen risk management systems and processes in the organisation • The policy set out more clearly roles and responsibilities in relation to managing risk and provided clarity on how a risk should be reported, escalated and de-escalated. • In terms of the implications for the Board, it was reported that the Board would start getting regular reports on risk from September, which would consider recommendations from the Trust Management Committee as to whether risks put forward should be added to the Corporate Risk Register or the Board Assurance Framework should the scoring be sufficiently high The Chair of the Audit Committee made some suggested comments to clarify that in the case of an immediate serious risk, then action was needed to escalate and mitigate it as soon as possible. The Director of Nursing & Clinical Governance noted that there was an initiative around 'Learning from Excellence' planned to provide a positive focus on upward reporting and the value of this. This would be fed into the incident reporting processes. Subject to the amendments discussed, the Trust Board approved the policy.	

8 Freedom to Speak Up Guardian appointment	ROHTB (7/16) 004 ROHTB (7/16) 004 (a)
The proposals to appoint a Freedom to Speak up Guardian were presented by the Director of Workforce & OD. The role would be embedded within the Clinical Governance team and it was the intention that the individual would visit and talk to staff in areas that rarely reported incidents. An open appointment would be advertised and a NED was requested to join the selection panel. The role needed to be implemented by October. It was agreed that the individual needed to have sufficient gravitas and political awareness to carry out the role effectively. For purposes of costing, a 0.5 Whole Time Equivalent (WTE) for a Band 6 had been provided for. It was suggested that the role be appointed to on a fixed term basis to provide an opportunity to change the individual regularly. The need to ensure that the ambassadorial role associated with the position was well executed was reinforced, as was the need to ensure that the position was truly independent. It was noted that the role was accountable to the Chief Executive but the line management was to the Governance Manager. It was highlighted that the role also had unfettered access to the office of the National Guardian and the Care Quality Commission. It was agreed that the individual needed the opportunity to meet with the Chief Executive as and when needed. In terms of credibility, it was suggested that consultants should not be excluded from applying for the position and should be encouraged. A biannual report would be presented to the Board from the Guardian. Taking all of the suggested points into consideration, the Board agreed to support the arrangements to appoint to the Freedom to Speak Up role on a part time basis, embedded within the Clinical Governance team.	
9 Safe Staffing Report	**ROHTB (7/16) 005** **ROHTB (7/16) 005 (a)**
The Director of Nursing & Clinical Governance presented the updated safe nurse staffing report. It was noted that Ward 3 looked as though staffing levels were less than desired, however this was due to the ward reporting on an incorrect template. This would be addressed shortly. It was agreed that the sign off process for templates needed to be more robust, given that this was reported externally. In terms of Ward 11, it was reported that additional healthcare assistants vacancies were not always filled, however the ward had more registered nurses. Long term sickness was being covered during the day shifts. In the High Dependency Unit (HDU), one individual was reported to be on long term sick leave.	

It was suggested that the information needed to be displayed graphically and the triangulation around other events also needed to be more effectively presented. It was reported that E-rostering would assist with visualising the position. The project manager for e-rostering was reported to be starting shortly with the plans being rolled out from September. The safe nurse staffing model was noted to be rudimentary and did not necessarily show how care needs were met. It was reported that nurse vacancies had increased and a nursing workforce group is in place to provide oversight to these vacancies; a recruitment campaign was also in place. The Board was advised that a significant number of nurse staff did not pass the numeracy pre-employments tests, however the standards set for this were to be reviewed. Agency staff usage was reported to be at 10.9% on wards, with HDU using significant temporary staff. A business case for increasing the nursing establishment in theatres was reported to have been presented to Trust Management Committee recently which would reduce agency staff in future. A good preceptorship programme was in place for Band 5 nurses. Nurses leaving were predominantly those within the first year and therefore work had been done to strengthen the preceptorship work. This would help with retention.	
10 CQC action plan update	**ROHTB (7/16) 006** **ROHTB (7/16) 006 (a)**
The Deputy Director of Nursing & Clinical Governance, Anne Crompton, joined the meeting to present progress against the CQC action plan. The progress with the delivery of actions was reported to be tracked together with an evidence base to demonstrate completion. The Trust was reported to be off track against the plans to deliver 6 out of 11 'Requirement Notice' actions. The revised timescales were discussed, including actions around block booking of outpatient clinics. It was reported that Division 1 had already completed a review of all clinic templates. Progress against other actions discussed. Some Outpatient issues were discussed, which originated from the July 2014 inspection. The Chief Executive noted that it was pleasing to refocus the plan on the patients and that it was assuring that there would be a body of evidence collated to support the delivery assurance.	
11 Performance reports	**ROHTB (7/16) 007** **ROHTB (7/16) 007 (a)** **ROHTB (7/16) 007 (b)**
The Director of Finance noted that costs were being well controlled. Cost	

Improvement Programme (CIP) targets were behind plan at present however. There had been a financial impact of theatre closures in June which would create a gap that needed to be closed. The majority of the cohort of patients who were cancelled during theatre closures had been rescheduled. Job planning would also assist with building up the capacity. It was reported that some of the discussions around job plans that should have happened in June had not yet occurred so remedial plans were being developed. Cancellations had reduced overall and there had been a reduction in delays out of recovery. A reduction in the 52 week waiting list was noted, which was reflective of the work with the Cromwell Hospital to treat patients. The high cost of agency staff was noted, which was reflective in part of the use of locum doctors in Pre-Operative Assessment Centre (POAC). The Director of Nursing & Clinical Governance presented the highlights of the Quality & Patient Safety report. Due to concerns over pressure ulcers, the Ward Manager of Ward 3 was due to attend the Quality & Safety Committee in July to outline the measures he was putting in place to prevent any further pressure ulcers. Pressure ulcer documentation would also be reviewed. It was noted that current bedside chairs did not have any pressure relieving qualities and therefore the Charitable Funds Committee would be approached to seek funds for the replacement of these. Additional work had been requested on the patient experience analysis of complaints, concerns and compliments to better understand this and identify any trends.	
12 Board Assurance Framework - Quarter 1 2016/17	**ROHTB (7/16) 009** **ROHTB (7/16) 009 (a)**
The Associate Director of Governance & Company Secretary presented the quarterly Board Assurance Framework update. A number of new risks were reported to have been added and some of the post mitigation scores had been altered. It was noted that a report would be presented on patients waiting a long time for treatment. It was noted that there were additional measures which might further reduce the waiting times in year for less complex cases.	
ACTION: Present a paper on long waiting times at the next Board meeting	
12.1 Pathology service update	**ROHTB (7/16) 009** **ROHTB (7/16) 009 (a**
The Divisional General Manager for Division 2 provided an update concerning Pathology services. The Pathology Manager was reported to have recently retired and the designated individual for the licence had passed to Neil Rogers. A recruitment exercise to fill	

the vacancy was scheduled for August. The risk around this gap was reported to be mitigated as much as it could be, although the Board was asked to note that there had been a number of attempts previously to recruit a replacement. It was highlighted that there was no risk for the imminent Human Tissue Authority inspection.	
13 Quality & Safety Committee	**ROHTB (7/16) 010**
The key highlights from the June meeting of the Quality & Safety Committee were presented. It was highlighted that there was a need to understand the reason for the changes in the Patient Reported Outcome Measures, which were now more positive. The risk associated with capital funding for replacement equipment was noted to have been discussed and there had been a useful presentation from the Nurse Lead for Infection prevention and Control.	
14 Finance & Performance Committee	**ROHTB (7/16) 010**
The Vice Chair reported that the Committee continued to review finance and performance in detail. There had been good work on prostheses rationalisation.	
15 Any Other Business	**Verbal**
There was none.	
Details of next meeting	**Verbal**
The next meeting would be held on 7th September 2016 at 1100h, Board Room, Trust Headquarters	

PUBLIC SESSION

Next Meeting: 7 September 2016, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

6 July 2016, Boardroom @ Trust Headquarters

Members present: Yve Buckland (YB), Tim Pile (TP), Rod Anthony (RJA), Tauny Southwood (TS), Frances Kirkham (FK), Kathryn Sallah (KS), Jo Chambers (JC), Paul Athey (PA), Garry Marsh (GM)

In Attendance: Anne Cholmondeley (AC), Phil Begg (PB)

Apologies: Andrew Pearson & Jonathan Lofthouse

Secretariat: Simon Grainger-Lloyd (SGL)

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
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	~~03/02/2016~~ 6-July-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. Further development work currently underway. Names of individuals suggested to trial the system have been put forward, however delay due to resolution of Information Governance issues for those wishing to use non-Trust iPads.	
ROHTBACT. 014	Patient Case – an illustration of the work we do	Presentation	06/04/2016	Quality & Safety Committee to consider the future plans for screening dementia patients	SGL	~~25/05/2016~~ 28/09/2016	Included on the agenda of the September meeting	
ROHTBACT. 020	Board Assurance Framework	ROHTB (5/16) 009 ROHTB (5/16) 009 (a)	04/05/2016	Update the BAF to include risks to the sustainability of the organisation agreed at the Board strategy day	SGL	~~06/07/2016~~ 1/10/2016	Will be updated once the strategy refresh is complete.	

ROHTBACT. 018	Annual inclusion report	ROHTB (5/16) 008 ROHTB (5/16) 008 (a)	04/05/2016	Review the scoring for Domain 3 of the EDS assessment	AC	~~01/06/2016~~ 6-July-16	Additional evidence gained which demonstrated that initial scoring was correct	
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~~ ~~03-Feb-16~~ ~~06-Apr-16~~ Jun-16	New performance report presented routinely to Finance & Performance Committee and Trust Board	
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 ~~6-Apr-16~~ Jun-16	New performance report presented routinely to Finance & Performance Committee and Trust Board	
ROHTBACT. 015	One year operational plan and budget sign-off	ROHTB (4/16) 005 ROHTB (4/16) 005 (a)	06/04/2016	Case studies from the material considered by the Finance & Performance Committee to be presented to the Trust Board	SGL	01-Jun-16	Action satisfied by presentation of comprehensive assurance report from the Chair of Finance & Performance Committee	
ROHTBACT. 021	Patient Story	Presentation	01/06/2016	Develop a forward plan of patient stories to the Board	GM	01-Sep-16	Patient stories lined up for future Board meetings but will formalise a schedule when new Deputy Director of Nursing & Clinical Governance is in post. Suggest close action.	
ROHTBACT. 022	Performance reports	ROHTB (6/16) 004 ROHTB (6/16) 004(a) ROHTB (6/16) 004(b)	01/06/2016	The process for approval of consultant leave to be considered at the F&P committee	JL	19-Jul-16	Included as part of discussions around finance and performance activity recovery	

ROHTBACT. 027	Board Assurance Framework	ROHTB (7/16) 009 ROHTB (7/16) 009 (a)	06/07/2016	Present a paper on long waiting times at the next Board meeting	GM	07-Sep-16	Presented to the Board as part of RCPCH report in the private session	

KEY:

	Verbal update at meeting
	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

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:	**7 September 2016**

EXECUTIVE SUMMARY:

This report provides an update to board members on the national context and key local activities not covered elsewhere on the agenda.

The report also provides a summary of key discussions and decisions taken by the Trust Management Committee since the Board last met.

REPORT RECOMMENDATION:

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

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:

The contents discuss a number of developments which have the potential to impact on the delivery of a number of the Trust's strategic ambitions

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (9/16) 002(a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 7 September 2016

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 Quarter 1 2016/17 financial position has just been published and shows that the provider sector is £461m in deficit overall, £5m better than plan after receiving Sustainability and Transformation Fund allocations for those providers which met control totals and agreed to performance improvement trajectories. Overall, 153 (of 214) providers are in deficit.

2.2 The planned outturn position is predicted to be worse than plan, from £580m deficit to £644m deficit because some providers are not confident of delivering the planned figure; NHS Improvement (NHSI) are adopting remedial actions to address this.

2.3 Cost Improvement Plans overall have fallen short of plans by £45m and Trusts have been asked to focus on tackling excess pay bill growth, taking forward Lord Carter's recommendations on back office and pathology consolidation and consolidating unsustainable services that rely on locum and agency staff.

2.4 Additionally, NHSI have challenged the sector to improve its overall deficit position to around £250m deficit and have asked all providers to take additional actions in relation to back office, pathology and unsustainable services to reduce the 2016/17 deficit and improve the 2017/18 'run-rate' full year effect position. STP leads have been asked to lead and coordinate this which is being addressed in Birmingham and Solihull through the finance directors group.

2.5 NHSI and NHS England (for commissioners) have introduced a new financial measures criteria outlined in a document *Strengthening financial performance and accountability in 2016/17 (https://improvement.nhs.uk/resources/strengthening-financial-performance-and-accountability-201617/).* The new financial special measures is designed to "help providers facing the biggest financial challenges and will underline the importance of all providers adhering to their control totals". Initial attention is on 5 providers who had not agreed control totals and from quarter 1 onwards will review negative variances from control total plan and any exceptional financial governance failures.

2.6 Operational performance continues to be challenging with the number of people waiting for elective care at its highest recorded level of 3.45million. There is continued aggregate underperformance (91.27%) against the 92% Referral to Treatment (RTT) incomplete target. The national target for A & E four hour waits was not met whilst demand rose to a record 5.34 million attendances.

2.7 As previously discussed, the new Single Oversight Framework is intended to replace Monitor's Risk Assessment Framework and the TDA Accountability Framework. A paper is attached at *Appendix 1* which provides further context, and the Trust's response to the recent consultation exercise.

3 Local Context

3.1 The Trust continues to engage fully in the local development of the Sustainability and Transformation Plan. Some members of the STP leadership team attended a review meeting with NHS England on 8 July in which the high-level principles of the STP were agreed. The detailed plans are being worked through and a financial model being developed with the objective to create sustainable services for Birmingham and Solihull whilst eradicating an overall system deficit if no changes were made.

3.2 The Trust continues to strengthen its partnership working with Birmingham Children's Hospital to ensure that there is a consistent approach to quality and standards across the system. A number of initiatives are under discussion which would optimise the use of resources across both providers and strengthen leadership and governance of children's services at ROH. Specific details area addressed in a separate report to the Board.

4 NHS Improvement

4.1 The Trust has received feedback from NHSI on its 2016/17 Operational Plan (see *Appendix 2*), which is now published on the website. The Trust will need to pay particular attention to delivery of its Cost Improvement Plan initiatives, its use of agency staffing and compliance with its agency cap, and delivery of the 52 week wait recovery plan. The long-waits plan is being delivered in partnership with Birmingham Children's Hospital where the Trust has to undertake the most complex surgical procedures with full back up in the event of any complications and is now supported by a CQUIN which seeks to guarantee access to an additional 26 theatre slots and paediatric intensive care back up.

4.2 On 31 August 2016, the Trust received confirmation from NHSI of its current financial sustainability risk rating and governance rating following the Q1 submissions. The letter containing further detail is attached at *Appendix 3.*

5 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

5.1 In addition to routine business meetings with partners, other key stakeholder and partnership engagement activities over the period include:

- Attended HSJ Provider Summit
- Birmingham Oncology and Arthroplasty Meeting (BOAM)
- Specialist Orthopaedic Alliance Board Meeting
- 'Inspiring Improvement – an interactive sharing event' – with NHS Improvement
- West Midlands CEO Providers Meeting
- Quality Meeting with Royal College of Paediatrics & Child Health, NHSI, NHSE, CQC, Commissioners and Birmingham Children's Hospital
- Meeting regarding future strategy and opportunities for collaboration - CEO & Chairman of Robert Jones & Agnes Hunt specialist orthopaedic hospital
- Quarterly 1:1 partnership meeting with Sarah-Jane Marsh, CEO Birmingham Children's Hospital
- Meeting with Mark Rogers (Birmingham City Council) and John Wilderspin to discuss the development of partnership working in the Birmingham and Solihull STP
- BSOL STP System Board.

6 UPDATE FROM TRUST MANAGEMENT COMMITTEE

6.1 Since the last meeting of the Board on 6 July 2016, the Trust Management Committee (TMC) was held on 27 July 2016 and 24 August 2016.

6.2 **27 July 2016**

TMC considered the following items to be of note to the Board:

- TMC gave support, in principle, to a business case for increased staffing in HDU in order to meet RCN and RCPCH staffing recommendations.
- Staff are not booking onto, or attending, Safeguarding Training which is a contractual requirement. This was escalated to the corporate risk register and a remedial plan required from the Operational Divisional General Managers.
- Mandatory training compliance is underperforming in all areas, with particular focus required on resuscitation training. Divisions agreed to ensure effective plans are in place for the release of staff to restore and retain compliance with mandatory training standards. All training compliance is reported upwardly to TMC on a monthly basis, as well as through the Finance & Performance Report at Finance & Performance Committee. Divisional Boards receive detailed breakdown of non-compliant staff, and this is also reviewed at Divisional Performance Reviews.
- A full business case for additional theatre staffing was considered and approved, with funding available in the current Division 2 budget reserves.
- TMC approved the draft Terms of Reference for the newly established Data Quality Committee which will report to TMC on a monthly basis.

6.3 The following policies were reviewed by TMC and recommended for approval:

- Long Service Award Policy
- Freedom To Speak Up Policy
- Education, Learning & Development Policy
- Waste Management Policy

6.4 **24 August 2016**

TMC considered the following items to be of note to the Board:

- Children's Nurse recruitment remains a challenge as none of the six shortlisted candidates attended the last assessment centre. A further assessment centre is planned for 9 September 2016.
- An operational delivery plan has been developed to plan for delivery of critical care whilst the building work takes place in HDU. This requires sign off from the Director of Operations, Nursing & Governance before it can proceed.
- TMC considered a business case for increased staffing in Physiotherapy, to deliver a seven day service. It was agreed that further detail was required in order to make the case, which can be considered in advance of the next TMC by a sub-group comprising the Director of Finance, Director of Operations, Nursing and Governance, and the Associate Director for Turnaround in order to reach a decision.
- From April 2017, every employer will be subject to an apprenticeship levy (0.5% of pay bill - £233k for ROH). This will represent a cost pressure.
- Planning for the 2016 flu campaign is underway, with incentives for vaccinators and staff to ensure that the Trust meets the CQUIN for 2016/17.
- The Trust is non-compliant in five key areas of the Accessible Information Standard and an action plan has been developed to ensure that compliance is reached.
- The Trust has appointed to the Guardian for Safe Working Hours, the nationally mandated role to support the safe introduction of the new junior doctor contract.
- Divisions have been requested to provide a bottom up trajectory for how they will meet mandatory training compliance as the Trust is still underperforming, despite discussion at July TMC.
- TMC was presented with an Outline Business Case for PAS replacement which was followed by an Interim Business Case for IT Network Improvements. The Head of IM&T and Director of Finance were asked to develop a revised IM&T plan that prioritises key IT schemes, with financial costings & implications, to report through the Transformation Committee for further review. The risk scoring for IM&T strategy and implementation related risks will also be reviewed and updated following this assessment.
- It was agreed that Divisional Performance Reviews would focus upon quality indicators with a contractual implications such as compliance with WHO checklist and Single Sex Accommodation breaches as well as activity, finance and workforce indicators.

6.5 The following policies were reviewed by TMC and recommended for approval:

- Delivering Same Sex Accommodation Policy

- Policy for the Release of Human Tissue and Explanted Orthopaedic Implants
- Safeguarding Children, Young People and Families Policy (subject to amending the format and ensuring alignment to BCH policy)
- Paediatric Policy for the Deteriorating Patient
- Permit to Work Policy – Infection Prevention & Control
- An update to the Policy on Policies (additional table added to 'Consultation' section to capture whose feedback is essential before the policy can be recommended for approval)

6.6 Risks that are discussed at TMC that are recommended to be added to the corporate risk register will be presented via a formal risk report to Trust Board from September 2016 onwards.

7 RECOMMENDATION(S)

7.1 The Board is asked to discuss the contents of the report, and

7.2 Note the contents of the report.

Jo Chambers
Chief Executive
2 September 2016

Appendix 1

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

SINGLE OVERSIGHT MODEL - BRIEFING FOR TRUST BOARD

7 September 2016

1.0 INTRODUCTION

1.1 On 1 April 2016, NHS Improvement (NHSI) came into being, bringing together Monitor (regulator for NHS Foundation Trusts) and the Trust Development Authority (TDA) (regulator for NHS Trusts), reflecting that both NHS trusts and NHS foundation trusts face similar challenges in the system. NHS Improvement also encompasses the Patient Safety, the Advancing Change and Intensive Support teams. The specific legal duties of Monitor and the TDA persist through the creation of NHSI.

2.0 SINGLE OVERSIGHT MODEL

2.1 In line with this coming together of the two key regulators of NHS bodies, in June 2016 a proposal was put forward by NHSI that a Single Oversight Framework would be developed, which would replace Monitor's Risk Assessment Framework and the TDA's Accountability Framework. It was proposed that as far as possible it was the intention to combine and build on both of these regulatory frameworks, but adapting them to reflect and enable NHSI's primary improvement role.

2.2 It is also the intention of the new framework to support providers in attaining and/or maintaining a Care Quality Commission (CQC) rating of 'Good or 'Outstanding' by focussing on five themes which are aligned to the CQC's key questions (although are not identical). The key difference to the CQC's key questions lies with supplementary oversight of use of resources, which is not currently included within the CQC regulatory framework.

2.3 The new oversight framework is proposed to focus on the following five themes:

Quality of Care: the CQC's most recent assessments of whether a provider's care is Safe, Caring, Effective and Responsive, in combination with in-year information where available will be used to judge performance against this theme. Delivery of the four priority standards for 7 day hospital services will also be taken into account.

Finance & use of resources: informed by oversight of a provider's financial efficiency and progress in meeting its financial control total. The approach is being co-developed with the CQC.

Operational performance: support will be available to providers to improve and sustain performance against the requirements of the NHS Constitution and other standards. These would include A & E waiting times, referral to treatment times, cancer treatment times, ambulance response times and access to mental health services.

Strategic change: NHSI will work with system partners to consider how well providers are delivering the strategic changes set out in the NHS Five Year Forward View (5YFV), with a particular focus on their contribution to Sustainability & Transformation Plans (STPs), new models of care and, where relevant, implementation of devolution.

Leadership and improvement capability: this domain builds on the joint CQC and NHSI well-led framework and will develop a shared system view with the CQC on what good governance and leadership looks like, including organisations' ability to learn and improve.

3.0 SEGMENTATION

3.1 It is proposed that providers will be categorised into one of four categories; this process is known as segmentation. Organisations will be segmented according to the scale of issues faced by individual organisations. This judgement will be informed by data monitoring and an understanding of providers' circumstances. The summary of the proposed approach is as below:

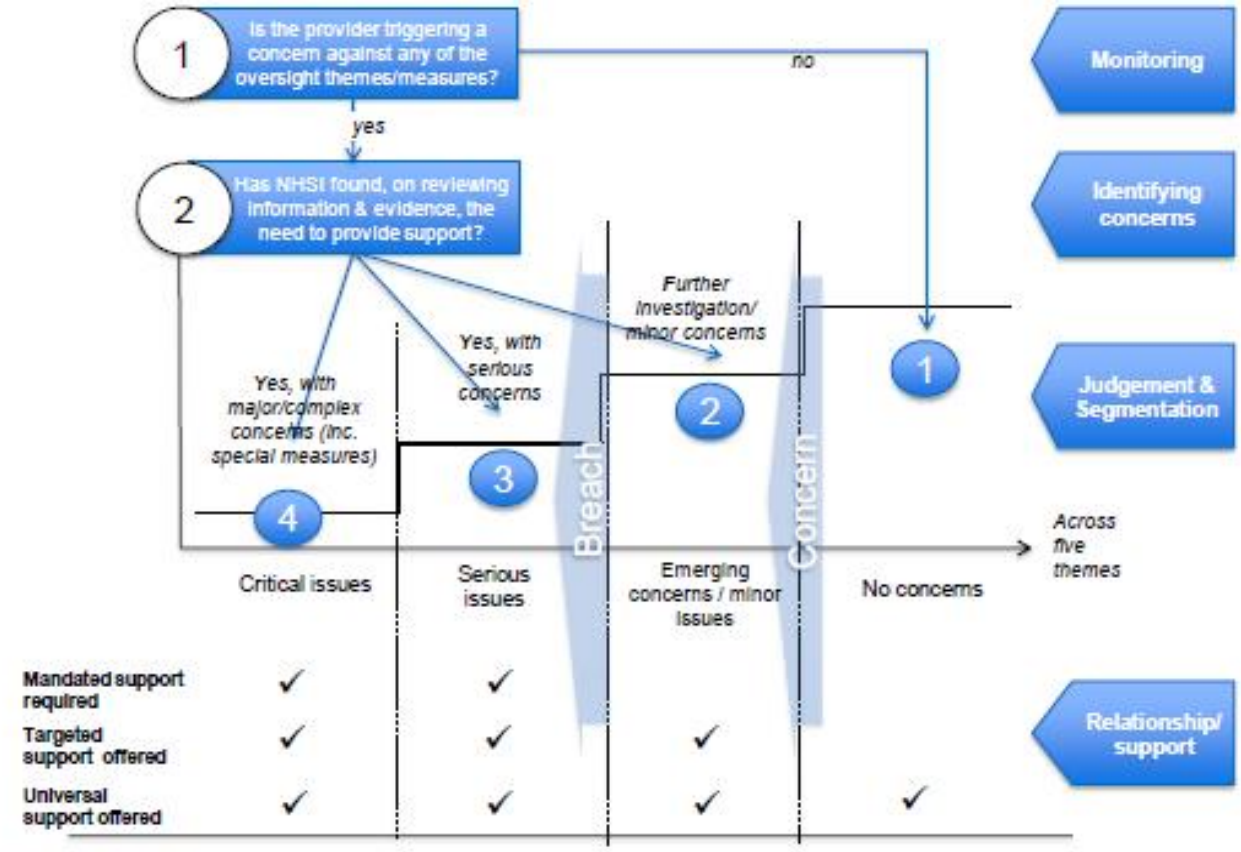


Figure 1: *Proposed approach to segmentation*

3.2 The segment a provider is within will determine the nature of the support NHSI will provide. While this will be tailored to the circumstances of providers, three broad categories of support for providers have been defined as: universal offers; targeted offers; and mandated (this is expanded upon in Section 6).

3.3 Segmentation does not in itself constitute an assessment of provider performance. NHSI teams will work with providers to determine the appropriate, tailored, support package for each, including directly provided support and support facilitated by, for example, other

parts of the sector.

3.4 The legal basis for actions in respect of NHS trusts and NHS foundation trusts remains unchanged. This means that, for example, a foundation trust will only be placed in segments 3 or 4 where it has been found to have been in breach or suspected breach of its licence.

4.0 MONITORING

4.1 Information from data monitoring processes will be used to identify where providers are triggering a potential concern in one or more of the five themes (which indicates they are not in Segment 1 and may benefit from support). This will be assessed, based on consistent principles, to determine whether or not they are in breach of their provider's licence, and if so, whether the issues are very serious/complex.

4.2 NHSI assert that the collection burden of information will be proportionate and where possible nationally available information will be used.

4.3 Monitoring information to be used will fall into three categories:

- **in-year** – following a regular in-year monitoring cycle using weekly/monthly/quarterly/six- monthly collections as appropriate
- **annual/less frequent** – annual provider submissions, such as annual plans, annual statements on quality or annually published data
- **ad-hoc** – results of CQC inspections, third-party information with governance implications, including audit reports, HSE reports, whistleblowing

4.4 During 2016/17 existing Monitor and TDA oversight templates will be used to collect information.

5.0 IDENTIFYING POTENTIAL CONCERNS

5.1 Information collected by NHSI will be used to identify where providers need support and there are 'triggers' of concern in each of the five themes. When providers trigger potential concern, NHSI will consider whether the level of interaction needs to change to monitor the issue and the provider's response to it.

6.0 SUPPORT TO PROVIDERS

6.1 While it is proposed that segmentation informs the oversight and support relationship with each provider, it will not determine the support package in its entirety, which will be tailored to a provider's particular circumstances.

6.2 The support offered will be provider specific, but it is proposed that it will fall into three categories:

- **universal support offer –** tools that providers can draw on if they wish to improve specific aspects of performance. Optional for providers to draw on.
- **targeted support offer –** support to help providers with specific areas – eg intensive support teams to help in emergency care or agency spend. Programmes of targeted support will be agreed with providers. This support is offered to providers – its use is voluntary.

- **mandated support –** where a provider has complex issues, NHSI may prepare a directed series of improvement actions to help it, eg appoint an improvement director, or agree a recovery trajectory and support providers to deliver this. In these serious and critical cases, providers are required to comply with NHSI's actions/expectations.

7.0 CONSULTATION AND ENGAGEMENT

7.1 A consultation process on the Single Oversight Framework was launched in June 2016, which was referenced in the July CEO public report. The closing date for the consultation was 4 August 2016. The Trust submitted a response to the detailed set of questions forming the consultation to this deadline and also provided a copy of the response to NHS Providers who submitted an overarching view taking into account wider provider feedback.

7.2 Additionally, the Associate Director of Governance/Company Secretary participated in a Webinar in July 2016 during which provider representatives were able to interrogate the plans set out in the consultation document further and therefore inform the consultation responses ahead of the deadline.

7.3 Key pieces of feedback provided to NHSI as part of the consultation and points of note from the webinar can be summarised as:

- Duplication of requests for information for monitoring purposes should be minimised where possible
- Language used in the new Framework needs to be harmonised with that of the CQC's framework where possible to avoid confusion
- There was concern that given the intention to launch the Framework in Autumn 2016, insufficient time had been allowed to build in any substantive comments arising from the consultation
- The Framework needed to take into account operational differences between large acute providers and smaller specialist organisations such as the ROH
- The principle of harmonising frameworks was welcomed and would ensure parity of treatment between providers, however as a general point, there was a concern that the Framework may constitute a 'blunt' instrument used to inform the initial segmentation that failed to take into account the direction of travel an organisation may be on.
- There might be limited scope for the Framework to reflect where organisations were starting from and to recognise the track record of the leadership team in addressing issues, with potential for additional monitoring or interventions posing a distraction just to comply with the additional requirements.
- There was a risk that as the Quality of Care theme is largely informed by the organisation's CQC ratings this may create a difficulty in moving with agility between segments given that CQC ratings are changed so infrequently
- Some indicators will be developed in line with the requirements of the Carter Review – these are however still under development. The use of the Weighted Activity Unit as a Framework metric within the Finance & use of resources theme is a concern, given that this is understood to be based on reference costs, which are known to be generally flawed

- The scoring ranges within the distance from the control total indicator are too tight, with, in the case of the ROH, as little as £15k difference in performance defining whether our organisation is classified as a top performing Trust (Category 1) to a one triggering concern (Category 4).
- The strategic change theme is the least developed of the themes and suggested indicators that would sit within this category might include: reported progress against the delivery of trusts strategic plans; progress with the delivery of the STP in which the trust sits; and progress with the delivery against the Vanguard quality indicators
- Given that there are indications that the Well Led Framework is likely to be redefined as a result of the introduction of the Single Oversight Framework, early notification of a change to the current deadline of May 2017 for completion of this assessment would be welcomed
- If any one or the five themes triggers concern, then this will trigger an overall consideration of the level of support needed to the organisation
- Trusts in special measures will automatically be placed into Segment 4 (Critical Issues)
- When an organisation is offered support, monitoring will be in place to determine how this support is used and a more directive approach will be taken if the support does not assist the trust
- A trust with a 'Requires Improvement' CQC rating would not automatically be placed into Segments 3 or 4, but could not be placed in Segment 1 (No Concerns)
- A 'bell curve' approach will not be applied during the segmentation exercise – trusts will be segmented on their own merits

8.0 NEXT STEPS

8.1 The consultation on the Single Oversight Framework formally closed on 4 August, however into mid-August additional engagement events were being hosted by NHSI to take further soundings from provider organisations who wished to provide a view.

8.2 A launch in early Autumn 2016 of the Single Oversight Framework had been proposed by NHSI. Notification of the exact details is awaited.

Simon Grainger-Lloyd
Associate Director of Governance & Company Secretary

1 September 2016

Appendix 2

Wellington House
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E: nhsi.enquiries@nhs.net
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Jo Chambers
Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham
B31 2AP

27 July 2016

Dear Jo

Operational plans 2016/17

Thank you for submitting your final operational plan for 2016/17. I am writing to acknowledge receipt of your plan and to highlight the next steps.

'*Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21',* set out our expectations for delivering high quality, sustainable services for the patients and communities that we serve. I would like to take this opportunity to recognise the significant work that has gone into delivering a clear plan for 2016/17 during a challenging period for the NHS.

It is critical that each trust meets the commitments in its annual plan to deliver safe, high quality services and the agreed access standards for patients within the resources available. This will mean maintaining an effective balance between demand and capacity and continuing to develop the workforce needed for local services.

The planning guidance also set out the steps to help local organisations deliver a sustainable, transformed health service and meet the three gaps identified in the *Five Year Forward View*: health and wellbeing; care and quality; funding and efficiency. This highlights the importance of your strategic work to help create a sustainable organisation as part of a strong local health care system with agreed Sustainability and Transformation Plans.

To this end, NHS Improvement will continue to work with trusts to review progress against your plans and to support you in the delivery of the required standards in line with our new oversight model.

Next Steps

As part of the assurance of your plan, NHS Improvement has identified the need for further oversight relating to:

- Delivery of the Trust's CIP plans to support delivery of the Trust's control total.
- The Trust's use of agency staffing and compliance with its agency cap.
- Delivery of the Trust's 52 week wait recovery plan.

We note too that the Trust's financial performance at month 3 is behind by £1.1m, partly driven by the need to close theatres w/c 6 June. We will, therefore, need to work closely with the Trust to assess whether the Trust's in-year recovery plan is deliverable.

NHS Improvement will undertake on-going monitoring, support and escalation as necessary against the specific areas identified in this letter and the key domains and indicators outlined in the NHS Improvement oversight model.

In addition, we would request that Trusts publish their finalised plan summaries on their websites by 26 August 2016 and advise their NHSI regional relationship manager when this has been completed.

We will continue to work with you to ensure you are able to access the necessary development support to strengthen the Trust's capability and capacity for delivery. Our central commitment to delivering a strong provider landscape can only be achieved through your success. We will ensure that wherever possible we support you to deliver your ambitions. In return, our expectation is a simple one - that the commitments you make through this planning round and through locally agreed contracts are delivered in full.

If you wish to discuss the above or any related issues further, please contact Rebecca Farmer on 020 3747 0617 (rebecca.farmer3@nhs.net).

Yours sincerely

Frances Shattock
Regional Director
NHS Improvement

cc. Paul Athey, Director of Finance

Appendix 3

31 August 2016

Ms Jo Chambers
Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust
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Dear Jo

Q1 2016/17 monitoring of NHS foundation trusts

Our analysis of your Q1 submissions is now complete. Based on this work, the trust's current ratings are:

- Financial sustainability risk rating: 2
- Governance rating: Green

These ratings will be published on NHS Improvement's website in September.

NHS Improvement is the operational name for the organisation which brings together Monitor and the NHS Trust Development Authority. In this letter, "NHS Improvement" means Monitor exercising functions under chapter 3 of Part 3 of the Health and Social Care Act 2012 (licensing), unless otherwise indicated.

The trust has been allocated a financial sustainability risk rating of 2.

NHS Improvement uses the measures of financial robustness and efficiency underlying the financial sustainability risk rating as indicators to assess the level of financial risk at foundation trusts. A failure by a foundation trust to achieve a financial sustainability risk rating of 3 or above could indicate that the trust is providing health care services in breach of its licence.

NHS Improvement will continue to monitor and assess the trust's actions towards delivery of the 2016/17 plans. The trust's governance rating has been reflected as 'Green'. Should any other relevant circumstances arise, NHS Improvement will consider what, if any, further action may be appropriate.

A report on the aggregate performance of all NHS providers (Foundation and NHS trusts) from Q1 2016/17 is available on our website (in the Resources section), which I hope you will find of interest.

For your information, we have issued a press release setting out a summary of the report's key findings.

If you have any queries relating to the above, please contact me by telephone on 02037470617 or by email (rebecca.farmer3@nhs.net).

Yours sincerely

Gareth Wu
Regional Manager

cc: Dame Yve Buckland, Chair,
Mr Paul Athey, Finance Director

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (9/16) 003

TRUST BOARD

DOCUMENT TITLE:	**Nurse Staffing Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Operations, Nursing and Clinical Governance**
AUTHOR:	**Ms Anne Crompton, Deputy Director of Nursing and Clinical Governance**
DATE OF MEETING:	**7 September 2016**

EXECUTIVE SUMMARY:

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. This paper provides the Trust Management Committee with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for July 2016.

In addition a summary of the findings of the recently completed Shelford Safer Staffing Tool is provided.

REPORT RECOMMENDATION:

The Trust Board is asked to note:

- Fill rates across ward areas are greater than 90% with the exception of Health Care Support Workers on Ward 3 and Ward 11. Both wards are experiencing long term sickness which is being managed in line with Trust Policy. It is anticipated that the sickness rate will reduce over the next two months.
- CHPPD is the principle measure of nurse deployment recommended by NHSI. It should therefore be a key measure in future nurse establishment reviews.
- Good progress has been made in appointing to adult nurse and health care support worker vacancies with the last assessment centres resulting in 12 offers to adult nurses and 7 to Healthcare support workers
- Children's Nurse recruitment remains challenging with none of the six shortlisted candidates attending the last assessment centre. A further Children's Nurse assessment centre is planned for 9 September 2016.
- The Safer Nursing Care Tool (SNCT) was used across the Trust in late June/early July 2016. There is wide variation in the data recorded with some wards recording low acuity and others higher than expected acuity. For this reason the data presented must be treated with caution. The SNCT should be repeated in November 2016 with much greater attention paid to quality assuring data collection.
- Agency use has risen this month, driven by an increase in agency use in theatres.

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

ROHTB (9/16) 003

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy	X	Patient Experience	X
Clinical	X	Equality & Diversity		Workforce	X

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. The provision of a monthly Safe Staffing report supports compliance CQC regulation.

PREVIOUS CONSIDERATION:

The report will be circulated to all matrons, general managers and ward sisters. It is an agenda item on the monthly Ward managers meeting and was added to Divisional board Meetings from August 2016.

Report considered by the Trust Management Committee on 24 August 2016

ROHTB (9/16) 003

Nurse Staffing Report

REPORT TO TRUST BOARD: July 2016 data

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 continued commitment to providing open, honest and transparent nurse staffing information through the publication of this data both on the Trust and NHS Choices Websites. This report provides details of Care hours Per Patient Day (CHPPD) which has become the principle measure of nurse deployment in line with NHSI (2016) requirements.

The paper provides the Trust Board with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for July 2016 with additional information relating to vacancy and plans for recruitment to vacant posts.

In addition the paper provides a summary of the findings of the Safer Nursing care Tool undertaken in late June/ early July 2016.

2.0 Workforce Information: Trust Overview of Planned Versus Actual Nursing Hours

The overall nurse staffing fill rate for July 2016 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. The actual staffing levels for July 2016 were manually entered into the data collection spreadsheet by the nurse in charge of the shift and subsequently verified by the senior sister and matron. Planned staffing hours are based on funded establishment which provides a minimum ratio of 1 to 8 on day shifts for all adult in patient wards. The planned hours are adjusted each month to allow for the number of days in the month.

Table 1 below provides further detail regarding nurse staffing fill rates for June 2016. The Unify upload for July 2016 is provided in Appendix 1. In the absence of national guidance, ROH will RAG rates each ward against a locally agreed framework as follows: Green - where actual available hours are within 5% of planned; Amber - within 5 and 10% and Red where the difference is greater than 10.

Table 1: Detailed Ward Breakdown

	Day		Night	
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
1	91.9%	98.2%	97.8%	96.8%
2	100.5%	98.5%	100.0%	90.3%
3	92.0%	86.2%	104.8%	85.1%
12	95.4%	94.7%	100.0%	102.8%
11	100.0%	82.2%	97.8%	-
HDU	99.3%	100.0%	101.6%	-

- There has been little change in the fill rates on ward 3 with improvement in fill rates for Registered Nurses sustained into July 2016 although the fill rate for care workers on both and night shifts is low. The ward continues to manage a high level of sickness in this staff group with sickness/absence processes in place. It is anticipated that the sickness rate amongst this staff group will reduce over the next two months due to anticipated conclusion of sickness management processes.
- The fill rate for non-registered staff on day shifts in Ward 11 is also due to long term sickness and appropriate absence processes are being followed to enable resolution of this concern. The move to 3 RNs on nights has removed the need for night support workers in line with the revised Ward 11 nursing model

2.1 Care Hours per Patient Day (CHPPD)

Following the publication of the Carter Review (2016**)** NHS Improvement have issued new guidance which requires all Trusts to report Care Hours per Patient Day. From May 2016 CHPPD will become the principle measure of nursing and care support deployment. CHPPD provides a single consistent metric of nursing and healthcare support worker deployment on inpatient wards and units.

CHPPD is calculated by dividing the number of actual nursing (both registered and unregistered) hours by the number of patients on the ward at midnight. It therefore represents the number of nursing hours that are available to each patient. Care Hours per Patient Day (CHPPD) is a way of representing staffing data that puts the nursing hours in the context of the patient activity and has been chosen as a measure because it is an easy to understand figure.

CHPPD provides:

- A single figure that represents both staffing levels and patient requirements, unlike actual hours alone, and
- A method of comparisons between wards/units. As CHPPD has been divided by the number of patients, the value doesn't increase due to the size of the unit therefore allowing comparisons between different units of different sizes.
- It is not an acuity measurement tool.

During July 2016, CHPPD were calculated by ward as detailed in Table 2 below, with the totals in brackets representing May and June results.

WARD	Table 2: Care Hours Per Patient Day (CHPPD) JUNE 2016			
	Cumulative count over the month of patients at 23:59 each day	**Registered midwives/ nurses**	**Care Staff**	**Overall CHPPD**
1	414	3.8	2.5	6.3 (7.6) (7.1)
2	493	3.3	2.4	5.7 (7.3) (6.1)
3	446	3.9	2.6	6.6 (8.5) (6.2)
12	444	4.2	2.9	7.1 (9.0) (7.8)
11	154	16.2	2.0	18.2 (14.5) (10.4)
HDU	122	16.8	0.8	17.5 (23.7) (21.8)

Benchmarking data is not currently available but it can be seen that there is variation in the number of CHPPD recorded over the past three months. The increase across all areas seen in June 2016 is likely to have been a result of the theatre closure that took place during this month and therefore the data for June is not reflective of normal activity. The Carter review (February 2016) notes significant variation in CHPPD in the sample of 1000 wards used to gather the original data source with a range from 6.3 CHPPD to 16.8 CHPPD. On this basis ROH is at the lower end of the spectrum but Carter (2016) notes that we should be mindful of comparing different types of wards and departments and that CHPPD should be used against measures of harm and experience in order to establish ward baselines.

More work is therefore required to understand the optimum number of CHPPD required in a specialist orthopaedic hospital. CHPPD has already been included as a measure on the monthly Ward Healthcheck. CHPPD will be used as one of the measures in staffing establishment reviews and as the data matures it will be possible to compare wards of similar type and activity in order to enable greater understanding of the requirements of patients here at ROH.

2.2 Vacancy Information

Table 3 below shows the rebased ward budgets at Band 5 and 2 for each of the ward areas with the figures in brackets representing the budget before rebase. Note that for HDU the baseline includes Band 6.

Table 3 Band 5 WTE Vacancy (Based on Revised Figures from Matron. July 2016)

Ward/Department	Band 5 Funded Establishment (WTE)	Band 5 Vacancy (WTE)	Band 2 Funded Establishment (WTE)	Band 2 Vacancy (WTE)
OPD	4.43	2.0	8.48	1
POAC	5.6	1.6	3.15	Nil
Ward 1	13.57	1.0	10.32	Nil
Ward 2	13.80	2.0	9.05	Nil
Ward 3	14.16	1.0	7.65	Nil
Ward 12/10	18.61	2.2	13.91	3.0
Ward 11	15.96	2.0	1.8	1.2 (held)
HDU (Includes Band 6)	23.32	2.27	1.8	Nil
Totals	109.45	14.47	56.16	5.2

A number of key actions are in place to address recruitment at the Trust and are listed below:

- The Nursing Workforce group is now meeting regularly. The group is responsible for the development of targeted recruitment campaigns and the introduction of accurate vacancy monitoring across the Trust. Good progress has been made against the establishment of a Trust wide recruitment plan with OPD/POAC and ADCU joining the generic assessment centres and conforming to the recruitment calendar for HCAs. Further work will be undertaken with the theatre team over the next three months to ensure that good practice is shared and where possible Trust wide recruitment events are planned.
- The development of an accurate data set in terms of vacancy numbers remains challenging but a template has been developed that will be completed monthly by Ward sisters/ Charge Nurses to ensure accurate. The introduction of e-rostering will ensure that vacancy data is accurately captured.
- The Band 6 vacancy on Ward 2 has been appointed to.
- The Paediatric Matron has a planned start date of 18 November 2016.
- The assessment centres completed in July and August 2016 resulted in 12 offers of employment for Registered Nurses and 7 offers of employment to Health Care Assistants. All Health Care Assistants will commence in October 2016 in order to meet the requirements of the Care Certificate. However no Children's nurses attended the assessment centre despite six having been shortlisted.
- A further assessment centre for Children's nurses is planned for 9 September 2016
- A further recruitment campaign for both Registered Nurses and Health Care Assistants will take place in October 2016. This will maximise the opportunity to attract the student nurses due to graduate in January 2016 and ensure that the next stage of Health Care support worker recruitment takes place in line with planned care certificate programme dates

2.3 Acuity data

Table 4 below shows the recommended staffing levels based on the daily acuity tool by ward for July 2016. TMC are asked to note that the Paediatric Ward is not included in this table because the acuity tool used is not appropriate for children and therefore an alternative appropriate tool has been identified (PANDA). The Division 1 team have supported the use of the PANDA tool and costings have been agreed. The next step is to identify the IT requirements and agree timescale for implementation. An update will be provided in the next staffing paper.

Table 4: Staffing by Acuity by ward

Ward	Recommended WTE	Actual WTE	Budgeted WTE
1	32.22	29.01	**27.68**
2	30.62	27.03	**26.41**
3	37.84	27.85	**25.01**
12	31.98	38.09	**36.52**
HDU	23.28	23.78	**25.72**

It is of note that during July 2016, three of the five areas reported that their recommended establishment based on patient acuity was greater than the numbers of staff available on the wards (Wards 1, 2 and 3). This is because the level of patient acuity recorded on a daily basis was higher during July than in previous months.

There are a number of caveats to using this single data source to draw conclusions about safe staffing levels on in patient wards:

- The Safer Nursing Care Tool which forms the basis of the data collection was not intended to be used on a daily basis because it is recognised that patient acuity will vary over time
- The tool is not completed at the same time each day.
- Variation is normal and the Safer Nursing Care tool makes clear that this should be expected.

Nevertheless, whilst we continue to use this tool it is recommended that change in demand must be kept under review over the next three months. As we move towards the introduction of e-rostering in October 2016, we will also enable the use of a Safer Staffing tool connected to the software which will enable recording of staffing numbers against acuity in real time.

2.4 Safer Nursing Care Tool: Overview

The RCN (2014) suggests that to determine appropriate levels of staffing, best practice is to triangulate the results of different methodologies and to evaluate these regularly against patient outcome data. For this reason the Safer Nursing Care Tool (SNCT) was used across the Trust during the period 13 June 2016 to 8 July 2016 (20 days Monday to Friday). Its findings will be used to inform establishment review alongside the other methods in use in the Trust which are:

- Daily monitoring of activity and staffing numbers (a modified version of the SNCT)
- Professional Judgement
- Care Hours per Patient day (from April 2016)

The SNCT was originally developed in conjunction with the Association of UK University Hospitals (AUKUH) and has subsequently been reviewed and updated in 2013. The tool comprises 2 parts:

- An Acuity and Dependency Tool which has been developed to help acute NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tool sets out how to measure the acuity (how ill a patients is) and dependency (how dependent a patient is to have their normal needs met, such as moving, eating and drinking, going to the toilet) of patients in a ward, what rules to follow to ensure that data are captured accurately and how to use this information to calculate the optimal level of staff needed in a particular ward using nursing multipliers to ensure the delivery of safe patient care.
- Nurse Sensitive Indicators (NSIs) which have been identified as quality indicators of care with specific sensitivity to nursing intervention. They can be used alongside the information captured using the Acuity and Dependency Tool to develop evidence-based workforce plans to support existing services or the development of new services. The SNCT demonstrates how NSI outcome data can be used alongside acuity and dependency information

During these months daily assessments of patients are undertaken using the criteria definitions (revised and updated in 2013) and each patient is scored at one of five levels of care. Each level of care has an assigned multiplier which represents the number of nursing staff required to provide care to the patient over a 24 hour period according to their level of acuity or dependency as shown in Table 5 below:

Table 5: Multiplier Applied: (Patient Acuity)

Level	Level Descriptor	Multiplier
0	Normal patients who can be cared for on a general ward	1.01
1a	Acutely ill patients who can be cared for on a general ward	1.41
1b	Stable patients with an increased dependency on nurses	1.76
2	Patients in ward areas awaiting transfer to High Dependency care	2.01
3	Patients in ward areas awaiting transfer to Intensive Care	6.09

The scores for every patient are then added together to calculate the nursing establishment required to provide the required level of care to each patient and collectively, for the in-patient area concerned. Comparisons are drawn between this information and the Budgeted Establishment (BE) .The multipliers account for the nursing staff required to manage patient flow (i.e. (i.e. the number of admissions, discharges, transfers, escorts and deaths).

2.5 Findings by ward

Table 6 overleaf provides a summary of the findings of the first round of the SNCT tool at ROH.

Table 6:

June 2016	Budgeted Establishment (WTE)	SNCT assessment (WTE)	Difference (WTE)	Skill Mix	Average bed occupancy
Ward 1	**27.68**	**18.87**	**+ 8.81**	**65:35**	**74%**
Ward 2	**26.41**	**26.05**	**- 0.36**	**65:35**	**89%**
Ward 3	**25.01**	**35.03**	**-10.02**	**65:35**	**86%**
Ward 12	**36.52**	**38.54**	**- 2.2**	**65:35**	**79%**
Overall	**115.62**	**118.49**	**-3.77**	**65:35**	**N/A**
July 2016	**Authorised Funded Establishment (WTE)**	**SNCT assessment (WTE)**	**Difference (WTE)**	**Skill Mix**	**Average Bed Occupancy**
Ward 1	**27.68**	**19.38**	**+ 8.3**	**65:35**	**94%**
Ward 2	**26.41**	**25.26**	**+ 1.15**	**65:35**	**92%**
Ward 3	**25.01**	**42.02**	**-17.01**	**70:30**	**94%**
Ward 12	**36.52**	**40.62**	**- 4.1**	**65:35**	**90**
Overall	**115.62**	**127.28**	**11.66**	**65:35**	**N/A**

Table 7 below provides an overview of ward staffing at ROH using all the information available via the data collection tools currently in use for July 201

Table 7: Safe Staffing data

July 2016	Authorised Funded Establishment (WTE)	SNCT assessment (WTE)	Daily acuity assessment	CHPPD
Ward 1	**27.68**	**19.38**	32.22	6.3
Ward 2	**26.41**	**25.26**	30.62	5.7
Ward 3	**25.01**	**42.02**	37.84	6.6
Ward 12	**36.52**	**40.62**	31.98	7.1
Overall	**115.62**	**127.28**	**132.66**	**N/A**

The results tabulated above should be treated with caution for the following reasons:

- The results are split over a two month period and the tool used to analyse the findings is based on a calendar month, therefore it was not possible to use the 20 days consecutively.
- Data quality was poor with some wards not completing forms correctly. Dates were missing and in some cases acuity was not completed. For this reason the daily input sheets were used to supplement data collected through the SNCT tool. This means that there is no assurance that data collection took place at the same time each day which is a key requirement of SNCT.
- There was significant inter-observer variation with some wards recording almost little patient acuity above 0 and others recording very high levels of level 1a and 1b care. This is likely to be the consequence of poor quality assurance.
- There is wide variation between the daily collection tool and SNCT and on that basis no conclusion can be drawn.

Nevertheless, the results can be used to provide baseline for the next SNCT exercise which should take place in November 2016. By that time the Safe Care module of e-rostering will be in place and will enable more robust data collection.

2.6 Skill Mix

The minimum skill mix recommended by the RCN (2014) is a ratio of 65/35 registered nurses/clinical support workers. All in patient wards at ROH meet this requirement within a percentage point and the ratio on Ward 3 is 70:30 Registered Nurse:Health Care support worker. Under no circumstances should the skill mix reduce below the RCN recommended level.

2.7 Safe Staffing and Efficiency

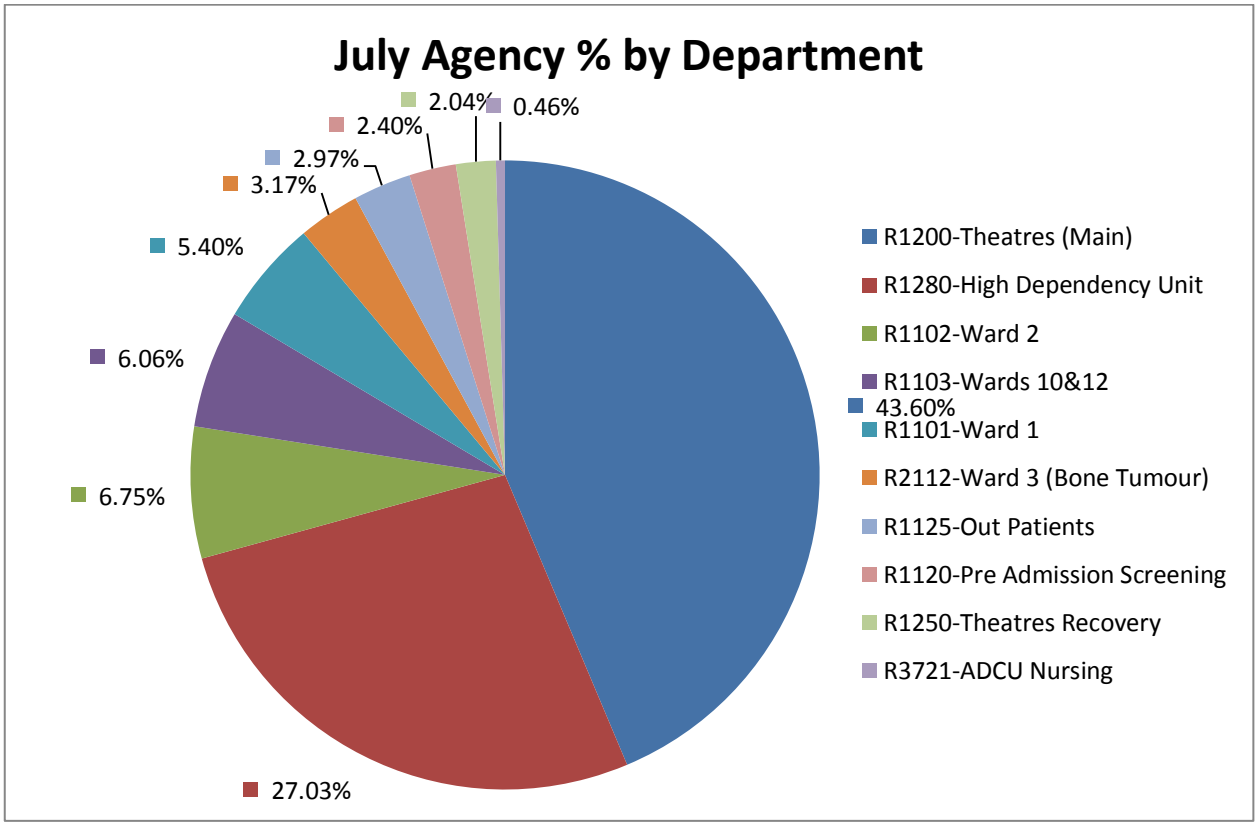
Caps on agency spend for Registered Nurses, mandated by NHS Improvement, have been in place at ROH since 1 October 2015. The ceiling for ROH has been set at 10% which is a reflection of the relatively high use of agency staff at the Trust. During June 2016 overall nurse agency use at ROH was 8.6% which is a significant decrease of 2.3%, however it should be noted that the Trust was closed to admissions for a 7 day period in early June 2016 and it is likely that this accounts for the reduction in agency use seen. Table 8 shows total nurse agency use across the Trust since June 2015.

Table 8: Registered Agency use as a % of total cost (Whole Trust)

June 15	July 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	April 16	May 16	June 16	Jul 16
11.8%	11.6%	12.3%	15.3%	20.9%	13.5%	15.9%	13.7%	14.2%	10.7%	11.2%	10.9%	8.6%	12.4%

Table 9 presents agency use by area as a total of agency spends across the Trust.

Table 9: Agency use (as a percentage of total spend)



The use of agency staff in theatre is the primary cause of the increase in agency spend across the trust. Agency use in theatre has returned to its normal level of 43%. The significant reduction in agency use in theatre seen in June 2016 was a direct result of the theatre closure which took place in this month. The high use in HDU continues to be driven by the requirement to staff all shifts with paediatric nurses and by the vacancy factor in HDU.

The SLA with Birmingham Children's Hospital to enable use of their staff bank became operational in August 2016 and will provide access to additional children's nurses at lower cost than agency use.

None of the in- patient ward areas have agency use of greater than 10%.

3.0 Progress against E–Rostering at ROH

- The commencement date for the roll out has been confirmed as 5th October 2016
- A system administrator will commence in post in September 2016
- Ward 3 and Ward 11/HDU will be the first wards involved in roll out with the others coming on board on a weekly basis from end October 2016
- The Project team and Project Board are established

4.0 Incident Reporting and Levels of Harm

In addition to the Safer Nurse Staffing tool being used and interpreted, clinical areas are encouraged to report all Safe Staffing incidents. In July 2016, a total of 8 staffing incidents were reported. This compares to a total of 4 reported in June, 7 reported in May and 6 reported in April 2016.

Of the 8 incidents reported 2 were graded as 'low harm' with the remaining 6 staffing incidents graded as 'no harm'. Table 7 details the incident categories recorded; whilst Table 8 provides detail of incidents by area

Table 10 Incident Categories

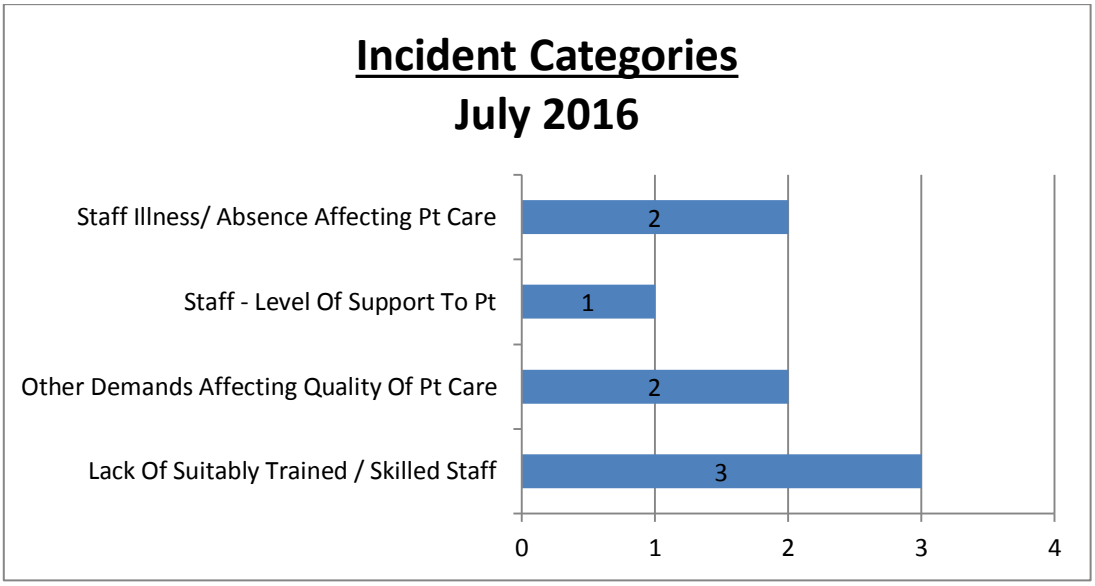
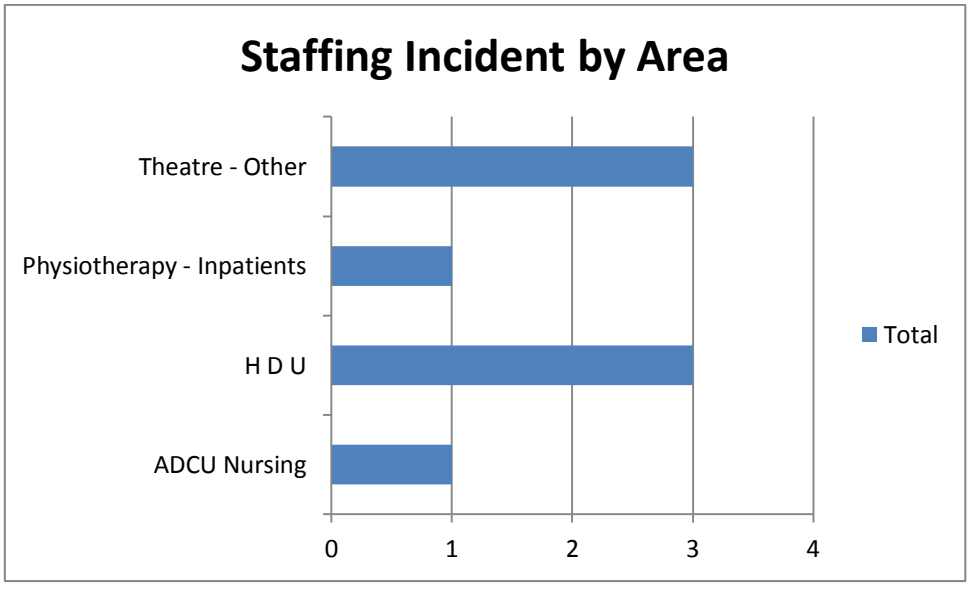


Table 11: Incidents by area/ward:



4.1 Red Flag Shifts June 2016

One of the 8 reported incidents, none met the criteria for NICE Red Flag. Details of all reported staffing incidents can be found at Appendix 2.

5.0 Conclusion and Recommendations.

The Trust Board is asked to note:

- Fill rates across ward areas are greater than 90% with the exception of Health Care Support Workers on Ward 3 and Ward 11. Both wards are experiencing long term sickness which is being managed in line with Trust Policy. It is anticipated that the sickness rate will reduce over the next two months.
- CHPPD is the principle measure of nurse deployment recommended by NHSI. It should therefore be a key measure in future nurse establishment reviews.
- Good progress has been made in appointing to adult nurse and health care support worker vacancies with the last assessment centres resulting in 12 offers to adult nurses and 7 to Healthcare support workers
- Children's Nurse recruitment remains challenging with none of the six shortlisted candidates attending the last assessment centre. A further Children's Nurse Assessment centre is planned for 9th September 2016.
- The Safer Nursing Care tool was used across the Trust in late June/ early July 2016. There is wide variation in the data recorded with some wards recording low acuity and others higher than expected acuity. For this reason the data presented must be treated with caution. The SNCT should be repeated in November 2016 with much greater attention paid to Quality assuring data collection.
- Agency use has risen this month, driven by an increase in agency use in theatres.

Appendix 1: UNIFY upload July 2016

Only complete sites your organisation is accountable for					Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
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 (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
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 - RRJ0	Ward 1	110 - TRAUMA & ORTHOPAEDICS		1548	1422	1250	1228	1023	1001	341	330	91.9%	98.2%	97.8%	96.8%	634	3.8	2.5	6.3
RRJ05	ROYAL ORTHOPAEDIC HOSPITAL - RRJ0	Ward 2	110 - TRAUMA & ORTHOPAEDICS		1473.5	1481.5	944.5	930.5	682	682	682	616	100.5%	98.5%	100.0%	90.3%	654	3.3	2.4	5.7
RRJ05	ROYAL ORTHOPAEDIC HOSPITAL - RRJ0	Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1785	1642.5	1162.5	1002.5	620	650	620	527.5	92.0%	86.2%	104.8%	85.1%	582	3.9	2.6	6.6
RRJ05	ROYAL ORTHOPAEDIC HOSPITAL - RRJ0	Ward 10 & 12	110 - TRAUMA & ORTHOPAEDICS		1929.5	1841.5	1391.4	1318	1254	1254	792	814	95.4%	94.7%	100.0%	102.8%	736	4.2	2.9	7.1
RRJ05	ROYAL ORTHOPAEDIC HOSPITAL - RRJ0	Ward 11	110 - TRAUMA & ORTHOPAEDICS		1073	1072.5	315	259	1023	1001	0	0	100.0%	82.2%	97.8%	-	128	16.2	2.0	18.2
RRJ05	ROYAL ORTHOPAEDIC HOSPITAL - RRJ0	HDU	110 - TRAUMA & ORTHOPAEDICS		1704.5	1693	140.5	140.5	1408	1430	0	0	99.3%	100.0%	101.6%	-	186	16.8	0.8	17.5

Appendix 2: Incident Details May 2016

Level of Harm	Cause 1	Details Of Incident	Outcome	Department
18161 Low Harm	Staff Illness/ Absence Affecting Patient Care	I have requested that a patient is mobilised by physio due to a pressure sore starting to develop and consultant is requesting that the patient is mobilised both on the 02/07/16 and 03/07/16 and both times the physiotherapy staff have declined to mobilise patient.	The patient in question has a high BMI. When she was stood out of bed it required 4 qualified Physio's to safely transfer her. On the Friday before the incident the patient twice refused to mobilise despite being told she would not be appropriate to be mobilised at the W/E so she would be in bed until Monday. On this Saturday the Physio was asked to mobilise the patient and he communicated to the Nurse that if he had time after treating the "First-ups" and "Discharges" he would return. However due to the reduced staffing on a Saturday they did not have time. Other "progressions" on the Wards were also not treated due to lack of time. On Sunday the criteria is "First-ups" and "discharges" only and as there were only 2 Physios at work and 1 of them pregnant they told the Nurse that it was not safe to attempt mobilisation. Reduced Staffing at W/E's makes it impossible to treat all patients. Patients that prove difficult to mobilise should be discussed with the Nursing Staff and other methods of pressure relief encouraged.	Physiotherapy - Inpatients

18205 No Harm	Other Demands Affecting Quality Of Patient Care	During the Bleep handover to HDU, ward 3 called and spoken to Sister and said that they needed a hand to look after a patient who was very agitated and was trying to pull his skin flap. According to the staffing level with other wards, only ADCU have an HCA that will be able to help temporarily since ADCU have only 4 patients and 2 staff nurse. ADCU contacted and spoken to HCA Molly. I asked her how many patients in the ward and also checked her if she was busy. She told me that there are only 4 patients in ADCU and she's going to make tea & toast for them at present. I then asked her if she can go to ward 3 temporarily when she's done with the tea but Sr. told her that she can't go to other ward because she's booked in ADCU for the night.	ADCU was supposed to have two patients overnight and ended up with four. ADCU is staffed until 7pm. Goodwill of ADCU staff stayed behind to assist with patients arriving back from theatre at 18.45 and 20.00hrs. This was due to waiting for a ROH bank staff to be changed over from an outside agency staff. When bank staff arrived, handover still needed to be done. With this in mind, when the call was taken to ask for HCA to be moved to ward three. No temporary measures were handed over and at that time HCA was needed on ADCU to help to settle the patients and to ensure the unit were safe before day staff left. HCA was moved to WARD three later on that evening. Due to HCA being utilised elsewhere, this left ADCU short in the morning.	ADCU Nursing
18168 Low Harm	Lack Of Suitably Trained / Skilled Staff	Staffing for ward 1 should be 3 RNs and 1 HCA twilight HCA on a weekend. Agency nurse did not arrive for ward 2 and therefore the bleep holder moved 1 agency nurse to ward 2 leaving ward 1 understaffed after 1am. During the night a patient fell which could be linked to reduced staffing numbers. The bleep holder covered some breaks but not all and she requested an HCA to assist from ward 12 but this was refused as they stated they were too busy. The bleep holder came to help with breakfasts but had to leave half way through due to needing to return to HDU. This meant that an HCA who arrived for the E shift had to assist with the breakfasts and missed half of the handover from the night staff.	This was immediately reported to Sister Turton on the morning of the 2nd July and escalated to Matron Okane on 4/7/16. JT 4/7/16	H D U

18192 No Harm	Staff - Level Of Support To Pt	No supernumerary coordinator on HDU on the late shift. Myself and my colleague unable to take dinner break due to patient dependency skill mix and admissions	Staff unable to take dinner break due to patient dependency skill mix and admissions. No delay to patient care	H D U
18376 No Harm	Other Demands Affecting Quality Of Pt Care	Six staff on the night shift in HDU only 2 substantive members of staff and four agency staff the one member of substantive staff is also the clinical site coordinator	No outcome in incident form	H D U
18281 No Harm	Staff Illness/ Absence Affecting Pt Care	6 staff absent for shift 18.7.16. 5 sick and 1 emergency annual leave: 5 staff on morning shift 1 staff member on a late shift	Bank office asked to find staff. Staff moved for designated areas to facilitate the theatres all working.	Theatre - Other
18293 No Harm	Lack Of Suitably Trained / Skilled Staff	At morning huddle, it was indicated that theatres were short of two first assistants for cases in theatres 1 and 9 for am and pm sessions. This was escalated to the DOM and Matron of Theatres, cover was sought via usage of the first assistants appointed to the trust, which proved unsuccessful. Two first assistants were identified by utilising the band 7 Senior of the Day, and the newly posted band 7 for a third first assistant gap that was only identified at lunch time via the Surgeons notifying us of the requirement. This caused a potential to harm the patients pathway as there was a likelihood of cancellation should first assistants not be made available	DOM and Matron notified of the shortfall, as too late to seek first assistant cover Cover for first assistant was sought via use of the Senior of the day Cover for the second first assistant for the pm list was sought via the use of the newly appointed band 7 (in training) The third pm case was delayed due to an over run in another theatre which meant that there was a gap which allowed movement of more staff to accommodate the first assisting role	Theatre - Other

18295 No Harm	Lack Of Suitably Trained / Skilled Staff	Identified by the Senior of the day , and escalated to the DOM, Matron and the huddle that a theatre had two scrub staff from an agency who identified themselves as unable to undertake either knee or hip arthroplasty surgical interventions. This helped to impede the search for first assistant cover when required in the department, as they were unable to provide the skills required to swap staff around to allow swift and timely cover for first assistant needs for morning and afternoon sessions. These scrub staff were utilised at cost , to do the theatre list that required the most minimal procedures within the orthopaedic remit, which is an under sight of agency supplying staff that are not fit for purpose	Senior of the day discussed with the agency staff, their potential to scrub for various cases to get information on suitability to move them appropriately to release trained staff to undertake first assisting roles in other theatres. The agency staff relayed that they were unable to undertake orthopaedic surgical interventions other that simple hand surgery, therefore there was no alternative but to utilise them in that theatre for the remainder of the day to promote patient safety and avert a staff shortage to the rest of the theatre complex	Theatre - Other

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (9/16) 004

TRUST BOARD

DOCUMENT TITLE:	**CQC Action Plan Update Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Operations, Nursing and Clinical Governance**
AUTHOR:	**Ms Anne Crompton, Deputy Director of Nursing and Clinical Governance**
DATE OF MEETING:	**7 September 2016**

EXECUTIVE SUMMARY:

The attached report presents a detailed summary of achievement against all of the milestones and actions identified in the CQC action plan developed following receipt of the CQC report in December 2015.

Trust Board has previously considered action plan updates in summary form and is therefore sighted on the risks and off- track issues identified within the detailed report. The version attached has been amended as follows:

- The RAG rating has been amended to reflect that used in other key documents used within the Trust.
- Each of the milestones has been RAG rated as in previous versions, and in this version the expected outcome and KPIs have also been RAG rated in order to provide an easily accessible overview of progress.
- The action plan has been separated into the two key areas that were the subject of the CQC inspection in July 2015, OPD and HDU, for ease of reference.
- Executive leads have been updated as required

REPORT RECOMMENDATION:

Trust Board is asked to note the progress that has been made against delivery of the CQC action plan and to note that where actions are off track a plan is in place to ensure delivery within a revised timescale.

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	X	Patient Experience	X
Clinical	X	Equality & Diversity		Workforce	X

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

The report has direct alignment to all the Trust's objectives

PREVIOUS CONSIDERATION:

Report considered by the Trust Management Committee on 24 August 2016

CQC ACTION PLAN UPDATE REPORT: OPD

1.0 Introduction

Following publication of the Care Quality Commission Report in December 2015, a detailed Action Plan was developed to respond to the recommendations made. This report provides an update on progress against all the actions detailed within that action plan including those not yet due and seeks to provide assurance that the monitoring process in use is both robust and thorough. A repository of evidence supporting compliance with the actions required is held by the governance team @ P:\governance\0. LIVE WORKING DOCUMENTS\CQC Action Plan.

The report is divided into sections in line with the recommendations made within the CQC action plan for ease of reference. Each of the recommendations has milestones and the report provides progress against each of those milestones. An update is provided for each of the Requirement notices, Must Do and Should do recommendations made by the CQC in December 2015 against the timescales originally outlined for delivery.

The version presented in this report has a number of key changes since the original action plan was developed. The changes have been made following feedback from colleagues at ROH and from the CQC. In summary these are:

1. The RAG rating has been amended to reflect that used in other key documents used within the Trust.
2. Each of the milestones has been RAG rated as in previous versions, and in this version the expected outcome and KPIs have also been RAG rated in order to provide an overview of progress.
3. The action plan has been separated into the two key areas that were the subject of the CQC inspection in July 2015, OPD and HDU, for ease of reference
4. Executive leads have been updated as required

1.0 RAG Key

Colour	Meaning
	Unsatisfactory progress
	Slow progress
	Satisfactory progress
	Completed

Quality Improvement Overview Plan

2.0 Updated Action Plan OUT- PATIENTS DEPARTMENT

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
REQUIREMENT NOTICES											
1	Improvement in waiting times in OPD. Improvement in access to imaging services for patien**ts Improved Patient Experience**	Improved access and flow to OPD Improved access to diagnostic tests Implementation of single clinic template.	Waiting times for clinic less than 60 minutes by ~~April 2016~~ August 2016 Waiting times for clinic less than 30 minutes by ~~October 2016~~ November 2016 Block booking of clinics to stop in line with timescale below: End ~~March 2016~~ July 2016: no more than 40% of clinics using block booking	**Garry Marsh**	Janet Davies	New reports developed to track bookings, cancellations and waiting times.	New report has been developed to track waiting times. Bookings, DNA's and cancellation data available from PAS.	Implementation of "In touch" system in OPD by April 2016. Monthly reports on clinic bookings, waiting time, DNA's and cancellations to Divisional Governance Board by end April 2016	The In touch system is operational. Delays occurred in implementation in radiology due to technical difficulties but the system became live in this area on 13th June 2016. The first report set to go to Division 1 Board in July 2016 (June data).	No further action required.	Reports are regularly presented at Divisional Governance boards
				Garry Marsh	Janet Davies	Roll out of training programme for all staff in use of IN TOUCH system.	Training was completed in line with this timescale	No further action required		No further action required	
				Garry Marsh	Janet Davies	Development of a waiting time SOP.	A waiting times SOP has been developed and is in place across all PODS.	Audit of compliance with waiting time SOP to be reported to Divisional Clinical Governance Board by end April 2016.	The report to June Divisional Board does not identify compliance with SOP and therefore cannot evidence assurance. Audit of compliance will be presented to Divisional Board In August 2016.	A report will be presented to Divisional Board By ~~July 2016~~ August 2016	A report was presented to Divisional Board On August 2016. However the action remains outstanding because the recommendations from that audit have not yet been implemented and re-audited

Quality Improvement Overview Plan

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
			End ~~June 2016~~ September 2016 : No more than 20% of clinics using block booking End ~~August 2016~~ November 2016:–no clinics will use block booking as a clinic template. All staff trained in use of' In Touch' software system by end March 2016.								
				Garry Marsh	Jo Phillips	Development of a SOP for booking diagnostic tests prior to OPD appointment	A SOP for booking diagnostic tests has been developed (completed March 2016)	Implementation of SOP for booking diagnostic tests prior to clinic appointment Develop roll out plan for implementation of revised clinic template	The SOP for booking diagnostic tests is in place but there has been no audit of compliance completed. Therefore cannot assure that this has been embedded. Audit of compliance will be reported to Division 1 Board in August 2016.	Regular reports of compliance presented to Divisional Board from September 2016 onwards	This action is not yet due
				Garry Marsh	Janet Davies	Commence Review of all consultant clinic templates in order to develop a standardised clinic template for use across all services	The review of consultant clinics commenced as planned with large Joints as the first service area to be reviewed.	Continue the review of all consultant clinics in order to develop a standardised clinic template for use across all services	There is a need to completely revise the timescales for this action. Due to the complexity, number of clinics and the need to tie this action in with job planning there will be a delay in the delivery. Job planning will be completed end June 2016 and without including this into the delivery would risk the loss in activity / capacity. In addition End July 2016: no more than 40% of clinics using block booking End Sept 2016 No more than 20% of clinics using block booking End November 2016: no clinics will use block booking	Complete review of all consultant templates by end ~~August 2016~~ September 2016 Implement changes to clinic templates by end ~~October 2016~~ November 2016 Half yearly report on waiting times, adherence to SOPs and patient experience to Divisional Governance Board by end ~~October 2016.~~November 2016	A comprehensive review of clinic templates by sub-specialty and individual clinician basis is underway with work started within Large Joints and Oncology. Issue with 'block booking' further understood and is in part related to the way the PAS system presents a clinic with more one clinician seeing patients at the same time. In addition to this further work is being undertaken to suitably reduce the size of clinics whenever a staff member is on leave and that agreed booking rules are followed whenever overbooked clinics are required (i.e. due to clinical need and agreed with the consultant. A comprehensive project plan has been developed by the Clinical Service Manager which

Quality Improvement Overview Plan

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
											is overseen by the Divisional Board. No risks to delivery of the November timescale have been identified
				Garry Marsh	Jo Phillips	Develop a local SOP to be followed in the event of a planned clinic cancellation	Local SOPs are in place	Evidence that Local SOPs are effective presented to Divisional Board	There is no evidence that an audit of practice has taken place and one is planned for August 2016	SOPs reviewed in line with agreed timescale ~~(end July 2016)~~ end August 2016	An audit of compliance was completed in July 2016 with submission of findings to Divisional Governance Board in August 2016

Quality Improvement Overview Plan

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
2	Staff access to appropriate level of Safeguarding Training	All staff will have received the appropriate level of safeguarding training.	100 % of nursing staff will have achieved: Level 2 Children's Safeguarding Training Level 1 Adult Safeguarding Training. 100% of A&C staff will have achieved:	**Garry Marsh**	Rebecca Hemming (Sister OPD)	Level 2 Children Safeguarding: 9/12: staff to have completed Level 2 Adult Safeguarding 12/12 staff to have completed	This action is on target All Staff have completed Level 2 Adult safeguarding training	Level 2 Children Safeguarding: 12/12 staff to have completed by end March 2016	All staff have completed Level 2 Training as planned	Evidence of monitoring of mandatory requirement that all staff are compliant with KPI to be reported monthly to Divisional Governance Board.	This action is completed. Compliance with mandatory training is reviewed at all Division 1 Board Meetings. A trajectory to ensure ongoing compliance has been developed.
MUST DO											
10	Compliance with Regulation 20- Statutory Duty of Candour	100% of all staff will comply with Duty of Candour	100% of staff will comply with CQC DoC Regulation 20	**Garry Marsh**	Anne Crompton	Relaunch of policy and process within the Trust by end January 2016 Review of mandatory training by end February 2016	DoC policy approved on 1st April 2016.	Implement revised mandatory training programme by end March 2016 Audit of compliance with DoC presented to QSC by end ~~April 2016:~~ May 2016	The mandatory training programme has been revised to include the revised DoC process	Bi –annual audit of compliance with DoC added to QSC work plan	An audit of compliance was completed By CCG in April 2016. Internal audit will complete audit of DoC in Q3 2016/17 with upward reporting to QSC Internal audit of awareness amongst staff was completed in July 2016.
11	Improved staff attendance	All staff will be managed in line with Trust sickness/ absence policy.	100% of all staff sickness will be managed in line with Trust Sickness/ absence Policy	**Garry Marsh**	Janet Davies	Provide evidence that Trust sickness management policy being fully adhered to within the Department to the Divisional Governance Board by end January 2016	The Divisional Board regular review sickness / absence as part of their monitoring of performance.	Monthly monitoring of sickness rates at Divisional Governance Board	Minutes of Divisional Board meetings confirm that sickness/ absence is regularly reviewed. Latest sickness absence position is 2.6%	Monthly monitoring of sickness rates at Divisional Governance Board	The review of all sickness/ absence and compliance with policy will form part of Divisional Board agenda. An audit of compliance with the Management of Sickness / Absence Policy has been completed by the manager for

Quality Improvement Overview Plan

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											OPD
12	Training and Development of staff	All staff will be up to date with mandatory training	95% of staff In OPD will be up to date with Mandatory Training	**Garry Marsh**	Janet Davies	Ensure schedule of training to ensure staff are meeting mandatory training. 4 staff January 2016 4 Staff February 2016	Review of mandatory training compliance is a regular agenda item at Divisional Board with reports presenting evidence of compliance	A detailed plan to ensure that all staff are up to date with mandatory training presented to Divisional Governance Board Implementation of monitoring programme for all mandatory training at Divisional Governance Board	Review of mandatory training compliance is a regular agenda item at Divisional Board with reports presenting evidence of compliance	Implementation of monitoring programme for all mandatory training at Divisional Governance Board	The review of all mandatory training and compliance with policy will form part of Divisional Board agenda and evidence that actions identified have been followed up will be added to the agenda in September 2016
13	Sharing learning and implementing actions from SIs	All staff will be aware of the process by which learning from incidents is disseminated and implemented	95% of all staff will be able to describe how learning from incidents and implementation of actions is shared across the Trust	**Garry Marsh**	Anne Crompton	Relaunch of SI policy and process within the Trust . Introduction to revised policy included as part of mandatory training programme	This action was not completed by end Feb due to need to ensure that feedback received from a range of stakeholders. However a revised policy and process was agreed in April and June 2016 respectively.	Audit of staff within OPD against principles outlined in SI Policy. Publication of audit findings and evidence of discussion at Divisional Governance Board	This action is delayed due to later ratification of policy and process. However an audit is planned by the Head of Governance for July 2016	Bi–annual audit against principles of SI policy. Publication of audit findings and evidence of discussion at Divisional Governance Board	An audit of compliance with SI policy was undertaken in July 2016. The findings demonstrate that awareness and understanding of the process amongst staff remains inconsistent. The following actions have been taken: • Additional training sessions for all OPD staff to raise awareness of SI and DoC policies and improve understanding of process • Updates on incidents and outcomes is to be added to OPD team meetings as a regular agenda item Bi-annual audit has been added to CQG work plan with next

Quality Improvement Overview Plan

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											audit due Dec 2016
SHOULD DO											
17	All Patients will a Learning disability will have full access to Trust services	All Patients with a learning disability will be supported to have full access to Trust Services	100% of patients with a Learning Disability will be supported to have full access to all Trust Services.	**Garry Marsh**	Evelyn O'Kane	Relaunch of Learning Disability services available to our patients 1 February 2016	The LD passport is in use	Develop and launch a LD strategy	A new Strategy is not yet in place. However action has been taken to move this forward including: Identification of the existing process and gap analysis completed. The Trust has a Nurse Lead for LD and she will be engaged in delivering next steps. The DNG has met with the local CCG Chief Nurse and requested support and advice on the development of a strategy that corresponds to local Health drivers and reflects best practice and delivery. In addition a shared learning event took place with RNOH on 09.06.2016 in which the care of patients with LD was discussed and reviewed. A detailed action plan responding to the reccommendations of the CIPOLD report is in place Timescales have been revised to enable delivery of a strategy by end Q2 2016/17	Undertake audit of compliance with principles of strategy and present to Safeguarding Committee	This action will be delayed due to delay of LD strategy

Quality Improvement Overview Plan

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
18	Improved Patient Experience	Improved access and flow to OPD Improved access to diagnostic tests Implementation of single clinic template.	No clinics will be block booked Block booking of clinics to stop in line with timescale below: End ~~March 2016:~~ July 2016 no more than 40% of clinics using block booking End ~~June 2016~~ September 2016: No more than 20% of clinics using block booking End ~~August 2016:~~ November 2016 no clinics will use block booking as a clinic template.	**Garry Marsh**	Janet Davies	Commence review of all consultant clinic templates in order to develop a standardised clinic template for use across all services. Development of a SOP for booking diagnostic tests prior to OPD appointment	The review of consultant clinics commenced as planned with large Joints as the first service area to be reviewed.	Continue the review of all consultant clinics in order to develop a standardised clinic template for use across all services	There is a need to completely revise the timescales for this action. Due to the complexity, number of clinics and the need to tie this action in with job planning there will be a delay in the delivery. Job planning will be completed end June 2016 and without including this into the delivery would risk the loss in activity / capacity. In addition End July 2016: no more than 40% of clinics using block booking End Sept 2016 No more than 20% of clinics using block booking End November 2016: no clinics will use block *booking*	Complete review of all consultant templates by end August 2016 Implement changes to clinic templates by end October 2016	A comprehensive review of clinic templates by sub-specialty and individual clinician basis is underway with work started within Large Joints and Oncology. Issue with 'block booking' further understood and is in part related to the way the PAS system presents a clinic with more one clinician seeing patients at the same time. In addition to this further work is being undertaken to suitably reduce the size of clinics whenever a staff member is on leave and that agreed booking rules are followed whenever overbooked clinics are required (i.e. due to clinical need and agreed with the consultant. A comprehensive project plan has been developed by the Clinical Service Manager which is overseen by the Divisional Board. No risks to delivery of the November timescale have been identified
19	Improved Patient experience		Evidence that improved management practice has been applied to all clinics held in OPD by end October 2016 by compliance with the	**Garry Marsh**	Jo Phillips	Implement SOP for clinic waits across all PODS and services within OPD. Develop roll out plan for implementation of revised clinic template	A SOP for booking diagnostic tests has been developed (completed March 2016	Audit of compliance with waiting time SOP to be reported to Divisional Clinical Governance Board by end April 2016.	The SOP for booking diagnostic tests is in place but there has been no audit of compliance completed. Therefore cannot assure that this has been embedded. Audit of compliance will be reported to Division 3 Board in August 2016.	Half yearly report on waiting times, adherence to SOPs and patient experience to Divisional Governance Board by end ~~October 2016.~~ November 2016	Delays in provision of evidence limit compalnce with this milestone.

Quality Improvement Overview Plan

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
			following metrics: Waiting times for clinic less than 60 minutes by ~~April 2016~~ August 2016 Waiting times for clinic less than 30 minutes by ~~October 2016~~ November 2016								

CQC ACTION PLAN UPDATE REPORT: HDU

Introduction

Following publication of the Care Quality Commission Report in December 2015, a detailed Action Plan was developed to respond to the recommendations detailed within. This report provides an update on progress against all the actions detailed within that action plan including those not yet due and seeks to provide assurance that the monitoring process in use is both robust and thorough. A repository of evidence supporting compliance with the actions required is held by the governance team @ P:\governance\0. LIVE WORKING DOCUMENTS\CQC Action Plan.

The report is divided into sections in line with the recommendations made within the CQC action plan for ease of reference. An update is provided for each of the Requirement notices, Must Do and Should do recommendations made by the CQC in December 2015 against the timescales originally outlined for delivery.

The report is divided into sections in line with the recommendations made within the CQC action plan for ease of reference. Each of the recommendations has milestones and the report provides progress against each of those milestones. An update is provided for each of the Requirement notices, Must Do and Should do recommendations made by the CQC in December 2015 against the timescales originally outlined for delivery.

The version presented in this report has a number of key changes since the original action plan was developed. The changes have been made following feedback from colleagues at ROH and from the CQC. In summary these are:

1. The RAG rating has been amended to reflect that used in other key documents used within the Trust.
2. Each of the milestones has been RAG rated as in previous versions, and in this version the expected outcome and KPIs have also been RAG rated in order to provide an overview of progress.
3. The action plan has been separated into the two key areas that were the subject of the CQC inspection in July 2015, OPD and HDU, for ease of reference
4. Executive leads have been updated as required

1.0 RAG Key

Colour	Meaning
	Unsatisfactory progress
	Slow progress
	Satisfactory progress
	Completed

Quality Improvement Overview Plan

2.0 Updated Action Plan- HDU

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
REQUIREMENT NOTICES											
3	Improved facilities for the care of paediatric patients on HDU	There will be a distinct paediatric facility on HDU which meets national and best practice standards	100% of children will be cared for in a distinct paediatric facility	**Phil Begg**	Stuart Lovack	Appoint architect by Jan 2016 Design development complete by end March 2016	Plans have been developed to enable tender to be completed	Tender and evaluation complete by ~~end April 2016~~ July 2016	This action was not completed by end April however a tender document has been completed by July 2016	Construction begins ~~June 2016~~ August 2016and completes ~~October 2016.~~ January 2017 New paediatric premises available for use by end ~~November 2016~~January 2017	**August 2016 Completion of works confirmed as January 2017 July 2016:** Construction has not yet started on this project. The final decision to commence construction has been delayed until the stakeholder discussion following receipt of the RCPCH report has been undertaken on 26th July 2016. If the approval to commence construction work is given following this meeting it is projected that this will be a 22 week programme of work therefore completion is likely to be January 2017 at the earliest.
4	Improved facilities for all adult patients on HDU ensuring compliance with DH MSSA requirements and compliance with NHS Contract	Separate Toilet and bathroom facilities will be available for male and female patients on HDU	Full compliance with MSSA Guidance and requirements of the NHS Contract	**Phil Begg**	Stuart Lovack	Identify additional facility Develop business plan and secure funding Draw up plans for new facility	Action complete as detailed above	Undertake building work to create additional facility Confirm compliance with DSSA requirements and NHS Contract requirements	This action is off track as its completion is dependent on the work detailed in Action 3 above	Escalate non compliance with DSSA requirements to executive team	**August 2016:** Work will commence on construction of new toilet facility in late August 2016. **July 2016:** The issue of non- compliance has been reviewed by the Executive team. Discussions are underway with contractors to undertake the construction of an additional

Quality Improvement Overview Plan

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
											toilet in HDU during August 2016 as a distinct project rather than one connected to the paediatric refurbishment . However there is no confirmed date for commencement of the works.
5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	**Garry Marsh**	Talitha Carding	Approve the SOPs for admission of elective and emergency patients to HDU (action complete- approved December 2015)	SOPS have been developed and ratified	Develop implementation plan for SOPS and demonstrate completion to TMC	SOPS are in pace and monitoring of compliance is ongoing	No further action required	
5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	**Garry Marsh**	Talitha Carding	Undertake recruitment of registered children's nurses	Recruitment has continued since December 2016. The Paediatric establishment on HDU has been increased to 7.6WTE	An increase to a minimum of 2 Registered Paediatric nurses at all times to achieve RCN standards.	This is an action still in progress with a trajectory for achievement as follows: ~~July 2016;~~ August 2016 4.6 WTE RSCN in post ~~Sept 2016~~: October 2016 6.6 WTE RSCN in post ~~Oct 2016~~ November 2016: 7.6 WTE RSCN in post. At 7.6 WTE HDU are established to their budget for paediatric nurses. The Trust is currently developing a model of paediatric provision which will be based on regular scheduling of paediatric surgery on fixed days of the week. Additional nurses, if required, will be sourced from the paediatric ward as	The Trust will be complaint with the requirement to staff each shift on HDU with 2 paediatric nurses by end Jan 2017	Good progress has been made against recruitment of paediatric nurses to HDU as follows: 1 to commence 22.08.2016 1 to commence 05.09.2016 1 to commence 01.10.2016 1 in recruitment check stage. Once all 4 are in post HDU will be fully established to their budgeted establishment of 7.6WTE. The action remains amber for the following reasons: • The rotational programme between ward11 and HDU requires review and is being evaluated during

Quality Improvement Overview Plan

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
									part of a planned rotational programme. In addition monitoring of paediatric nurse cover continues on a shift by shift basis with every shift having paediatric nurse cover from June 2016, even where no children were present on HDU. This is to ensure that there is an appropriate nurse available to care for a child should there be a paediatric emergency admission to HDU		August 2016. • E –rostering will commence in October 2016 and will enable development of a single rota between Ward 11 and HDU • Some initial scoping work has taken place regarding the possibility of Children only lists however given that there a number of surgeons who operate on both adults and children , it is unlikely that we will be able to produce this without significantly compromising theatre list utilisation and prolonging waiting times for adults
5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	**Garry Marsh**	Talitha Carding	All Children's Nurses to complete 'Children's Critical care Passport' arrangements at BCH by end January 2016 Assess adult nurses against the passport competencies in line with trajectory agreed at TMC in December 2015	A plan has been developed to ensure delivery of this action. All Children's nurses in HDU completed rotation by end January 2016	All eligible adult nurses on HDU will have completed the paediatric competency document by end ~~March 2016.~~ May 2016	All eligible adult nurses completed the paediatric competency document by end May 2016. Delays in meeting the March deadline due to staff sickness/ absence. In addition one member of staff who is a new starter to HDU has been supported to attend BCH HDU where his competency document will be completed in September 2016.	No further action required once final rotation complete	Plan in place for outstanding adult nurse to complete two week rotation to BCH in Sept 2016.

Quality Improvement Overview Plan

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5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	**Garry Marsh**	Talitha Carding	Implement rotation programme between paediatric HDU and in-patient ward.	Implementation programme has been developed	Rotational programme between Ward 11 and HDU fully implemented.	A rotational programme has been fully implemented.	All nursing staff on ward 11 will have completed rotation to HDU by end ~~December 2016~~ May 2017	August 2016: The rotational programme in place will be reviewed by the matron for HDU and the lead nurse for paediatrics in order to ensure that the experience of the nursing team inform future rotation. Due to the nature of work on HDU it has been necessary to expand the programme to include care of the child in theatre and recovery. It is unlikely that all nurses will have completed this rotation by end December 2016 and the trajectory is currently under review with a likely completion date of May 2017.

Quality Improvement Overview Plan

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	**Garry Marsh**	Talitha Carding	Develop a programme of collaboration with BCH to access competency based training for all HDU nursing staff and present to TMC by end January 2016.	Discussion have commenced with BCH in respect of access to their training programmes	Implement a revised preceptorship programme for all new starters to HDU Develop roll out programme for competency based training with BCH	Good progress has been made against delivery of this action. As detailed below: 4 staff have attended a deteriorating child course at BCH in April 2016 2 staff attended an airway management course at BCH in June 2016 A RAPT Course is planned for August 2016 with 8 members of the HDU team attending. An SLA has been developed with BCH which formalises access to their training programme.	All relevant nursing staff on HDU will have completed competency based training programmes at BCH by end October 2016 to include: -Assisted Airway Course Paediatric Assessment Course -Deteriorating Child Course -RAPT courses A TNA will be developed to evidence achievement by end October 2016.	**August 2016** The TNA is in progress following agreement with BCH about access to their in house courses. The education component of the SLA has been identified and work is underway to agree costs and numbers. Expected completion by September 2016 **July 2016:** A detailed TNA needs to be completed identifying the nurses who require the additional level of training It is unlikely that all nurses will need this level of training once TNA and skill mix review complete
5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	**Garry Marsh**	Talitha Carding	Review and approve Transitional Care Policy by end March 2016	The Transitional Care Policy was ratified at TMC in June 2016.	Complete implementation of Transitional Care Policy by end May 2016	The action has been delayed due to delay in ratification of the Policy. A detailed implementation plan is due to CQG in July 2016.	Audit implementation of revised Transitional Care Policy by end ~~September~~ November 2016	Delayed due to late submission of policy and implementation plan . However audit will take place in November 2016
6	Improved access to paediatric medical cover	Completion of a review by RCPCH to include: Review of current arrangements for medical advice, nursing support and management	Completion of RCPCH review	**Andrew Pearson**	Dr Da Silva	Agree TORs for review Establish timeframe for review	Terms of reference agreed In December 2015 Review planned for March 2016	Completion of review Development of an action plan to respond to review recommendations	Review completed March 2016 Final report received 17th June 2016 Medical Director has written to the Division 2 GM detailing the requirement	Monitoring arrangements for implementation of action plan in place Audit of compliance with this requirement is	Action plan developed. Quality Meeting Chaired by NHSI planned 26 July 2016 Ongoing conversations between BCH and ROH to provide Associate Medical

Quality Improvement Overview Plan

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
		Review of the processes for risk assessing children prior to admission Review of processes for management of the deteriorating child and the safety of arrangements for transfer through the Critical Care Network							that all children in the Trust must have review by visiting paediatrician with the inclusion of HDU.	required by end August 2016	director time to ROH via SLA which is currently in development with anticipated final version by September 2016
MUST DO											
7	Locked storage is available for intravenous fluids on HDU	IV Fluids will be stored in a locked cupboard.	IV Fluids are secured in locked cupboard 100% of the time	**Garry Marsh**	Talitha Carding	Lock away all intravenous fluids. Completed December 2015 Undertake audit of compliance by end Feb 2016	Action completed immediately	No further action	Matron walkabout and review confirms that cupboard has remained closed and locked	No further action	
8	Consistency in recording and reporting Safety Thermometer Data	Accurate completion and recording of Safety Thermometer data	Data accurately recorded and presented 100% of the time from end February 2016	**Garry Marsh**	Talitha Carding	Review process of Safety Thermometer data collection by end Jan 2016 Make recommendations for implementation of revised process Implement revised process	A revised Safety thermometer SOP has been developed The SOP was shared at Ward managers meetings for roll out. The SOP includes collection of paediatric safety thermometer data	No further action required	The upload of Paediatric Safety Thermometer data commenced in April 2016. ST reports to UNIFY include paediatric data	No further action required	Paediatric Safety Thermometer results reported monthly via UNIFY
9	Enable benchmarking against other Critical care Units	Upload of monthly data to ICNARC website	100% benchmarking uploaded to ICNARC monthly from	**Garry Marsh**	Talitha Carding	Secure Software – complete September 2015 Roll out Training	The software has been secured and the Trust is enrolled with ICNARC	Begin Upload to ICNARC by end April 2016	The ICNARC upload takes place on a quarterly basis. The first upload will take place in July 2016.	No further action required	First data upload complete

Quality Improvement Overview Plan

No	Quality Improvement Project	Expected Outcome	KPI/Measure	Exec Lead	Clinical/ Project Lead	2 Month Milestones (Feb 2016)	Progress against 2 month milestones	5 Months Milestones (Dec – May 2016)	Progress against 5 month milestones	8 Months Milestones (Dec – Aug 2016) & Beyond	Progress against 8 month milestones
			March 2016			programme- complete November 2015 Complete recruitment for admin assistant to enable data input Enrol with ICNARC		Monthly benchmarking reports to Divisional Governance Board by end May 2016	However data collection has begun in Q1 2016/17 in preparation for upload.		
14	Access in an emergency situation enabled	All side rooms will have adequate space to allow access to emergency equipment	N/A	**Jonathan Lofthouse**	Talitha Carding	Patient & Carer beds removed from side rooms November 2015 Source and procure recliner for parent use completed by December 2015	Action complete. Beds removed and recliners purchased for parent use	No further action required		No further action required	
15	Adequate storage facilities for HDU equipment when not in use	All staff will have access to improved storage facilities	There will be no equipment stored in bays on HDU	**Jonathan Lofthouse**	Stuart Lovack	Scoping of additional storage creation within estates plan to be completed. Identification of additional storage facilities	This action is within scope of the refurbishment plan	This action will be completed as part of the refurbishment of HDU detailed in action 3 above	This action was not completed by end April however a tender document has been completed by July 2016	No further action once refurbishment complete. Expected completion January 2017.	August 2016: The development of storage facilities is included as part of the HDU refurbishment works planned for completion in January 2017 July 2016 Construction has not yet started on this project. The final decision to commence construction has been delayed until the stakeholder discussion following receipt of the RCPCH report has been undertaken on 26th.
16	All ward rounds will have MDT input	All patients will have a MDT ward round daily	100% of ward rounds will have MDT input	**Andrew Pearson**	Matt Payne	Reviews ward round process to include NHS England seven day services standard around MDT working.	Progress has been made against introduction of MDT ward rounds with physiotherapist and pharmacist joining the team	Implementation of revised ward round to ensure compliance with NHS England seven day services standard around MDT working	Progress has been made against introduction of MDT ward rounds with physiotherapist and pharmacist joining the team	Audit of compliance undertaken and presented to Divisional Governance Board by December 2016	Action not yet due.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Finance & Performance Report – May 2016**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Director of Finance & Performance**
AUTHOR:	**Various**
DATE OF MEETING:	**7th September 2016**

EXECUTIVE SUMMARY:

This paper, alongside the Quality report, replaces the old Corporate Performance report as the mechanism for reporting performance against the Trust's key targets and performance metrics. It is intended that this structure will provide a consistent reporting style from Board level down to Divisional reporting. The report covers the main performance metrics related to finance, activity, operational efficiency and operational workforce.

The Trust is currently £2,237,000 in deficit, £842,000 behind plan at the end of Month 4. This position is driven by an under-recovery of clinical income of £1,826,000. The main driver for this was the closure of theatres for the week commencing 6th July. It is estimated that this closure cost the Trust a net £954,000. Without this impact, the Trust would be ahead of plan by £112,000. Expenditure controls continue to have a positive impact on the position, whilst there is currently a small under-delivery of CIP savings.

Theatre sessional utilisation has dropped in the first 4 months of this year, and is a key driver for the under-delivery of inpatient activity. This is a focus of the Finance & Activity recovery plan. Some improvements to flow have been successful, with continued reductions in delays out of recovery and a reduction in the number of patient admitted the day before surgery. That said, there has currently been limited impact on the overall length of stay.

The percentage of staff filling funded posts shows another decline in month, however this is linked to the continued process of converting long standing agency spend to substantive posts, as opposed to being indicative of an increase in the number of historic vacancies. Sickness increased significantly in July, however there is currently no suggestion that this is likely to continue as a trend. There are concerns around a deterioration in the number of staff completing mandatory training, and this is being reviewed at Divisional level.

REPORT RECOMMENDATION:

Trust Board is asked to note this report and discuss actions to be taken with regards to the issues outlined in the 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	**X**	Environmental	**X**	Communications & Media	
Business and market share	**X**	Legal & Policy	**X**	Patient Experience	
Clinical	**X**	Equality and Diversity		Workforce	**X**
Comments:					
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
The Finance & Performance Report, alongside the Quality Report, demonstrates performance against a number of key metrics linked to the delivery of the Trust objectives.					
PREVIOUS CONSIDERATION:					
This report was considered by Finance & Performance committee and TMC in August 2016.					

FINANCE & PERFORMANCE REPORT

AUGUST 2016

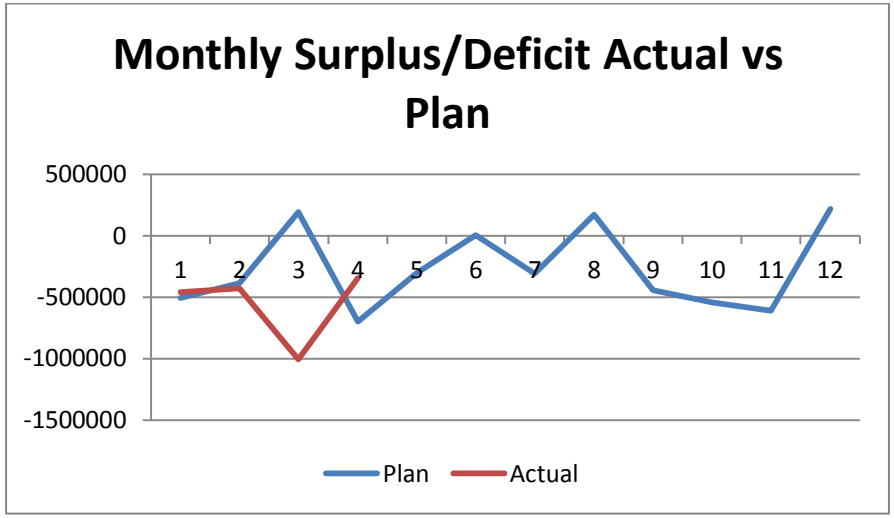
CONTENTS

INTRODUCTION

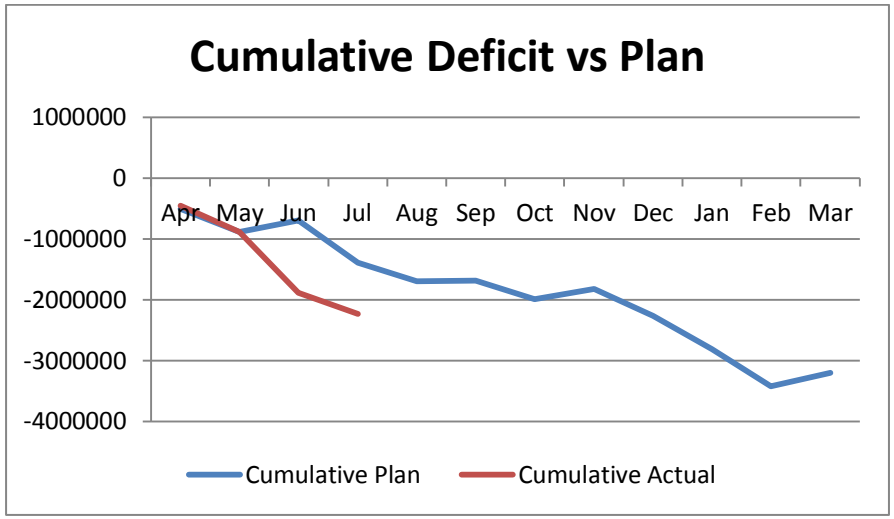
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

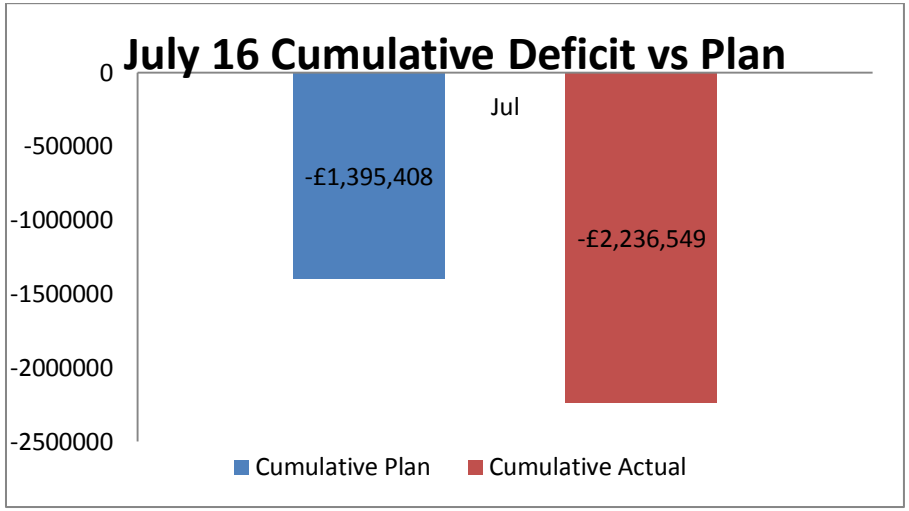
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Financial Sustainability Risk Rating (FSRR)



NHSI Financial Sustainability Risk Rating (FSRR)		
	Plan	**Actual**
Capital Service Cover	1	1
Liquidity	4	4
I&E Margin	1	1
I&E Margin – Variance against plan	2	1
Overall FSRR	2	2





INFORMATION

The Trust has delivered a cumulative deficit of £2,237,000 as at the end of July against a planned deficit of £1,395,000. In month, the Trust delivered a deficit of £346,000 against a planned deficit of £698,000.

The Trust is therefore £842,000 behind plan at the end of M4. During the month of June all operating theatres were closed for a week due to problems with the air filtration canopy system. It is estimated that this closure resulted in a loss of £908,000. Excluding the impact of this closure, the Trust would be ahead of plan by £66,000.

Further detail on the key drivers of the financial position is provided in the income and expenditure sections below.

CIP savings released in July were in line with the plan for the month, however they remain £200k behind plan for the year to date.

The deficit position results in the Trust achieving ratings of 1 for our Capital Service Cover, I&E Margin metrics and I&E Margin Metrics against plan. As part of the NHSI Financial Sustainability Risk Rating. The achievement of a 1 in any metric caps the overall performance level for the Trust at a maximum rating of 2, despite receiving the highest available rating for liquidity.

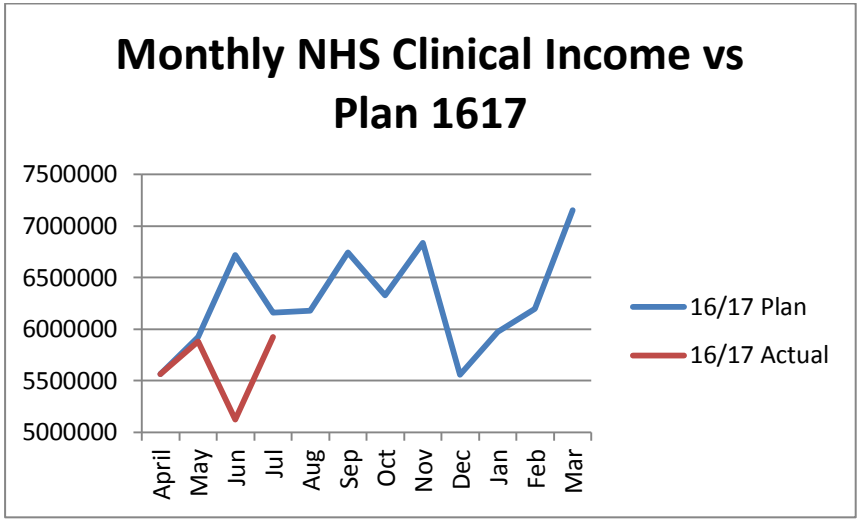
ACTIONS FOR IMPROVEMENTS / LEARNING

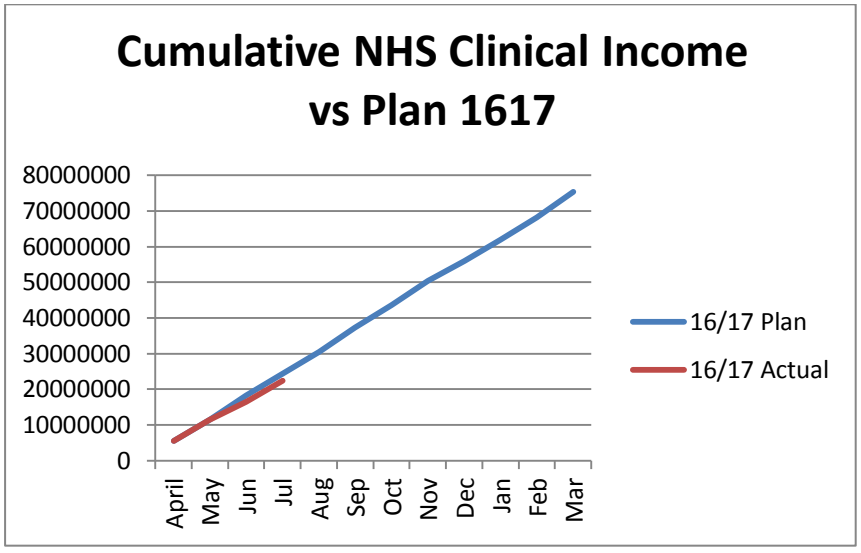
See income & expenditure sections for more details

RISKS / ISSUES

Achievement against the overall financial target for the Trust remains a challenging ask, and it is vital that the combination of activity delivery, cost control and efficiency improvements are all achieved to enable the target to be hit. The Trust is not eligible for its £200,000 sustainability funding until our financial position is back in line with our planned trajectory.

2. Income – This illustrates the total income generated by the Trust in 2016/17, including the split of income by category



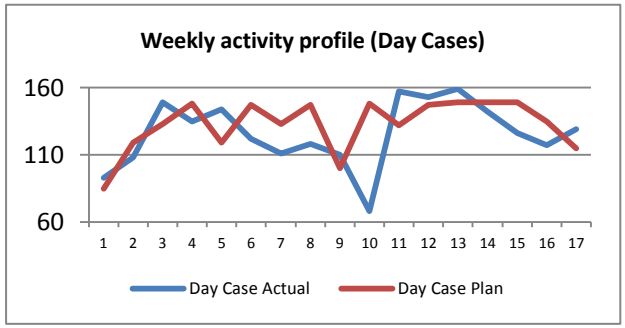


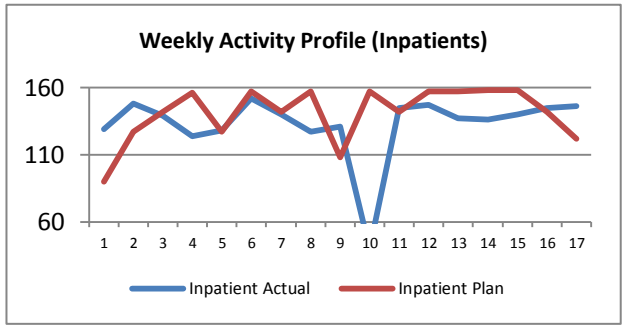
NHS Clinical Income – July 2016			
	Plan	**Actual**	**Variance**
Inpatients (inc XBDs)	3,204	2,950	(254)
Day Cases	736	720	(16)
Outpatients	677	575	(102)
Critical Care	230	221	(9)
Therapies	228	236	8
Pass-through income	201	213	12
Other variable income	379	464	85
Block income	506	527	21
TOTAL	6,161	5,906	(255)

NHS Clinical Income – YTD 2016			
	Plan	**Actual**	**Variance**
Inpatients (inc XBDs)	12,544	11,078	(1,466)
Day Cases	2,883	2,647	(236)
Outpatients	2,742	2,508	(234)
Critical Care	901	870	(31)
Therapies	926	993	67
Pass-through income	809	821	12
Other variable income	1,516	1,522	6
Block income	2,052	2,108	56
TOTAL	24,373	22,547	(1,826)

INFORMATION

NHS Clinical income under-performed by 4% in July as a result of under-performance in both inpatient and outpatient activity. Inpatients and Day Cases both underperformed in the month, with a circa 15 patient per week underperfomance in both categories in the early part of the month, before an improvement at the end of the month as activity was maintained into the school holiday period as demonstrated by the graphs below (July = Wks 14-17). Casemix was largely similar to plan in all categories of activity in July.





Outpatients continued to under-perform from an income point of view, driven by a significant reduction in the number of outpatient procedures undertaken in month. This largely relates to the retirement of a pain management consultant, and the difficulties in recruiting to a full time locum post to cover. A proportion of his workload has been transferred to other services including therapies, which partly explains the over-performance in that service in the year to date.

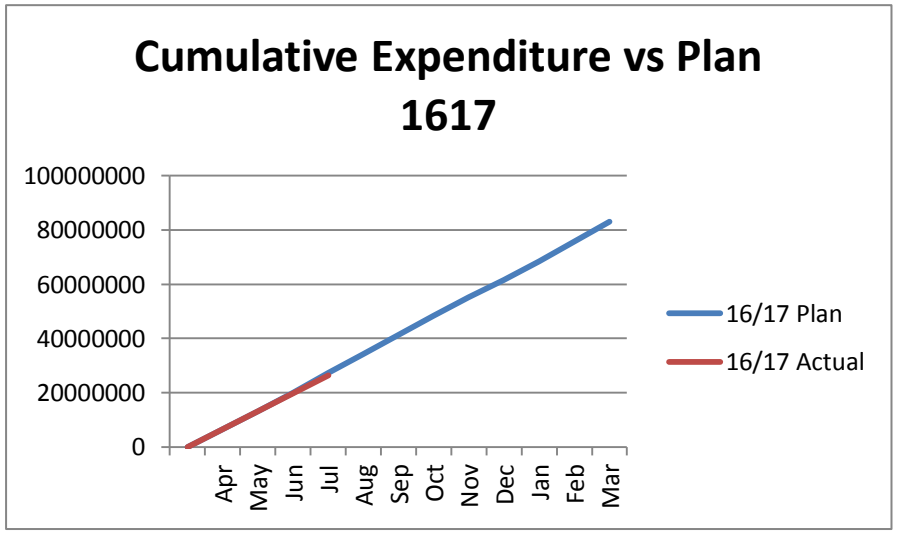
ACTIONS FOR IMPROVEMENTS / LEARNING

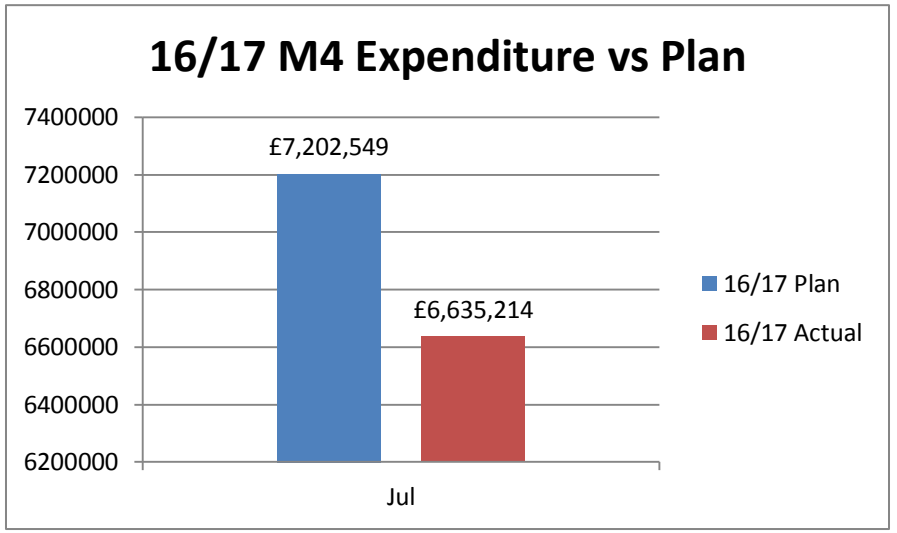
A full stock take of all programmes of work designed at improving activity levels and ensuring the availability of appropriate capacity in terms of people, theatres and beds has taken place following the resignation of the Director of Operations. This has highlighted that whilst some projects are on track, others will need remedial action. This information has been combined with the impact assessment from the June theatre closure to quantify the level of work required to claw the income position back to planned levels. A plan is currently being finalised to demonstrate how this will be achieved.

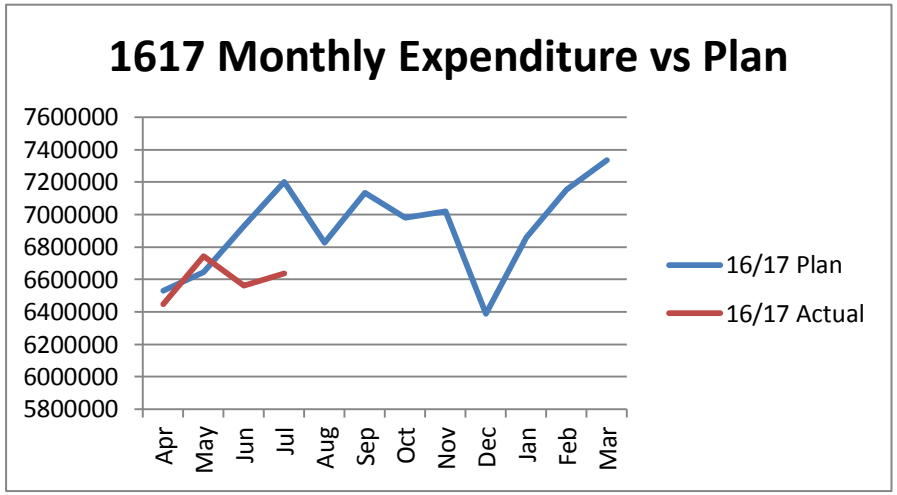
RISKS / ISSUES

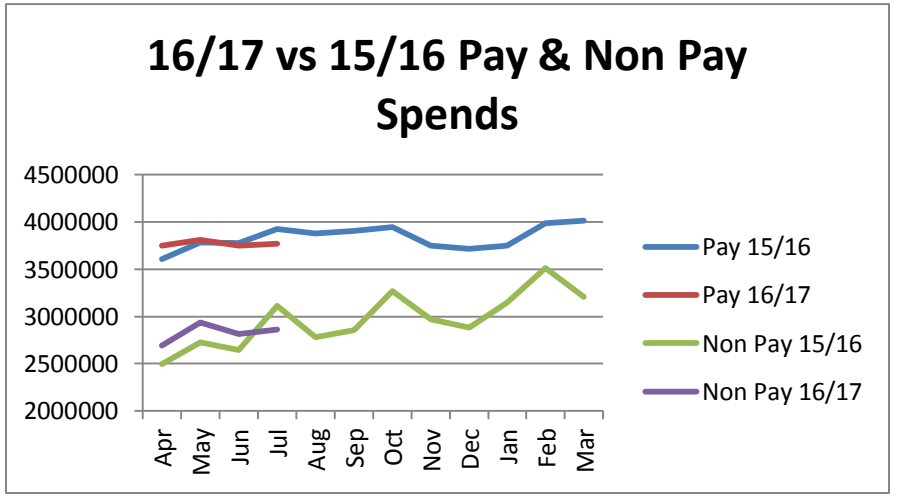
Proactive action is ensure that the step up in activity from September onwards still takes place, along with further action to clawback the shortfall in June. Failure to deliver activity levels, and the associated income commensurate to this will make the achievement of the overall financial position extremely difficult given that our savings target is already stretched to reach our £3.2m control total deficit.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2016/17, compared to historic trends









INFORMATION

The Trust's improved financial performance in July is significantly driven by the continued control of expenditure, with spend levels £568,000 behind plan for the month. The majority of the Trust underspend in July relates to clinical supplies and services, with spend levels maintained in line with previous months, despite an increase in planned expenditure based on previous year's trajectories. The Trust is also holding on to some small reserves that have not been required to be released due to good budget management at departmental level. These include planned cover for inflationary costs and funding for CQUIN pressures, the latter of which may be required over the coming months.

Division 2 (Patient support services) and the Corporate Division are both underspent at the end of Month 4, with small overspends in Division 3 (Patient Access) and Division 4 (Estates & Facilities). Division 1 (Patient services) remains the biggest concern, with an overspend of £185k for the year to date. The biggest drivers for this position include an increase in the cost of the BCH Spinal Deformity service (currently not offset by a corresponding increase in income), medical staffing and an underperformance on CIP.

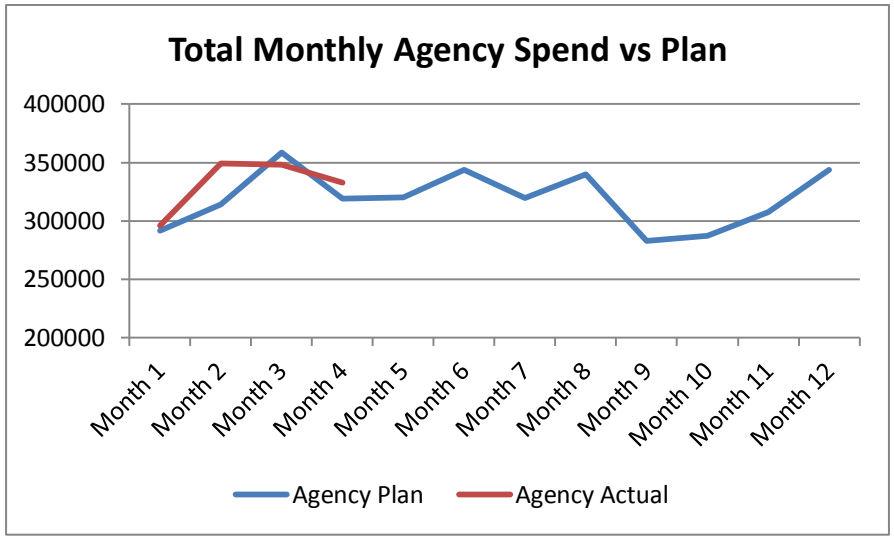
ACTIONS FOR IMPROVEMENTS / LEARNING

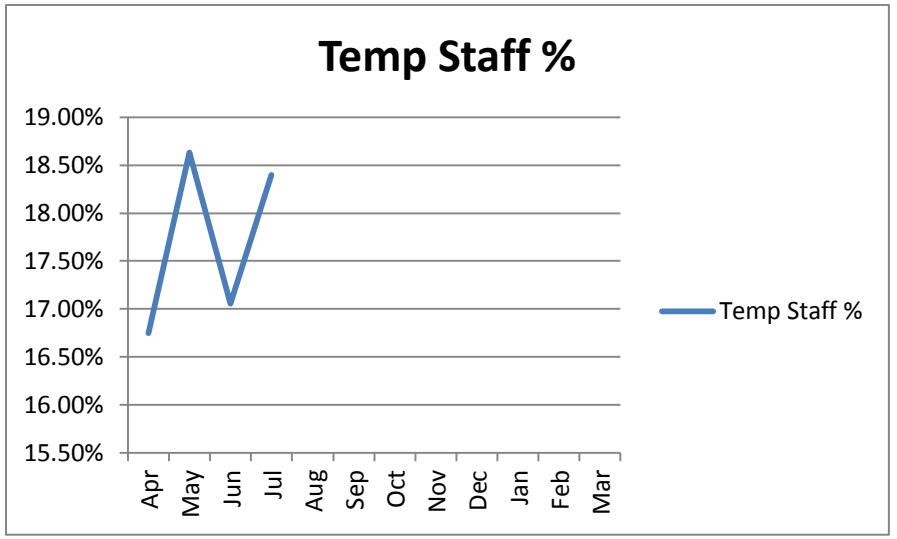
A financial recovery plan, linked to the Trust's activity recovery plan, is being developed for consideration at Finance & Performance Committee at the end of August / start of September.

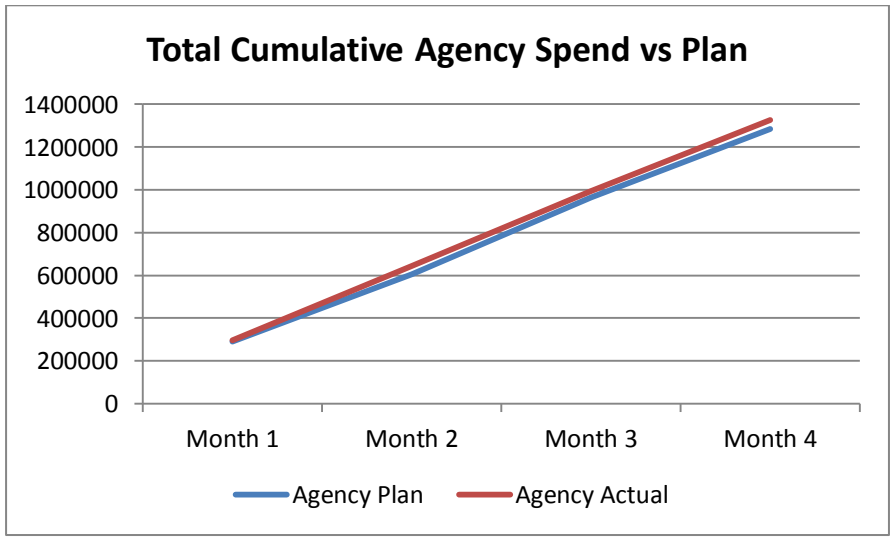
RISKS / ISSUES

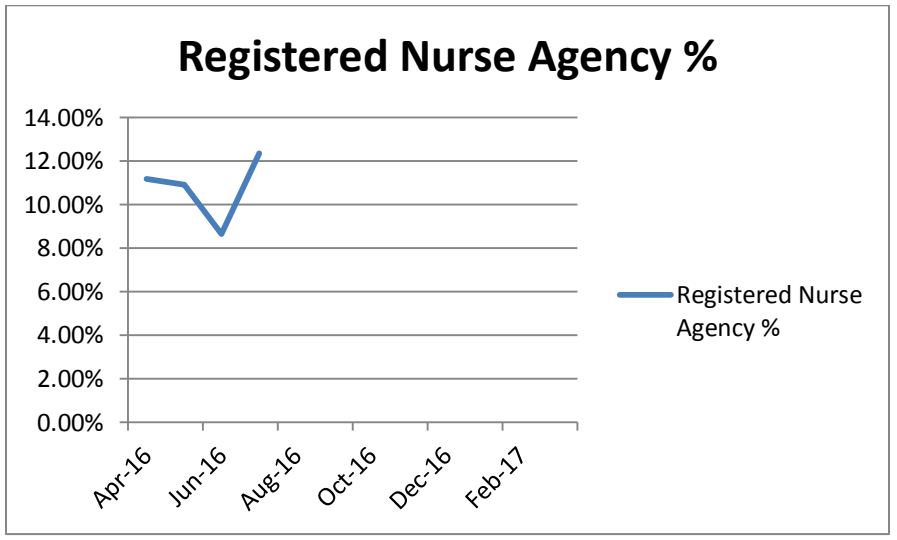
Further work is required to implement the full recommendations of the review into theatre stock control and processes, as there remains a risk that without these improvements, full reliance cannot be placed on non-pay expenditure.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2016/17, and performance against the NHSI agency requirements









INFORMATION

Overall levels of agency spend reduced in July, however this reduction was less than the planned trajectory, resulting in a further deterioration in performance against this trajectory. Overall agency spend for 2016/17 currently stands at £1,326k against a plan of £1,283k, an overspend of £43k (3.2%).

The overspend continues to be driven by additional expenditure on agency medical locums, which has resulted in a £146k overspend for the year to date. By comparison, agency spend on nursing is underspent by £91k and on management/clerical staff is underspent by £15k. The overspend on medical locums largely relates to the inability to realise savings from the introduction of Physicians Associates. Actions being taken to rectify this are shown below.

Nursing agency spend did increase against the previous month, however this was largely due to the one-off reduction in June due to the theatre closure. The remaining agency spend relates to the Trust's ongoing recruitment challenges, although some traction is now being gained with ward recruitment, whilst the Trust's overseas nurses in theatres will shortly be completing their supervisory period of work.

ACTIONS FOR IMPROVEMENTS / LEARNING

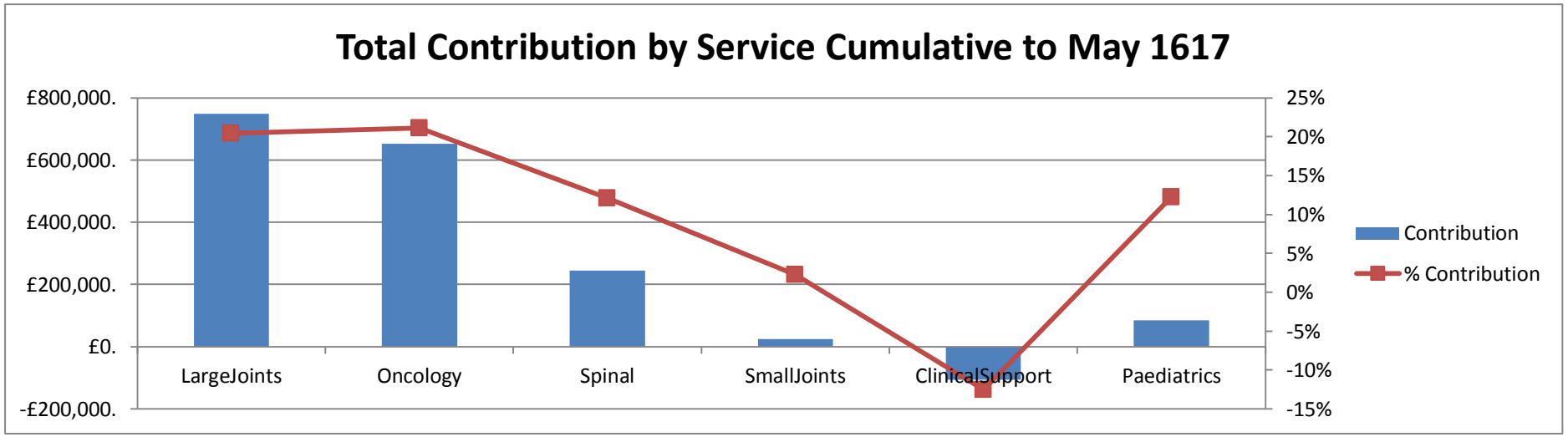
A task & finish group has been set up to look at the overall provision of middle level medical cover and the potential for replacing locum costs with other clinical professionals, This is due to report back in early September.

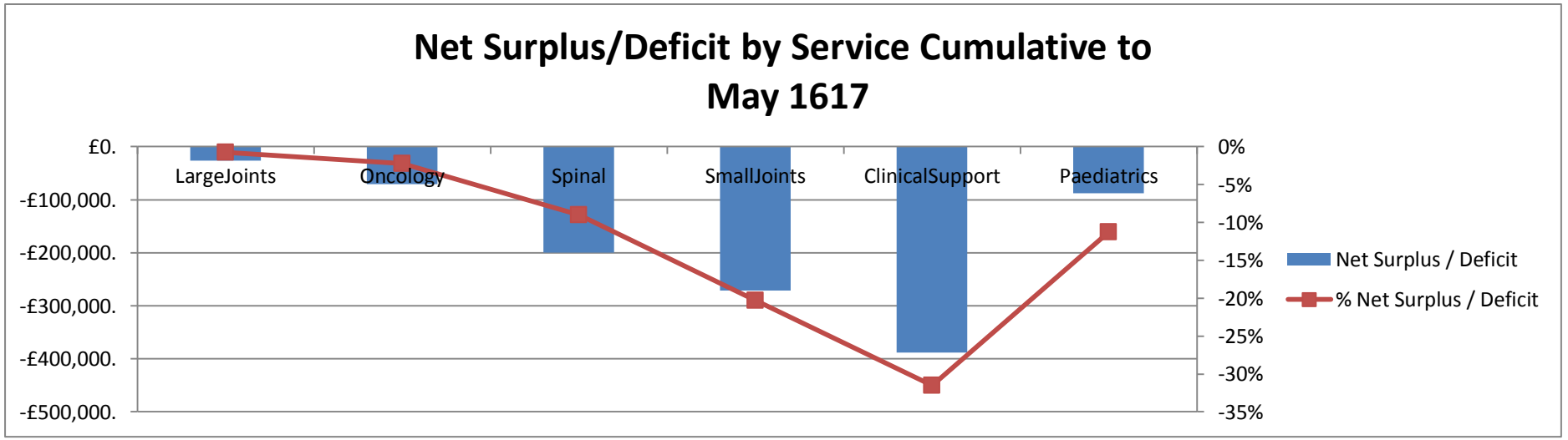
Action has also been taken to review the staffing model in POAC with a view to removing the expensive locums supporting the service, with proposals expected in the next couple of weeks.

RISKS / ISSUES

Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls. The Trust will need to take all necessary steps to bring expenditure back in line with the capped trajectory.

5. Service Line Reporting – This represents the profitability of service units, in terms of both consultant and HRG groupings





INFORMATION

The graphs above, and the associated narrative, relate to the financial year 2016-17.

The first graph is showing the contribution each service is generating, currently the Trust target is set at <20%. The only services currently achieving this set target are Oncology and Large Joints. Clinical Support is the only service that has provided a negative contribution of £106K, this is mainly due to consultant vacancies in the pain management service resulting in reduced activity and agency staff costs being incurred to support maintenance of the 18 week target in this service.

The second graph is comparing the total contribution each service made towards the trust's position as at May 16. It can be seen that once the finance costs for overheads, depreciation and interest are applied all service lines are then running at a net loss, this is reflected in the overall Trust position of a £886K deficit in the first 2 months of 2016-17.

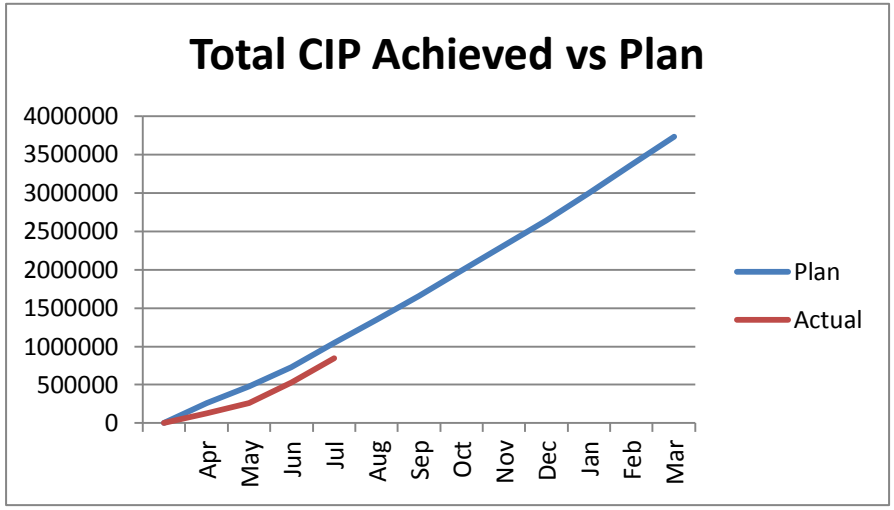
After applying Trust overheads Small Joints is the second lowest contributing service with a net deficit of £271k, which is mainly due to its Tariff configuration and service provision.

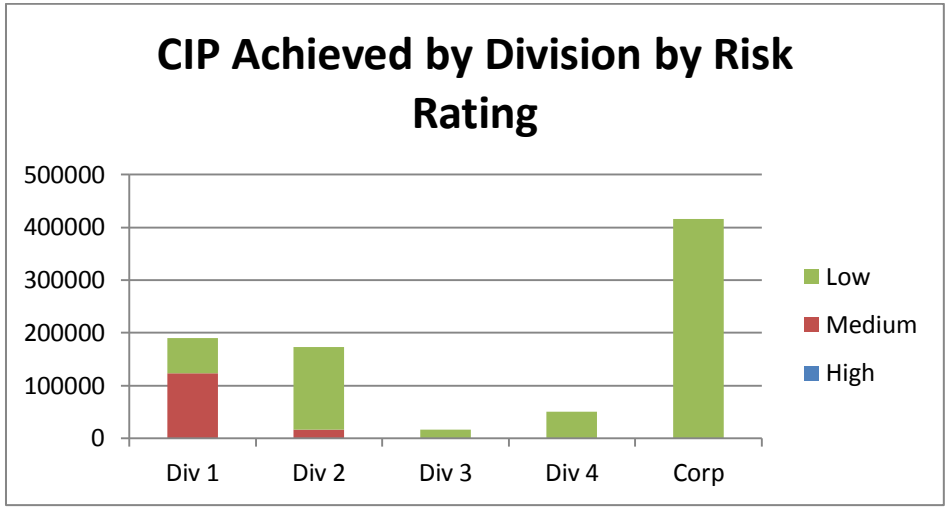
ACTIONS FOR IMPROVEMENTS / LEARNING

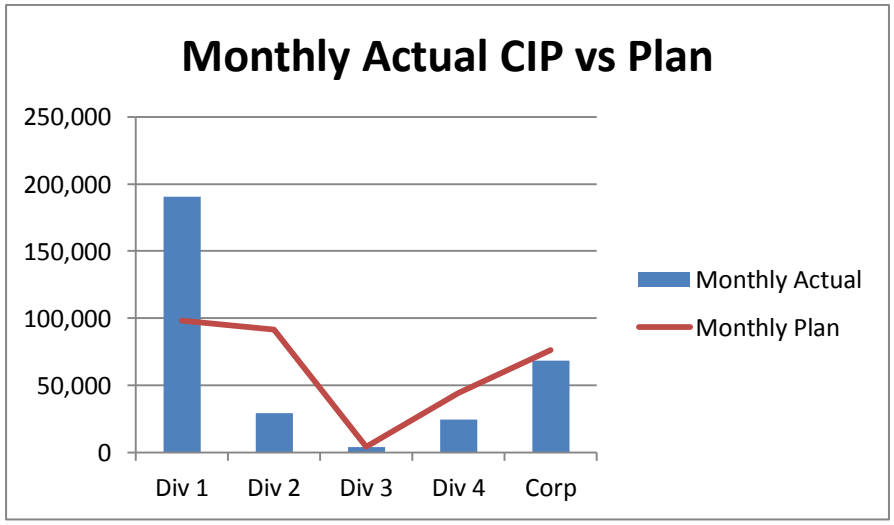
It is important that the use of SLR is embedded into the Trust, as this information provides the vehicle to challenge clinical and price variation at all levels. SLR reporting will form part of the divisional reporting moving forwards, and will be challenged at monthly performance meetings.

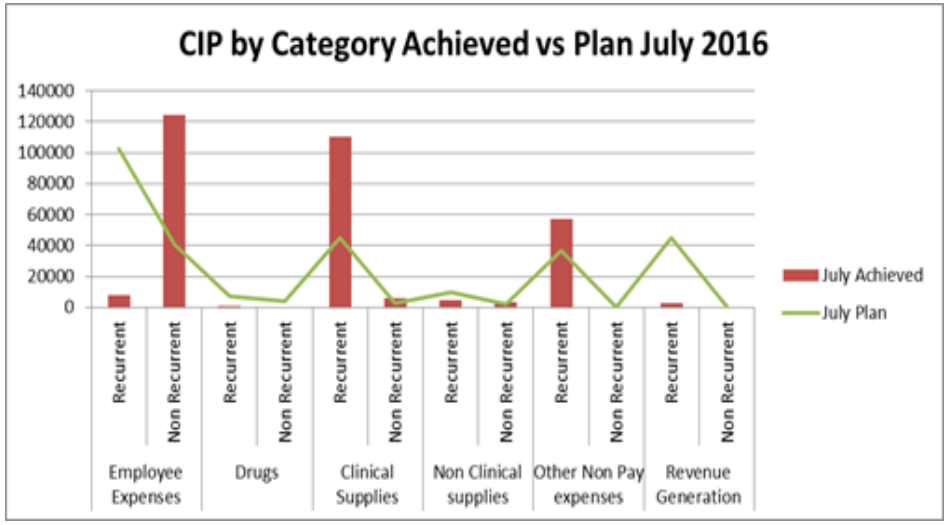
RISKS / ISSUES

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2016/17









INFORMATION

As at the end of Month 4, the Trust has recognised £847k of savings, against a plan of £1,045k. £219k (26%) of savings to date are non-recurrent. The in month savings recognised were £316k against a July target of £314k.

- A number of key decision points are CIP proposals are due during the next month. These include:
  - Options for prosthesis savings (either direct engagement or via NHS Supply Chain)
  - Proposals for improving the patient booking process, linked to Phase 2 of digital dictation/speech recognition
  - Business case review of theatre, anaesthetic and HDU staffing

The majority of undelivered CIP schemes are still rated as medium or high risk in terms of likely delivery. Further work is required by CIP leads to ensure that these schemes are delivered, and that additional mitigation schemes are developed to cover any future slippage.

The majority of Quality Impact Assessments for in year CIP schemes have been developed and the process of review by the Director of Nursing & Governance and the Medical Director for formal sign off is ongoing. These will then be monitored through the Quality Committee. The use of the Quality Committee as an assurance route for QIAs will ensure a more timely process of review during 2016-17.

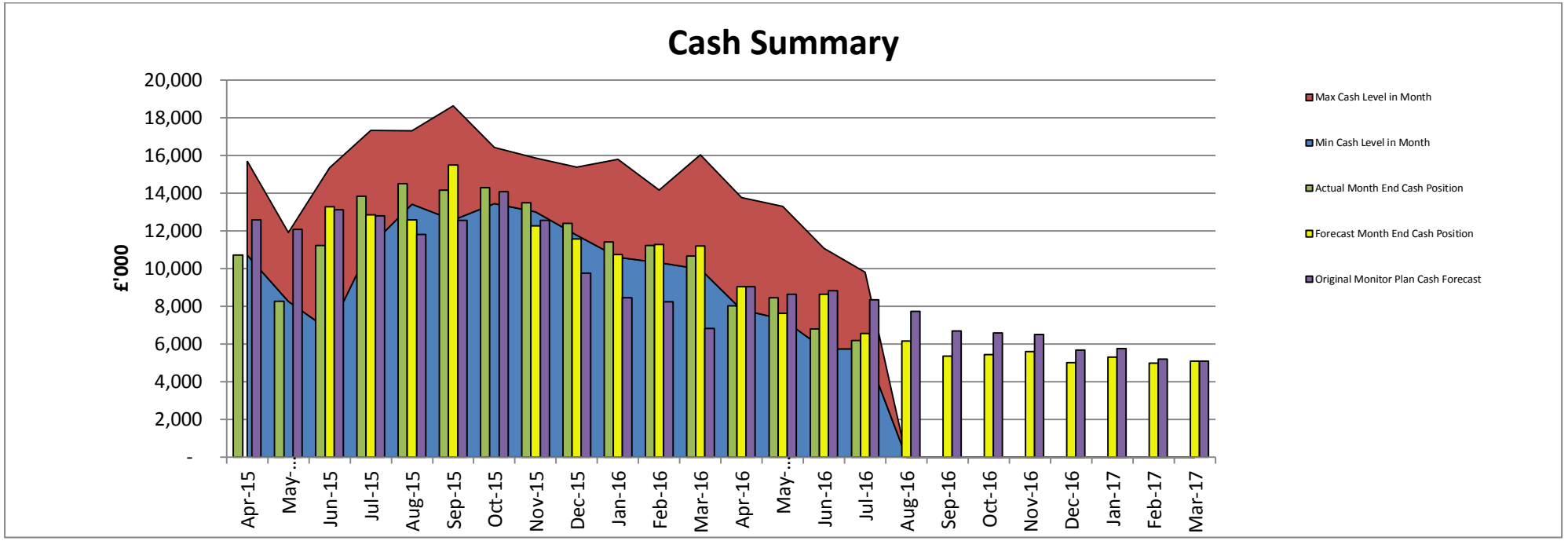
ACTIONS FOR IMPROVEMENTS / LEARNING

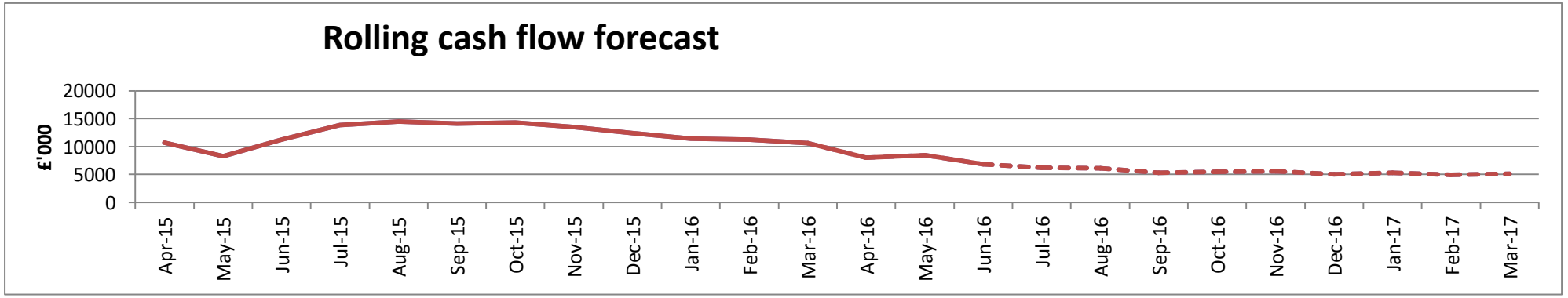
There are still gaps in some areas with regards to the required CIP documentation, largely relating to implementation plans and QIAs however the majority of these relate to newly developed schemes within the Corporate Division. A mid-July deadline was set for this paperwork to be completed and the majority of the QIA's have been received. For the QIA's that are outstanding, all Leads have been reminded to submit their paperwork.

RISKS / ISSUES

The CIP target of £3.67m represents a significant challenge to the Trust. It is vital that we remain on target in the early months as it will not be possible to make significant clawbacks against this level of savings target later in the year.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet





INFORMATION

Cash levels are £2m million lower than planned levels at the end of July 2016. The Trust is forecasting an end of year cash balance of circa £5m, which relies upon the delivery of our deficit plan and the control of capital spend within the budget that has been set.

The lower than planned cash position is mainly due to the lower level of brought forward balance of June 2016. Cash was in line with the planned position at the end of July.

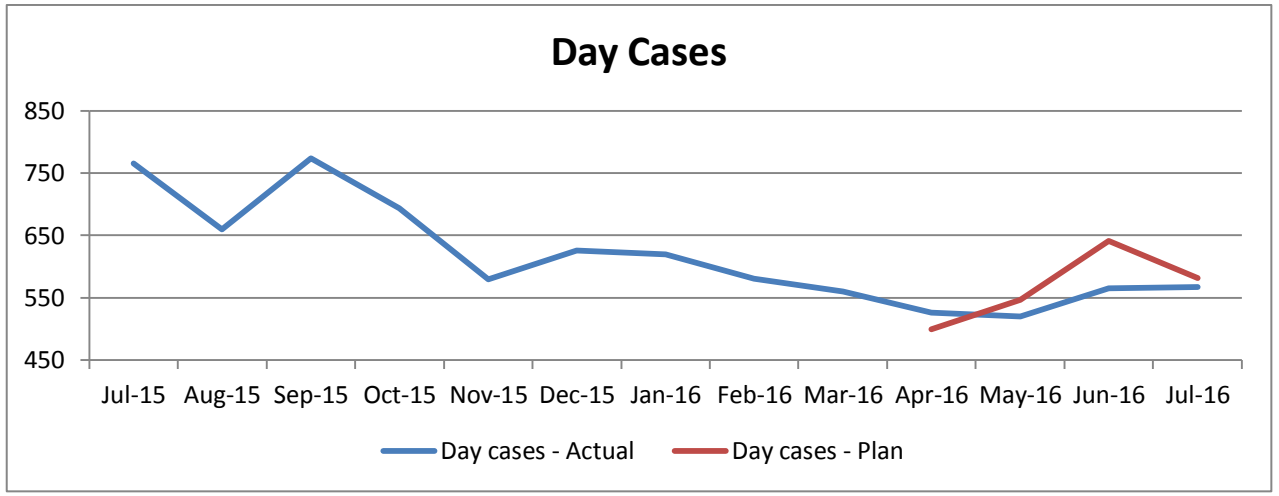
ACTIONS FOR IMPROVEMENTS / LEARNING

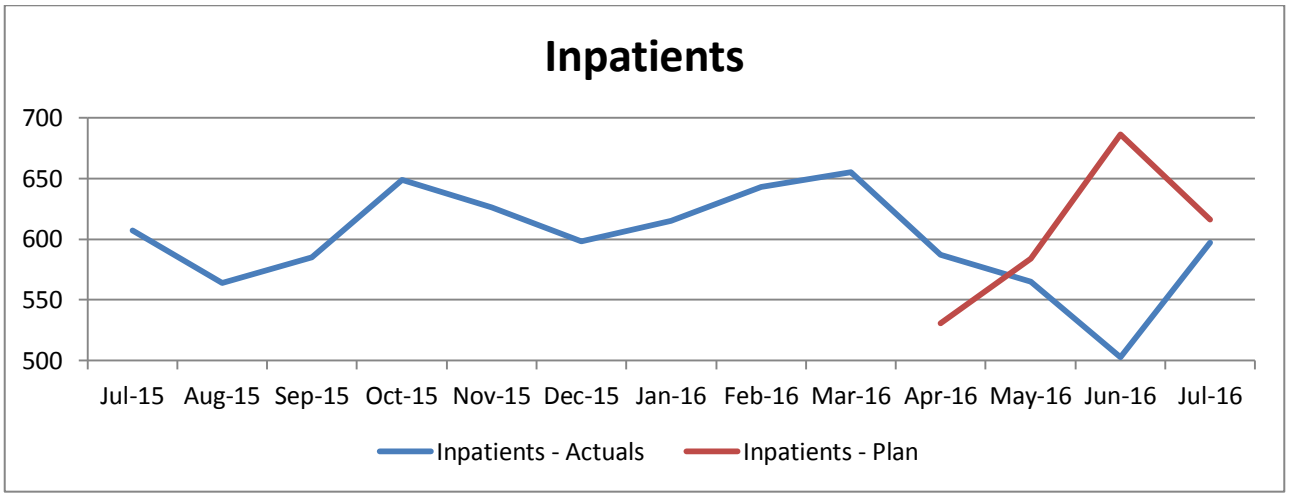
The Financial accounting team are continuing to review opportunities to improve the monitoring and projection of working capital movements, particularly in relation to early warnings around stock purchases and issuing.

RISKS / ISSUES

Given the in-month fluctuation of the cash position, which can potentially hit levels £1m-£2m below month end figures before mandate payments are received, it is vital that financial projections are met to ensure that cash can be comfortably managed within safe tolerances.

8. Activity: Admitted Patient Care – This illustrates the number of inpatient and day case discharges in the month, and year to date





INFORMATION

Activity levels for both day cases and inpatients were both circa 2.5% down on planned levels of the month of July. As highlighted in the graphs in section 2, this position was driven by under-delivery in the "busy" weeks planned for the early part of July, with some clawback in the final week as planned levels were anticipated to drop.

A review of performance against the various workstreams within the activity plan have highlighted that the majority of the underperformance in the year to date (excluding the impact of the theatre closure) relates to delivery of the underlying baseline. Anticipated growth from the appointment of a spinal locum and the reduction of on the day theatre cancellations has been delivered in line with, or ahead of, planned levels, and whilst there has been some under-delivery against growth expected from the perfect day pilot, the overall performance is driven by baseline activity.

ACTIONS FOR IMPROVEMENTS / LEARNING

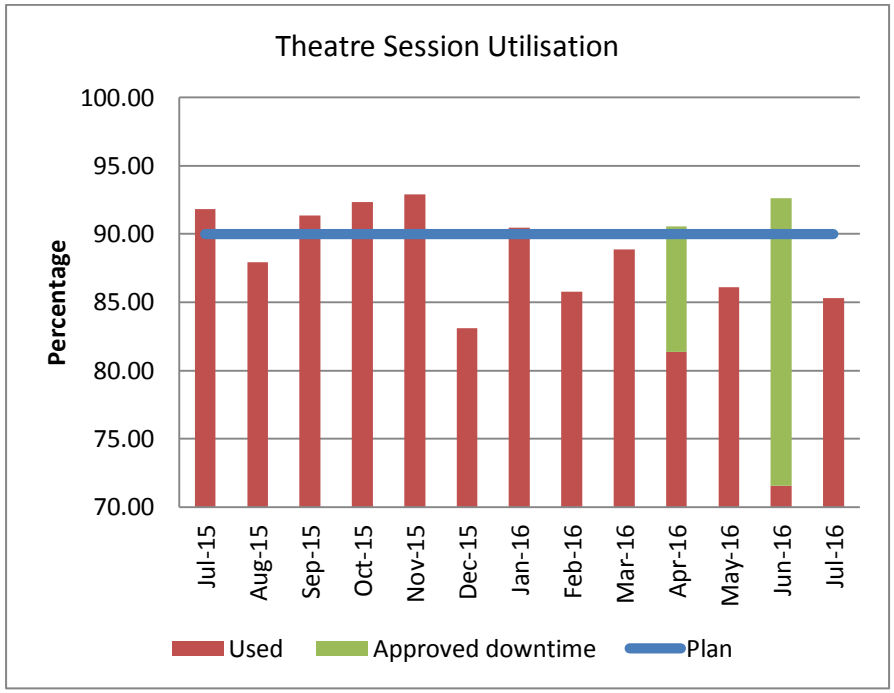
A full stock take of all projects either delivering current growth or aimed at increasing capacity for the growth planned for Q3/4 has now been completed and the information from this will feed into the Trusts financial and activity recovery plan due for consideration at F&P committee on 1st September.

RISKS / ISSUES

The events of week commencing 6th June, leading to a week of cancelled elective operating, clearly present a risk in terms of the catch up of the overall planned activity levels.

Evidence continues to suggest that the Trust is struggling to deliver activity levels in the planned "busy" weeks, and this challenge must to addressed given the expect step change from September onwards.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

383 sessions were used in May against an available total of 449. This equates to a theatre session utilisation of 85%.

ACTIONS FOR IMPROVEMENTS / LEARNING

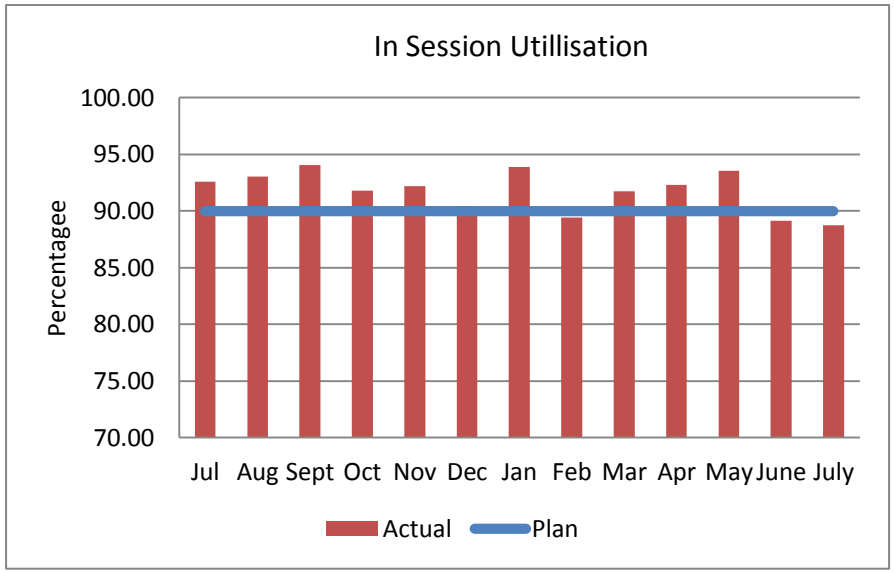
Due to annual leave / study leave, we should typically expect surgeons to cover a 42 week year. Timetables are currently based on a 52 week year. Discussions take place proactively as part of the "6,4,2" process to ensure that other surgeons pick up lists that would otherwise be fallow. A more robust approach to job planning to build in buddy arrangements and prospective cover, as well as recruitment to specialities where there are vacancies or that are under pressure from an activity / RTT / 52 week perspective, will improve this position.

In the meantime, there is a process to take down outpatient clinics to provide surgeons to recycle theatre lists, where it is practical to do so for the speciality concerned.

RISKS / ISSUES

Engagement in the job planning process and delivery of timescales. Notice required to establish buddying timetable arrangements and co-ordination of leave evenly through the year.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



Add graph showing theatre in-session usage by month – may need to wait for Theatreman for this

INFORMATION

Utilisation against this measure had remained consistently above the target 90%. However, the previous measure was flawed in that it included the overrun minutes in the numerator, against the planned time available in the denominator. From June, this has been amended to follow national best practice (The Productive Operating Theatre) with overrun minutes not included, so as not to skew performance to look better than it is in reality.

A realistic target against this measure is 85% with performance hovering around the 88%/89% mark for June & July.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are a range of actions being undertaken as part of the Patient Journey 2 project to ensure continual improvement in theatre in session utilisation, focussing on start time, turnaround, optimal list composition and the eradication of unplanned overruns.

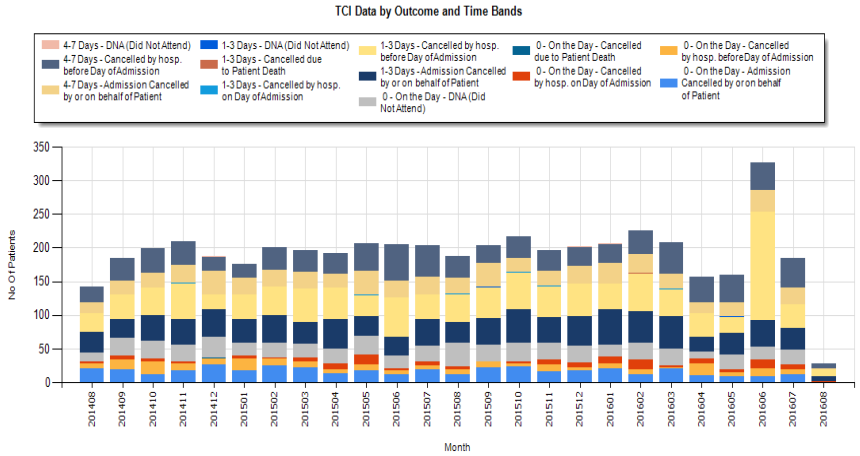
The implementation of the new Theatre Management System (Theatreman) planned for October will be a further vehicle to ensure that lists are optimally booked based on the available time.

RISKS / ISSUES

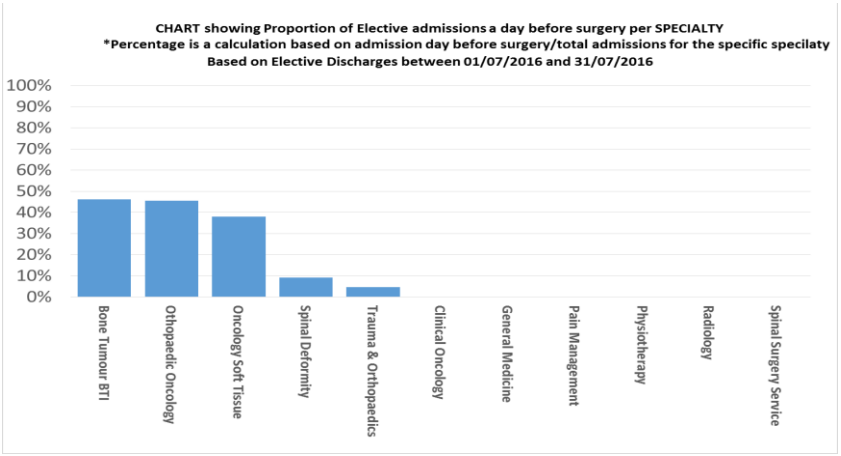
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (eg experience in spinal scrub) to ensure the best possible use of available operating time.

11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

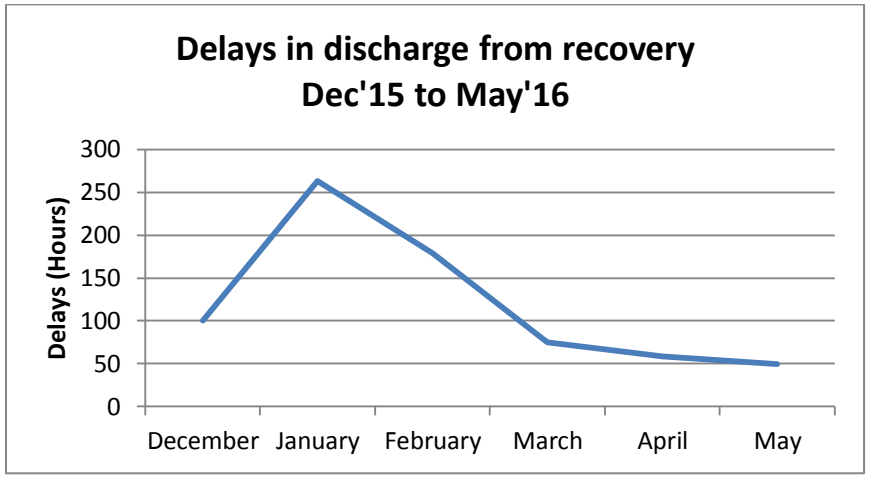
Cancellations by patient / hospital



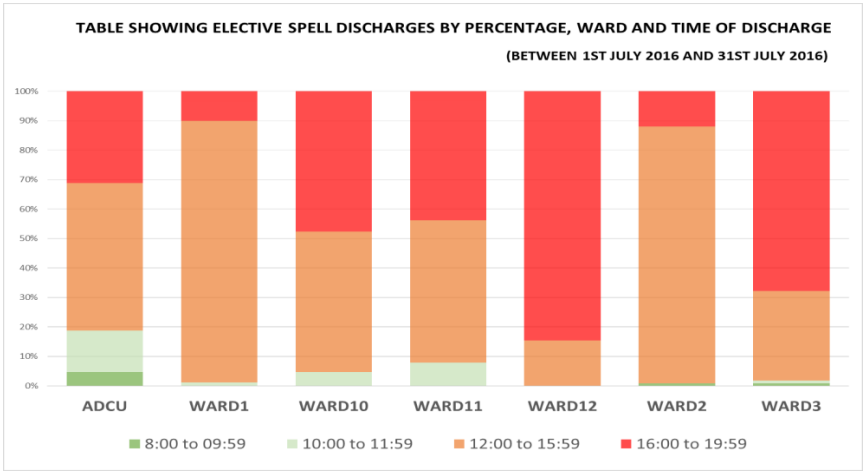
Admission the day before surgery



Delays out of recovery



Time of day patients discharged



INFORMATION

Cancellations in July has increased against the levels seen in April and May (ignoring June given the skewing of data linked to the theatre closure), however they remain at a level below the monthly position in 2015/16.

There has been some minor improvement in reducing the number of patients admitted prior to their day of surgery. Orthopaedic Oncology and Soft Tissue admissions in advance have reduced from over 50% in June to 46% and 39% respectively, although Bone tumour advance admissions did increase by about 15%. The biggest change relates to Spinal Deformity, which dropped from over 80% in June to 10% in July. Given the very low numbers of admissions in this specialty, it is too early to determine whether this is representative of a material change in the trend.

There has been little change in the trends around the timing of discharges. Wards 1 and 2 continue to discharge the vast majority of their patients prior to 4pm, however this is not the case in Wards 3 and 12 where further work is required to improve performance.

ACTIONS FOR IMPROVEMENTS / LEARNING

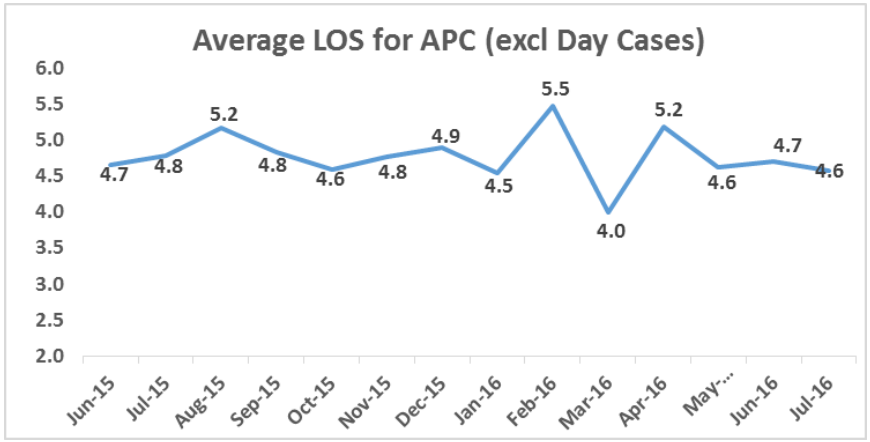
Continued work is required to ensure that all specialties have a pool of patients who are pre-op'd and available to be called in at short notice to fill cancellation slots. The concept of pooling of appropriate patients between consultants also needs to be undertaken to maximise efficiency.

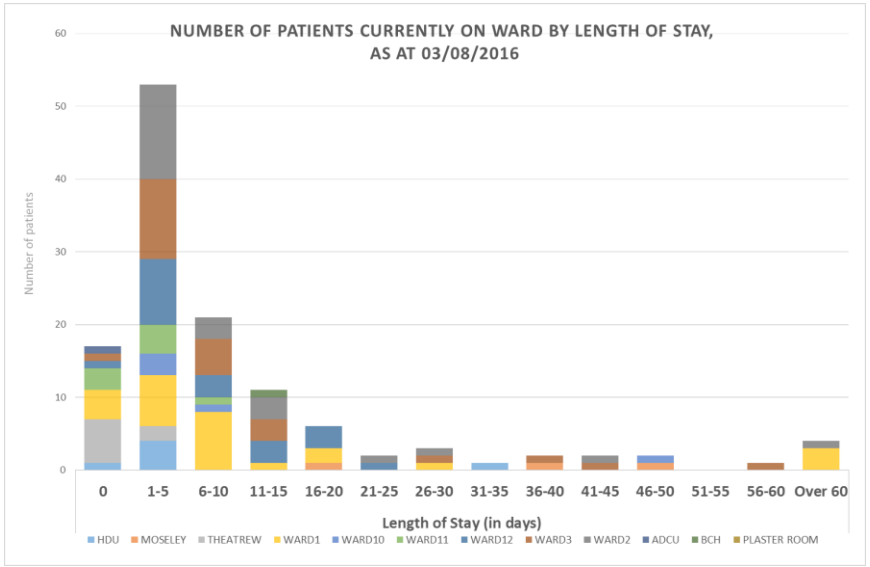
Work is required to draft and agree criteria for admission night before – clinical and social (ie if someone is coming from a long way) for agreement with consultants. As activity increases in line with the commissioned profile, it is important that these issues are addressed so that bed availability does not become a constraint to delivery. A case is also being worked up to increase the capacity and hours of ADCU to be able to undertake all appropriate work on a day case basis, to liberate further inpatient beds.

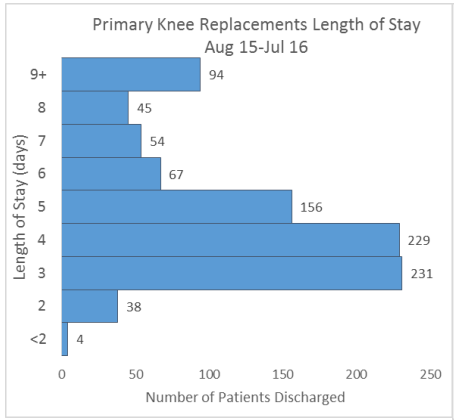
RISKS / ISSUES

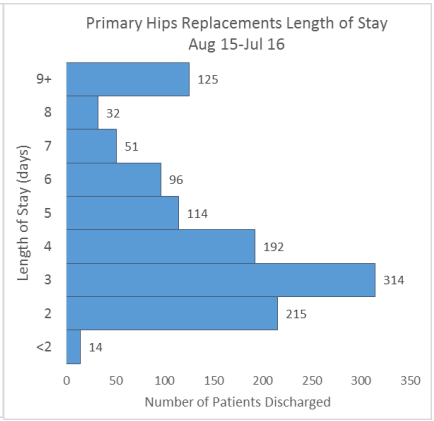
As activity increases in line with the profiled plan, it will become increasingly difficult to sustain admission before the day of surgery, and necessary to achieve a higher level of discharges before midday. This is covered within Patient Journey 2.

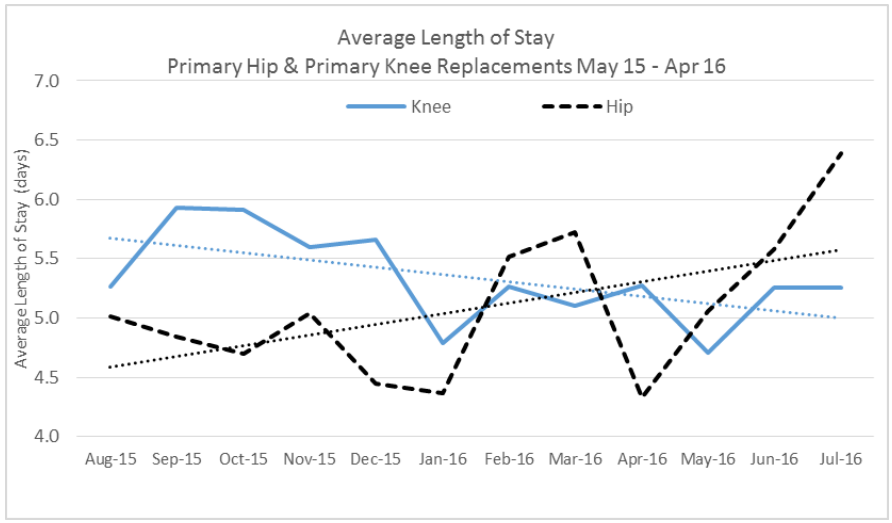
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Overall length of stay remains reasonably stable, however the average length of stay for hips has seen a significant increase in July. This has mirrored a trend that has been taking place since April 2016, and will be a key issue for the Trust to manage as bed capacity becomes more of a constraint over the coming months.

The profile of long waiting patients has also remained fairly stable, although there has been a slight increase in the very long stay patients (over 60 days) from 2 in June to 4 in July.

ACTIONS FOR IMPROVEMENTS / LEARNING

Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.

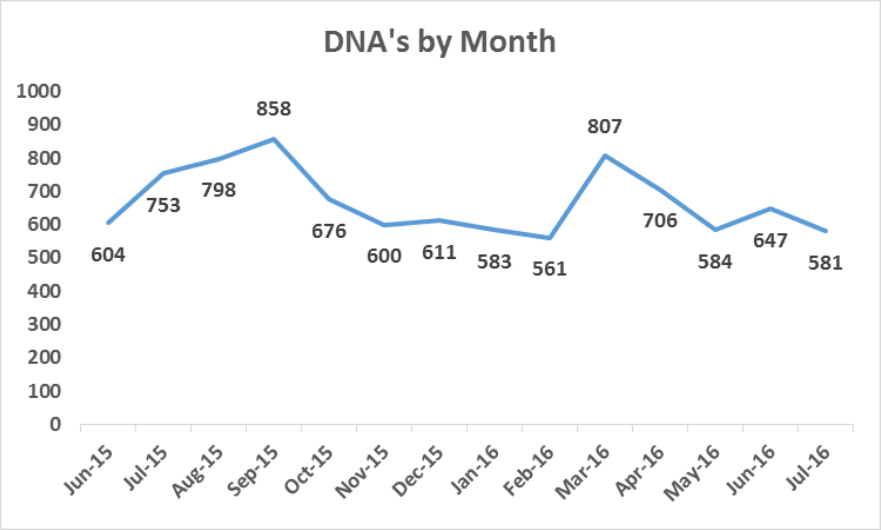
The Rapid Recovery project places particular focus on the actions needed to speed up discharge, initially in our primary joint pathways. This is anticipated to have a significant impact on length of stay in this area.

More formalised ward reviews should be part of consultant job planning discussions, which will be helpful in speeding up decision making and therefore shaving days off individual patient length of stay, or bringing discharge earlier in the day so that the bed can be recycled for incoming patients.

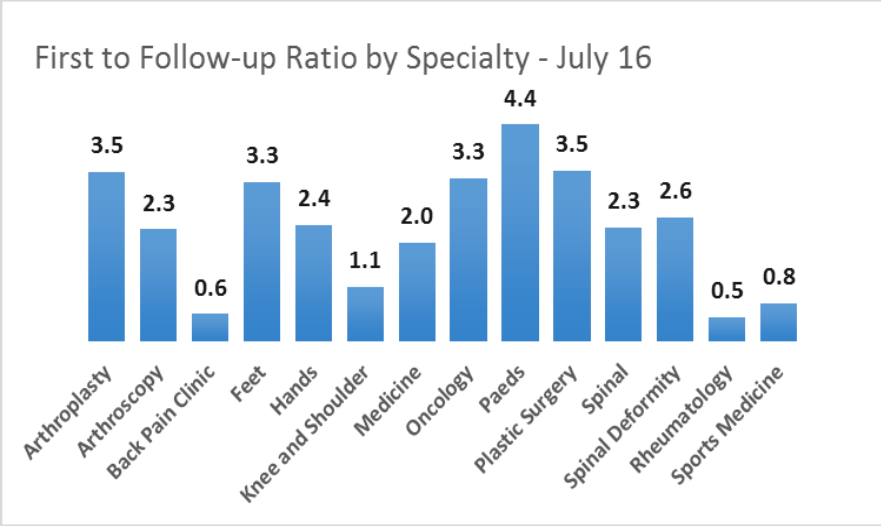
RISKS / ISSUES

With a defined bed stock, these changes need to happen at pace in order to deliver the commissioned level of activity.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients



Graph showing average waiting time in outpatients by month under development



Graph showing under / overbooking of clinic by specialty under development

INFORMATION

DNAs continue to slowly reduce from a high point in March 2016 however this has, to date, only reduced down to the stable level of DNAs experienced in 2015/16. Division 1 has a CIP related to the reduction of DNAs in outpatients; this is currently at risk based on performance to date.

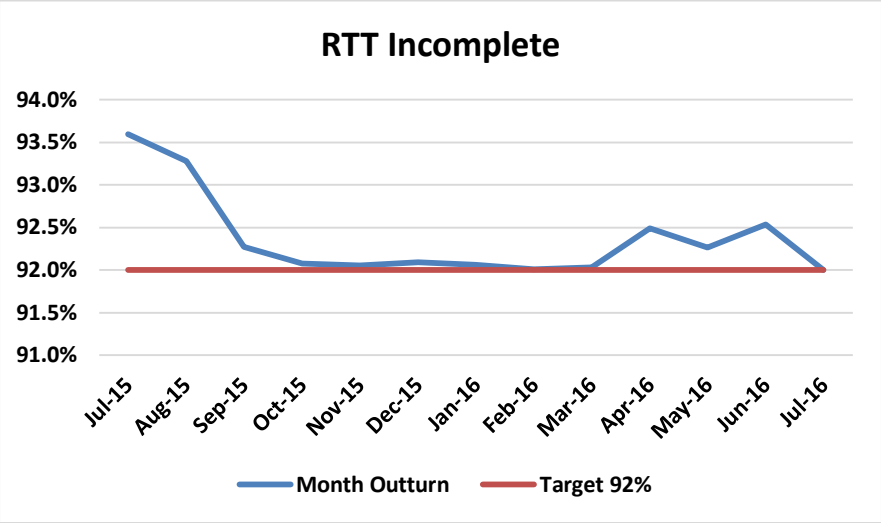
ACTIONS FOR IMPROVEMENTS / LEARNING

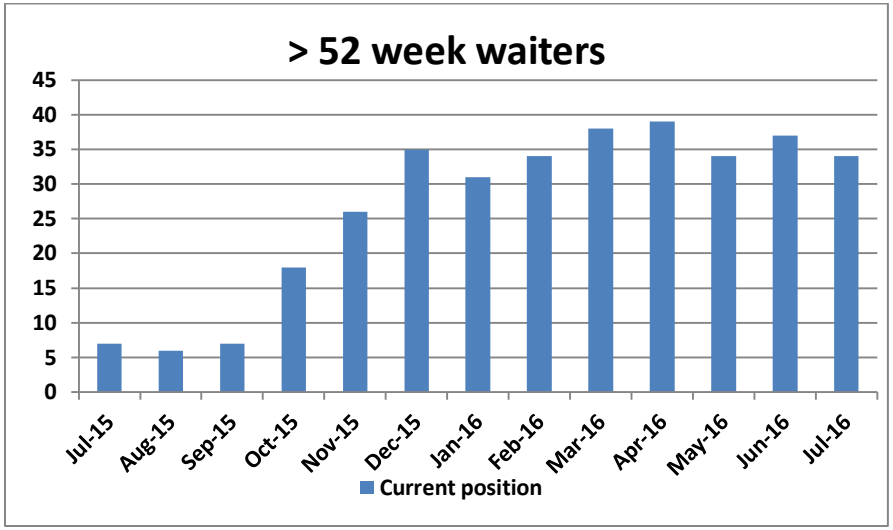
There are a range of actions as part of Patient Journey 2, and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

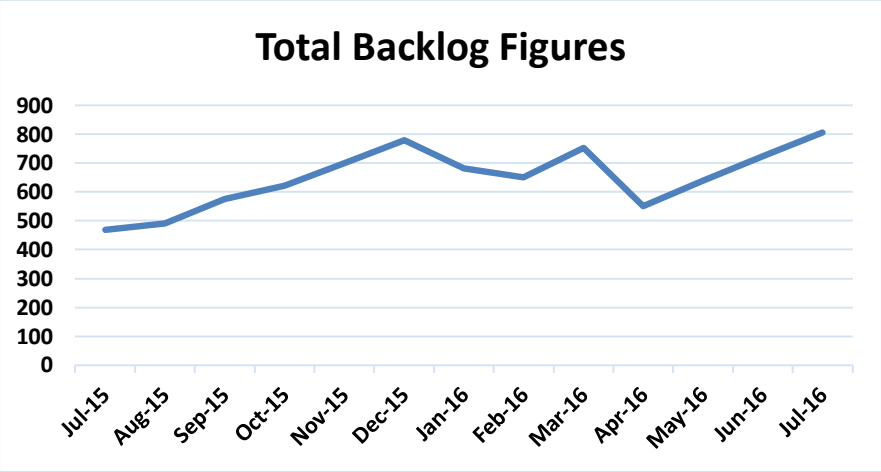
RISKS / ISSUES

Clinical engagement in the redesign of patient pathways.

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets	Target / Trajectory	Actual (July)	Actual (YTD)
52 week waiters	52	34	
18 week RTT	92%	92.00%	
Cancer (2 week wait)	93%	100%	100%
Cancer (31 days from diagnosis for 1st treatment)	96%	91.67%	96.55%
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	94.44%
Cancer (62 days)	85%	N/A	N/A

INFORMATION

The Trust remains on target against all year to date performance trajectories. The 96% cancer target for 1st treatment was missed in July, however as with all cancer targets, this is influenced by small numbers of patients and the Trust would still anticipate overall achievement for Quarter 2.

Focus remains on the clearance of 52 week breaches for spinal deformity, and these numbers have been held at a stable level since December 2015. Work continues to identify additional capacity to support this work, with trajectories showing an expected increase in waiters until significant extra capacity at BCH is sourced in 17/18.

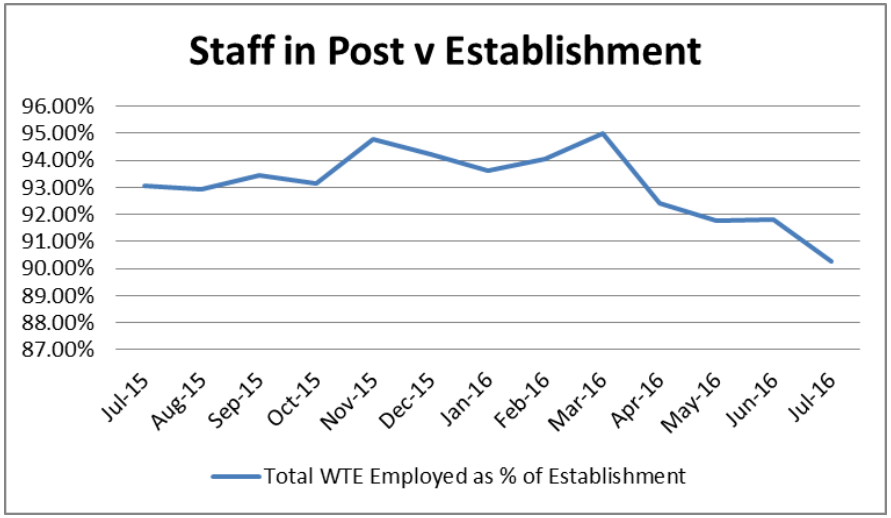
ACTIONS FOR IMPROVEMENTS / LEARNING

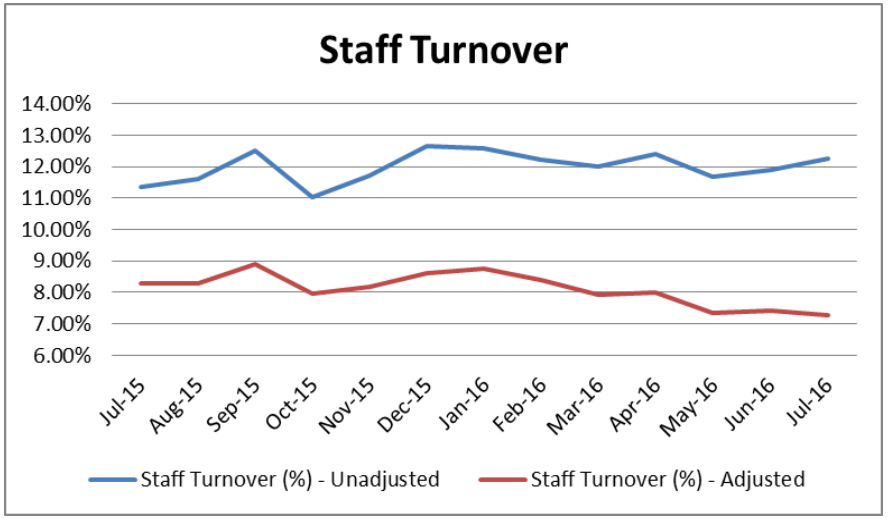
Effective use of additional operating lists at BCH, with potential requirement to treat further 52 weeks breaches in an alternative setting.

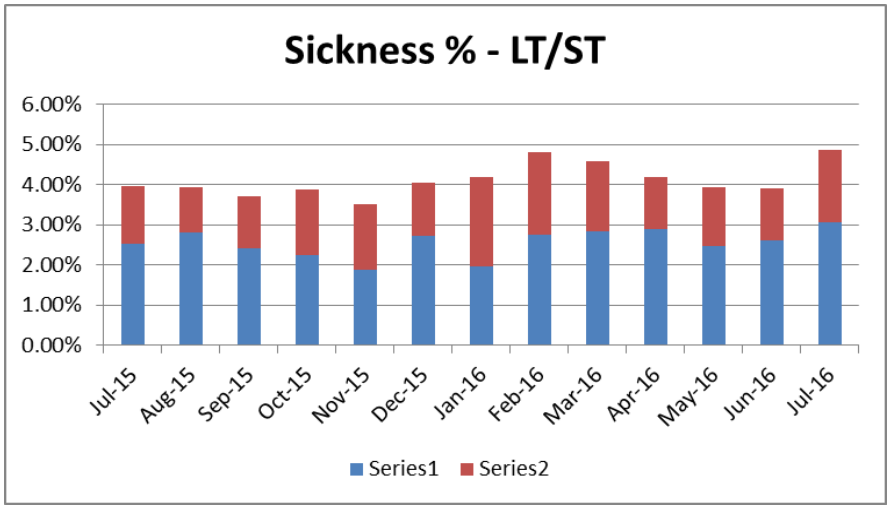
RISKS / ISSUES

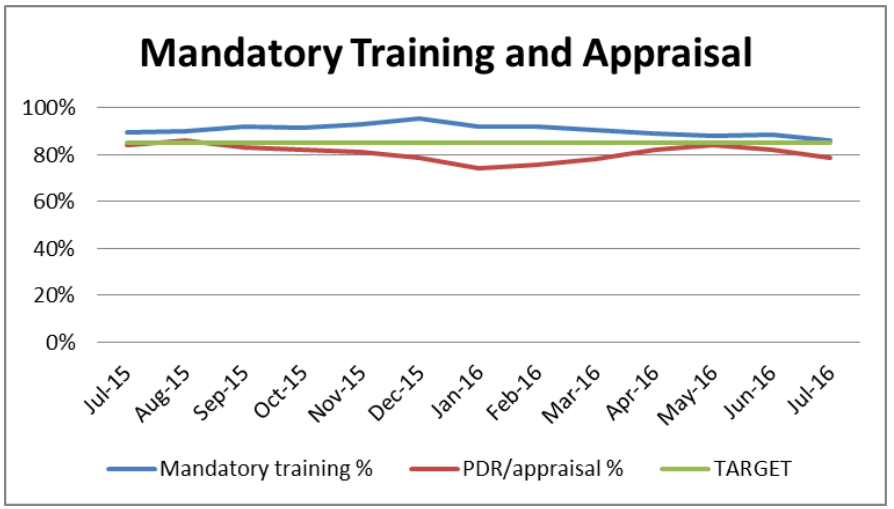
Spinal deformity remains a risk with regard to overall Trust performance, and discussions continue with BCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position. There is a risk that the amnesty with regard to fines is only for the 2016-17 financial year, and that this regime could resume from April 2017.

15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training









INFORMATION

Sickness absence has increased by almost 1% and unfortunately turned red in month. In context, sickness absence has not been this high since Jan 2015. There has been an increase both in short and long term absence, and the worsening of the in month position has just tipped the underlying 12 month position into amber at 4.22% (it had been green for the two previous months). At this stage, it appears a singularly unusual month – but further analysis will be undertaken as below.

The vacancy position taken from the ledger has declined again this month to 90.25%, but still remains amber. This is due in no small part to an increase in funded establishment of c 30WTE which has been added into Divisional and departmental base budgets. Whilst the number of staff employed has risen by c 11WTE compared with June, this has worsened the position. By way of assurance, the number of candidates in the recruitment checking and clearing process (96) broadly reflects the vacancy position.

The unadjusted turnover figure (all leavers minus junior medical staff and excluding employees who retire and return to work,) has increased again this month, but still remains amber. The adjusted turnover figure ("true leavers", so excluding fixed term contract expiries and dismissals) has decreased, however, and is at its lowest rate since May 2014.

The mandatory training position has decreased again this month by 3% but remains high amber at 86%. This is being raised at divisional boards, and managers are being reminded of the importance of attending. It will also be picked up at the Divisional Performance Clinics.

The appraisal position has decreased again despite the importance of completion and recording being raised at divisional boards. There is a view from divisions that they may not be recording all appraisals appropriately in ESR, so it is possible that this is slightly under-reported.

ACTIONS FOR IMPROVEMENTS / LEARNING

Further analysis of the reasons for absence will be undertaken. Additionally, Divisional Boards will be invited to cleanse and verify their data for the September submission and this will also be addressed with them at their divisional performance clinics.

RISKS / ISSUES

The decrease in mandatory training is a particular cause for concern, both from a patient safety perspective and also the likelihood of performance notices from our commissioner.

GOVERNANCE DEPARTMENT

QUALITY REPORT

August 2016

EXECUTIVE DIRECTOR: Garry Marsh *Director of Nursing and Clinical Governance*
AUTHOR: Faye Rafferty *Governance Manager*

CONTENTS

1. INTRODUCTION

This integrated Quality Report aims to provide a trust wide overview and assurance relating to patient safety, quality and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham Cross City Clinical Commissioning Group in order to satisfy contractual information requirements.

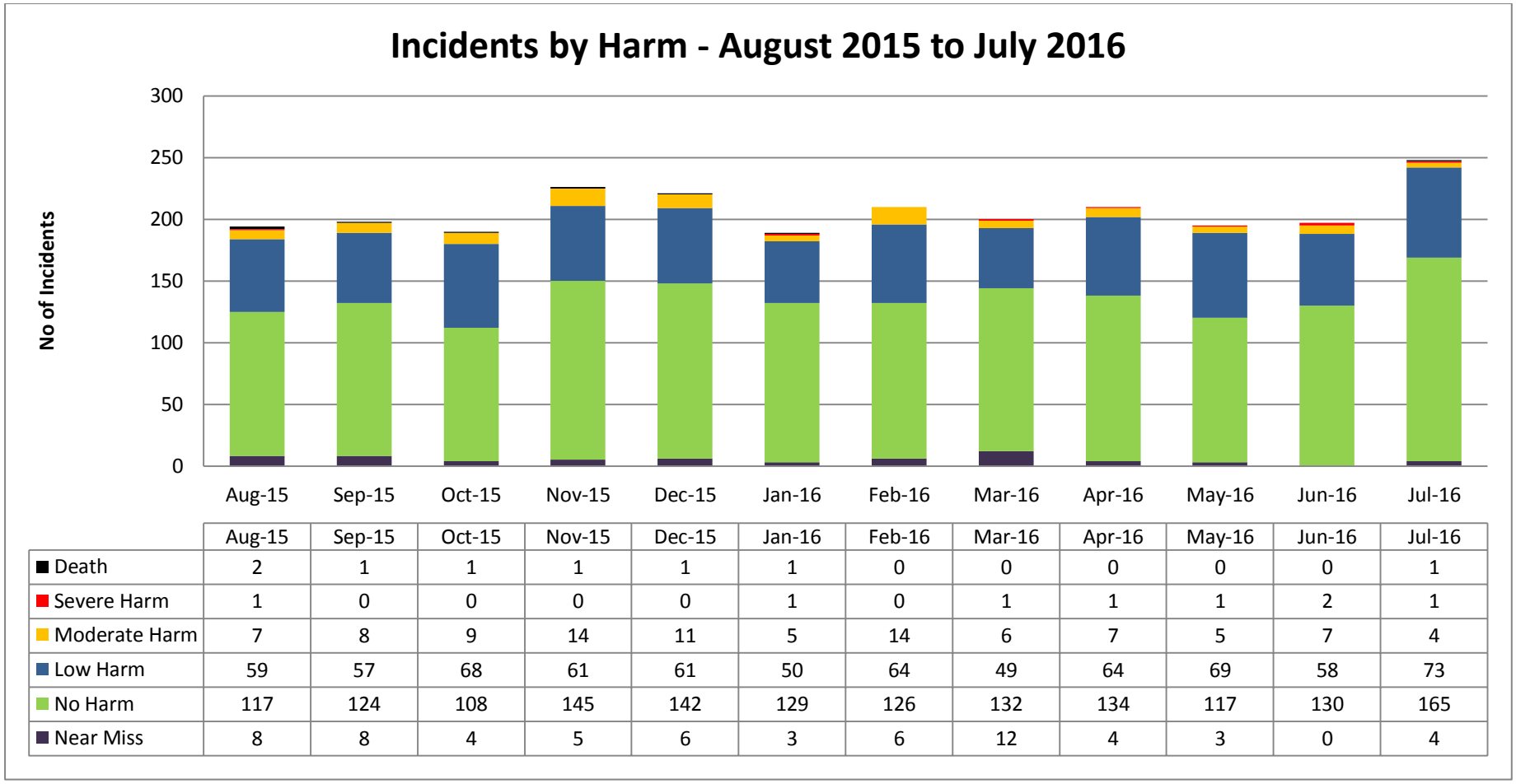
This Quality Report is a dynamic document, the data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this Quality Report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department;

Email: **roh-tr.governance@nhs.net**

Tel: 0121 685 4000 (ext. 55641)

2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Death	2	1	1	1	1	1	0	0	0	0	0	1
Severe Harm	1	0	0	0	0	1	0	1	1	1	2	1
Moderate Harm	7	8	9	14	11	5	14	6	7	5	7	4
Low Harm	59	57	68	61	61	50	64	49	64	69	58	73
No Harm	117	124	108	145	142	129	126	132	134	117	130	165
Near Miss	8	8	4	5	6	3	6	12	4	3	0	4

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

INFORMATION

There were 248 incidents reported during July 2016, including;

1 Death

1 Severe Harm

4 Moderate Harms

An update to the Ulysses has now been made to ensure the Trust is able to identify and report on incidents that have been reported that relate to Paediatric patients separately as recommended by the Royal College of Paediatrics and Child Health. This information will be included in next month's Quality Report.

ACTIONS FOR IMPROVEMENTS / LEARNING

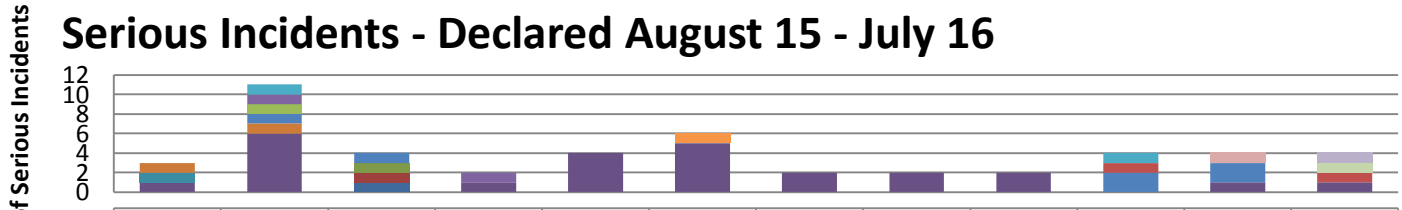
An audit has been completed in the outpatient department in response to CQC findings to assess current knowledge and understanding of the Incident reporting and duty of candour processes. Recommendations have been made. Training sessions for outpatient staff are being delivered through August and September. A roll out programme for other areas will then be developed.

This complements the mandatory training for governance that is delivered to all staff annually

RISKS / ISSUES

There can be delays in the response from incident managers when a request is made to review and amend incidents' harm ratings. Division 2 holds a weekly governance meeting where all incidents rated moderate and above are reviewed. Division 1 will begin to hold regular weekly governance meetings from September. This will ensure incidents are escalated and avoid unnecessary delays.

3. **Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.**



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Wrong Site Incision												1
Wrong Implant												1
Suspension to services											1	
Delayed diagnosis						1						
Wrong side injection		1								1		
Unexpected deaths		1		1								
Staff conduct incidents		1										
Slips, trips & falls										1		1
Pressure Ulcers		1	1							2	2	
Emergency transfer out of Trust	1	1										
Appointment delay	1											
VTE meeting SI criteria	1	6		1	4	5	2	2	2		1	1
Surgical incident meeting SI criteria			1									
Emergency transfer to HDU			1									
Failure to act on test results			1									

INFORMATION

There were 4 Serious Incidents (SI) declared in July 2016.

All 4 Serious incidents reported to commissioners during July 2016 are currently under investigation within contractual timescales.

ACTIONS FOR IMPROVEMENTS / LEARNING

2 SIs were submitted for closure to Commissioners in July 2016.

- 1 report was in response to a pressure ulcer met the criteria for reporting to commissioners. Details of recommendations are provided in the pressure ulcer section below.
- 1 report was in response to a patient fall that resulted in a fractured radius. Details of actions and recommendations are provided in the falls section of this report.

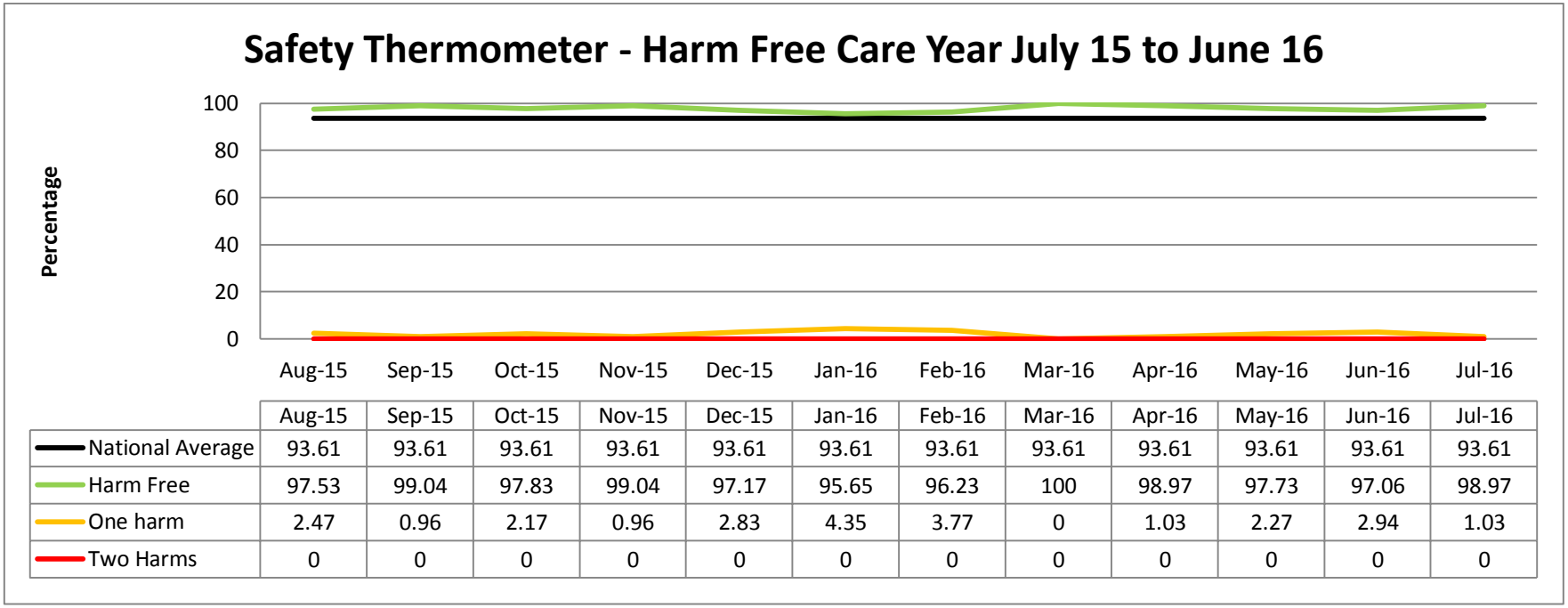
All of the reports and associated action plans submitted to the commissioners during July were closed without further queries being received from the commissioners.

The Trust submitted 1 request for a downgrade of an SI during July. This related to a grade 3 pressure ulcer that was present on admission to the Trust. This downgrade has been agreed by commissioners.

RISKS / ISSUES

None identified.

4. **NHS Safety Thermometer - provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month. In February 2016, a revised standard operating procedure for the collection of data was introduced at ROH. It is of note that ROH continues to perform well against the national average as shown in the table below.**



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
National Average	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61
Harm Free	97.53	99.04	97.83	99.04	97.17	95.65	96.23	100	98.97	97.73	97.06	98.97
One harm	2.47	0.96	2.17	0.96	2.83	4.35	3.77	0	1.03	2.27	2.94	1.03
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

There was 1 harm reported during July 2016 relating to an inpatient fall that occurred on ward 2.

Children and Young Person's Safety Thermometer

The Trust has started to submit data to the Children and Young Person's Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. Due to the limited number of data points submitted graphical representation of the data is not yet available from the national tool. This report will include information form the tool once available.

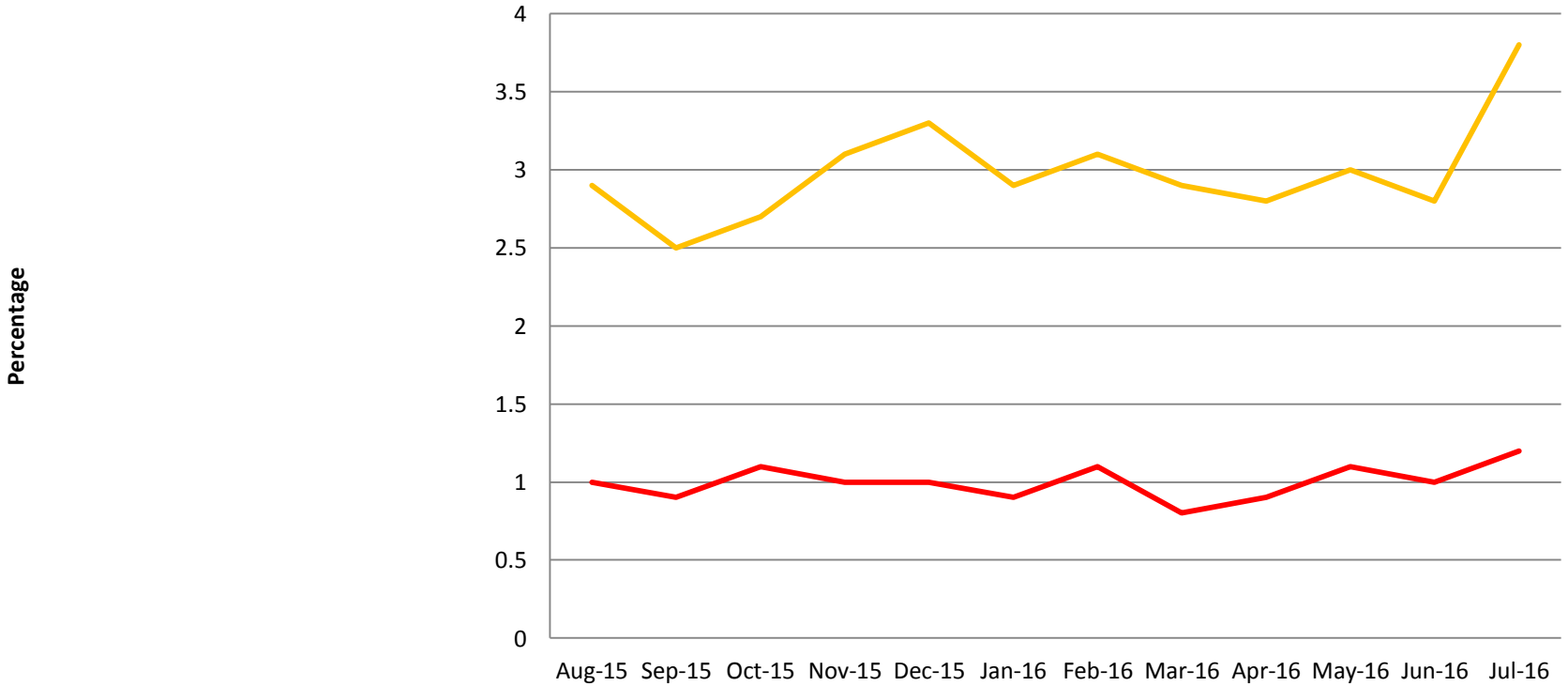
5. **All patient contact and harm – In contrast to the Safety Thermometer which measures the number of harm on one particular day of the month, the following data represents the total number of patient contacts in June 2016 compared to all incidents reported and incidents resulting in harm. Harm includes low harm, moderate harm, severe harm and deaths.**

	Low Harm	Moderate Harm	Severe Harm	Death	Total Incident with Harm	All Incidents Total	Total Patient Contacts
Aug-15	59	7	1	2	69	194	6651
Sep-15	58	8	0	1	67	195	7700
Oct-15	68	9	0	1	78	190	7082
Nov-15	61	14	0	1	76	226	7251
Dec-15	61	11	0	0	72	220	6714
Jan-16	50	5	1	1	57	189	6627
Feb-16	64	14	0	0	78	210	6768
Mar-16	49	6	1	0	56	200	6862
Apr-16	64	7	1	0	72	210	7636
May-16	69	5	1	0	75	195	6528
Jun-16	58	7	2	0	67	197	7037
Jul-16	73	4	1	1	79	248	6426

* This report is written prior to the validation of the total patient contacts. This figure is therefore subject to change following publication.

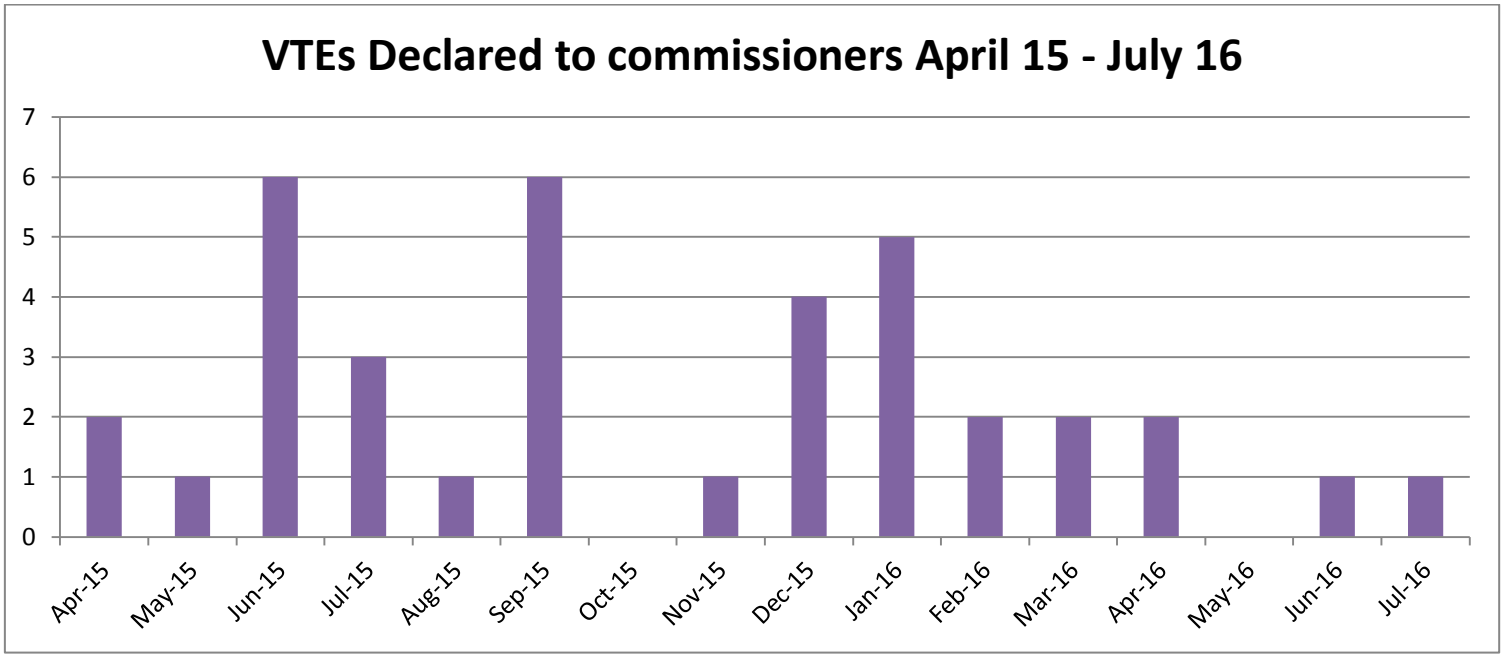
In July 2016, there were a total of 6426 patient contacts. There were 248 incidents reported which is 3.8 percent of the total patient contacts. Of those 248 reported incidents, 79 incidents resulted in harm which is 1.2% of the total patient contact for the month. The Trust is currently reviewing the possibility of benchmarking this data with similar organisations and will include the data as and when it is available.

% of Patient Contact Compared to Number of Incidents and Incidents with Harm August to 15 to July 2016



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
% of Patient Contacts with Incidents Causing Harm	1	0.9	1.1	1	1	0.9	1.1	0.8	0.9	1.1	1	1.2
% of Patient Contact With All Incidents Reported	2.9	2.5	2.7	3.1	3.3	2.9	3.1	2.9	2.8	3	2.8	3.8

6. **VTEs - A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called a venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism).**



RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION
First choice for orthopaedic care

INFORMATION

There was 1 VTE incident reported to Commissioners during July 2016. This was discovered post discharge.

ACTIONS FOR IMPROVEMENTS / LEARNING

There were no final investigation reports in response to VTEs due for submission to Commissioners during July 2016.

VTE training continues for student nurses, registered and non-registered staff (clinical update days) and for junior doctors on induction. It is mandatory for clinical staff that have direct patient contact to complete a VTE e-learning module. Targeted learning will take place with individuals identified within RCAs as being none compliant with expected standards.

ROH continues to exceed expected targets set in relation to VTE risk assessment on admission and compliance with Thromboprophylaxis for high risk patients.

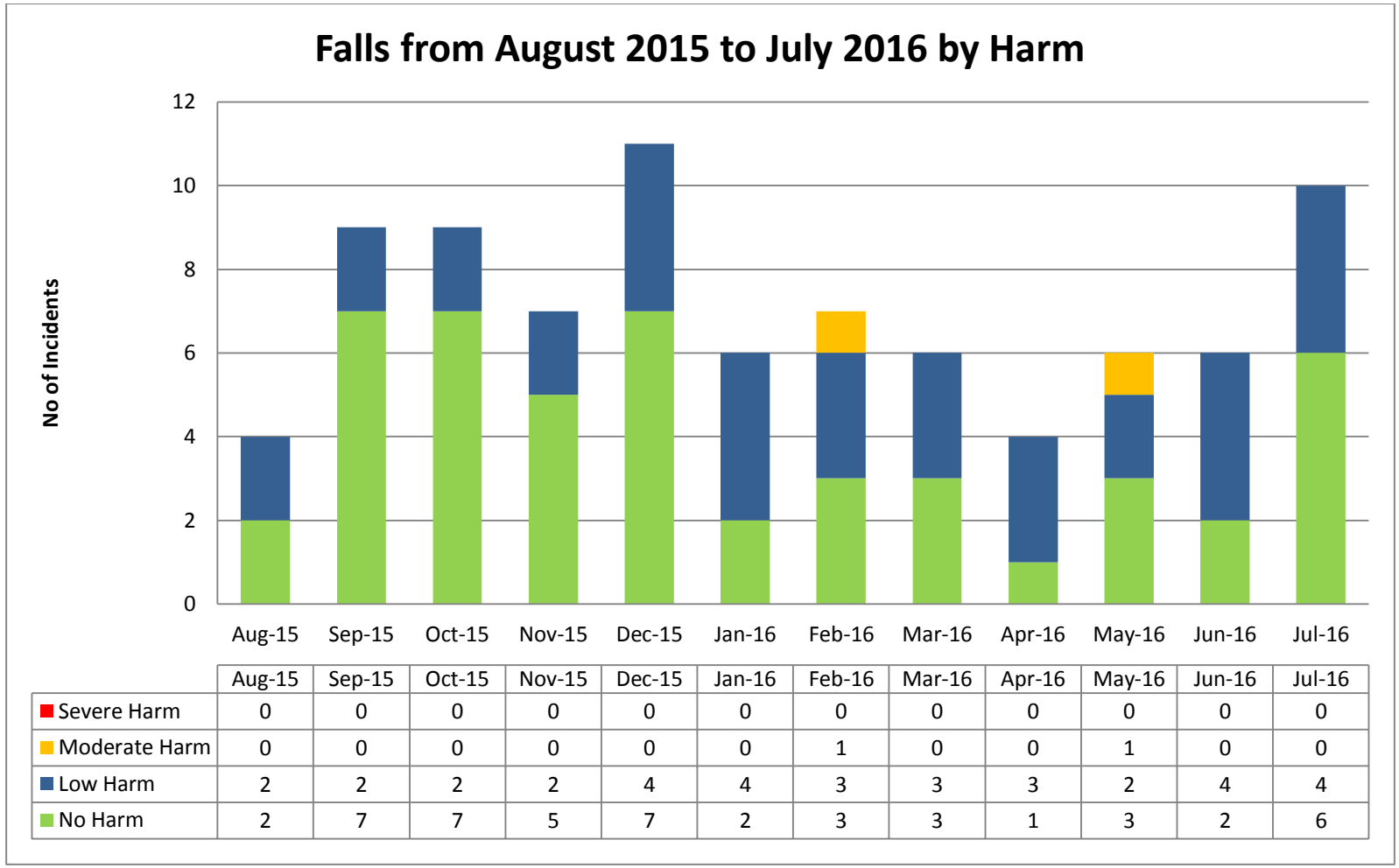
Many of the requirements within the 2016/17 CQUIN have either been achieved or partially achieved. Through outpatients follow ups, the Infection Control hotline and Surgical site 90 day questionnaires the trust is able to identify and review patients who have been diagnosed with a VTE post discharge. Work to fully meet the requirements of the CQUIN will enhance this further.

Following investigation of VTEs a trend has been identified relating to documentation which can sometimes result in potentially unavoidable VTEs being deemed as avoidable particularly around compliance with 24 hour post admission/readmission requirements. Education relating to documentation continues within the Trust.

RISKS / ISSUES

None identified.

7. Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	0	1	0	0	1	0	0
Low Harm	2	2	2	2	4	4	3	3	3	2	4	4
No Harm	2	7	7	5	7	2	3	3	1	3	2	6

INFORMATION

During July 2016, 10 inpatient falls have been reported.

The Head of Nursing will be responsible for reviewing falls within the Trust. Findings from these reviews will be included within future quality reports.

ACTIONS FOR IMPROVEMENTS / LEARNING

A final report in response to a fall that resulted in a fractured wrist was submitted to commissioners during July the investigation of this incident found that

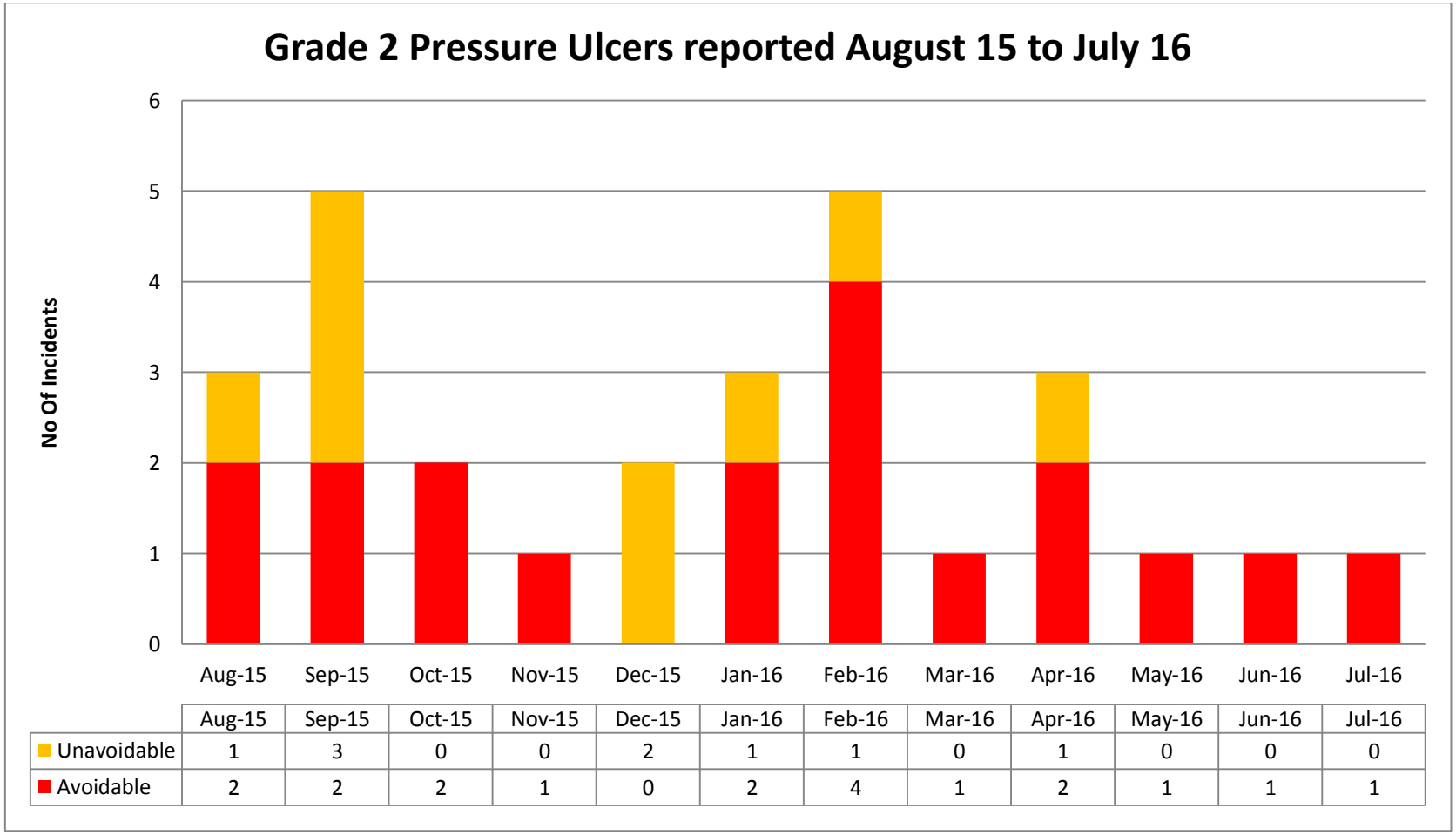
- All risk assessments and care plans were completed appropriately pre- and post-fall.
- The patient had been deemed safe and independent by the therapy team and had been discharged from their input
- This fall was deemed as unavoidable.

Although this fall was deemed unavoidable a recommendation and action has been identified relating to HDU reviewing care plan usage for post-operative patients, in particular, reduced mobility and pain care plans.

RISKS / ISSUES

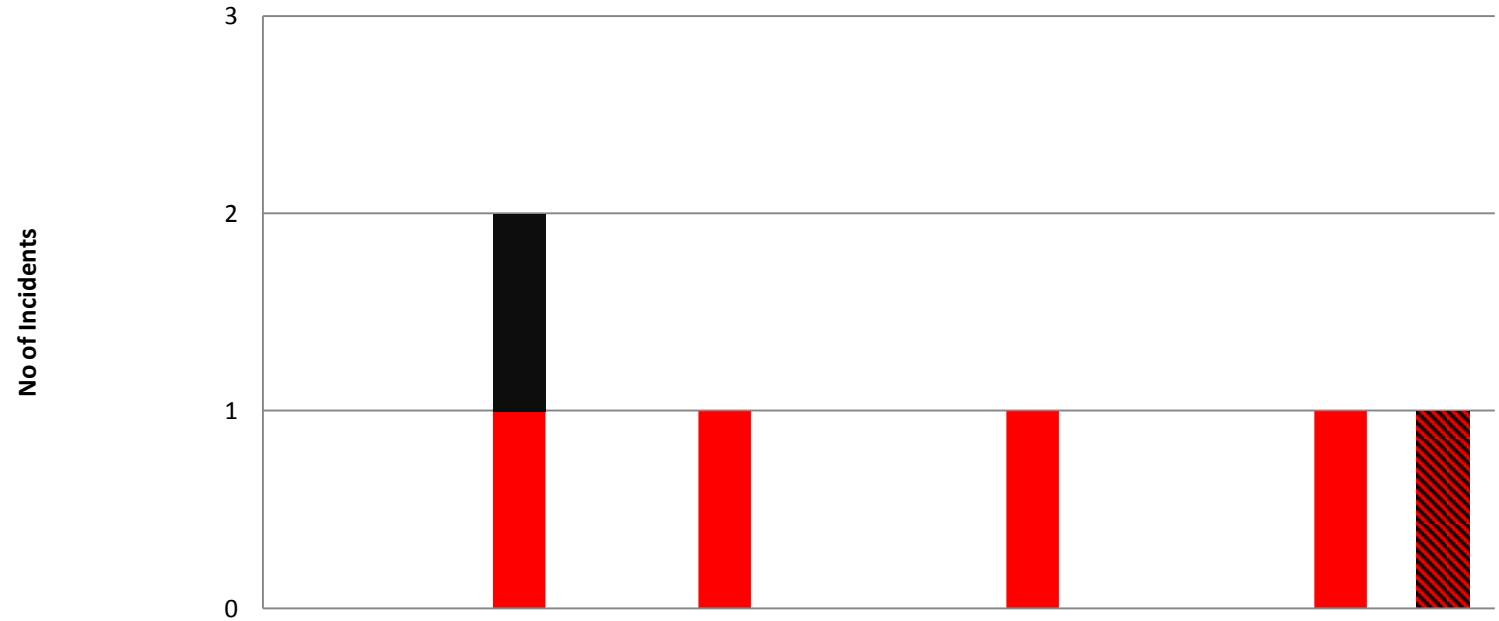
None identified.

8. **Pressure Ulcers - are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.**



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Unavoidable	1	3	0	0	2	1	1	0	1	0	0	0
Avoidable	2	2	2	1	0	2	4	1	2	1	1	1

Grade 3 & 4 Pressure Ulcers reported August 15 to July 16



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Under investigation												1
Grade 4 (Avoidable)			1									
Grade 3 (Avoidable)			1		1			1			1	

INFORMATION

During July there was 1 avoidable grade 2 pressure ulcer reported.

There was 1 Grade 3 pressure ulcer reported during July. The RCA is ongoing to determine avoidability. This incident has been reported to commissioners and will appear in the next month's report under the SI section as this was reported externally in August.

ROH contractual limit for Pressure Ulcers in 2016/17
Grade 2 Avoidable Limit is 15 - at July 2016 = 5 avoidable
Grade 3 Avoidable Limit is 0 - at July 2016 = 2. 1 has been deemed avoidable the remaining 1 is currently under investigation.
Grade 4 Avoidable Limit is 0 **- at July** 2016 = 0

ACTIONS FOR IMPROVEMENTS / LEARNING

A pressure ulcer reduction plan has been developed in order to reduce the number of grade 2 pressure ulcers and eliminate all grade 3 and grade 4 pressure ulcers for 2016/17. There are 10 actions of which all have been commenced and are ongoing.

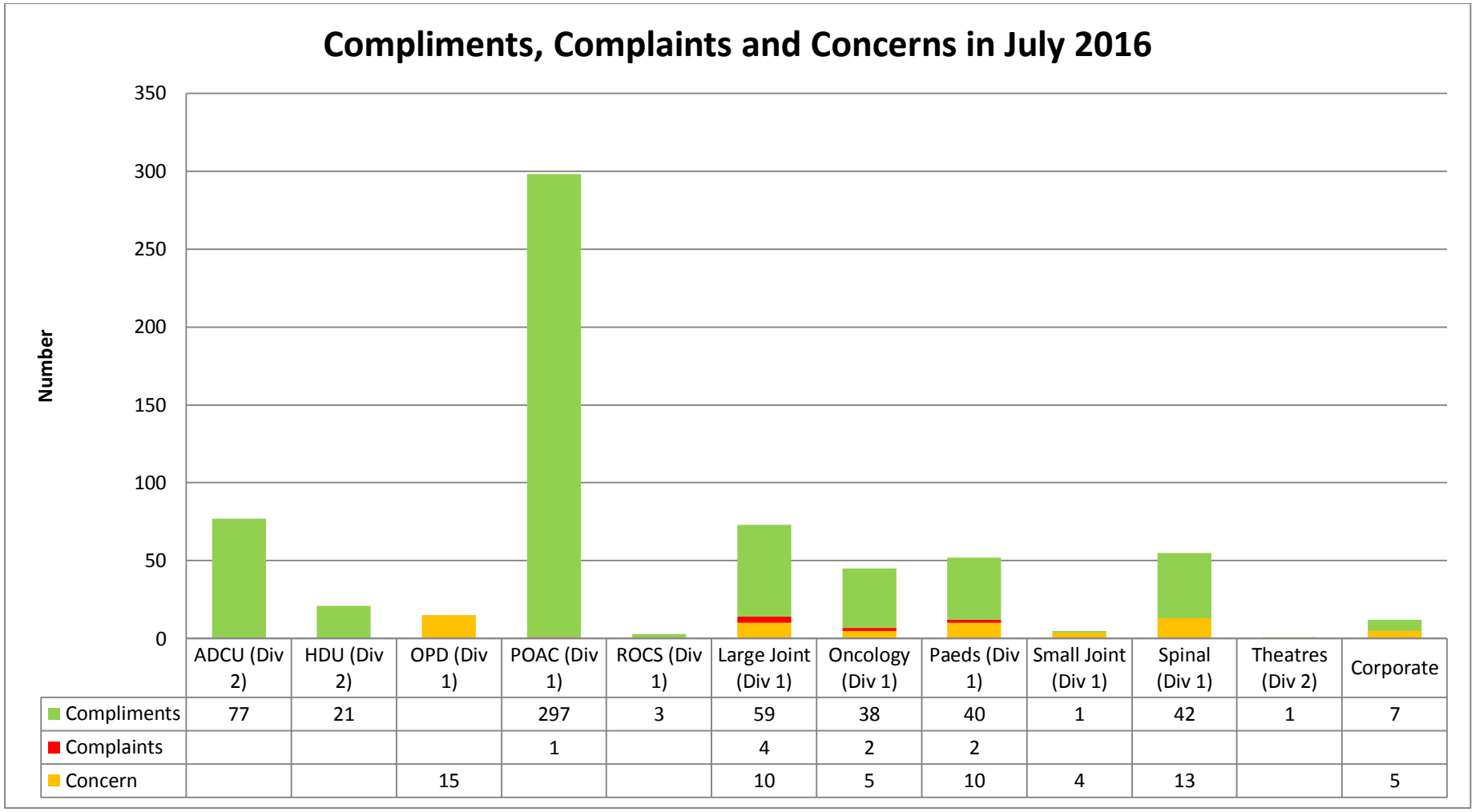
A report was submitted to commissioners in response to a grade 3 pressure ulcer. This pressure ulcer was deemed to be unavoidable. Actions identified following investigation included –

- Plaster care to be recorded on a plaster care plan team to be reminded and compliance monitored
- Ward team to be reminded at ward meeting and compliance to be monitored

RISKS / ISSUES

There is a risk of a financial penalty to the Trust by the Commissioners as ROH have exceeded the contractual threshold set relating to the number of grade 3/4 pressure ulcers reported during 2016/17. The fines associated with pressure ulcers within this year's contract are as follows
Grade 2 first 3 pressure ulcers reported above the 15 threshold = £1000
Grade 3 first 3 reported - £1000
Grade 4 first 2 reported - £1000

9. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



	ADCU (Div 2)	HDU (Div 2)	OPD (Div 1)	POAC (Div 1)	ROCS (Div 1)	Large Joint (Div 1)	Oncology (Div 1)	Paeds (Div 1)	Small Joint (Div 1)	Spinal (Div 1)	Theatres (Div 2)	Corporate
Compliments	77	21		297	3	59	38	40	1	42	1	7
Complaints				1		4	2	2				
Concern			15			10	5	10	4	13		5

INFORMATION

In July there were 9 complaints, 62 concerns and 586 compliments received.

ACTIONS FOR IMPROVEMENTS / LEARNING

4 complaints were closed in July 2016, all of which were closed within the agreed timescales. This gives a 100% completion on time and meets the KPI.

Of the 4 complaints closed in July 2016:

- 2 were upheld
- 0 were partially upheld
- 2 were not upheld

The two complaints upheld relate to the lack of demonstration of the Trust's expected values and behaviours when dealing with patients.

Learning identified and actions taken as a result of complaints closed in July 2016 include:

- Patients and General Practitioners are not always aware of the BMI threshold for knee and hip surgery
  Action: Head of Commissioning is writing to patients and GP's who have been inappropriately referred.

- Attitude of contracted member of staff inappropriate
  Action: Professional Conversation undertaken and individual will not be returning to work at the Trust.

- Clinical treatment by member of staff not as would be expected
  Action: Appropriate monitoring and action being taken

There have been no complaints referred to the Parliamentary Health Service Ombudsman during July 16.

There are currently 2 complaints with the Ombudsman.

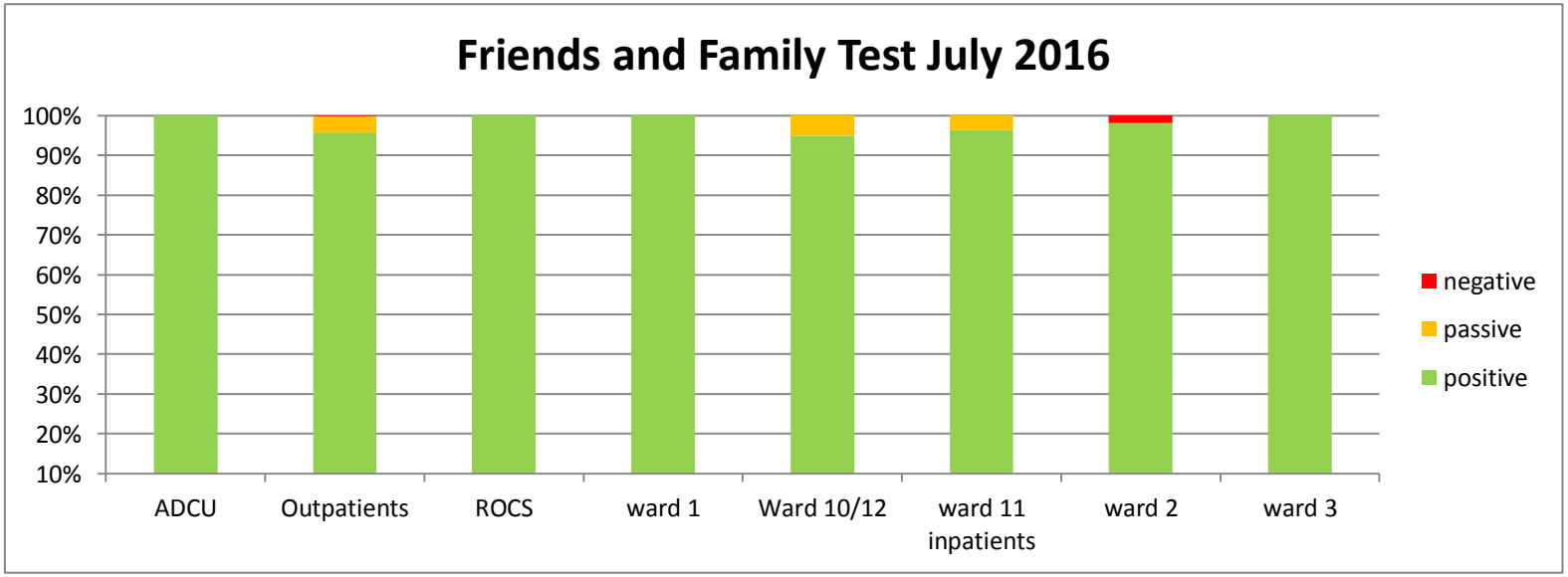
RISKS / ISSUES

None Identified

10. Friends and Family Test Results - The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

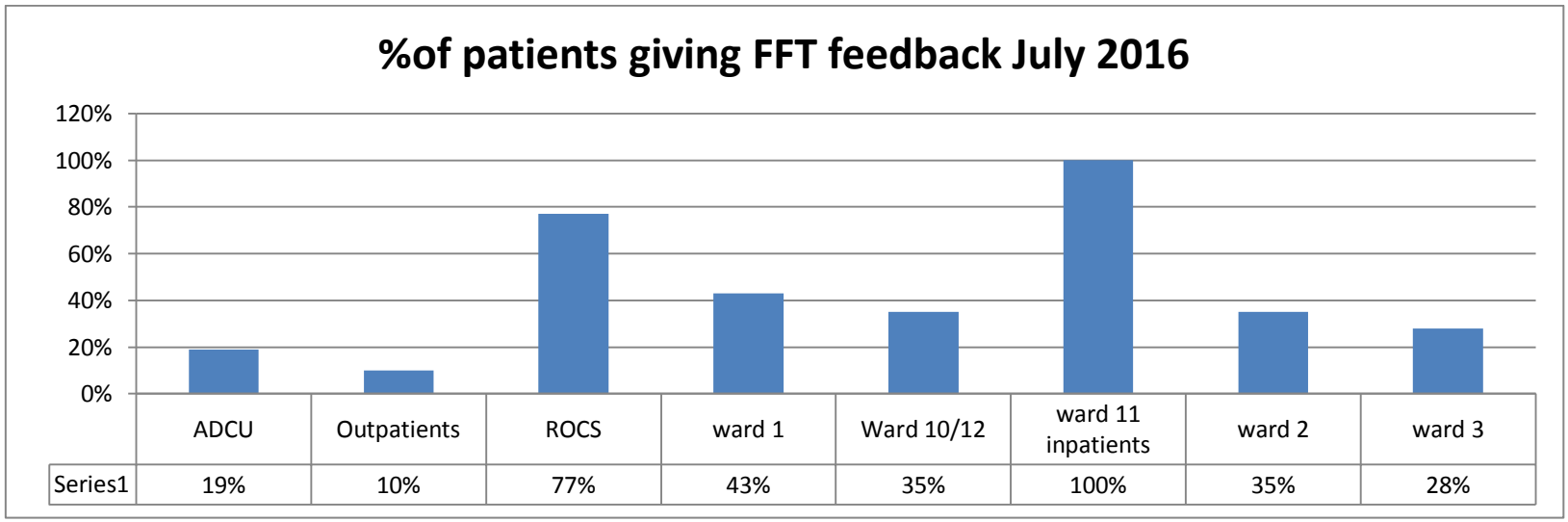
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting patient choice

This is a positive percentage score and it can be seen that almost all patients that we care for would recommend ROH to their family and friends.



The Scores for Friends and Family are calculated using a straightforward percentage response to the question 'How likely are you to recommend this area to friends or family if they require similar care or treatment?' Any patients answering the question as Extremely Likely / Likely are classified as Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely/Extremely Unlikely are classified as negative.

The percentages for all inpatient activity for July 2016 are 97% of those who responded would promote ROH.



Department	Positive	Passive	Negative	satisfaction rate	Eligible	Completion rate
ADCU	106	1	0	99%	558	19%
Outpatients	645	29	5	95%	6833	10%
ROCS	98	1	0	99%	128	77%
ward 1	41	4	0	91%	105	43%
Ward 10/12	39	2	0	95%	118	35%
ward 11 inpatients	37	0	0	100%	37	100%
ward 2	39	1	0	98%	115	35%
ward 3	30	1	1	94%	115	28%

There is an improvement plan in place for the Communications Department to increase the level of responses in the OPD and ADCU. Actions include having extra forms available for patients to complete and prompting staff members to ask patients to complete the forms. The possibility of implementing additional software to aid this process is also being explored.

11. Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.

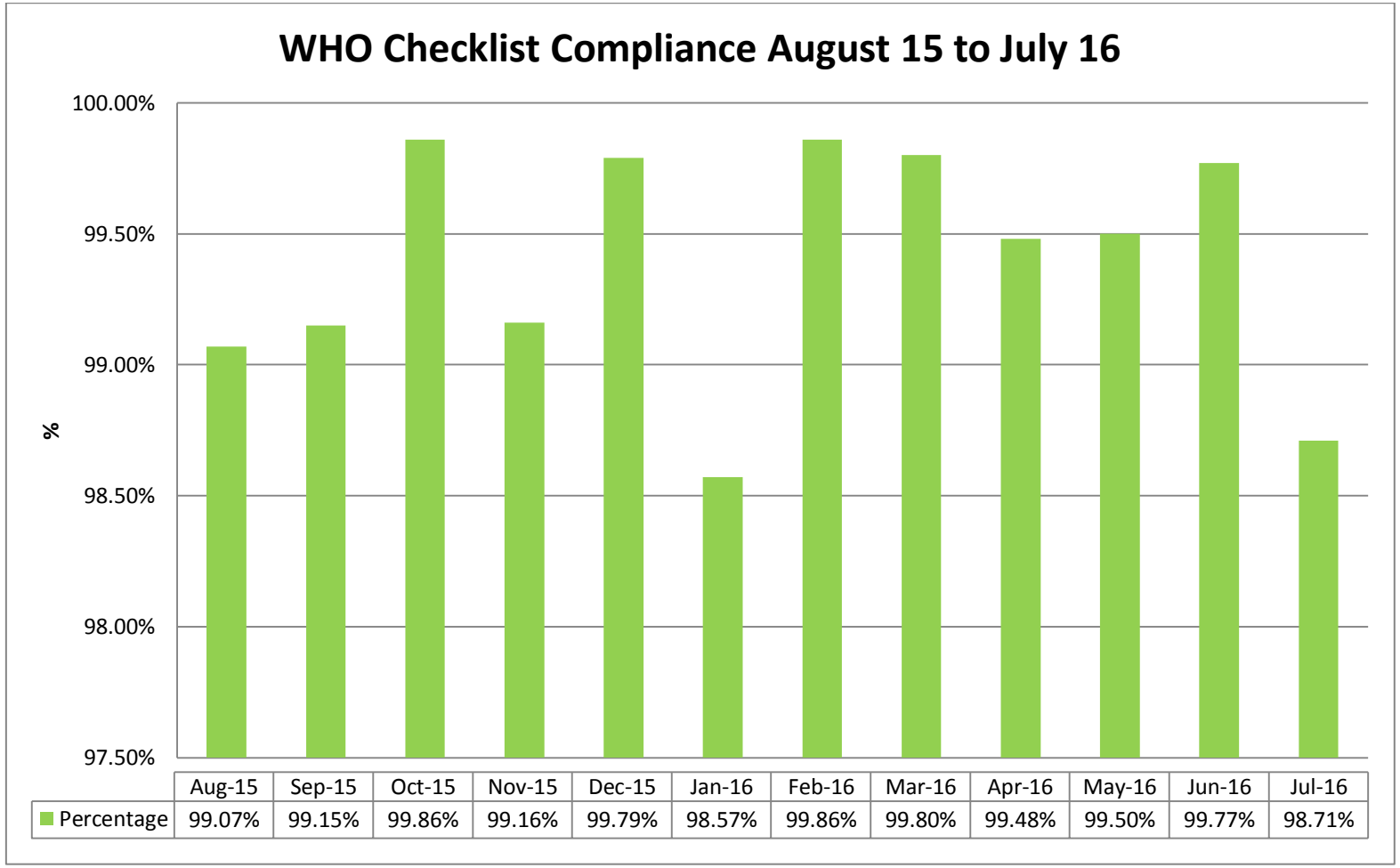
There are currently 17 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

An internal audit has been completed to review arrangements for demonstrating compliance with Regulation 20 with a particular emphasis on the robustness of internal tracking of compliance with the Duty of Candour. The Trust awaits the final report and recommendations following this audit.

12. Litigation

- The Trust is handling two new claims.

13. WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases of perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Percentage	99.07%	99.15%	99.86%	99.16%	99.79%	98.57%	99.86%	99.80%	99.48%	99.50%	99.77%	98.71%

INFORMATION

Total Cases in July 2016 = 543

Total Non-Compliance = 7

Total Compliance = **98.7% Total**

An external review of the Trust's safety processes within theatres has been commissioned for assurance and learning.

ACTIONS FOR IMPROVEMENTS / LEARNING

The following recommendations are made following the audit collation:

1. Quarterly report to be disseminated to the Medical director, Clinical Directors, Clinical Leads, Consultants and Team Leaders.
2. Directorates with consistent 100% compliance to share best practice.
3. Continue with weekly and monthly reporting to the Medical Director and Director of Nursing &Clinical Governance.
4. Monthly reporting to the Commissioners.
5. Non-compliance percentages and incomplete sections and areas of the WHO Patient Safety Checklist to continue to be emailed directly to the Consultant and the staff member involved.
6. Audit results are also discussed as a standing agenda item at the Theatre User Group meetings

RISKS / ISSUES

None identified.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Declaration to NHS Improvement – Quarter 1 2016/17**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**7 September 2016**

EXECUTIVE SUMMARY:

The Trust is required to submit a quarterly declaration to NHS Improvement (NHSI) 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 1 submission was due on the 29th July 2016.

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 NHSI on 29 July 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	X	Patient Experience	X
Clinical	X	Equality and Diversity		Workforce	

Comments: None
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 (9/16) 006 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUARTER 1 2016/17 GOVERNANCE DECLARATION TO NHS IMPROVEMENT

Report to Trust Board on 7 September 2016

Background

1.0 The Trust is required to submit a quarterly declaration to NHS Improvement (NHSI) concerning financial and governance performance. This covers achievement of national targets and core standards as outlined in NHSI's Risk Assessment Framework (RAF). The Quarter 1 submission was due on the 29th July 2016.

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 NHSI 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 three months from the 1st April 2016 to 30th June 2016 is contained in the Trust's Finance & Performance overview report.

2.1.3 The Trust's deficit stands at £1.89m at the end of Quarter 1, against a planned deficit of £0.7m.

2.1.4 The main driver for underperformance in Quarter 1 was the closure of theatres during the week commencing 6th June 2016. This resulted in a net financial impact of circa £0.9m.

2.1.5 The remaining underperformance is linked to reduced activity in the final three weeks of June and an under-delivery of Cost Improvement Savings in the operational divisions, partly offset by

corporate savings.

2.1.6 The Trust had planned to deliver a Financial Sustainability Risk Rating of 2 in Quarter 1 of 2016/17. The Trust has delivered this rating of 2, however it 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).

2.1.7 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 circa £800,000 for 2016/17. This is not felt to be deliverable in 2016/17. 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.

2.1.8 The quarterly governance declaration requires the Trust 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. The Trust is currently reviewing its planned capital spend against a number of pressures, and also with consideration to our overall cash position however at this point we are not anticipating any material movement against the overall plan.

3.0 Service Performance Targets

3.1 Summary

3.1.1 The table of NHSI 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 NHSI 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 As of 30th June 2016 the Trust was managing 7836 patients on its 18 week RTT patient tracking list. Of these 585 have exceed the 18 week standard, reflecting an unvalidated performance of 92.53% for the month (92.43% for Quarter 1) against the 92% incomplete standard. The performance for this patient group at the end of June 2016 being 469 open pathways of which 127 patients have waited in excess of 18 weeks, reflecting 72.92% performance against the 18 week RTT. ROH is therefore viewed locally as performing at 93.66% against the 92% incomplete

standard for Quarter 1.

3.2.2 As a point of clarification, this position is predicated by an agreement following discussions with NHSI, that spinal deformity waiting time performance is excluded from the overall RTT position, there being a multi-year recovery trajectory in partnership with the Birmingham Children's Hospital to achieve equilibrium for this element.

3.2.3 With the support of Commissioners and in partnership with Birmingham Children's Hospital (BCH), ROH has brokered a tripartite agreement to increase by 26 patients the number of treatment slots available for Spinal Deformity children. It had been anticipated that this capacity will be made available flexibly from Q3 2016/17. Whilst this capacity increase would be insufficient to meet all 52 week demand 2016/17, it should be seen as a positive development, paving the way for further future partnership arrangements. However, it is clear from recent discussions with BCH as part of a wider Quality Meeting about the Paediatric Service on 26th July that there are significant risks associated with the delivery of this additional capacity during the 2016-17 financial year. There were 37 patients waiting in excess of 52 weeks at the end of June, compared to 34 at the end of May and 39 at the end of April. A clinical review of these patients will be undertaken.

3.2.4 The Trust has seen a small increase in long waiting patients classified as young adult hip. The reasons for this increase have been reviewed and are currently being resolved.

3.2.5 From a wider activity planning perspective, the Trust plans to extend the use of its GooRoo capacity planning software, and has worked with assistance from NHS Improvement to develop 92% incomplete pathway compliant trajectories across the 2016/17 activity year. An RTT internal audit has been commissioned to provide assurance on the Trust's management of the RTT standards, and this report is due for sign off shortly

3.3 Cancer 62 Day target

3.3.1 The Trust's performance against the cancer target for Quarter 1 was 71.4% of patients treated within 62 days, against a target of 85%, meaning that at an overall position, the target was not achieved.

Within the Quarter there were four individual patients with a shared pathway with another provider where the 62 day target was breached, giving an aggregate patients' breached score of 2 (= 0.5*4) as demonstrated in the table over the page:

Month & Year	Total Patients	Accountable Total Treated	Accountable Total Treated within Time	Total RRJ Breach	Total Shared Breach	Total Breach	% Meeting Standard
Apr-16	3	2.0	1.5	**0.0**	**0.5**	**0.5**	75.0%
May-16	3	1.5	0.5	**0.0**	**1.0**	**1.0**	33.3%
Jun-16	7	3.5	3.0	**0.0**	**0.5**	**0.5**	85.7%

3.3.2 As described in previous submissions, it is difficult to predict future performance on 62 days with any degree of accuracy because the numbers of cancer patients being referred are variable and within these the incidence of patients with complex cancer pathways is also unpredictable. 2 week wait performance is easier to predict based on past performance, and delivery in Quarter 1 remains strong (April 100% with 27 patients, May 100% with 39 patients.) Similarly, 31 day performance remains strong (April 100% with 5 patients, May 100% with 2 patients.)

3.4 Access to healthcare for people with a learning disability

3.4.1 In April 2016, the Trust reviewed its compliance against the six components of the access to healthcare standard for people with a learning disability which is based on recommendations in Healthcare for all (DH 2008). The rationale for the decision to declare non-compliance is detailed in the table below:

Standard	Evidence of Compliance
Does the NHS foundation trust have a mechanism to identify and flag patients with learning disabilities and protocols that ensure pathways of care are reasonably adjusted to meet the health needs of these patients?	***Partial:*** An email alert is sent to the Learning Disability lead nurse and safeguarding team from pre-admission to the Trust is planned. Contact will be made with the family to enable plans for admission are made and for capacity assessment to be completed in order to ensure that pathways of care are adjusted to meet healthcare needs. There is however, no Trustwide alert on the system and this requires amending.
Does the NHS foundation trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: • treatment options • complaints procedure • appointments	***Partial:*** Communication boxes designed to aid communication with people with a learning disability are in place in the ward areas. An easy access consent form is in use for all patients. Work is in progress to meet the requirements of the Accessible Information Standard
Does the NHS foundation trust have protocols to provide suitable support for family/ carers who support patients with learning disabilities?	***No:*** A new Learning Disability Strategy is in development which will detail the protocols required to support families and carers.
Does the NHS foundation trust have protocols to routinely include training on providing healthcare to patients with learning disabilities for all staff? Yes	***Yes:*** Included as part of safeguarding training

Does the NHS foundation trust have protocols to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports?	***Partial:*** The Learning Disabilities action plan is regularly reviewed by the Trust Safeguarding Committee and outcomes are monitored. As a result, an audit tool has been developed. Audit reports have not yet been developed for public reports.

4.0 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. Throughout Quarter 1, there have been several further development events held.
- Work has progressed to recruit non-executive directors, with particular skill sets around firstly commercial acumen, experience of partnership working, supported by strengths around finance and risk and a second with a clinical background. Interviews for the posts will be held in July and September respectively. The recruitment and selection process has been organised internally, thereby avoiding the need to meet the cost of search agents which have been used in the past.
- 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 Quality & Safety Committee has met three times during the quarter and reviewed the relevant assurances that risks to compliance are being managed. The agenda for the Committee is now well embedded and includes systematic reporting from a series of subcommittees. A public governor and a representative from our Clinical Commissioning Group now attend as observers at each meeting.
- The Finance & Performance Committee established in Quarter 4 2015/16, has met routinely during the quarter and continues to be focussed on, in addition to the overall financial performance of the organisation, the plan to create additional capacity to allow additional patients to be treated and achievement of the control total set in the Trust's annual plan.
- The Audit Committee has met formally twice during the quarter – the agenda of the April meeting considered progress reports from internal and external audit, the draft Annual Governance Statement, annual accounts, the losses & compensation register and the updated Board Assurance Framework. The Committee also considered received some feedback from the Quality & Safety Committee on matters of interest & escalation. The meeting of the Committee in May considered the draft annual report & accounts.
- A specific area of focus for the Audit and Finance & Performance Committees during the quarter was the need to strengthen controls around some aspects of operational management and performance reporting. Of particular concern was a discrepancy on stock valuation which was identified as the Trust prepared to submit its end of year draft accounts. Much work was undertaken to verify the position, through into the new financial year ahead of the submission of the audited accounts to NHS Improvement at the end of May 2016. Strengthened controls have now been put into place, including the substantive recruitment into the theatres logistics manager post and a plan to implement a revised electronic stock management system later in the year.
- The action plan to address the recommendations within the CQC Inspection report published in December 2015, continues to be monitored through the Quality & Safety Committee and Trust

Board on a routine basis, this being timed to coincide with the deadline for the completion of milestones in the action plan. Within the quarter, the Trust has also hosted a review by the Royal College of Paediatrics and Child Health to more fully understand the concerns raised by the CQC on Paediatric Care in HDU. A quality meeting involving Board members from ROH & BCH, together with NHSI, CQC and commissioners will be held in Quarter 2 to review the Trust's plan to address the recommendations in the report and gain system wide support where required.

- Governor elections were held for three public governors; two existing governors were re-elected for a further term, with a new governor from the Rest of England & Wales constituency being selected to replace a long serving governor whose term of office had expired. A new stakeholder governor has been appointed from Birmingham City Council.
- The Trust has started to make plans for its assessment against the Well Led Framework, with work underway to develop the initial self-assessment and supporting evidence base. Later in Quarter 2, early Quarter 3 an external partner will be selected and appointed to undertake the independent assessment.
- The Trust is continuing to address a number of matters relating to clinical & corporate governance as summarised in the table below:

Issue	Actions taken	Work in progress
Policies It had been identified that Policy governance within the organisation currently required improvement, such that robust systems are in place to ensure that policies created are digestible and well-constructed, reviewed in a timely way and are presented for approval in a systematic way	Work continues to ensure that all policy having exceeded their planned review date are reviewed as a matter of priority. The Clinical Quality Committee takes a role in reviewing policies prior to approval of the CEO on the advice of the Trust Management Committee. A refreshed Policy on Policies has been developed during the period, which was approved by the Trust Board in February 2016. This provides a more effective framework for the development of policies going forward and a simpler approval process for policies requiring only minor changes.	Work continues to improve policy governance and address those policies in a couple of key corporate areas where there remain an undesirable number of policies beyond their review date. The Quality & Safety Committee is appraised of progress on a quarterly basis.
Risk Management Risk Management processes and risk registers need to be improved, such that escalation of key risks to the Board and Senior Management is effective and timely and entries on the relevant registers are meaningful	Work has been undertaken to refresh both the risk register and Board Assurance Framework format, and to refine the content such that risk descriptors are more robust and scoring is consistent. A new risk management policy has been developed and was to be	Over Quarter 2, work will be undertaken to embed the new risk management policy and ensure that risk registers fully reflect the wide range of clinical, operational and corporate risks.

	presented to the Board in July for approval.	

4.2 The Audit Committee met in April and in respect to this declaration can offer the following positive assurances:

- Good progress had been made with the delivery of the internal audit plan with all audits with the exception of the 18 weeks RTT plan having been completed; positive progress was noted with the delivery of some recommendations particularly around the review of NICE guidance and clinical audit
- The 2016/17 internal audit plan was approved
- There was good progress with the counter fraud work plan and the plan for 2016/17 was approved.
- The Committee was appraised of the shortlist of quality account priorities for 2016/17, noting that two of the indicators would be audited by External Audit as part of the year end work
- The refreshed BAF was noted to be more comprehensive and provided greater assurance that the risks to the delivery of the Trust's strategic objectives were being controlled
- The hospitality register was reviewed and its comprehensiveness was noted to be positive

The Committee challenged the following areas or noted the following the key risks:

- The external audit report highlighted that the forecast financial outturn for 2015/16 was likely to be a departure from the original and revised positions
- An update on the position regarding sign off of contracts with commissioners for 2016/17 was discussed – further work was required to finalise the position concerning CQUINs and the position regarding spinal deformity services
- There are risks to the delivery of the £3.2m control total that the Board had reviewed and signed up to at its April Board meeting
- The internal audit progress report highlighted that some improvements to the arrangements to adhere to the new regulator requirement around the use of agency staff were needed; the new e-rostering system would assist
- The draft head of internal audit opinion was reviewed which highlighted that although the system of internal control was adequate, there was further work to do to strengthen it; overall the position was positive however
- Given the current variation in the approach to consent, a further high level update was required at a future meeting, with main oversight being through the Quality & Safety Committee
- Counter fraud highlighted that there was work to do to verify the declarations for consultants undertaking private practice work, given that of a sample of 20 consultants reviewed, 13 had registered directorships at private companies
- The review of recommendation trackers suggested that there was some work to do to improve the timeliness of addressing the actions raised, as a number remained either partially completed or unstarted
- The impact of a new methodology for valuing the Trust's estate was discussed, which had a negative impact on the value of the Trust's overall assets
- The deterioration in the cash position during 2015/16 was noted
- The Committee was made aware of an increase in inventories, which included stock in theatres, a position which was to be reviewed as a matter of priority to understand the position better. The

mismatch in activity vs. stock was to be investigated particularly.

- The draft Annual Governance Statement (AGS) was reviewed, which included the internal control systems including risk management and some matters of weakness of internal control which had been identified in year, including review of NICE guidance, a void in uploading of incident reporting data to the national system and some gaps in the control of operational performance during the year
- The key risks to the delivery of the Trust's objectives were reviewed, both through the draft AGS and the Board Assurance Framework, including contract arrangements for spinal deformity, the adequacy of business intelligence and the inability to manage costs thereby potentially impacting on the Trust's Going Concern status.

The following actions arose from the Committee:

- Matters for remitting to the Quality & Safety Committee included: WHO Safety Checklist and Consent
- Consolidation of the recommendation trackers
- Verification of the declarations made by those undertaking private practice
- Refocusing the BAF on the top risks to the organisation and identifying areas for a 'deep dive'

The May meeting of the Committee considered the draft Annual Report and Accounts, which subject to some final adjustments, the Committee agreed to recommend to the Board for approval and adoption respectively.

APPENDIX ONE

The Trust provides financial information reflected in the Finance & Performance Report (FPR) as assurance and performance and quality information as set out in the Patient Quality & Safety Report as assurance.

The Trust can confirm that there are no exception reports to be provided in Quarter 1 with regard to:

- Financial sustainability
- Financial governance
- Governance

Targets and indicators with thresholds for 2016/17

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	F&P Paper	Achieved
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	85%	1.0	F&P Paper	Not Achieved
Cancer 31 day wait for second or subsequent treatment - surgery	94%	1.0	F&P Paper	Not Achieved
Cancer 31 day wait from diagnosis to first treatment	96%	1.0	F&P paper	Achieved
Cancer 2 week (all cancers)	93%	1.0	F&P Paper	Achieved
C.Diff due to lapses in care	0	1.0	Nurse Lead	Achieved
Compliance with requirements regarding access to healthcare for people with a learning disability	N/A	1.0		Not 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 were identified as part of the CQC review published on 4th December, which followed the reinspection in July 2015. A plan is in place to deliver the actions, which has been submitted to the CQC and is currently being monitored by the Trust Board.

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Monthly In Year Governance Reporting Return 30 Jun 2016

The Royal Orthopaedic Hospital NHS Foundation Trust

Plan data sourced from your latest submitted plan

IYR - Version: 17.3.13.3

Validation errors: 0

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Name: Simon Grainger-Lloyd

Job Title: Associate Director of Governance & Company Secretary

Telephone number: 0121 685 4353

Email address: s.grainger-lloyd@nhs.net

Date: 28-Jul-16

Approved on behalf of the Board of Directors by:

Name: Jo Chambers

Job Title: Chief Executive

Signature:

Your relationship management team at NHS Improvement:

Contact: Rebecca Farmer
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Activity: Monthly Monitoring

Index to workbook

This index page also allows you to set a selection of sheets to print in one go.

			Print
Worksheet	Cover	Click to go to	No
Worksheet	Guidance	Click to go to	No
Worksheet	Targets and Indicators	Click to go to	No
Worksheet	Org Health Indicators	Click to go to	No
Worksheet	Elections	Click to go to	No
Worksheet	Governance Statement	Click to go to	No

Click to go to index

NHS Improvement Governance Template General Guidance

Cell colour coding

	These cells are unlocked and trusts should either be entering a numeric value or the required description. Numbers entered can be either plan, actual or forecast figures, depending on the column description in row 10 of each worksheet.
	These cells are locked with numeric plan values.
	These cells are locked with a numeric actual values from a previous period.
	These cells are linked cells and the values within them are derived from values entered on other worksheets within this workbook. These cells are locked and trusts are unable to input values directly into them.
	These cells are calculated values based on values on the same worksheet. These cells are locked and trusts are unable to input values directly into them.
	These cells are locked and are populated with a trust's previous year-end outturn results as declared in the Annual Plan Review (APR) return.
	These cells are locked and trusts should enter a numeric value into them in the M2 return only to adjust their APR outturn in order to form the audited year-end actuals in column K of the financial statements.
i	These cells contain information / guidance on completing the adjacent cells. Click the "i" cell to show the pop-up box containing the information / guidance.

Checks and Validations

Data Validation sheet

The checks on this page are divided into those that, when triggered, raise an ERROR or a FLAG.
All ERRORs need to be corrected. FLAGS may or may not be problems with the return. For each FLAG please investigate why the check has been triggered. If there has been an input error, correct it: but if not, then please add text in the yellow cell to explain why the check is still triggered despite your numbers being correct.
If you believe a check is faulty then contact us by email to nhsi.compliance@nhs.net , we will guide you on what to do.

Suggested approach to completing this workbook/return

Cover sheet

1	ONLY if there are validation checks not passed but the FT has agreed with their NHS Improvement relationship team that these will be dealt with post-submission, enter a 1 in the box next to the validation check message box.
2	Fill in the details of the person approving the template on behalf of the FT. For returns submitted at quarter ends, an additional sign off is required from the Board of Directors. Follow the instructions in the "i" box regarding adding a signature for this additional sign-off.

Targets and Indicators Sheet

3	Enter your results on the Target and Indicators worksheet.

Various Governance Sheets

4	Complete the various Board declarations.

MARS Portal

Login to MARS and put the return in the outbox.

Click to go to index

Declaration of risks against healthcare targets and indicators for 201617 by The Royal Orthopaedic Hospital NHS Foundation Trust

Targets and indicators as set out in the Risk Assessment Framework (RAF) - definitions per RAF Appendix A
NOTE: If a particular indicator does not apply to your FT then please enter "Not relevant" for those lines.

Key:

must complete
may need to complete

Target or Indicator (per Risk Assessment Framework)		Annual Plan				Quarter 1			
		Threshold or target YTD	Scoring Per Risk Assessment Framework	Risk declared	Scoring Per Risk Assessment Framework	Performance	Declaration	Comments / explanations	Scoring Per Risk Assessment Framework
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	i	92%	1.0	No	0	92.4%	Achieved		0
A&E Clinical Quality - Total Time in A&E under 4 hours	i	95%	1.0	N/A	0	0.0%	Not relevant		0
Cancer 62 Day Waits for first treatment (from urgent GP referral) - post local breach re-allocation	i	85%	1.0	No	0	81.9%	Not met	The target was missed April a	1
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - post local breach re-allocation	i	90%	1.0	No		0.0%	Not relevant		
Cancer 62 Day Waits for first treatment (from urgent GP referral) - pre local breach re-allocation	i					0.0%			
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral) - pre local breach re-allocation	i					0.0%			
Cancer 31 day wait for second or subsequent treatment - surgery	i	94%	1.0	No		93.9%	Not met	The target was missed in Jun	
Cancer 31 day wait for second or subsequent treatment - drug treatments	i	98%	1.0	N/A	0	0.0%	Not relevant		1
Cancer 31 day wait for second or subsequent treatment - radiotherapy	i	94%	1.0	N/A		0.0%	Not relevant		
Cancer 31 day wait from diagnosis to first treatment	i	96%	1.0	No	0	100.0%	Achieved		0
Cancer 2 week (all cancers)	i	93%	1.0	No	0	100.0%	Achieved		0
Cancer 2 week (breast symptoms)	i	93%	1.0	N/A		0.0%	Not relevant		
Care Programme Approach (CPA) follow up within 7 days of discharge	i	95%	1.0	N/A	0	0.0%	Not relevant		0
Care Programme Approach (CPA) formal review within 12 months	i	95%	1.0	N/A		0.0%	Not relevant		
Admissions had access to crisis resolution / home treatment teams	i	95%	1.0	N/A	0	0.0%	Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 1 Calls	i	75%	1.0	N/A	0	0.0%	Not relevant		0
Ambulance Category A 8 Minute Response Time - Red 2 Calls	i	75%	1.0	N/A	0	0.0%	Not relevant		0
Ambulance Category A 19 Minute Transportation Time	i	95%	1.0	N/A	0	0.0%	Not relevant		0
C.Diff due to lapses in care (YTD)	i	0.5	1.0	No	0	0	Achieved		0
Total C.Diff YTD (including: cases deemed not to be due to lapse in care and cases under review)	i					0			
C.Diff cases under review	i					0			
Minimising MH delayed transfers of care	i	<=7.5%	1.0	N/A	0	0.0%	Not relevant		0
Early intervention in psychosis: first experience treated with a NICE-approved package within 2 weeks	i	50%	1.0	N/A	0	0.0%	Not relevant		0
Improving access to psychological therapies: % patients beginning treatment within 6 weeks of referral	i	75%	1.0	N/A	0	0.0%	Not relevant		0
Improving access to psychological therapies: % patients beginning treatment within 18 weeks of referral	i	95%	1.0	N/A	0	0.0%	Not relevant		0
Data completeness, MH: identifiers	i	97%	1.0	N/A	0	0.0%	Not relevant		0
Data completeness, MH: outcomes	i	50%	1.0	N/A	0	0.0%	Not relevant		0
Compliance with requirements regarding access to healthcare for people with a learning disability	i	N/A	1.0	No	0	N/A	Not met	The Trust is working on being	1
Community care - referral to treatment information completeness	i	50%	1.0	N/A		0.0%	Not relevant		
Community care - referral information completeness	i	50%	1.0	N/A	0	0.0%	Not relevant		0
Community care - activity information completeness	i	50%	1.0	N/A		0.0%	Not relevant		
Risk of, or actual, failure to deliver Commissioner Requested Services		N/A	Report by Exception	No			No		
Date of last CQC inspection	i	N/A		N/A			28/07/2015		
CQC compliance action outstanding (as at time of submission)		N/A		Yes			Yes	The Trusts re-review by CQC in July 2015 has closed the outst	
CQC enforcement action within last 12 months (as at time of submission)		N/A		No			No		
CQC enforcement action (including notices) currently in effect (as at time of submission)		N/A		No			No		
Moderate CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	i	N/A		No			No		
Major CQC concerns or impacts regarding the safety of healthcare provision (as at time of submission)	i	N/A		No			No		
Overall rating from CQC inspection (as at time of submission)	i	N/A		N/A			Requires improvement		
CQC recommendation to place trust into Special Measures (as at time of submission)		N/A		N/A			No		
Trust unable to declare ongoing compliance with minimum standards of CQC registration		N/A		No			No		
Trust has not complied with the high secure services Directorate (High Secure MH trusts only)		N/A		N/A			N/A		
Results left to complete:	i						0		
Checks Count:	i								
Checks left to clear:	i						OK		
Service Performance Score	i				0				3

Click to go to index

In Year Organisational Health Indicators for The Royal Orthopaedic Ho

The Risk Assessment Framework (table 7) sets out that NHS Improvement will use executive team turnover as one of the potential indicators of quality governance concerns. Please provide the information requested below and ensure that any changes are explained in your commentary:

	units	Actual Quarter ending 30-Jun-16
Executive Directors		
Total number of Executive posts on the Board (voting)	Posts	5
Number of posts currently vacant	Posts	-
Number of posts currently filled by interim appointments	Posts	-
Number of resignations in quarter	Resignations	-
Number of appointments in quarter	Appointments	-

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List of Governors' elections for The Royal Orthopaedic Hospital NHS Foundation Trust

The Risk Assessment Framework requires a quarterly report of elections held and results as below:

Elections held in the quarter ending 30 Jun 2016

		Constituency Type	Full Name of Constituency	No. of candidates	No. of Votes cast	Turnout	No. of Eligible voters	Date of election
	Example	Public	North West ourtown	4	1,345	16.3%	8,230	01/05/2016
WTE	1	Public	Birmingham & Solihull	5	633	17.8%	3,566	12/05/2016
WTE	2	Public	Rest of England & Wal	6	325	18.0%	1,811	12/05/2016
WTE	3							
WTE	4							
WTE	5							
WTE	6							
WTE	7							
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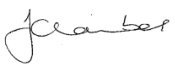
In Year Governance Statement from the Board of The Royal Orthopaedic Hospital NHS Fou

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (see notes below)

	Board Response
For finance, that:	
The board anticipates that the trust will continue to maintain a financial sustainability risk rating of at least 3 over the next 12 months.	Not Confirmed
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.	Confirmed
For governance, that:	
The board is satisfied that plans in place are sufficient to ensure: ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forwards.	Not Confirmed
Otherwise:	
The board confirms that there are no matters arising in the quarter requiring an exception report to NHS Improvement (per the Risk Assessment Framework, Table 3) which have not already been reported.	Confirmed
Consolidated subsidiaries:	
Number of subsidiaries included in the finances of this return. This template should not include the results of your NHS charitable funds.	0

Signed on behalf of the board of directors

Signature		Signature	
Name	Jo Chambers	Name	Yve Buckland
Capacity	Chief Executive	Capacity	Chairman
Date	28-Jul-16	Date	28-Jul-16

Responses still to complete: 0

Notes:
NHS Improvement will accept either 1) electronic signatures pasted into this worksheet or 2) hand written signatures on a paper printout of this declaration posted to NHS Improvement to arrive by the submission deadline.
In the event than an NHS foundation trust is unable to confirm these statements it should NOT select 'Confirmed' in the relevant box. It must provide a response (using the section below) explaining the reasons for the absence of a full certification and the action it proposes to take to address it.
This may include any significant prospective risks and concerns the foundation trust has in respect of delivering quality services and effective quality governance.
NHS Improvement may adjust the relevant risk rating if there are significant issues arising and this may increase the frequency and intensity of monitoring for the NHS foundation trust.

The board is unable to make one of more of the confirmations in the section above on this page and accordingly responds:

A

B

C

Click to go to index

Checks & Flags

		units		Actual Month ending 30-Jun-16	Explanation For Flags For Month ending 30-Jun-16
ERRORS			i	-	
FLAGS			i	-	
Checks					
1 All targets and Indicators responses have been completed	*From T & I*	Check	i	OK	
2 Governance inputs completed	*From Governance Statement*	Check	i	OK	
3 Flags	*From Data Validation*	Check	i	OK	
Flags					
1 Targets and Indicators checks cleared	*From T&I*	Check	i	OK	
2 Organisational Health Indicators statements completed	*From Org Health Indicators*	Check	i	OK	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	30 August 2016 The July meeting had been cancelled due to unavailability of key members who were otherwise involved in the Quality meeting and urgent operational changes. There was no meeting scheduled in August and therefore this briefing had been put in pace to assure the Board that the key quality reports and quality committee reports had been scrutinised.
Guests	None – the briefing consisted of the Chair of the Quality & safety Committee, the Director of Operations, Nursing & Clinical Governance, the Governance Manager and the Associate Director of Governance/Company Secretary (Secretariat).
Presentations received	None
Major agenda items discussed	• This was an assurance briefing which covered the key sources of assurance to the Committee: the July and August Patient Safety & Quality reports and the upward reports from the Clinical Quality Committee for July and August.
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Board	• The detail of the reported Serious Incidents and Never Events was discussed. It was noted that the incidents have involved some non-adherence to Trust policies and that an external review commissioned recently was to assess the practices in theatres in this respect. • A number of pressure ulcers were noted to have been reported, a number of which were avoidable. It was agreed that as further assurance was needed as to handling of these, the Ward Manager of Ward 3 would attend the next meeting of the Quality & Safety Committee to describe the measures he had put into place to prevent Pressure Ulcers in his area. • The expected death case was discussed and a review was currently being undertaken to establish the appropriateness and anticipated benefit of the surgicial intervention that had occurred. • Further assurance as agreed to be needed as to the WHO checklist process, particularly in the light of the Never Events reported recently

	• The outcome of the quality walkabouts was discussed and it was noted that some areas had been classified as 'Requires Improvement'. It was noted that the actions to address this rating were tracked by the Divisional Management Boards, however the Clinical Quality Group should review the improvement action plans as an additional source of assurance. These should also be dicussed at Ward Managers meetings • The risk around blood fridge and management of blood was discussed specificially and agreed that further assurance was needed that the policies and practice around this were appropriate
Positive assurances and highlights of note for the Board	• The Committee agreed that the reports provided a good source of assurance and opportunity for challenge on Quality & Safety matters
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• It was agreed that the Patient Safety & Quality reports should be shared with Ward Managers in future, to create Board to Ward visibility of the information that was being used to hold to account and the significance of this. • It was agreed that the Head of Communications should be invited to the next meeting to provide an overview of handling the Friends & Family Test process, particularly the detail of information requested on outpatient questionnaires • It was agreed that the upward report from Clinical Quality Committee are adequately reflected in the associated minutes of the meeting. Work would also be undertaken to ensure that the actions agreed at the meeting, were reflected in the minutes, progress with which the Committee could then monitor.
Decisions made	• None specifically

Kathryn Sallah
NON EXECUTIVE DIRECTOR AND CHAIR OF QUALITY & SAFETY COMMITTEE

For the meeting of the Trust Board scheduled for 7 September 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	20 July 2016 1 September 2016
Guests	None
Presentations received and discussed	None
Major agenda items discussed	**20 July 2016** • Stock management update • Finance & Performance Overview • Prospective order book and plan to achieve control total • Reference cost process • Turnaround programme and performance framework • In Touch assurance update **1 September 2016** • Stock management update • Progress with rationalising implants • Finance & Performance Overview • Finance & Activity recovery plan • Turnaround programme and performance framework
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Committee	**20 July 2016** • The key concern for the Committee was the lack of a plan to achieve recovery of the finance and performance position and previous assurances appeared to lack substance or be grounded in reality. • The Committee was advised that activity performance remained behind plan, with the numbers of inpatients being below that expected particularly. Fallow lists caused by annual leave or other absence were not routinely being covered by alternative surgeons. Pooling of caseloads was also proposed as a potential solution to the issue. • There remained a residual risk around stock management in that reporting was not at present in real time; EDC Gold, a new stock management system was being implemented however which would assist • Financial performance had deteriorated, with a significant contributory factor being theatre closures in June

	• The CIP position was below plan, with shortfalls particularly in Divisions 1 & 2 • Average length of stay for hip replacements appeared to have increased. **1 September 2016** • A deficit of £346k was reported in month, although this was ahead of expectations. • The continued absence of a pain management consultant was impacting on the day case position, although the vacancy would be filled shortly. • Inpatient levels continued to be below plan and there were reported to be concerns over the theatre session booking process which did not appear to be robust at present. There had been two exceptionally light activity weeks in August. • Agency spend was reported to be slightly above trajectory. • Performance against the CIP appeared to be mixed, with a particular concern in clinical schemes. • Length of stay was noted to be of concern, with some long lengths of stay attributed to social care delays • Sickness absence was reported to have increased and mandatory training compliance had deteriorated. Both issues would be picked up as part of performance clinics. • The risks associated with the finance and activity recovery plan were discussed at length, which included having appropriately skilled staff in Pre-Operative Assessment and the ability of the organisation to embrace the changes quickly and whole heartedly. The recovery plan might incur some additional costs. Improving theatre utilisation and creating a strong focus on CIP delivery were suggested to be key to delivering the plan.
Positive assurances and highlights of note for the Board	**20 July 2016** • The Committee was advised that cost control was good and there was good focus on agency spend. Discussions around controls were in place at a divisional level and divisional control totals had been set. • A stocktake was underway to establish progress with the delivery of the actions to achieve turnaround • The Committee was provided with good assurance that the national reference costs guidance was being followed • The Committee received a turnaround programme and performance framework update which provided a helpful view of the position with the various activities and programmes that would could assist with the turnaround; work was underway to segregate the matters that would be reported to the Transformation Committee as opposed to the Finance & Performance Committee

	• In Touch was reported to have been implemented, albeit with slight delay; there was national interest in the Trust's use of this system **1 September 2016** • The Committee was advised that good progress was being made to deliver the actions arising from the Internal Audit on stock management. • Good progress continued to be made on rationalising stock implants and discussions were planned with some key suppliers to take this work forward. • There remained good costs control overall. • Cancellations and admissions on the day of surgery were reported to have improved. • It was reported that following feedback on the Quarter 1 position, the Trust's governance rating had been moved from one of 'Under Review' to 'Green'. The Risk Rating remained at '2'. • The Committee considered a finance and activity recovery plan which set out a set of measures which would assist with returning to a performance towards the control total. Re-engineering the pre-operative assessment process was noted to be key to the plans.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	**20 July 2016** • A recovery plan was agreed to be needed as a matter of urgency. • An update on stock management would be provided at the next meeting **1 September 2016** • Undertake a review of consultant retirements to determine any vulnerability in terms of income • Present a further update on theatre utilisation at the next meeting • Present the revised capital plan to Trust Board • Develop the recovery plan to specify the timescales and responsibilities for delivery
Decisions made	• None specifically

Mr Tim Pile
VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 7 September 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AGENDA

COUNCIL OF GOVERNORS

Venue Board Room, Trust Headquarters **Date** 14 September 2016: 1400h – 1600h

TIME	ITEM	TITLE	PAPER REF	LEAD
1400h	1	Exclusion of the press and public	Verbal	SGL
1402h	2	Trust Chairman's appraisal[#1]	Verbal	TP
1420h	3	Non Executive appraisals	Verbal	Chair
1440h	4[#2]	Apologies and welcome	Verbal	Chair
1447h	5	Declarations of interest	Verbal	ALL
1450h	6	Minutes of previous meetings on 11 May 2016	ROHGO (5/16) 008	Chair
1455h	7	Update on actions arising from previous meetings	Verbal	SGL
1500h	8	Non Executive recruitment - progress and recommendation to appoint	ROHGO (9/16) 002 ROHGO (9/16) 002 (a)	Chair
1510h	9	Chief Executive's update	ROHGO (9/16) 003 ROHGO (9/16) 003 (a)	JC
1520h	10	STP update	Verbal	YB/JC
1530h	11	Strategy refresh update	Verbal	PB
1540h	12	Finance & Performance Committee update including financial & activity recovery	ROHGO (9/16) 004	TP
1550h	13	Quality & Safety Committee update	ROHGO (9/16) 005	KS
1555h	14	Governor updates	Verbal	ALL

[#1] Excludes Chair of Council of Governors
[#2] Public, CEO and Non Executives join meeting

1600h	15	For information: • Finance & performance update • Quality & Patient Safety update • Dates of forthcoming meetings	ROHGO (9/16) 006 ROHGO (9/16) 007 Verbal	Chair
	Date of next meeting: Wednesday 18 January 2017 @ 1400h – 1600h in Trust Headquarters			

[#1] Excludes Chair of Council of Governors
[#2] Public, CEO and Non Executives join meeting

MINUTES

Council of Governors - Version 0.1

Venue Boardroom, Trust Headquarters **Date** 11 May 2016 @ 1400h

Members present

Yve Buckland	Chairman	YB
Alan Last	Lead Governor	AL
Marion Betteridge	Public Governor	MB
Anthony Thomas	Public Governor	AT
Petro Nicolaides	Public Governor	PN
Carol Cullimore	Public Governor	CC
Karen Hughes	Staff Governor	KH
Alex Gilder	Staff Governor	AG
Ronan Treacey	Staff Governor	RT
Paul Sabapathy	Appointed Governor	PS

In attendance

Tim Pile	Vice Chairman & Non Executive Director	TP
Tauny Southwood	Non Executive Director	TS
Rod Anthony	Non Executive Director	RA
Jo Chambers	Chief Executive	JC
Paul Athey	Director of Finance	PA
Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	SGL

Minutes	**Paper Ref**
1 Apologies and welcome	**Verbal**
Apologies were received from Sue Arnott and Richard Burden. Rob Talboys and Jean Rookes had hoped to join the meeting but were unable to attend. Sue Lococco was not present.	
2 Declarations of interest	**All**
There were none.	
3 Minutes of the previous meeting on 9 March 2016	**ROHGO (3/16) 008**
It was noted that following concerns expressed by Mr Treacy around the resource within spinal deformity, advice had been sought from the Director of Operations	

who had confirmed that four surgeons would be appointed into the speciality and the handover arrangements between the retiring and new consultants would be carefully managed. Mr Treacy confirmed that he was happy with this assurance.	
4 Update on actions arising from previous meetings	**Verbal**
The Council noted that all actions raised at the last meeting had been addressed.	
5 DRAFT annual report (including Quality Account) & Accounts 2015/16	**ROHGO (5/16) 003** **ROHGO (5/16) 003 (a)** **ROHGO (5/16) 003 (b)** **ROHGO (5/16) 003 (c)**
The Council 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. [redacted]	

[redacted]

[redacted]	
6 Chief Executive's update	**ROHGO (5/16) 002** **ROHGO (5/16) 002 (a)**
The Chief Executive drew attention to the shifts in the System and the way in which the Trust was engaging in this work to promote our own work. It was reported that since the last meeting there had been a celebration of long service awards, which had been a positive event. The Chief Executive reported that at the event she had engaged in a discussion with the storemen and it was encouraging that understand from them that there was an appetite to cease wasting resources and time. These discussions will be followed through and the understanding and ideas from a ground level would be harnessed. It was reported to be pleasing that a set of care certificates had been issued recently. This was a set of recognised competencies and a first cohort of willing	

volunteers had these signed off, including therapy assistants. The car park policy discussed at TMC was highlighted. This had not been approved, pending further engagement and consultation. The costs of car parking were reported to be to cover costs of maintaining the car parks with a small amount of income generation that was reinvested.	
7 Update on the work of the Finance & Performance Committee	**Verbal**
Tim Pile reported that the Finance & Performance Committee had met four times and was making a positive impact on the discussions of the Board. It had been set up for greater understanding of the underlying finances and performance of the organisation. The Committee was currently chaired by the Trust Chairman with other members being the Vice Chair, Chair of Audit Committee, Chief Executive, Director of Finance and Director of Operations. In due course, the chairmanship would pass to the Vice Chair, however while the focus of the Committee was on turnaround improvement, the Committee would continue to be chaired by the Trust Chairman. The Chief Executive advised that she was the lead Executive Director for the Committee and this would change to the Director of Finance when stability was reached. It was reported that income was flat and activity had stabilised. A year on year increase in costs had been seen. These were key preoccupations of the Committee at present. Significant improvements had been seen in terms of activity in particular. Cancellations and Did Not Attend (DNAs) instances were also reviewed as were bed and theatre utilisation. It was reported that the Committee also considered details of the activity casemix and a forward look of patient bookings was being reviewed routinely. The areas of contribution by firm were also reviewed which provided a clearer understanding of where improvements were needed. The Chief Executive added that the activity plan was adjusted for bank holidays, annual leave and theatre down time. The Executive was congratulated for the clarity of information provided. It was noted that there was a degree of overlap with the work of the Transformation Committee. The governors commented that the development of this Committee was pleasing and provided an opportunity for addressing inefficiencies, particularly as there appeared to be a significant number of empty beds. It was noted that the Committee was also looking at new models and efficiencies. It was suggested that a postage issue might be to blame for some DNAs in clinic. It was also observed that patients were now rung routinely prior to admission. One public governor highlighted that for his cancelled appointment he had not receive a text message advising him that this was the case. The importance of quality IT systems to the work was underlined. The Chairman	

agreed, noting that the information was generated manually and the Committee needed to ensure it was asking for the correct information. Rod Anthony left the meeting.	
8 Staff survey results and action plan	**ROHGO (5/16) 004** **ROHGO (5/16) 004 (a)** **ROHGO (5/16) 004 (b)**
Tauny Southwood delivered a presentation on the staff survey results and action plan. This was based on a full census, rather than a sample survey around five key areas. It was noted that some of the results did not chime with the accolade of being one of the '100 Best Places' to work. The Chief Executive explained that all Trusts would have a bottom four set of indicators and the indicators used to make a judgement as to whether the Trust was one of the 100 Best Places to work was based on a response to a subset of indicators within the overall staff survey. The issues related to reticence to report unsafe clinical practice would be given particular attention and work would be directed to understanding the barriers to reporting It was noted that there had been little change in the overall responses over a six year period which was reassuring. It was noted that the Board was more focussed on staff strategy and morale.	
9 Quality & Safety walkabouts	**Presentation**
Anne Crompton, Deputy Director of Nursing & Clinical Governance presented a programme of quality & safety walkabouts. It was noted that an invitation had been issued to governors to participate. It was suggested that some walkabouts were needed out of hours. The Council was advised that two walkabouts had been undertaken to date and patients appeared happy to talk when approached. It was noted that an effectiveness assessment would be undertaken after circa 6 months. It was also suggested that peer review (ward to ward) was used. A 'You Said, We Did' methodology could be used and might be helpful.	
10 Governor matters	**Verbal**
An update on the governor elections was provided by the Associate Director of Governance and Company Secretary.	
11 Feedback from the Patient & Carers' Council	**Verbal**
There was none.	

12 Matters for information	**ROHGO (5/16) 005** **ROHGO (5/16) 005 (a)** **ROHGO (5/16) 006** **ROHGO (5/16) 006 (a)** **ROHGO (5/16) 007**
It was agreed that in time, the divisional structure needed to be discussed in terms of added value, patient flow and lines of responsibility. It was suggested that it would be helpful to consider this in the context of staff morale and the financial position. It was agreed that the governor quality indicator should more clearly be highlighted in the Corporate Performance Report.	
ACTION: Include an item on the agenda of a future meeting to discuss the divisional structure **ACTION: More clearly highlight the governor quality indicator in the corporate performance report**	
13 Any other business	**Verbal**
The governors were invited to the History of Orthopaedics lecture at 6.30pm on 12 May which would be held in the Max Harrison Lecture Theatre.	
Details of next meeting	**Verbal**
The next meeting is planned for 14 September 2016 at 1400h – 1600h in the Boardroom, Trust HQ.	

ROHGO (9/16) 002

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Proposal to Recruit a Non Executive Director**
SPONSOR:	**Dame Yve Buckland, Trust Chairman**
AUTHOR:	**Mr Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**14 September 2016**

EXECUTIVE SUMMARY:

The attached paper outlines the process that has been followed over the summer to recruit and select Non Executive Directors (NED) to join the Trust Board, given that the terms of office of two of the Board's existing Non Executives are drawing to a close.

To date the work to identify a candidate to fulfil the Non Clinical NED vacancy has been completed and the Council is asked to consider the Nomination & Remuneration Committee's proposal that Richard Philips be appointed into this role.

The recruitment of a Clinical NED is due to be completed later in September with a recommendation to appoint expected at the winter meeting of the Council.

REPORT RECOMMENDATION:

The Council is asked to:

- NOTE the recruitment process for Non executives followed to date
- APPROVE the Nomination & Remuneration Committee's proposal that Richard Philips be appointed as a non-clinical Non-Executive

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		Equality and Diversity		Workforce	x

Comments: Pages within the report refer in some manner to all of the key areas highlighted above.

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Highly motivated, skilled and inspiring colleagues

PREVIOUS CONSIDERATION:

The Council has previously been appraised of the intention to recruit new Non Executive Directors.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PROPOSAL TO APPOINT A NON-EXECUTIVE DIRECTOR

REPORT TO THE COUNCIL OF GOVERNORS – 14 SEPTEMBER 2016

1.0 BACKGROUND

1.1 The Non Executive cadre of the Trust Board currently comprises five Non Executive Directors (NEDs), plus the Chairman of the Trust. The terms of office of two of the NEDs (Professor Tauny Southwood and HH Frances Kirkham) are due to conclude in early 2017. Both individuals have completed two terms of three years, the maximum permissible under the terms of the Trust's constitution. Therefore as the Council was advised previously, a process to recruit replacement NEDs was organised, which started over the summer.

2.0 RECRUITMENT AND SELECTION

2.1 Given the changing national and local context where a more commercial focus is required, the recruitment process focussed on attracting candidates with a commercial & partnership working skillset and separately candidates with a clinical background who would replace the experience currently provided by Tauny Southwood.

2.2 Although the use of an external agency to help with the recruitment was considered, given the stringent financial environment it was agreed to manage the process in house by the Chairman, Company Secretary and the Chairman's PA. Having received an indication of likely cost of using an external agent for the recruitment and selection, the saving the Trust achieved by managing the recruitment internally was c. £45k.

2.3 The recruitment pack was circulated to a number of targeted organisations and individuals, in addition to being more widely advertised on national websites and social media sites, such as Women on Boards, NonExecutiveDirectors.com, Cabinet Office, NHSI Improvement and LinkedIn.

2.4 The response to the advertisement was very positive from the outset, with in excess of 30 applications being received.

2.5 The initial longlisting was undertaken on 11 July by a panel comprising the Chairman, Lead Governor and the Associate Director of Governance/Company Secretary. This exercise made a judgment of the applications against a framework based on the person specification that considered for instance whether the individual's application

demonstrated that they had experience of operating at Board level, were a strategic thinker, had expertise in chairing and whether they possessed the partnership working or clinical skill set that was necessary.

2.6 A further shortlisting exercise was undertaken on 14 July by the Council of Governors' Nominations & Remuneration Committee, which identified a set of ten individuals (five clinical and five non-clinical) who were suitable for interview.

2.7 Interviews for the non-clinical post were held on 22 July, with the interview panel being the Nominations & Remuneration Committee, plus the Chief Executive and the Associate Director of Governance/Company Secretary.

2.8 The panel unanimously selected Richard Phillips as the most suitable candidate for the role for the non-clinical role and his summary biography is as below:

Richard Phillips
• Currently Director of Healthcare Policy for the Association of British Healthcare Industries • 30 years' experience in operating in a commercial environment • Extensive partnership work experience (private companies and health systems) • Holds Non Executive Director positions with the Academic Health Science Network and has been chair of the South West AHSN • Previously a member of the Technology Appraisal Advisory Committee of NICE

2.9 Following the receipt of references, Richard was offered and accepted the role, subject to the formal approval of the Council of Governors & further pre-engagement checks. The terms & conditions for this post will be in line with that of the other NEDs. For reasons of ensuring that there is an appropriate balance of voting directors on the Board, Richard would commence in post as an associate NED, with voting rights being conferred when HH Frances Kirkham's term of office concludes in February 2017.

2.10 The interviews for the clinical NED role are scheduled for 19 September, with the recommended outcome being presented to the Council of Governors at the winter meeting for consideration.

3.0 NEXT STEPS AND RECOMMENDATION

3.1 It is the Council of Governor's responsibility to approve all Non Executive Director appointments. The Council is therefore asked to:

APPROVE the Nominations & Remuneration Committee's recommendation that Richard Philips be appointed as a Non Executive Director, subject to usual pre-

engagement processes, including satisfactory completion of the Fit and Proper Persons Test.

Simon Grainger-Lloyd
Associate Director of Governance & Company Secretary

9 September 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Chief Executive's update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Jo Chambers, Chief Executive**
DATE OF MEETING:	**14 September 2016**

EXECUTIVE SUMMARY:

This report provides an update to Council members on the national context and key local activities not covered elsewhere on the agenda.

The report also provides a summary of key discussions and decisions taken by the Trust Management Committee recently.

REPORT RECOMMENDATION:

The Council is asked to note and discuss the contents of this report

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:

The contents discuss a number of developments which have the potential to impact on the delivery of a number of the Trust's strategic ambitions

PREVIOUS CONSIDERATION:

Trust Board on 7 September 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Council of Governors on 14 September 2016

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 Quarter 1 2016/17 financial position has just been published and shows that the provider sector is £461m in deficit overall, £5m better than plan after receiving Sustainability and Transformation Fund allocations for those providers which met control totals and agreed to performance improvement trajectories. Overall, 153 (of 214) providers are in deficit.

2.2 The planned outturn position is predicted to be worse than plan, from £580m deficit to £644m deficit because some providers are not confident of delivering the planned figure; NHS Improvement (NHSI) are adopting remedial actions to address this.

2.3 Cost Improvement Plans overall have fallen short of plans by £45m and Trusts have been asked to focus on tackling excess pay bill growth, taking forward Lord Carter's recommendations on back office and pathology consolidation and consolidating unsustainable services that rely on locum and agency staff.

2.4 Additionally, NHSI have challenged the sector to improve its overall deficit position to around £250m deficit and have asked all providers to take additional actions in relation to back office, pathology and unsustainable services to reduce the 2016/17 deficit and improve the 2017/18 'run-rate' full year effect position. STP leads have been asked to lead and coordinate this which is being addressed in Birmingham and Solihull through the finance directors group.

2.5 NHSI and NHS England (for commissioners) have introduced a new financial measures criteria outlined in a document *Strengthening financial performance and accountability in 2016/17 (https://improvement.nhs.uk/resources/strengthening-financial-performance-and-accountability-201617/).* The new financial special measures is designed to "help providers facing the biggest financial challenges and will underline the importance of all providers adhering to their control totals". Initial attention is on 5 providers who had not agreed control totals and from quarter 1 onwards will review negative variances from control total plan and any exceptional financial governance failures.

2.6 Operational performance continues to be challenging with the number of people waiting for elective care at its highest recorded level of 3.45million. There is continued aggregate underperformance (91.27%) against the 92% Referral to Treatment (RTT) incomplete target. The national target for A & E four hour waits was not met whilst demand rose to a record 5.34 million attendances.

2.7 As previously discussed, the new Single Oversight Framework is intended to replace Monitor's Risk Assessment Framework and the TDA Accountability Framework. A paper is attached at *Appendix 1* which provides further context, and the Trust's response to the recent consultation exercise.

3 Local Context

3.1 The Trust continues to engage fully in the local development of the Sustainability and Transformation Plan. Some members of the STP leadership team attended a review meeting with NHS England on 8 July in which the high-level principles of the STP were agreed. The detailed plans are being worked through and a financial model being developed with the objective to create sustainable services for Birmingham and Solihull whilst eradicating an overall system deficit if no changes were made.

3.2 The Trust continues to strengthen its partnership working with Birmingham Children's Hospital to ensure that there is a consistent approach to quality and standards across the system. A number of initiatives are under discussion which would optimise the use of resources across both providers and strengthen leadership and governance of children's services at ROH. Specific details area addressed in a separate report to the Board.

4 NHS Improvement

4.1 The Trust has received feedback from NHSI on its 2016/17 Operational Plan (see *Appendix 2*), which is now published on the website. The Trust will need to pay particular attention to delivery of its Cost Improvement Plan initiatives, its use of agency staffing and compliance with its agency cap, and delivery of the 52 week wait recovery plan. The long-waits plan is being delivered in partnership with Birmingham Children's Hospital where the Trust has to undertake the most complex surgical procedures with full back up in the event of any complications and is now supported by a CQUIN which seeks to guarantee access to an additional 26 theatre slots and paediatric intensive care back up.

4.2 On 31 August 2016, the Trust received confirmation from NHSI of its current financial sustainability risk rating and governance rating following the Q1 submissions. The letter containing further detail is attached at *Appendix 3.*

5 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

5.1 In addition to routine business meetings with partners, other key stakeholder and partnership engagement activities over the period include:

- Attended HSJ Provider Summit
- Birmingham Oncology and Arthroplasty Meeting (BOAM)
- Specialist Orthopaedic Alliance Board Meeting
- 'Inspiring Improvement – an interactive sharing event' – with NHS Improvement
- West Midlands CEO Providers Meeting
- Quality Meeting with Royal College of Paediatrics & Child Health, NHSI, NHSE, CQC, Commissioners and Birmingham Children's Hospital
- Meeting regarding future strategy and opportunities for collaboration - CEO & Chairman of Robert Jones & Agnes Hunt specialist orthopaedic hospital
- Quarterly 1:1 partnership meeting with Sarah-Jane Marsh, CEO Birmingham Children's Hospital
- Meeting with Mark Rogers (Birmingham City Council) and John Wilderspin to discuss the development of partnership working in the Birmingham and Solihull STP
- BSOL STP System Board.

6 UPDATE FROM TRUST MANAGEMENT COMMITTEE

6.1 Since the last meeting of the Board on 6 July 2016, the Trust Management Committee (TMC) was held on 27 July 2016 and 24 August 2016.

6.2 **27 July 2016**

TMC considered the following items to be of note to the Board:

- TMC gave support, in principle, to a business case for increased staffing in HDU in order to meet RCN and RCPCH staffing recommendations.
- Staff are not booking onto, or attending, Safeguarding Training which is a contractual requirement. This was escalated to the corporate risk register and a remedial plan required from the Operational Divisional General Managers.
- Mandatory training compliance is underperforming in all areas, with particular focus required on resuscitation training. Divisions agreed to ensure effective plans are in place for the release of staff to restore and retain compliance with mandatory training standards. All training compliance is reported upwardly to TMC on a monthly basis, as well as through the Finance & Performance Report at Finance & Performance Committee. Divisional Boards receive detailed breakdown of non-compliant staff, and this is also reviewed at Divisional Performance Reviews.
- A full business case for additional theatre staffing was considered and approved, with funding available in the current Division 2 budget reserves.
- TMC approved the draft Terms of Reference for the newly established Data Quality Committee which will report to TMC on a monthly basis.

6.3 The following policies were reviewed by TMC and recommended for approval:

- Long Service Award Policy
- Freedom To Speak Up Policy
- Education, Learning & Development Policy
- Waste Management Policy

6.4 **24 August 2016**

TMC considered the following items to be of note to the Board:

- Children's Nurse recruitment remains a challenge as none of the six shortlisted candidates attended the last assessment centre. A further assessment centre is planned for 9 September 2016.
- An operational delivery plan has been developed to plan for delivery of critical care whilst the building work takes place in HDU. This requires sign off from the Director of Operations, Nursing & Governance before it can proceed.
- TMC considered a business case for increased staffing in Physiotherapy, to deliver a seven day service. It was agreed that further detail was required in order to make the case, which can be considered in advance of the next TMC by a sub-group comprising the Director of Finance, Director of Operations, Nursing and Governance, and the Associate Director for Turnaround in order to reach a decision.
- From April 2017, every employer will be subject to an apprenticeship levy (0.5% of pay bill - £233k for ROH). This will represent a cost pressure.
- Planning for the 2016 flu campaign is underway, with incentives for vaccinators and staff to ensure that the Trust meets the CQUIN for 2016/17.
- The Trust is non-compliant in five key areas of the Accessible Information Standard and an action plan has been developed to ensure that compliance is reached.
- The Trust has appointed to the Guardian for Safe Working Hours, the nationally mandated role to support the safe introduction of the new junior doctor contract.
- Divisions have been requested to provide a bottom up trajectory for how they will meet mandatory training compliance as the Trust is still underperforming, despite discussion at July TMC.
- TMC was presented with an Outline Business Case for PAS replacement which was followed by an Interim Business Case for IT Network Improvements. The Head of IM&T and Director of Finance were asked to develop a revised IM&T plan that prioritises key IT schemes, with financial costings & implications, to report through the Transformation Committee for further review. The risk scoring for IM&T strategy and implementation related risks will also be reviewed and updated following this assessment.
- It was agreed that Divisional Performance Reviews would focus upon quality indicators with a contractual implications such as compliance with WHO checklist and Single Sex Accommodation breaches as well as activity, finance and workforce indicators.

6.5 The following policies were reviewed by TMC and recommended for approval:

- Delivering Same Sex Accommodation Policy

- Policy for the Release of Human Tissue and Explanted Orthopaedic Implants
- Safeguarding Children, Young People and Families Policy (subject to amending the format and ensuring alignment to BCH policy)
- Paediatric Policy for the Deteriorating Patient
- Permit to Work Policy – Infection Prevention & Control
- An update to the Policy on Policies (additional table added to 'Consultation' section to capture whose feedback is essential before the policy can be recommended for approval)

6.6 Risks that are discussed at TMC that are recommended to be added to the corporate risk register will be presented via a formal risk report to Trust Board from October 2016 onwards.

7 RECOMMENDATION(S)

7.1 The Council of Governors is asked to discuss the contents of the report, and

7.2 Note the contents of the report.

Jo Chambers
Chief Executive
2 September 2016

Appendix 1

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

SINGLE OVERSIGHT MODEL - BRIEFING FOR TRUST BOARD

7 September 2016

1.0 INTRODUCTION

1.1 On 1 April 2016, NHS Improvement (NHSI) came into being, bringing together Monitor (regulator for NHS Foundation Trusts) and the Trust Development Authority (TDA) (regulator for NHS Trusts), reflecting that both NHS trusts and NHS foundation trusts face similar challenges in the system. NHS Improvement also encompasses the Patient Safety, the Advancing Change and Intensive Support teams. The specific legal duties of Monitor and the TDA persist through the creation of NHSI.

2.0 SINGLE OVERSIGHT MODEL

2.1 In line with this coming together of the two key regulators of NHS bodies, in June 2016 a proposal was put forward by NHSI that a Single Oversight Framework would be developed, which would replace Monitor's Risk Assessment Framework and the TDA's Accountability Framework. It was proposed that as far as possible it was the intention to combine and build on both of these regulatory frameworks, but adapting them to reflect and enable NHSI's primary improvement role.

2.2 It is also the intention of the new framework to support providers in attaining and/or maintaining a Care Quality Commission (CQC) rating of 'Good or 'Outstanding' by focussing on five themes which are aligned to the CQC's key questions (although are not identical). The key difference to the CQC's key questions lies with supplementary oversight of use of resources, which is not currently included within the CQC regulatory framework.

2.3 The new oversight framework is proposed to focus on the following five themes:

Quality of Care: the CQC's most recent assessments of whether a provider's care is Safe, Caring, Effective and Responsive, in combination with in-year information where available will be used to judge performance against this theme. Delivery of the four priority standards for 7 day hospital services will also be taken into account.

Finance & use of resources: informed by oversight of a provider's financial efficiency and progress in meeting its financial control total. The approach is being co-developed with the CQC.

Operational performance: support will be available to providers to improve and sustain performance against the requirements of the NHS Constitution and other standards. These would include A & E waiting times, referral to treatment times, cancer treatment times, ambulance response times and access to mental health services.

Strategic change: NHSI will work with system partners to consider how well providers are delivering the strategic changes set out in the NHS Five Year Forward View (5YFV), with a particular focus on their contribution to Sustainability & Transformation Plans (STPs), new models of care and, where relevant, implementation of devolution.

Leadership and improvement capability: this domain builds on the joint CQC and NHSI well-led framework and will develop a shared system view with the CQC on what good governance and leadership looks like, including organisations' ability to learn and improve.

3.0 SEGMENTATION

3.1 It is proposed that providers will be categorised into one of four categories; this process is known as segmentation. Organisations will be segmented according to the scale of issues faced by individual organisations. This judgement will be informed by data monitoring and an understanding of providers' circumstances. The summary of the proposed approach is as below:

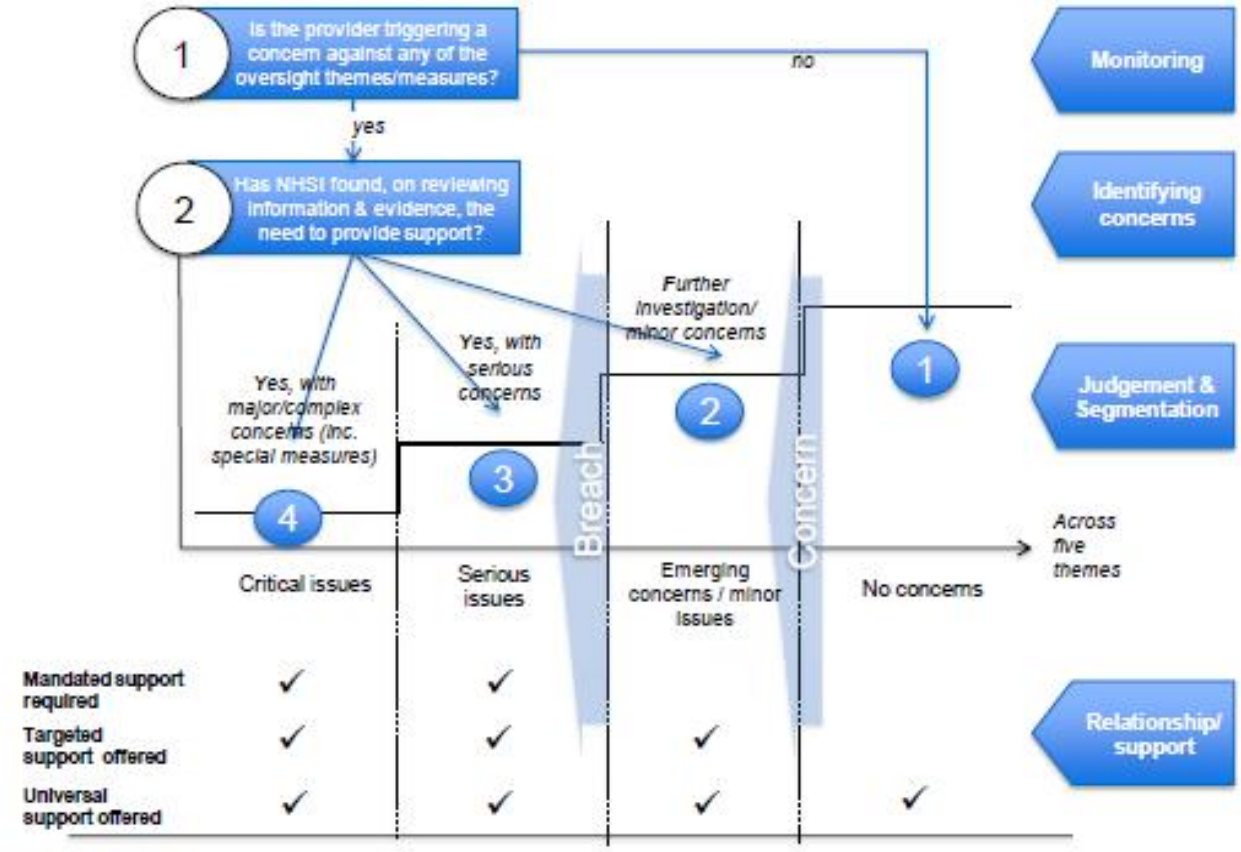


Figure 1: *Proposed approach to segmentation*

3.2 The segment a provider is within will determine the nature of the support NHSI will provide. While this will be tailored to the circumstances of providers, three broad categories of support for providers have been defined as: universal offers; targeted offers; and mandated (this is expanded upon in Section 6).

3.3 Segmentation does not in itself constitute an assessment of provider performance. NHSI teams will work with providers to determine the appropriate, tailored, support package for each, including directly provided support and support facilitated by, for example, other

parts of the sector.

3.4 The legal basis for actions in respect of NHS trusts and NHS foundation trusts remains unchanged. This means that, for example, a foundation trust will only be placed in segments 3 or 4 where it has been found to have been in breach or suspected breach of its licence.

4.0 MONITORING

4.1 Information from data monitoring processes will be used to identify where providers are triggering a potential concern in one or more of the five themes (which indicates they are not in Segment 1 and may benefit from support). This will be assessed, based on consistent principles, to determine whether or not they are in breach of their provider's licence, and if so, whether the issues are very serious/complex.

4.2 NHSI assert that the collection burden of information will be proportionate and where possible nationally available information will be used.

4.3 Monitoring information to be used will fall into three categories:

- **in-year** – following a regular in-year monitoring cycle using weekly/monthly/quarterly/six- monthly collections as appropriate
- **annual/less frequent** – annual provider submissions, such as annual plans, annual statements on quality or annually published data
- **ad-hoc** – results of CQC inspections, third-party information with governance implications, including audit reports, HSE reports, whistleblowing

4.4 During 2016/17 existing Monitor and TDA oversight templates will be used to collect information.

5.0 IDENTIFYING POTENTIAL CONCERNS

5.1 Information collected by NHSI will be used to identify where providers need support and there are 'triggers' of concern in each of the five themes. When providers trigger potential concern, NHSI will consider whether the level of interaction needs to change to monitor the issue and the provider's response to it.

6.0 SUPPORT TO PROVIDERS

6.1 While it is proposed that segmentation informs the oversight and support relationship with each provider, it will not determine the support package in its entirety, which will be tailored to a provider's particular circumstances.

6.2 The support offered will be provider specific, but it is proposed that it will fall into three categories:

- **universal support offer –** tools that providers can draw on if they wish to improve specific aspects of performance. Optional for providers to draw on.
- **targeted support offer –** support to help providers with specific areas – eg intensive support teams to help in emergency care or agency spend. Programmes of targeted support will be agreed with providers. This support is offered to providers – its use is voluntary.

- **mandated support –** where a provider has complex issues, NHSI may prepare a directed series of improvement actions to help it, eg appoint an improvement director, or agree a recovery trajectory and support providers to deliver this. In these serious and critical cases, providers are required to comply with NHSI's actions/expectations.

7.0 CONSULTATION AND ENGAGEMENT

7.1 A consultation process on the Single Oversight Framework was launched in June 2016, which was referenced in the July CEO public report. The closing date for the consultation was 4 August 2016. The Trust submitted a response to the detailed set of questions forming the consultation to this deadline and also provided a copy of the response to NHS Providers who submitted an overarching view taking into account wider provider feedback.

7.2 Additionally, the Associate Director of Governance/Company Secretary participated in a Webinar in July 2016 during which provider representatives were able to interrogate the plans set out in the consultation document further and therefore inform the consultation responses ahead of the deadline.

7.3 Key pieces of feedback provided to NHSI as part of the consultation and points of note from the webinar can be summarised as:

- Duplication of requests for information for monitoring purposes should be minimised where possible
- Language used in the new Framework needs to be harmonised with that of the CQC's framework where possible to avoid confusion
- There was concern that given the intention to launch the Framework in Autumn 2016, insufficient time had been allowed to build in any substantive comments arising from the consultation
- The Framework needed to take into account operational differences between large acute providers and smaller specialist organisations such as the ROH
- The principle of harmonising frameworks was welcomed and would ensure parity of treatment between providers, however as a general point, there was a concern that the Framework may constitute a 'blunt' instrument used to inform the initial segmentation that failed to take into account the direction of travel an organisation may be on.
- There might be limited scope for the Framework to reflect where organisations were starting from and to recognise the track record of the leadership team in addressing issues, with potential for additional monitoring or interventions posing a distraction just to comply with the additional requirements.
- There was a risk that as the Quality of Care theme is largely informed by the organisation's CQC ratings this may create a difficulty in moving with agility between segments given that CQC ratings are changed so infrequently
- Some indicators will be developed in line with the requirements of the Carter Review – these are however still under development. The use of the Weighted Activity Unit as a Framework metric within the Finance & use of resources theme is a concern, given that this is understood to be based on reference costs, which are known to be generally flawed

- The scoring ranges within the distance from the control total indicator are too tight, with, in the case of the ROH, as little as £15k difference in performance defining whether our organisation is classified as a top performing Trust (Category 1) to a one triggering concern (Category 4).
- The strategic change theme is the least developed of the themes and suggested indicators that would sit within this category might include: reported progress against the delivery of trusts strategic plans; progress with the delivery of the STP in which the trust sits; and progress with the delivery against the Vanguard quality indicators
- Given that there are indications that the Well Led Framework is likely to be redefined as a result of the introduction of the Single Oversight Framework, early notification of a change to the current deadline of May 2017 for completion of this assessment would be welcomed
- If any one or the five themes triggers concern, then this will trigger an overall consideration of the level of support needed to the organisation
- Trusts in special measures will automatically be placed into Segment 4 (Critical Issues)
- When an organisation is offered support, monitoring will be in place to determine how this support is used and a more directive approach will be taken if the support does not assist the trust
- A trust with a 'Requires Improvement' CQC rating would not automatically be placed into Segments 3 or 4, but could not be placed in Segment 1 (No Concerns)
- A 'bell curve' approach will not be applied during the segmentation exercise – trusts will be segmented on their own merits

8.0 NEXT STEPS

8.1 The consultation on the Single Oversight Framework formally closed on 4 August, however into mid-August additional engagement events were being hosted by NHSI to take further soundings from provider organisations who wished to provide a view.

8.2 A launch in early Autumn 2016 of the Single Oversight Framework had been proposed by NHSI. Notification of the exact details is awaited.

Simon Grainger-Lloyd
Associate Director of Governance & Company Secretary

1 September 2016

Appendix 2

Wellington House
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Jo Chambers
Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham
B31 2AP

27 July 2016

Dear Jo

Operational plans 2016/17

Thank you for submitting your final operational plan for 2016/17. I am writing to acknowledge receipt of your plan and to highlight the next steps.

'*Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21',* set out our expectations for delivering high quality, sustainable services for the patients and communities that we serve. I would like to take this opportunity to recognise the significant work that has gone into delivering a clear plan for 2016/17 during a challenging period for the NHS.

It is critical that each trust meets the commitments in its annual plan to deliver safe, high quality services and the agreed access standards for patients within the resources available. This will mean maintaining an effective balance between demand and capacity and continuing to develop the workforce needed for local services.

The planning guidance also set out the steps to help local organisations deliver a sustainable, transformed health service and meet the three gaps identified in the *Five Year Forward View*: health and wellbeing; care and quality; funding and efficiency. This highlights the importance of your strategic work to help create a sustainable organisation as part of a strong local health care system with agreed Sustainability and Transformation Plans.

To this end, NHS Improvement will continue to work with trusts to review progress against your plans and to support you in the delivery of the required standards in line with our new oversight model.

Next Steps

As part of the assurance of your plan, NHS Improvement has identified the need for further oversight relating to:

- Delivery of the Trust's CIP plans to support delivery of the Trust's control total.
- The Trust's use of agency staffing and compliance with its agency cap.
- Delivery of the Trust's 52 week wait recovery plan.

We note too that the Trust's financial performance at month 3 is behind by £1.1m, partly driven by the need to close theatres w/c 6 June. We will, therefore, need to work closely with the Trust to assess whether the Trust's in-year recovery plan is deliverable.

NHS Improvement will undertake on-going monitoring, support and escalation as necessary against the specific areas identified in this letter and the key domains and indicators outlined in the NHS Improvement oversight model.

In addition, we would request that Trusts publish their finalised plan summaries on their websites by 26 August 2016 and advise their NHSI regional relationship manager when this has been completed.

We will continue to work with you to ensure you are able to access the necessary development support to strengthen the Trust's capability and capacity for delivery. Our central commitment to delivering a strong provider landscape can only be achieved through your success. We will ensure that wherever possible we support you to deliver your ambitions. In return, our expectation is a simple one - that the commitments you make through this planning round and through locally agreed contracts are delivered in full.

If you wish to discuss the above or any related issues further, please contact Rebecca Farmer on 020 3747 0617 (rebecca.farmer3@nhs.net).

Yours sincerely

Frances Shattock
Regional Director
NHS Improvement

cc. Paul Athey, Director of Finance

Appendix 3

31 August 2016

Ms Jo Chambers
Chief Executive
The Royal Orthopaedic Hospital NHS Foundation Trust
Bristol Road South
Northfield
Birmingham
B31 2AP

Wellington House
133-155 Waterloo Road
London SE1 8UG

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Dear Jo

Q1 2016/17 monitoring of NHS foundation trusts

Our analysis of your Q1 submissions is now complete. Based on this work, the trust's current ratings are:

- Financial sustainability risk rating: 2
- Governance rating: Green

These ratings will be published on NHS Improvement's website in September.

NHS Improvement is the operational name for the organisation which brings together Monitor and the NHS Trust Development Authority. In this letter, "NHS Improvement" means Monitor exercising functions under chapter 3 of Part 3 of the Health and Social Care Act 2012 (licensing), unless otherwise indicated.

The trust has been allocated a financial sustainability risk rating of 2.

NHS Improvement uses the measures of financial robustness and efficiency underlying the financial sustainability risk rating as indicators to assess the level of financial risk at foundation trusts. A failure by a foundation trust to achieve a financial sustainability risk rating of 3 or above could indicate that the trust is providing health care services in breach of its licence.

NHS Improvement will continue to monitor and assess the trust's actions towards delivery of the 2016/17 plans. The trust's governance rating has been reflected as 'Green'. Should any other relevant circumstances arise, NHS Improvement will consider what, if any, further action may be appropriate.

A report on the aggregate performance of all NHS providers (Foundation and NHS trusts) from Q1 2016/17 is available on our website (in the Resources section), which I hope you will find of interest.

For your information, we have issued a press release setting out a summary of the report's key findings.

If you have any queries relating to the above, please contact me by telephone on 02037470617 or by email (rebecca.farmer3@nhs.net).

Yours sincerely

Gareth Wu
Regional Manager

cc: Dame Yve Buckland, Chair,
Mr Paul Athey, Finance Director

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	20 July 2016 1 September 2016
Guests	None
Presentations received and discussed	None
Major agenda items discussed	**20 July 2016** • Stock management update • Finance & Performance Overview • Prospective order book and plan to achieve control total • Reference cost process • Turnaround programme and performance framework • In Touch assurance update **1 September 2016** • Stock management update • Progress with rationalising implants • Finance & Performance Overview • Finance & Activity recovery plan • Turnaround programme and performance framework
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Committee	**20 July 2016** • The key concern for the Committee was the lack of a plan to achieve recovery of the finance and performance position and previous assurances appeared to lack substance or be grounded in reality. • The Committee was advised that activity performance remained behind plan, with the numbers of inpatients being below that expected particularly. Fallow lists caused by annual leave or other absence were not routinely being covered by alternative surgeons. Pooling of caseloads was also proposed as a potential solution to the issue. • There remained a residual risk around stock management in that reporting was not at present in real time; EDC Gold, a new stock management system was being implemented however which would assist • Financial performance had deteriorated, with a significant contributory factor being theatre closures in June

	• The CIP position was below plan, with shortfalls particularly in Divisions 1 & 2 • Average length of stay for hip replacements appeared to have increased. **1 September 2016** • A deficit of £346k was reported in month, although this was ahead of expectations. • The continued absence of a pain management consultant was impacting on the day case position, although the vacancy would be filled shortly. • Inpatient levels continued to be below plan and there were reported to be concerns over the theatre session booking process which did not appear to be robust at present. There had been two exceptionally light activity weeks in August. • Agency spend was reported to be slightly above trajectory. • Performance against the CIP appeared to be mixed, with a particular concern in clinical schemes. • Length of stay was noted to be of concern, with some long lengths of stay attributed to social care delays • Sickness absence was reported to have increased and mandatory training compliance had deteriorated. Both issues would be picked up as part of performance clinics. • The risks associated with the finance and activity recovery plan were discussed at length, which included having appropriately skilled staff in Pre-Operative Assessment and the ability of the organisation to embrace the changes quickly and whole heartedly. The recovery plan might incur some additional costs. Improving theatre utilisation and creating a strong focus on CIP delivery were suggested to be key to delivering the plan.
Positive assurances and highlights of note for the Board	**20 July 2016** • The Committee was advised that cost control was good and there was good focus on agency spend. Discussions around controls were in place at a divisional level and divisional control totals had been set. • A stocktake was underway to establish progress with the delivery of the actions to achieve turnaround • The Committee was provided with good assurance that the national reference costs guidance was being followed • The Committee received a turnaround programme and performance framework update which provided a helpful view of the position with the various activities and programmes that would could assist with the turnaround; work was underway to segregate the matters that would be reported to the Transformation Committee as opposed to the Finance & Performance Committee

	• In Touch was reported to have been implemented, albeit with slight delay; there was national interest in the Trust's use of this system **1 September 2016** • The Committee was advised that good progress was being made to deliver the actions arising from the Internal Audit on stock management. • Good progress continued to be made on rationalising stock implants and discussions were planned with some key suppliers to take this work forward. • There remained good costs control overall. • Cancellations and admissions on the day of surgery were reported to have improved. • It was reported that following feedback on the Quarter 1 position, the Trust's governance rating had been moved from one of 'Under Review' to 'Green'. The Risk Rating remained at '2'. • The Committee considered a finance and activity recovery plan which set out a set of measures which would assist with returning to a performance towards the control total. Re-engineering the pre-operative assessment process was noted to be key to the plans.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	**20 July 2016** • A recovery plan was agreed to be needed as a matter of urgency. • An update on stock management would be provided at the next meeting **1 September 2016** • Undertake a review of consultant retirements to determine any vulnerability in terms of income • Present a further update on theatre utilisation at the next meeting • Present the revised capital plan to Trust Board • Develop the recovery plan to specify the timescales and responsibilities for delivery
Decisions made	• None specifically

Mr Tim Pile

VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 7 September 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	30 August 2016 The July meeting had been cancelled due to unavailability of key members who were otherwise involved in the Quality meeting and urgent operational changes. There was no meeting scheduled in August and therefore this briefing had been put in pace to assure the Board that the key quality reports and quality committee reports had been scrutinised.
Guests	None – the briefing consisted of the Chair of the Quality & safety Committee, the Director of Operations, Nursing & Clinical Governance, the Governance Manager and the Associate Director of Governance/Company Secretary (Secretariat).
Presentations received	None
Major agenda items discussed	• This was an assurance briefing which covered the key sources of assurance to the Committee: the July and August Patient Safety & Quality reports and the upward reports from the Clinical Quality Committee for July and August.
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Board	• The detail of the reported Serious Incidents and Never Events was discussed. It was noted that the incidents have involved some non-adherence to Trust policies and that an external review commissioned recently was to assess the practices in theatres in this respect. • A number of pressure ulcers were noted to have been reported, a number of which were avoidable. It was agreed that as further assurance was needed as to handling of these, the Ward Manager of Ward 3 would attend the next meeting of the Quality & Safety Committee to describe the measures he had put into place to prevent Pressure Ulcers in his area. • The expected death case was discussed and a review was currently being undertaken to establish the appropriateness and anticipated benefit of the surgicial intervention that had occurred. • Further assurance as agreed to be needed as to the WHO checklist process, particularly in the light of the Never Events reported recently

	• The outcome of the quality walkabouts was discussed and it was noted that some areas had been classified as 'Requires Improvement'. It was noted that the actions to address this rating were tracked by the Divisional Management Boards, however the Clinical Quality Group should review the improvement action plans as an additional source of assurance. These should also be dicussed at Ward Managers meetings • The risk around blood fridge and management of blood was discussed specificially and agreed that further assurance was needed that the policies and practice around this were appropriate
Positive assurances and highlights of note for the Board	• The Committee agreed that the reports provided a good source of assurance and opportunity for challenge on Quality & Safety matters
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• It was agreed that the Patient Safety & Quality reports should be shared with Ward Managers in future, to create Board to Ward visibility of the information that was being used to hold to account and the significance of this. • It was agreed that the Head of Communications should be invited to the next meeting to provide an overview of handling the Friends & Family Test process, particularly the detail of information requested on outpatient questionnaires • It was agreed that the upward report from Clinical Quality Committee are adequately reflected in the associated minutes of the meeting. Work would also be undertaken to ensure that the actions agreed at the meeting, were reflected in the minutes, progress with which the Committee could then monitor.
Decisions made	• None specifically

Kathryn Sallah
NON EXECUTIVE DIRECTOR AND CHAIR OF QUALITY & SAFETY COMMITTEE

For the meeting of the Trust Board scheduled for 7 September 2016

FINANCE & PERFORMANCE REPORT

AUGUST 2016

NOTE: The performance against the Governor-sponsored quality indicator, cancellation on the day of surgery, is detailed in Section 11.

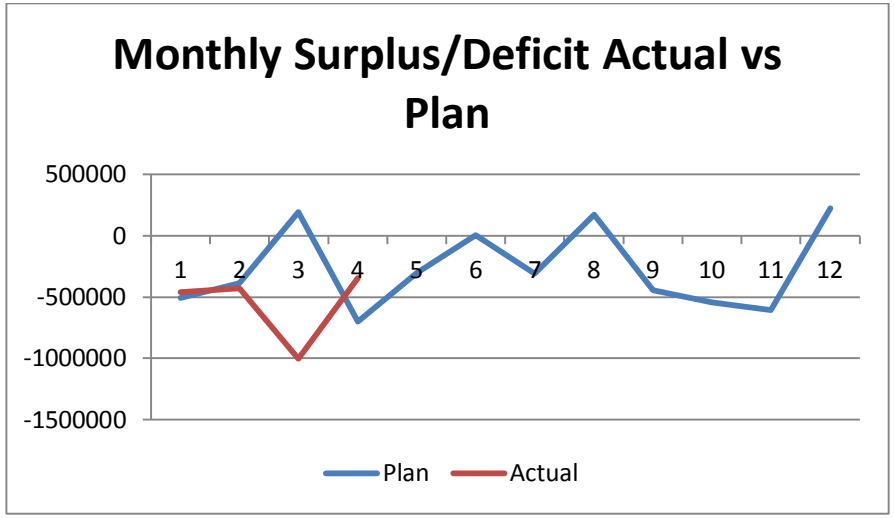
CONTENTS

INTRODUCTION

The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

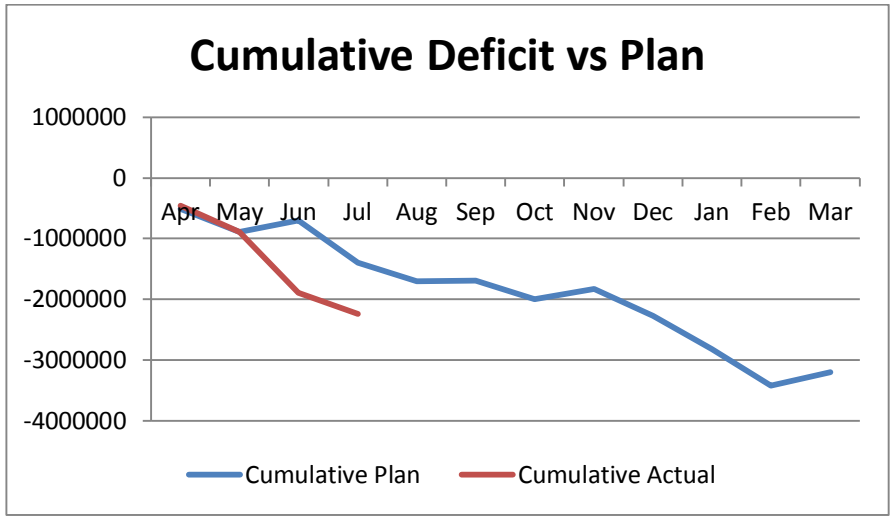
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

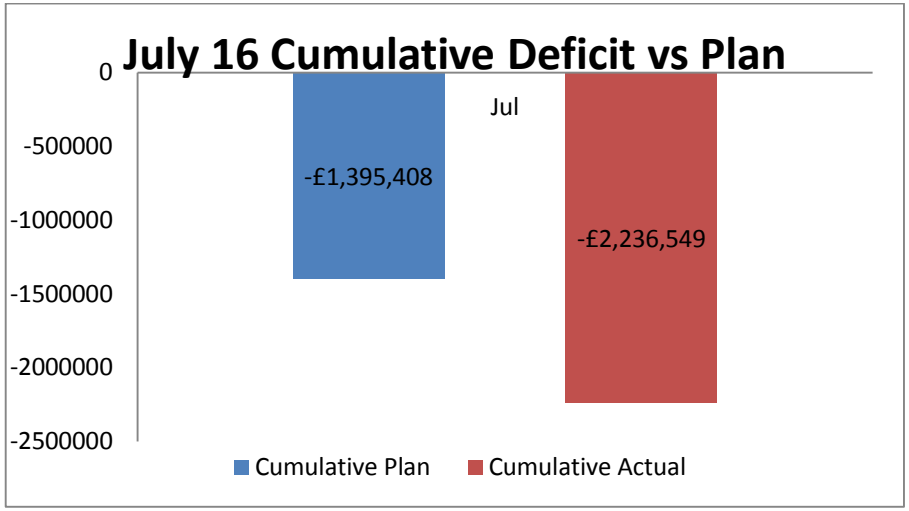
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Financial Sustainability Risk Rating (FSRR)



NHSI Financial Sustainability Risk Rating (FSRR)

	Plan	Actual
Capital Service Cover	1	1
Liquidity	4	4
I&E Margin	1	1
I&E Margin – Variance against plan	2	1
Overall FSRR	2	2





INFORMATION

The Trust has delivered a cumulative deficit of £2,237,000 as at the end of July against a planned deficit of £1,395,000. In month, the Trust delivered a deficit of £346,000 against a planned deficit of £698,000.

The Trust is therefore £842,000 behind plan at the end of M4. During the month of June all operating theatres were closed for a week due to problems with the air filtration canopy system. It is estimated that this closure resulted in a loss of £908,000. Excluding the impact of this closure, the Trust would be ahead of plan by £66,000.

Further detail on the key drivers of the financial position is provided in the income and expenditure sections below.

CIP savings released in July were in line with the plan for the month, however they remain £200k behind plan for the year to date.

The deficit position results in the Trust achieving ratings of 1 for our Capital Service Cover, I&E Margin metrics and I&E Margin Metrics against plan. As part of the NHSI Financial Sustainability Risk Rating. The achievement of a 1 in any metric caps the overall performance level for the Trust at a maximum rating of 2, despite receiving the highest available rating for liquidity.

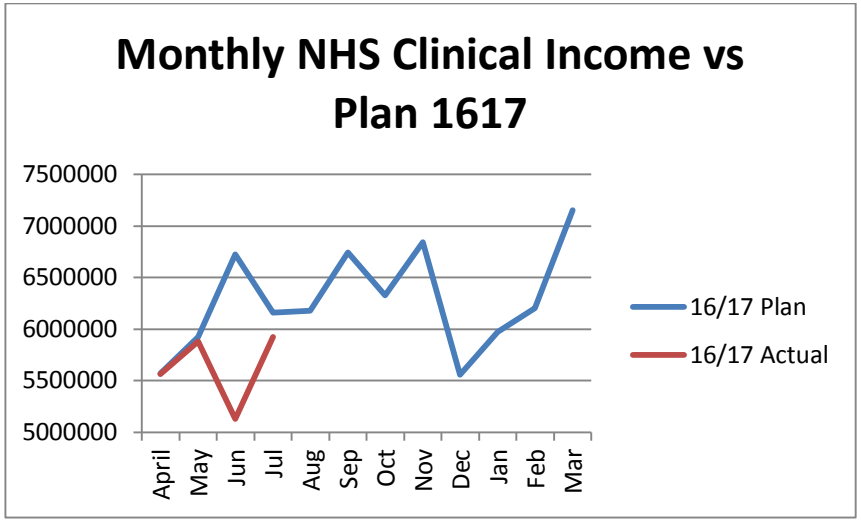
ACTIONS FOR IMPROVEMENTS / LEARNING

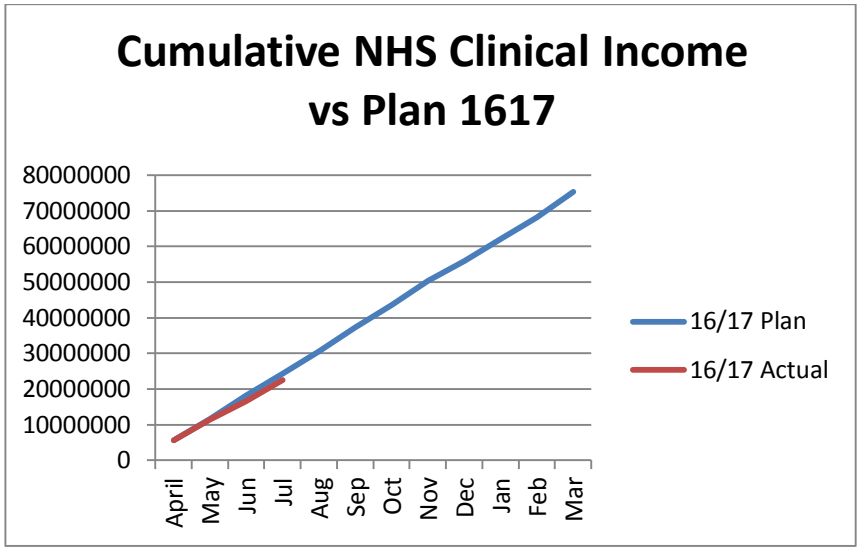
See income & expenditure sections for more details

RISKS / ISSUES

Achievement against the overall financial target for the Trust remains a challenging ask, and it is vital that the combination of activity delivery, cost control and efficiency improvements are all achieved to enable the target to be hit. The Trust is not eligible for its £200,000 sustainability funding until our financial position is back in line with our planned trajectory.

2. Income – This illustrates the total income generated by the Trust in 2016/17, including the split of income by category



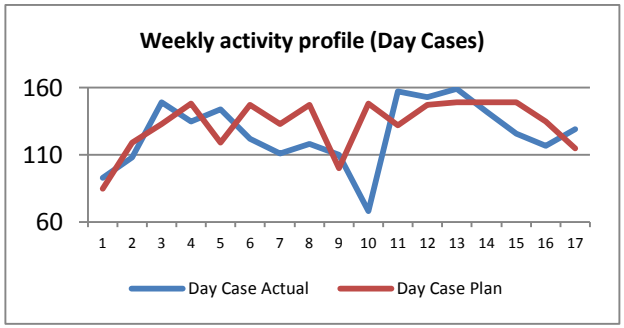


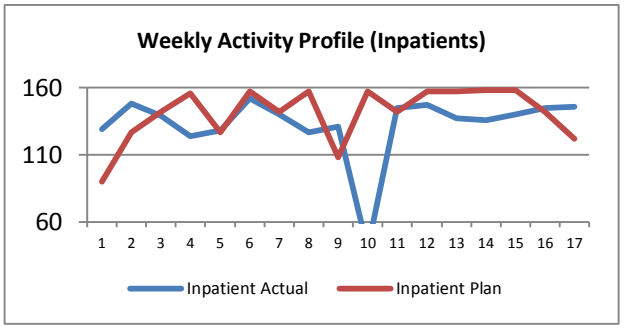
NHS Clinical Income – July 2016			
	Plan	**Actual**	**Variance**
Inpatients (inc XBDs)	3,204	2,950	(254)
Day Cases	736	720	(16)
Outpatients	677	575	(102)
Critical Care	230	221	(9)
Therapies	228	236	8
Pass-through income	201	213	12
Other variable income	379	464	85
Block income	506	527	21
TOTAL	6,161	5,906	(255)

NHS Clinical Income – YTD 2016			
	Plan	**Actual**	**Variance**
Inpatients (inc XBDs)	12,544	11,078	(1,466)
Day Cases	2,883	2,647	(236)
Outpatients	2,742	2,508	(234)
Critical Care	901	870	(31)
Therapies	926	993	67
Pass-through income	809	821	12
Other variable income	1,516	1,522	6
Block income	2,052	2,108	56
TOTAL	24,373	22,547	(1,826)

INFORMATION

NHS Clinical income under-performed by 4% in July as a result of under-performance in both inpatient and outpatient activity. Inpatients and Day Cases both underperformed in the month, with a circa 15 patient per week underperfomance in both categories in the early part of the month, before an improvement at the end of the month as activity was maintained into the school holiday period as demonstrated by the graphs below (July = Wks 14-17). Casemix was largely similar to plan in all categories of activity in July.





Outpatients continued to under-perform from an income point of view, driven by a significant reduction in the number of outpatient procedures undertaken in month. This largely relates to the retirement of a pain management consultant, and the difficulties in recruiting to a full time locum post to cover. A proportion of his workload has been transferred to other services including therapies, which partly explains the over-performance in that service in the year to date.

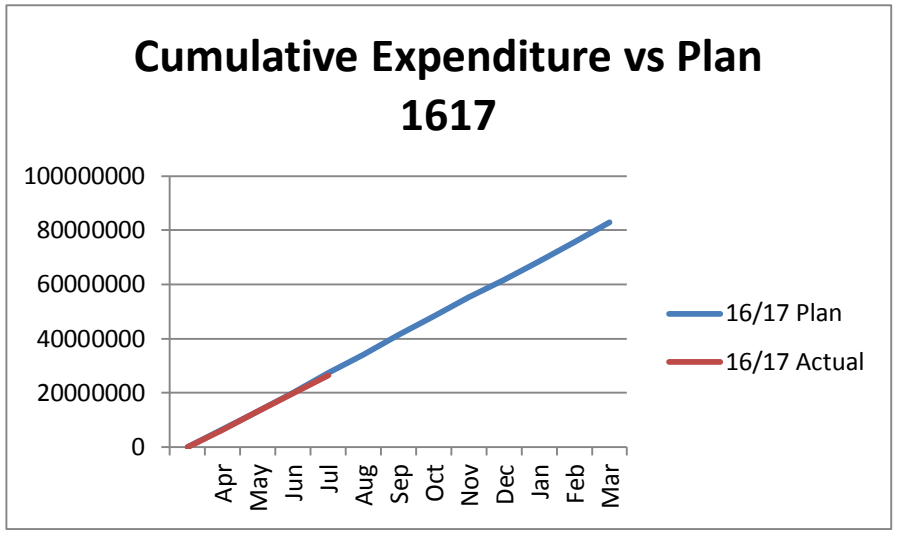
ACTIONS FOR IMPROVEMENTS / LEARNING

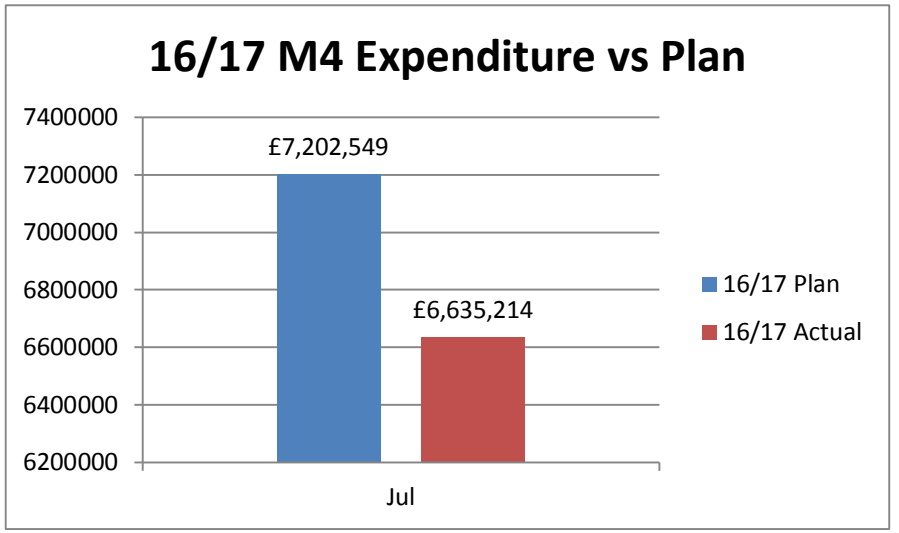
A full stock take of all programmes of work designed at improving activity levels and ensuring the availability of appropriate capacity in terms of people, theatres and beds has taken place following the resignation of the Director of Operations. This has highlighted that whilst some projects are on track, others will need remedial action. This information has been combined with the impact assessment from the June theatre closure to quantify the level of work required to claw the income position back to planned levels. A plan is currently being finalised to demonstrate how this will be achieved.

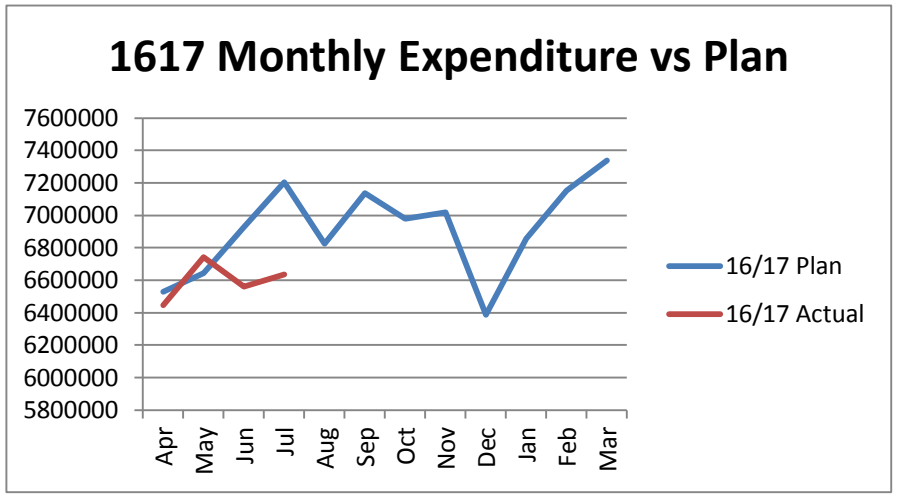
RISKS / ISSUES

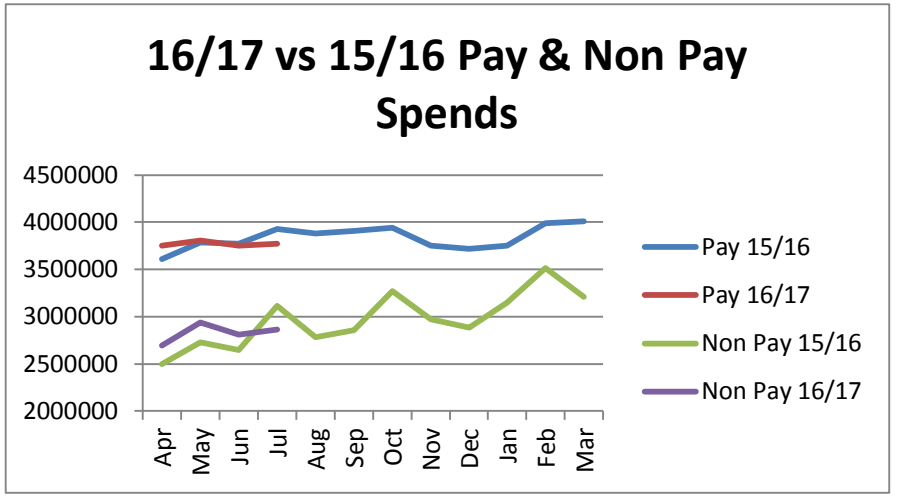
Proactive action is ensure that the step up in activity from September onwards still takes place, along with further action to clawback the shortfall in June. Failure to deliver activity levels, and the associated income commensurate to this will make the achievement of the overall financial position extremely difficult given that our savings target is already stretched to reach our £3.2m control total deficit.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2016/17, compared to historic trends









INFORMATION

The Trust's improved financial performance in July is significantly driven by the continued control of expenditure, with spend levels £568,000 behind plan for the month. The majority of the Trust underspend in July relates to clinical supplies and services, with spend levels maintained in line with previous months, despite an increase in planned expenditure based on previous year's trajectories. The Trust is also holding on to some small reserves that have not been required to be released due to good budget management at departmental level. These include planned cover for inflationary costs and funding for CQUIN pressures, the latter of which may be required over the coming months.

Division 2 (Patient support services) and the Corporate Division are both underspent at the end of Month 4, with small overspends in Division 3 (Patient Access) and Division 4 (Estates & Facilities). Division 1 (Patient services) remains the biggest concern, with an overspend of £185k for the year to date. The biggest drivers for this position include an increase in the cost of the BCH Spinal Deformity service (currently not offset by a corresponding increase in income), medical staffing and an underperformance on CIP.

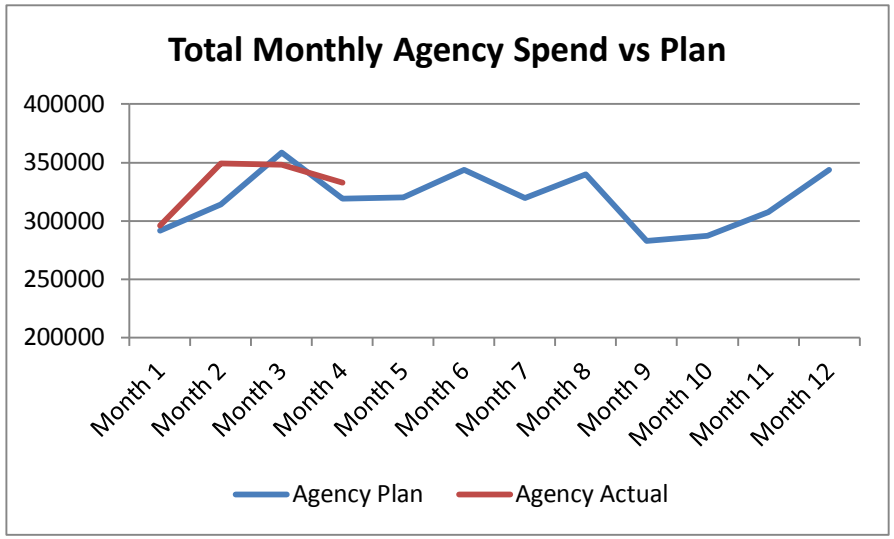
ACTIONS FOR IMPROVEMENTS / LEARNING

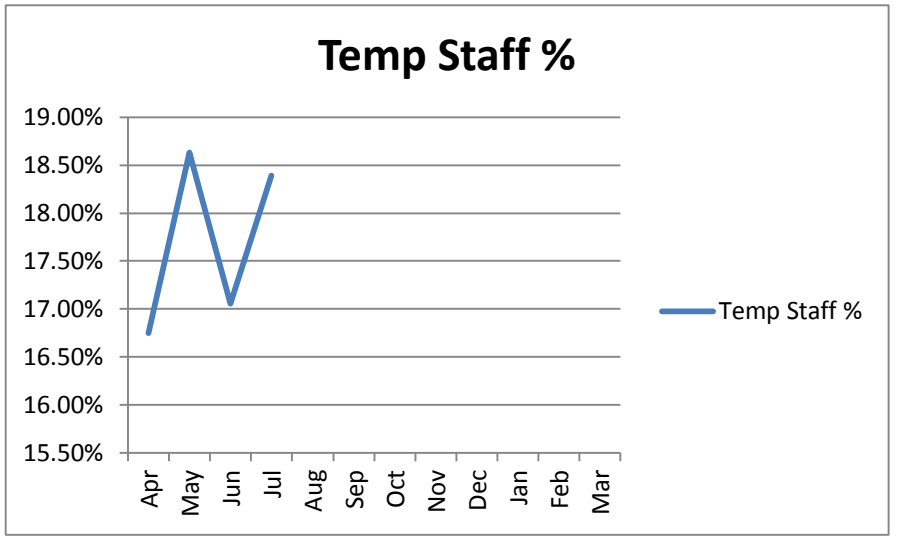
A financial recovery plan, linked to the Trust's activity recovery plan, is being developed for consideration at Finance & Performance Committee at the end of August / start of September.

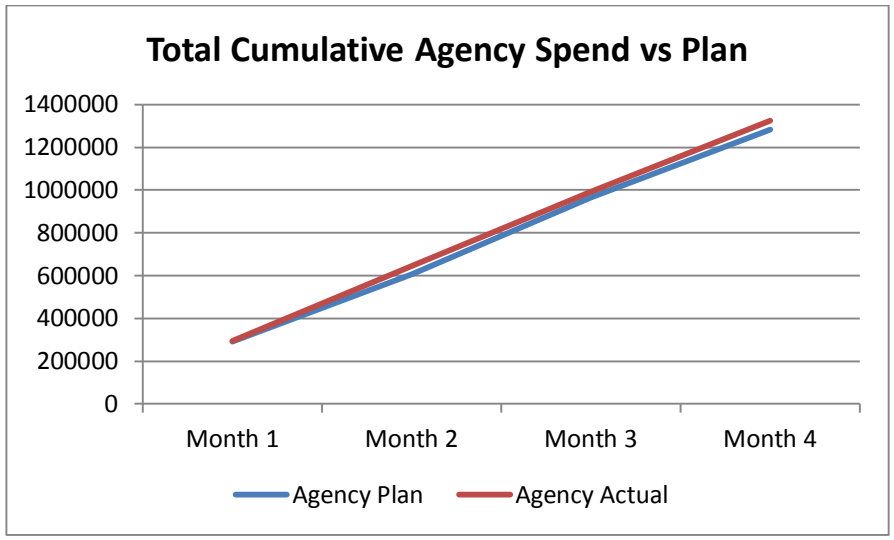
RISKS / ISSUES

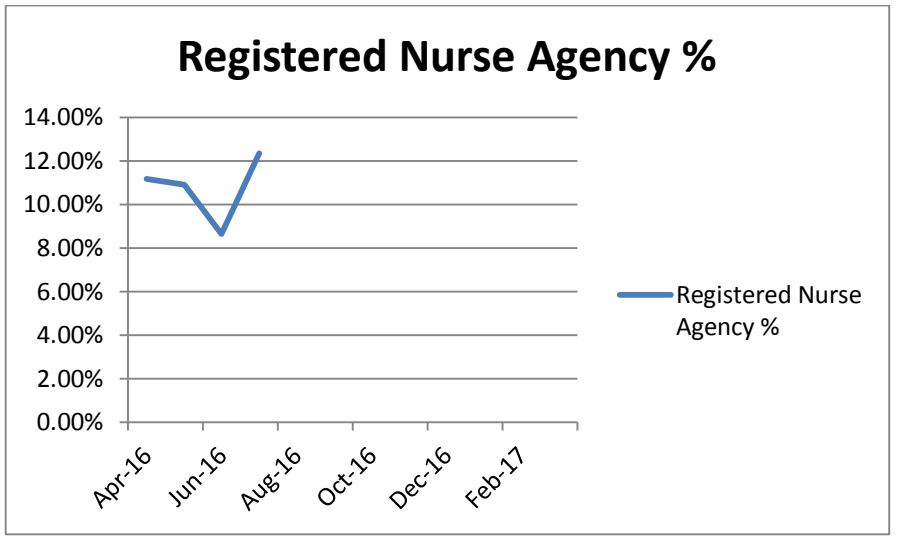
Further work is required to implement the full recommendations of the review into theatre stock control and processes, as there remains a risk that without these improvements, full reliance cannot be placed on non-pay expenditure.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2016/17, and performance against the NHSI agency requirements









INFORMATION

Overall levels of agency spend reduced in July, however this reduction was less than the planned trajectory, resulting in a further deterioration in performance against this trajectory. Overall agency spend for 2016/17 currently stands at £1,326k against a plan of £1,283k, an overspend of £43k (3.2%).

The overspend continues to be driven by additional expenditure on agency medical locums, which has resulted in a £146k overspend for the year to date. By comparison, agency spend on nursing is underspent by £91k and on management/clerical staff is underspent by £15k. The overspend on medical locums largely relates to the inability to realise savings from the introduction of Physicians Associates. Actions being taken to rectify this are shown below.

Nursing agency spend did increase against the previous month, however this was largely due to the one-off reduction in June due to the theatre closure. The remaining agency spend relates to the Trust's ongoing recruitment challenges, although some traction is now being gained with ward recruitment, whilst the Trust's overseas nurses in theatres will shortly be completing their supervisory period of work.

ACTIONS FOR IMPROVEMENTS / LEARNING

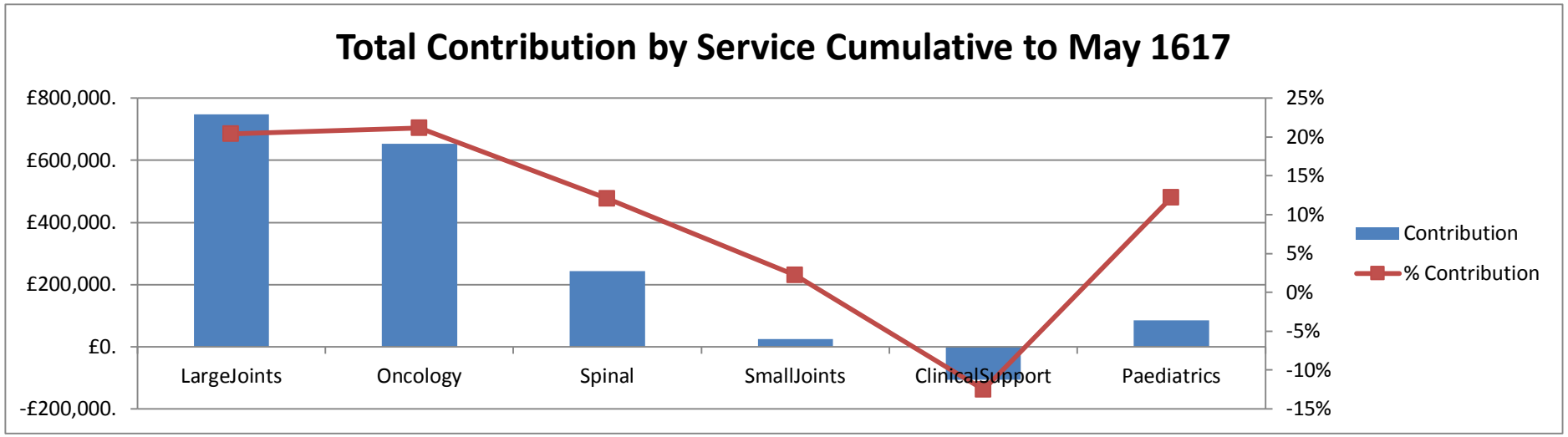
A task & finish group has been set up to look at the overall provision of middle level medical cover and the potential for replacing locum costs with other clinical professionals, This is due to report back in early September.

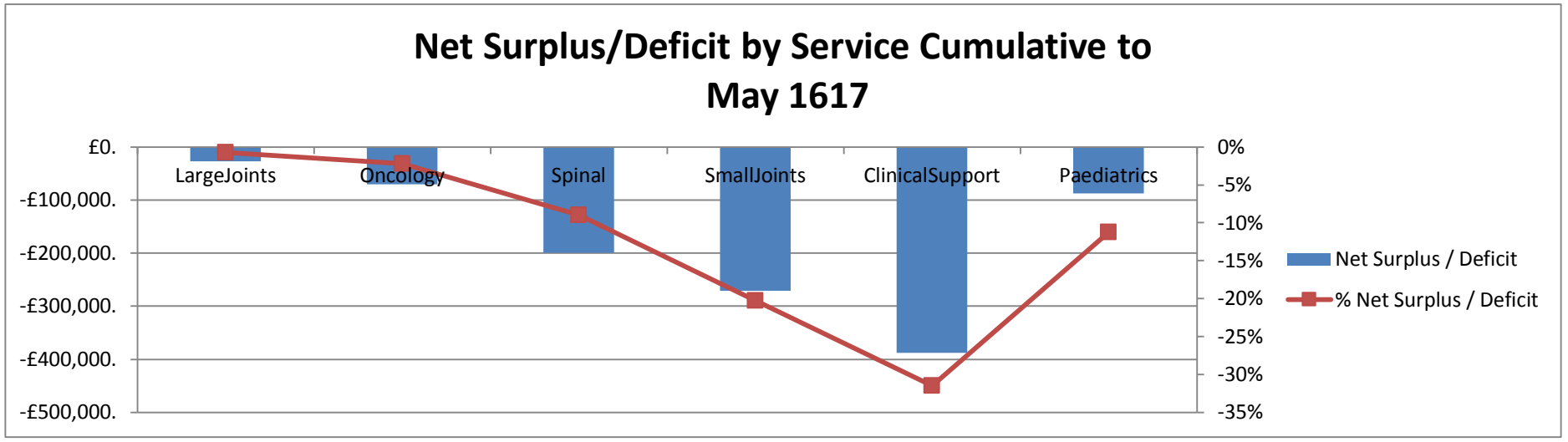
Action has also been taken to review the staffing model in POAC with a view to removing the expensive locums supporting the service, with proposals expected in the next couple of weeks.

RISKS / ISSUES

Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls. The Trust will need to take all necessary steps to bring expenditure back in line with the capped trajectory.

5. Service Line Reporting – This represents the profitability of service units, in terms of both consultant and HRG groupings





INFORMATION

The graphs above, and the associated narrative, relate to the financial year 2016-17.

The first graph is showing the contribution each service is generating, currently the Trust target is set at <20%. The only services currently achieving this set target are Oncology and Large Joints. Clinical Support is the only service that has provided a negative contribution of £106K, this is mainly due to consultant vacancies in the pain management service resulting in reduced activity and agency staff costs being incurred to support maintenance of the 18 week target in this service.

The second graph is comparing the total contribution each service made towards the trust's position as at May 16. It can be seen that once the finance costs for overheads, depreciation and interest are applied all service lines are then running at a net loss, this is reflected in the overall Trust position of a £886K deficit in the first 2 months of 2016-17.

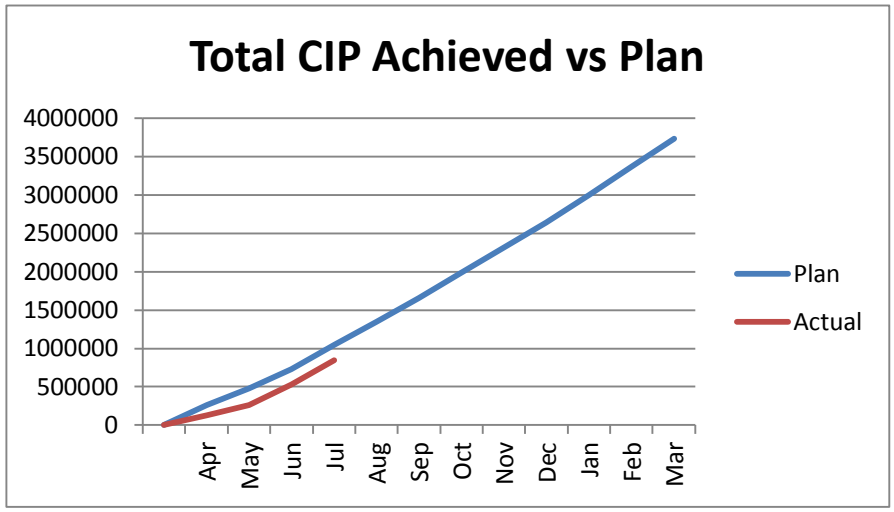
After applying Trust overheads Small Joints is the second lowest contributing service with a net deficit of £271k, which is mainly due to its Tariff configuration and service provision.

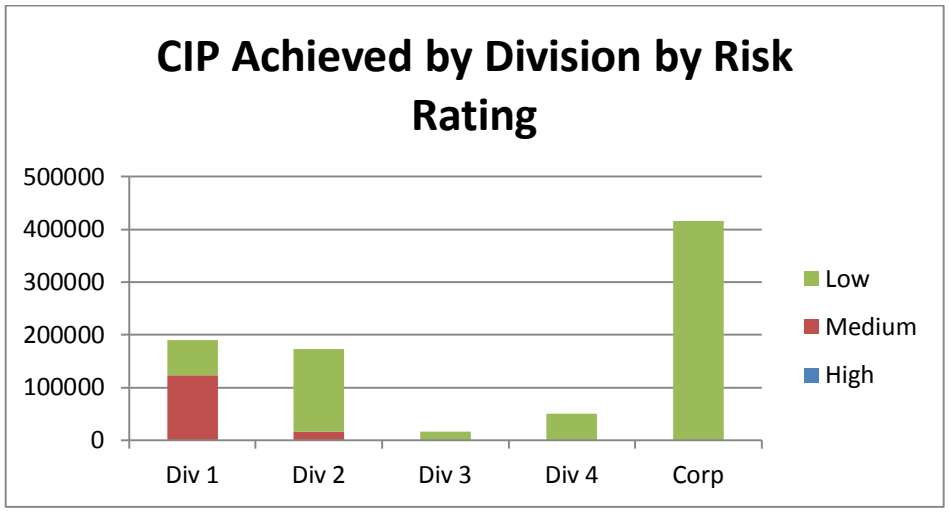
ACTIONS FOR IMPROVEMENTS / LEARNING

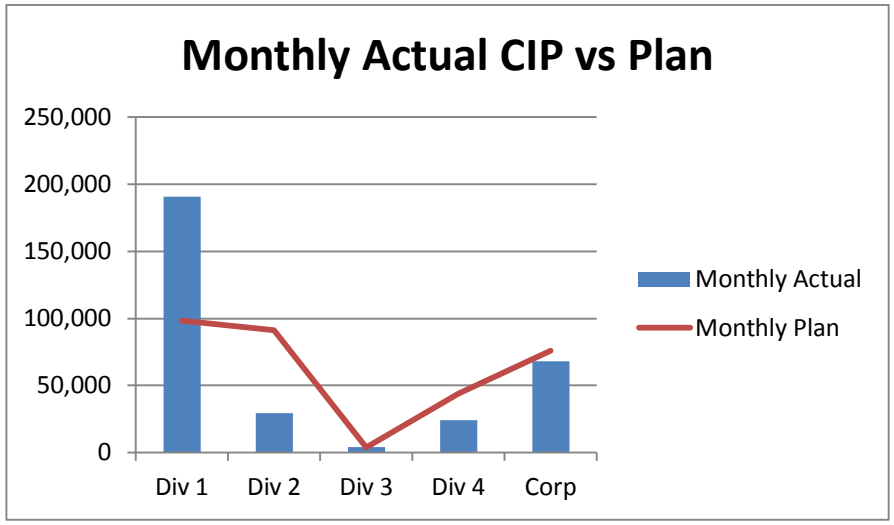
It is important that the use of SLR is embedded into the Trust, as this information provides the vehicle to challenge clinical and price variation at all levels. SLR reporting will form part of the divisional reporting moving forwards, and will be challenged at monthly performance meetings.

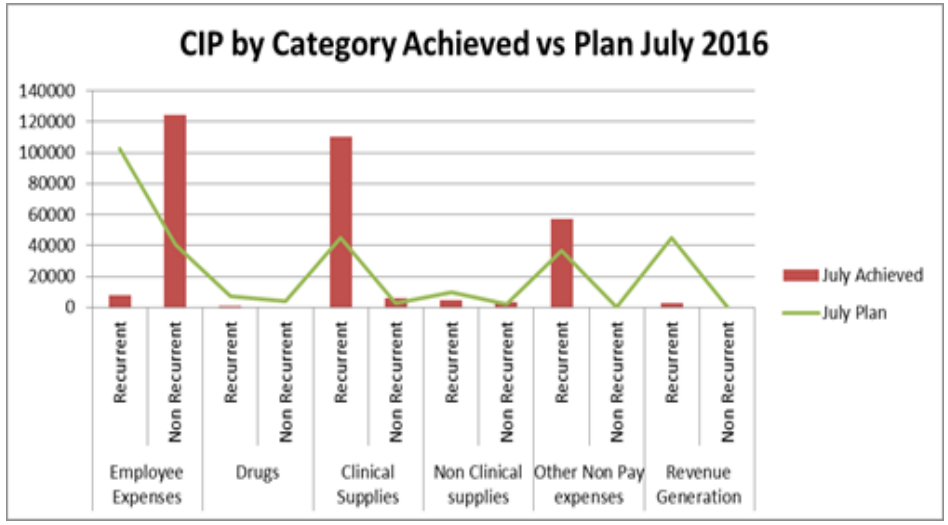
RISKS / ISSUES

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2016/17









INFORMATION

As at the end of Month 4, the Trust has recognised £847k of savings, against a plan of £1,045k. £219k (26%) of savings to date are non-recurrent. The in month savings recognised were £316k against a July target of £314k.

- A number of key decision points are CIP proposals are due during the next month. These include:
  - Options for prosthesis savings (either direct engagement or via NHS Supply Chain)
  - Proposals for improving the patient booking process, linked to Phase 2 of digital dictation/speech recognition
  - Business case review of theatre, anaesthetic and HDU staffing

The majority of undelivered CIP schemes are still rated as medium or high risk in terms of likely delivery. Further work is required by CIP leads to ensure that these schemes are delivered, and that additional mitigation schemes are developed to cover any future slippage.

The majority of Quality Impact Assessments for in year CIP schemes have been developed and the process of review by the Director of Nursing & Governance and the Medical Director for formal sign off is ongoing. These will then be monitored through the Quality Committee. The use of the Quality Committee as an assurance route for QIAs will ensure a more timely process of review during 2016-17.

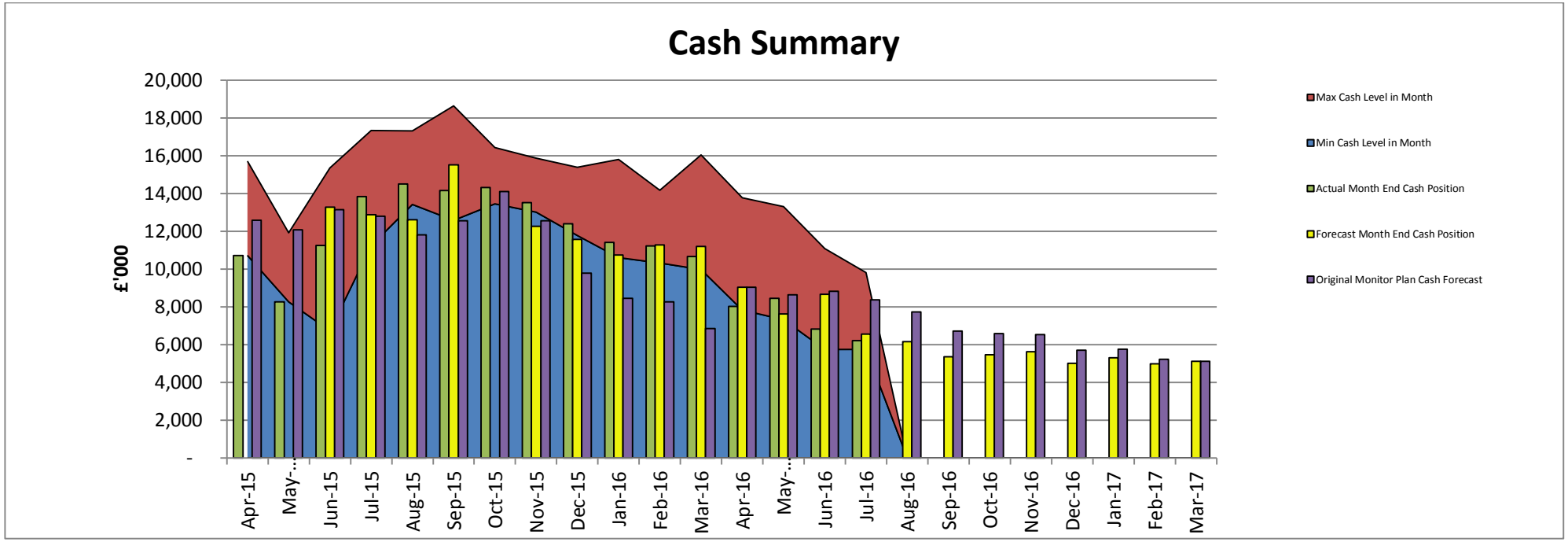
ACTIONS FOR IMPROVEMENTS / LEARNING

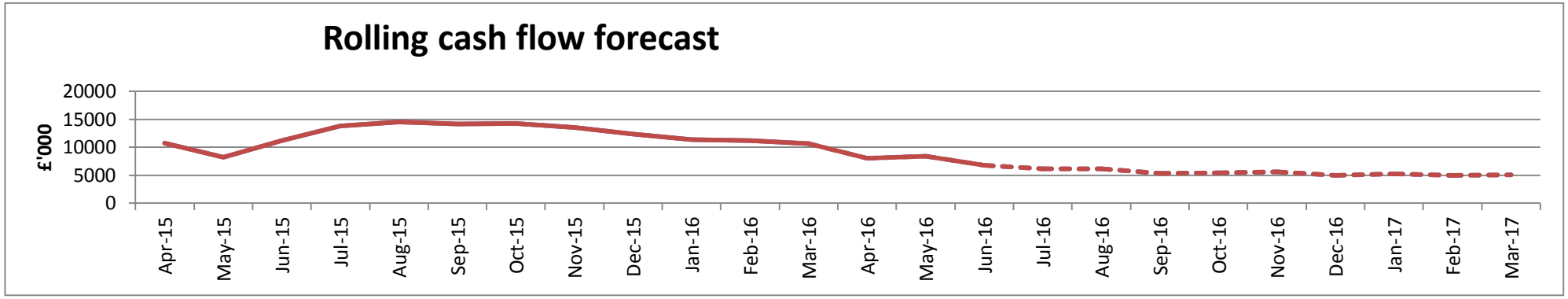
There are still gaps in some areas with regards to the required CIP documentation, largely relating to implementation plans and QIAs however the majority of these relate to newly developed schemes within the Corporate Division. A mid-July deadline was set for this paperwork to be completed and the majority of the QIA's have been received. For the QIA's that are outstanding, all Leads have been reminded to submit their paperwork.

RISKS / ISSUES

The CIP target of £3.67m represents a significant challenge to the Trust. It is vital that we remain on target in the early months as it will not be possible to make significant clawbacks against this level of savings target later in the year.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet





INFORMATION

Cash levels are £2m million lower than planned levels at the end of July 2016. The Trust is forecasting an end of year cash balance of circa £5m, which relies upon the delivery of our deficit plan and the control of capital spend within the budget that has been set.

The lower than planned cash position is mainly due to the lower level of brought forward balance of June 2016. Cash was in line with the planned position at the end of July.

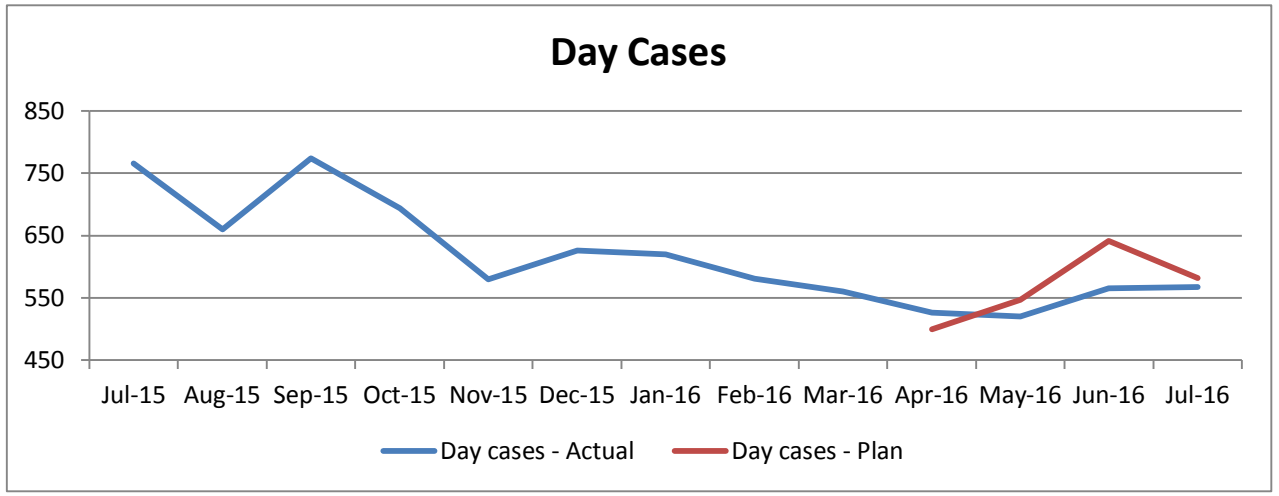
ACTIONS FOR IMPROVEMENTS / LEARNING

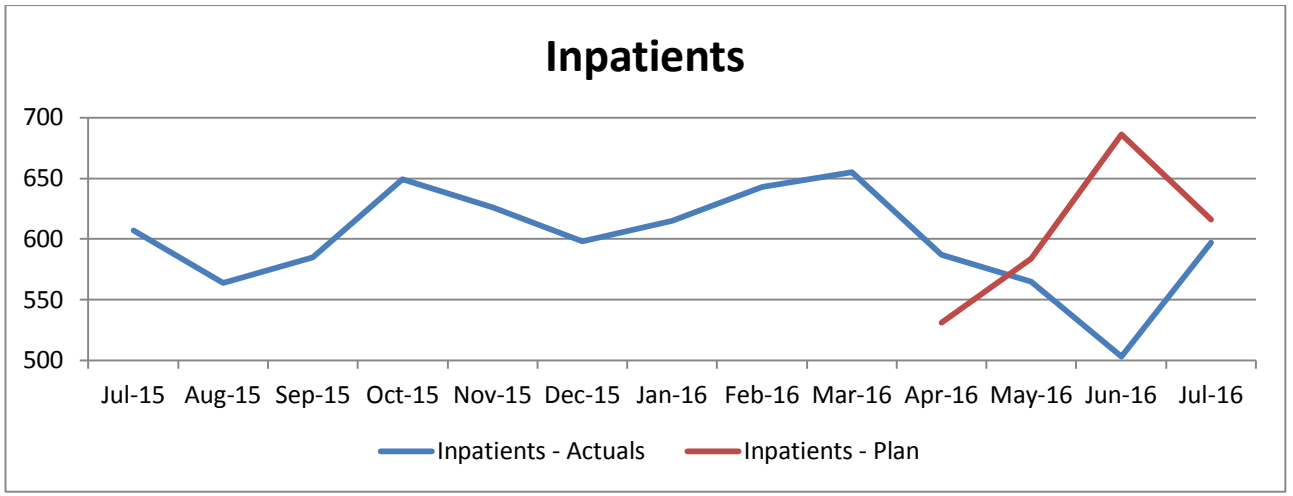
The Financial accounting team are continuing to review opportunities to improve the monitoring and projection of working capital movements, particularly in relation to early warnings around stock purchases and issuing.

RISKS / ISSUES

Given the in-month fluctuation of the cash position, which can potentially hit levels £1m-£2m below month end figures before mandate payments are received, it is vital that financial projections are met to ensure that cash can be comfortably managed within safe tolerances.

8. Activity: Admitted Patient Care – This illustrates the number of inpatient and day case discharges in the month, and year to date





INFORMATION

Activity levels for both day cases and inpatients were both circa 2.5% down on planned levels of the month of July. As highlighted in the graphs in section 2, this position was driven by under-delivery in the "busy" weeks planned for the early part of July, with some clawback in the final week as planned levels were anticipated to drop.

A review of performance against the various workstreams within the activity plan have highlighted that the majority of the underperformance in the year to date (excluding the impact of the theatre closure) relates to delivery of the underlying baseline. Anticipated growth from the appointment of a spinal locum and the reduction of on the day theatre cancellations has been delivered in line with, or ahead of, planned levels, and whilst there has been some under-delivery against growth expected from the perfect day pilot, the overall performance is driven by baseline activity.

ACTIONS FOR IMPROVEMENTS / LEARNING

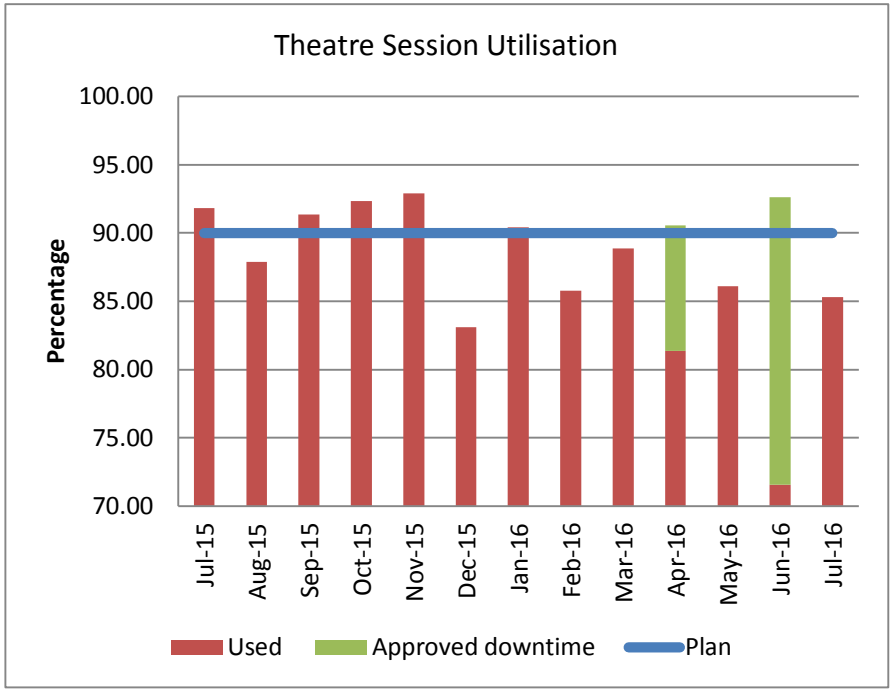
A full stock take of all projects either delivering current growth or aimed at increasing capacity for the growth planned for Q3/4 has now been completed and the information from this will feed into the Trusts financial and activity recovery plan due for consideration at F&P committee on 1st September.

RISKS / ISSUES

The events of week commencing 6th June, leading to a week of cancelled elective operating, clearly present a risk in terms of the catch up of the overall planned activity levels.

Evidence continues to suggest that the Trust is struggling to deliver activity levels in the planned "busy" weeks, and this challenge must to addressed given the expect step change from September onwards.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

383 sessions were used in May against an available total of 449. This equates to a theatre session utilisation of 85%.

ACTIONS FOR IMPROVEMENTS / LEARNING

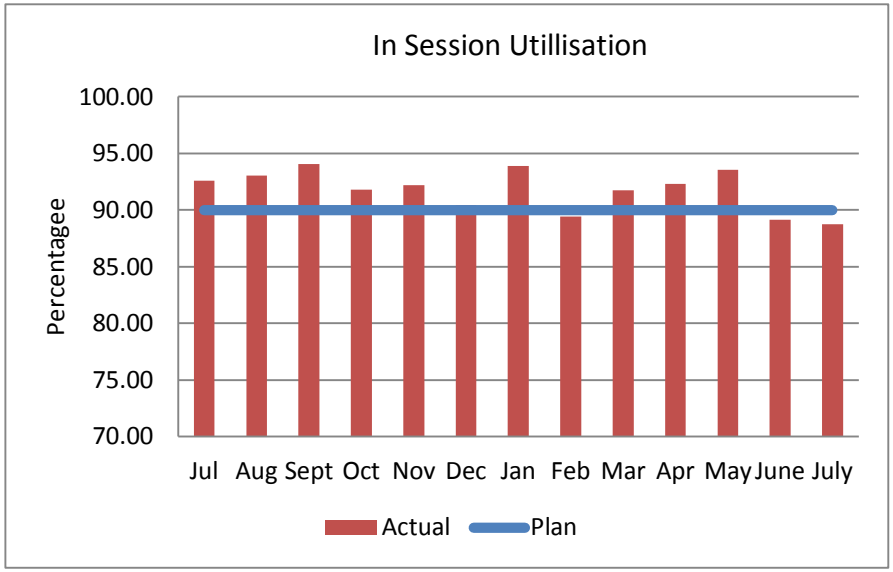
Due to annual leave / study leave, we should typically expect surgeons to cover a 42 week year. Timetables are currently based on a 52 week year. Discussions take place proactively as part of the "6,4,2" process to ensure that other surgeons pick up lists that would otherwise be fallow. A more robust approach to job planning to build in buddy arrangements and prospective cover, as well as recruitment to specialities where there are vacancies or that are under pressure from an activity / RTT / 52 week perspective, will improve this position.

In the meantime, there is a process to take down outpatient clinics to provide surgeons to recycle theatre lists, where it is practical to do so for the speciality concerned.

RISKS / ISSUES

Engagement in the job planning process and delivery of timescales. Notice required to establish buddying timetable arrangements and co-ordination of leave evenly through the year.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



Add graph showing theatre in-session usage by month – may need to wait for Theatreman for this

INFORMATION

Utilisation against this measure had remained consistently above the target 90%. However, the previous measure was flawed in that it included the overrun minutes in the numerator, against the planned time available in the denominator. From June, this has been amended to follow national best practice (The Productive Operating Theatre) with overrun minutes not included, so as not to skew performance to look better than it is in reality.

A realistic target against this measure is 85% with performance hovering around the 88%/89% mark for June & July.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are a range of actions being undertaken as part of the Patient Journey 2 project to ensure continual improvement in theatre in session utilisation, focussing on start time, turnaround, optimal list composition and the eradication of unplanned overruns.

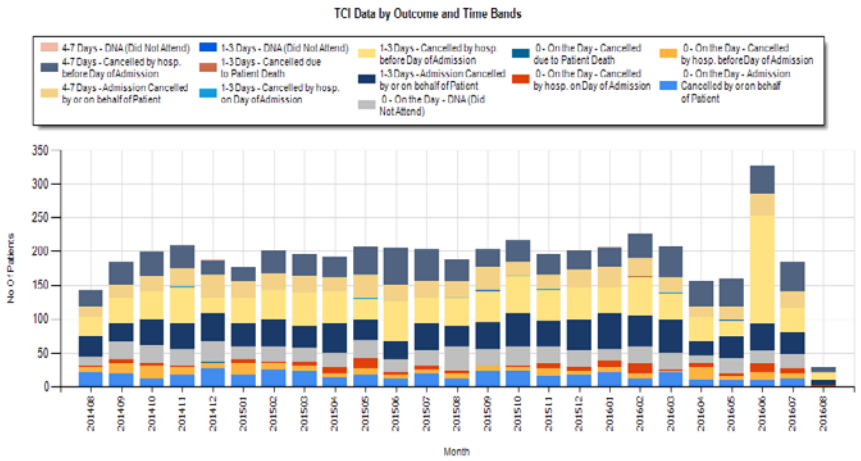
The implementation of the new Theatre Management System (Theatreman) planned for October will be a further vehicle to ensure that lists are optimally booked based on the available time.

RISKS / ISSUES

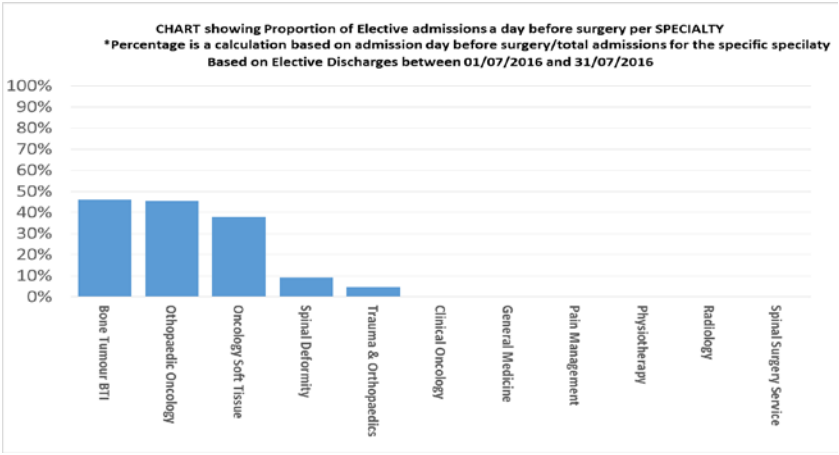
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (eg experience in spinal scrub) to ensure the best possible use of available operating time.

11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

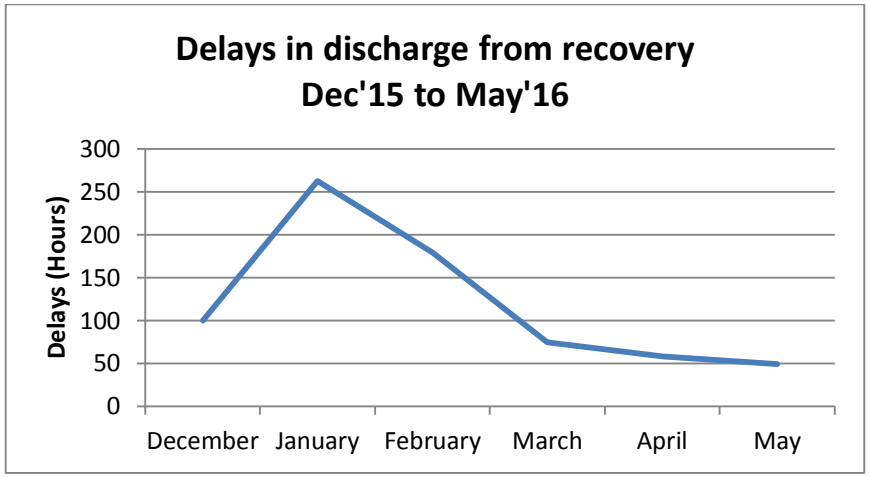
Cancellations by patient / hospital



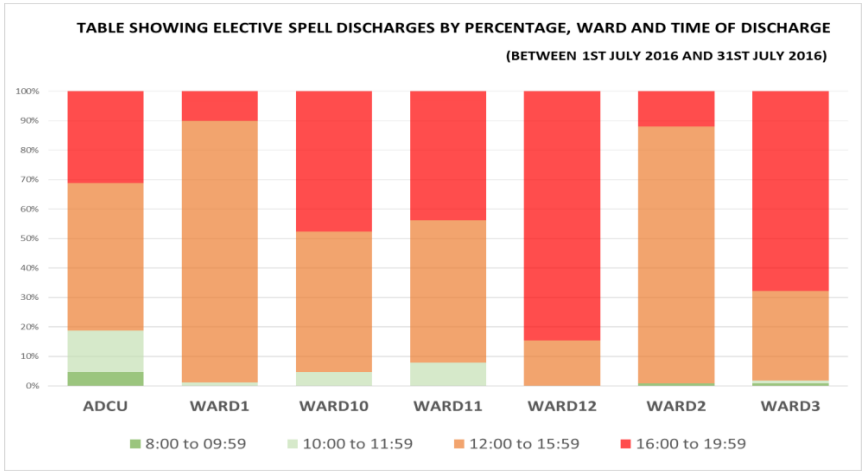
Admission the day before surgery



Delays out of recovery



Time of day patients discharged



INFORMATION

Cancellations in July has increased against the levels seen in April and May (ignoring June given the skewing of data linked to the theatre closure), however they remain at a level below the monthly position in 2015/16.

There has been some minor improvement in reducing the number of patients admitted prior to their day of surgery. Orthopaedic Oncology and Soft Tissue admissions in advance have reduced from over 50% in June to 46% and 39% respectively, although Bone tumour advance admissions did increase by about 15%. The biggest change relates to Spinal Deformity, which dropped from over 80% in June to 10% in July. Given the very low numbers of admissions in this specialty, it is too early to determine whether this is representative of a material change in the trend.

There has been little change in the trends around the timing of discharges. Wards 1 and 2 continue to discharge the vast majority of their patients prior to 4pm, however this is not the case in Wards 3 and 12 where further work is required to improve performance.

ACTIONS FOR IMPROVEMENTS / LEARNING

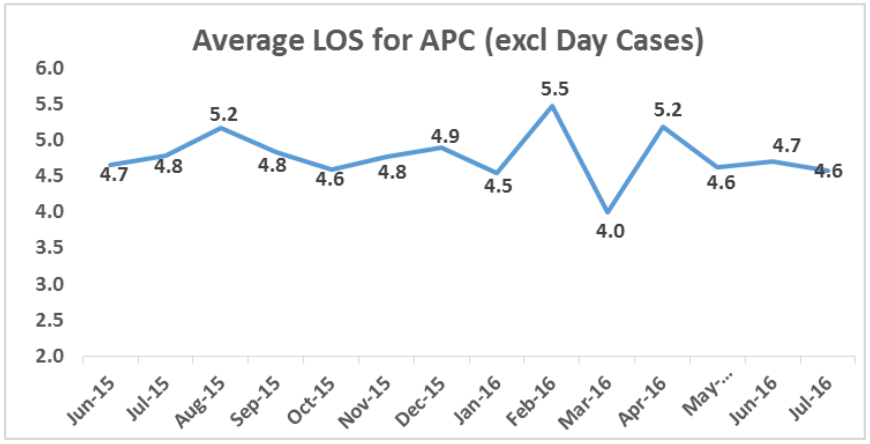
Continued work is required to ensure that all specialties have a pool of patients who are pre-op'd and available to be called in at short notice to fill cancellation slots. The concept of pooling of appropriate patients between consultants also needs to be undertaken to maximise efficiency.

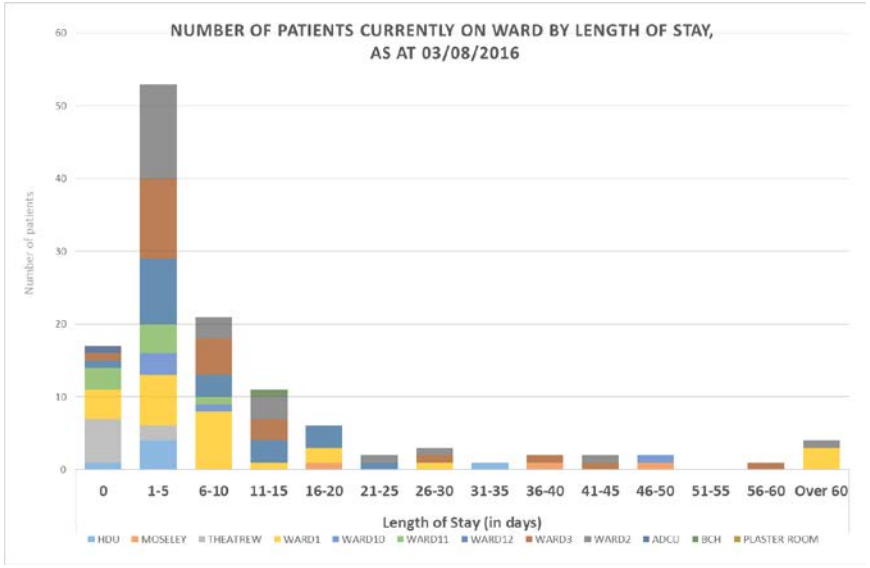
Work is required to draft and agree criteria for admission night before – clinical and social (ie if someone is coming from a long way) for agreement with consultants. As activity increases in line with the commissioned profile, it is important that these issues are addressed so that bed availability does not become a constraint to delivery. A case is also being worked up to increase the capacity and hours of ADCU to be able to undertake all appropriate work on a day case basis, to liberate further inpatient beds.

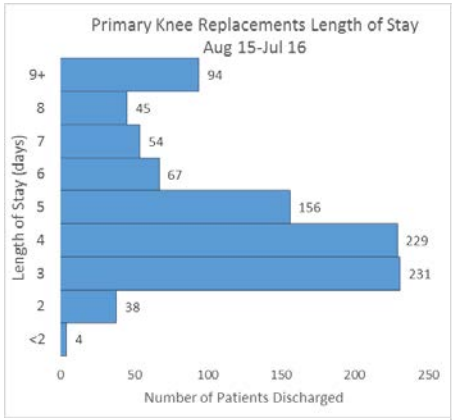
RISKS / ISSUES

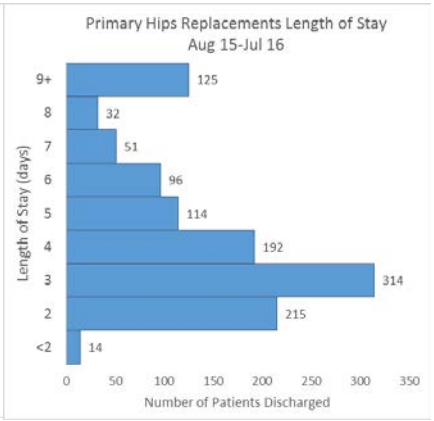
As activity increases in line with the profiled plan, it will become increasingly difficult to sustain admission before the day of surgery, and necessary to achieve a higher level of discharges before midday. This is covered within Patient Journey 2.

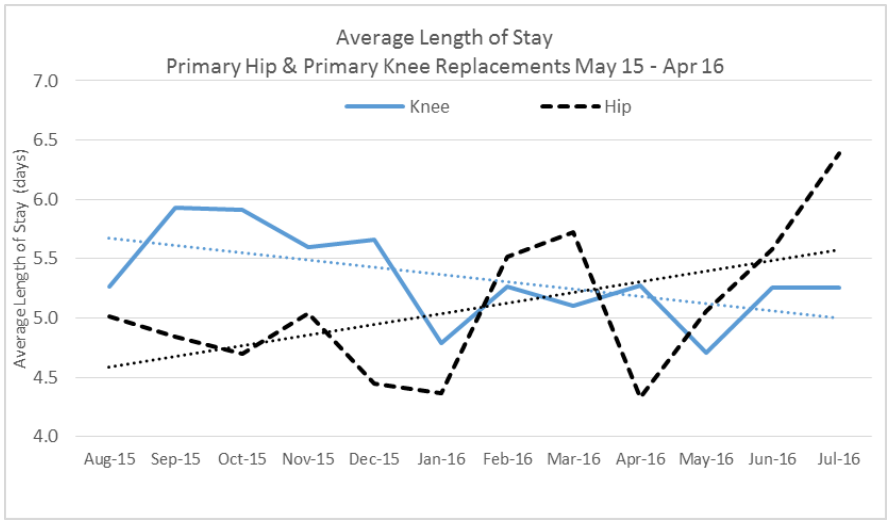
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Overall length of stay remains reasonably stable, however the average length of stay for hips has seen a significant increase in July. This has mirrored a trend that has been taking place since April 2016, and will be a key issue for the Trust to manage as bed capacity becomes more of a constraint over the coming months.

The profile of long waiting patients has also remained fairly stable, although there has been a slight increase in the very long stay patients (over 60 days) from 2 in June to 4 in July.

ACTIONS FOR IMPROVEMENTS / LEARNING

Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.

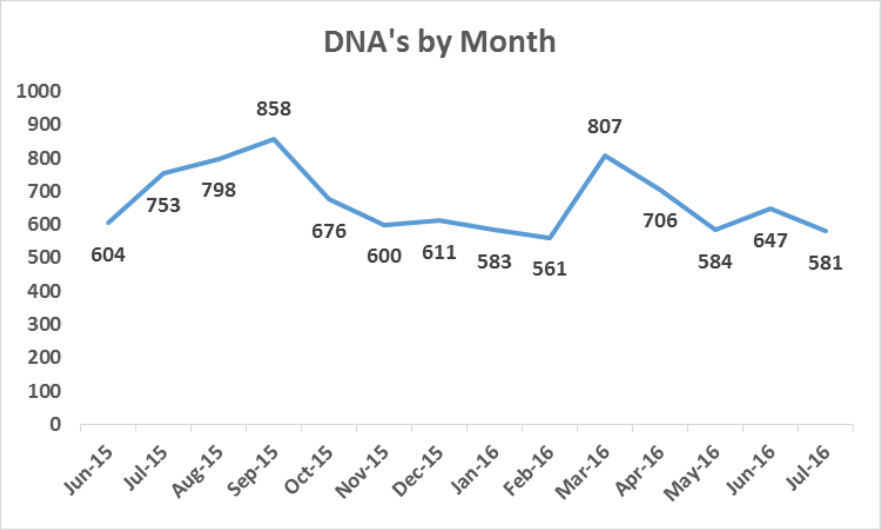
The Rapid Recovery project places particular focus on the actions needed to speed up discharge, initially in our primary joint pathways. This is anticipated to have a significant impact on length of stay in this area.

More formalised ward reviews should be part of consultant job planning discussions, which will be helpful in speeding up decision making and therefore shaving days off individual patient length of stay, or bringing discharge earlier in the day so that the bed can be recycled for incoming patients.

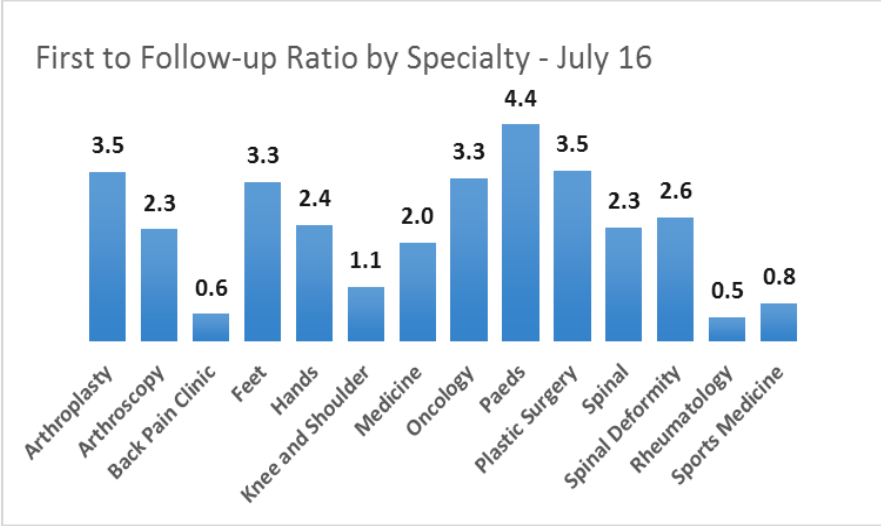
RISKS / ISSUES

With a defined bed stock, these changes need to happen at pace in order to deliver the commissioned level of activity.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients



Graph showing average waiting time in outpatients by month under development



Graph showing under / overbooking of clinic by specialty under development

INFORMATION

DNAs continue to slowly reduce from a high point in March 2016 however this has, to date, only reduced down to the stable level of DNAs experienced in 2015/16. Division 1 has a CIP related to the reduction of DNAs in outpatients; this is currently at risk based on performance to date.

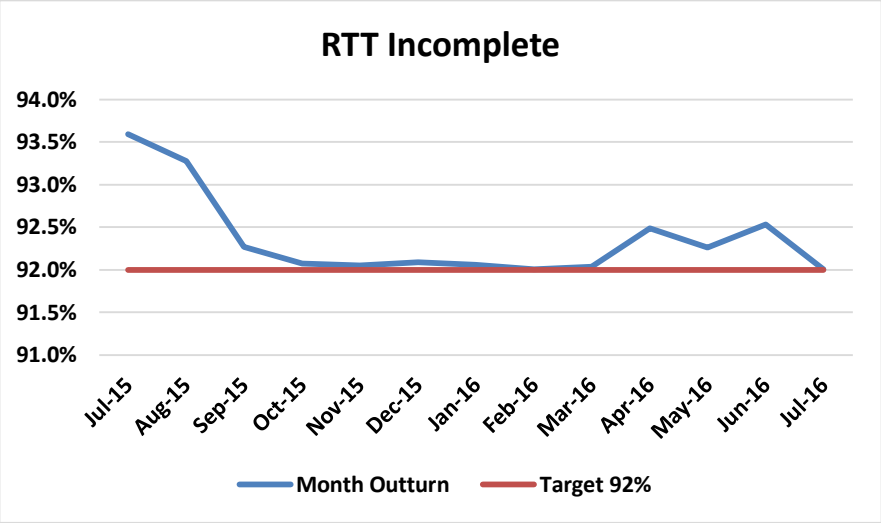
ACTIONS FOR IMPROVEMENTS / LEARNING

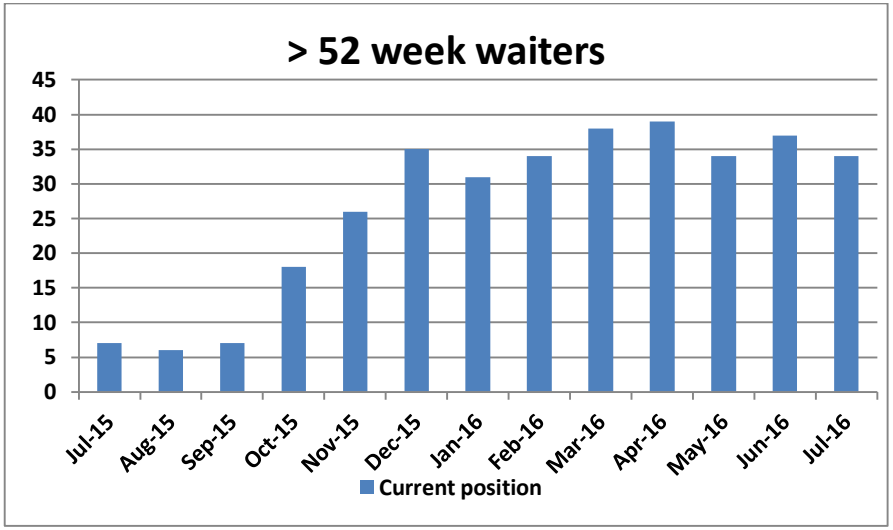
There are a range of actions as part of Patient Journey 2, and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

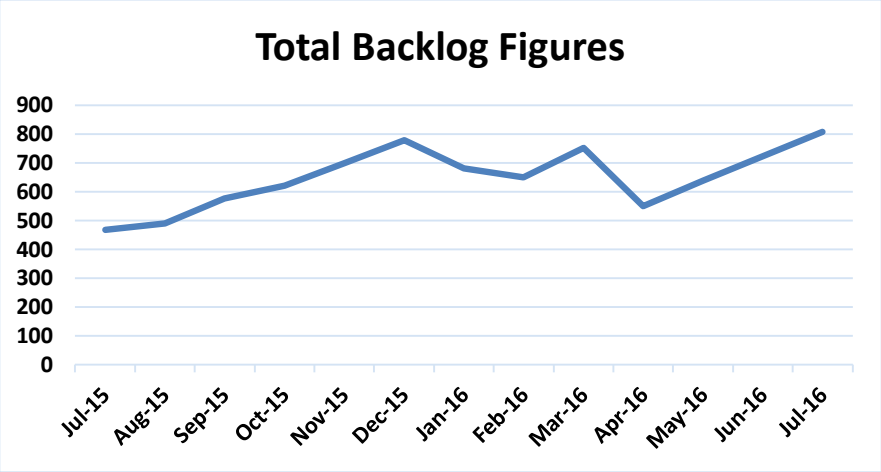
RISKS / ISSUES

Clinical engagement in the redesign of patient pathways.

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets	Target / Trajectory	Actual (July)	Actual (YTD)
52 week waiters	52	34	
18 week RTT	92%	92.00%	
Cancer (2 week wait)	93%	100%	100%
Cancer (31 days from diagnosis for 1st treatment)	96%	91.67%	96.55%
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	94.44%
Cancer (62 days)	85%	N/A	N/A

INFORMATION

The Trust remains on target against all year to date performance trajectories. The 96% cancer target for 1st treatment was missed in July, however as with all cancer targets, this is influenced by small numbers of patients and the Trust would still anticipate overall achievement for Quarter 2.

Focus remains on the clearance of 52 week breaches for spinal deformity, and these numbers have been held at a stable level since December 2015. Work continues to identify additional capacity to support this work, with trajectories showing an expected increase in waiters until significant extra capacity at BCH is sourced in 17/18.

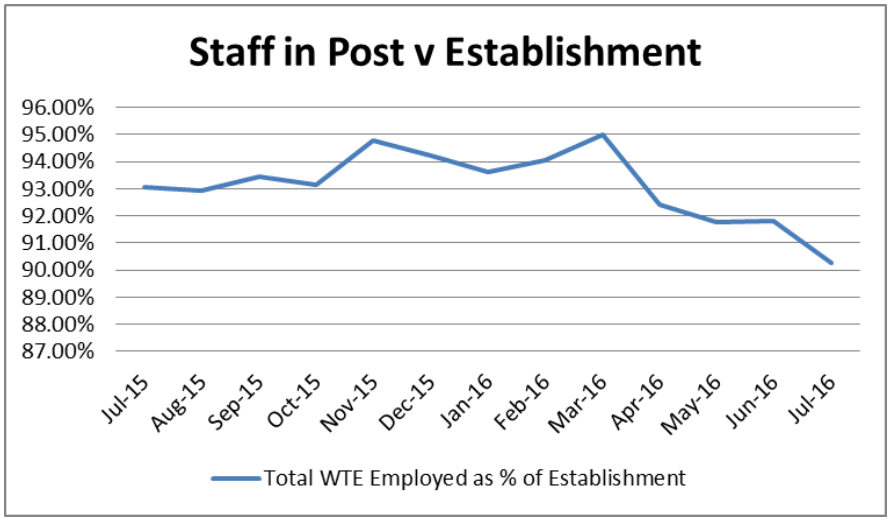
ACTIONS FOR IMPROVEMENTS / LEARNING

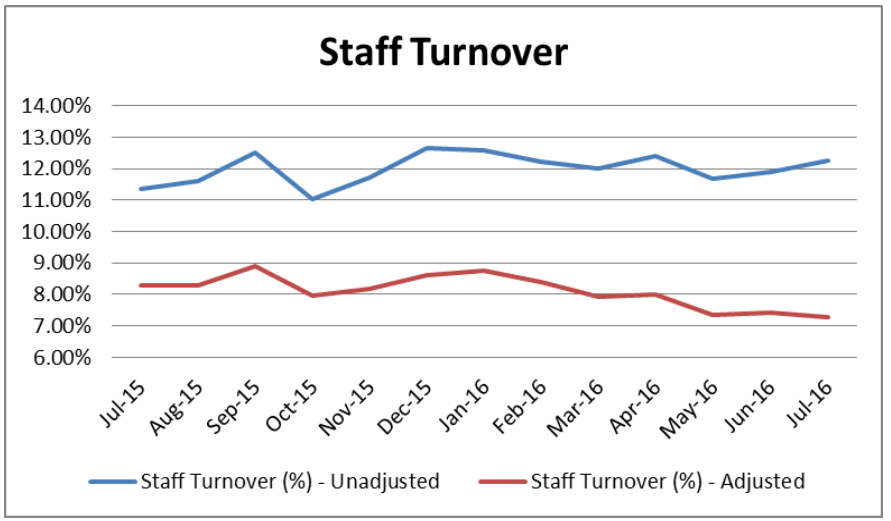
Effective use of additional operating lists at BCH, with potential requirement to treat further 52 weeks breaches in an alternative setting.

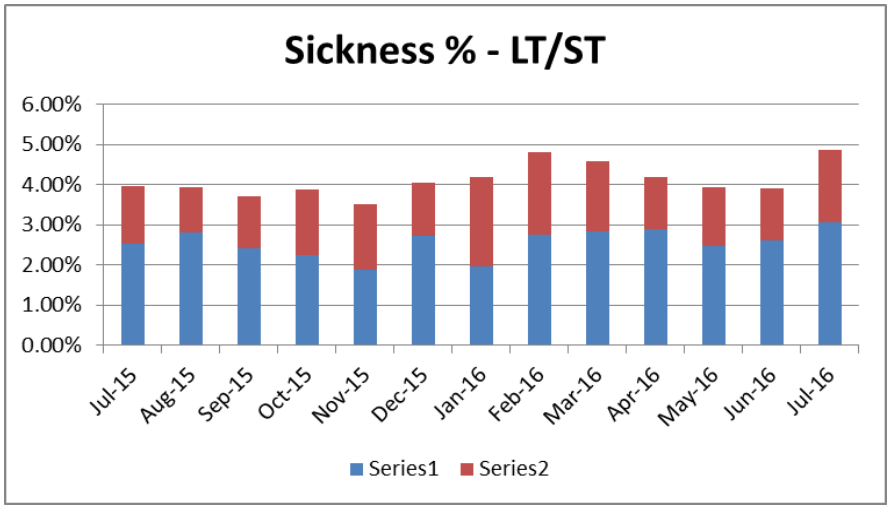
RISKS / ISSUES

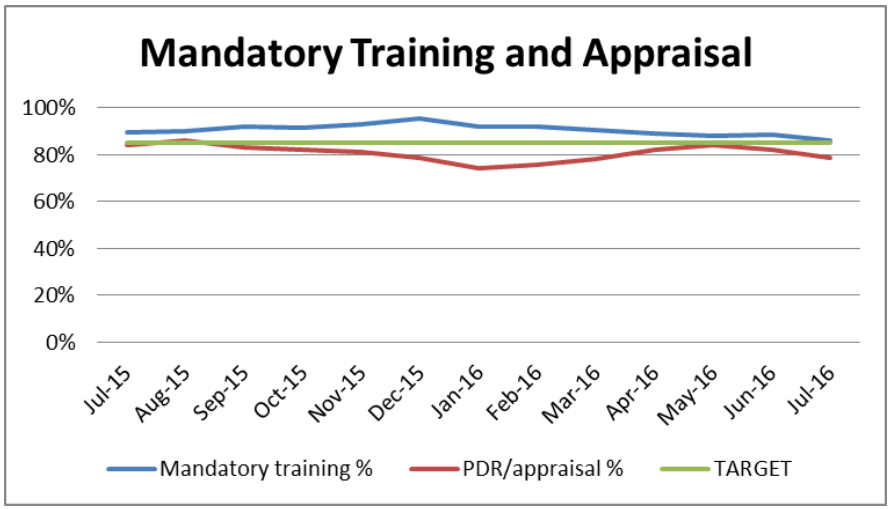
Spinal deformity remains a risk with regard to overall Trust performance, and discussions continue with BCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position. There is a risk that the amnesty with regard to fines is only for the 2016-17 financial year, and that this regime could resume from April 2017.

15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training









INFORMATION

Sickness absence has increased by almost 1% and unfortunately turned red in month. In context, sickness absence has not been this high since Jan 2015. There has been an increase both in short and long term absence, and the worsening of the in month position has just tipped the underlying 12 month position into amber at 4.22% (it had been green for the two previous months). At this stage, it appears a singularly unusual month – but further analysis will be undertaken as below.

The vacancy position taken from the ledger has declined again this month to 90.25%, but still remains amber. This is due in no small part to an increase in funded establishment of c 30WTE which has been added into Divisional and departmental base budgets. Whilst the number of staff employed has risen by c 11WTE compared with June, this has worsened the position. By way of assurance, the number of candidates in the recruitment checking and clearing process (96) broadly reflects the vacancy position.

The unadjusted turnover figure (all leavers minus junior medical staff and excluding employees who retire and return to work,) has increased again this month, but still remains amber. The adjusted turnover figure ("true leavers", so excluding fixed term contract expiries and dismissals) has decreased, however, and is at its lowest rate since May 2014.

The mandatory training position has decreased again this month by 3% but remains high amber at 86%. This is being raised at divisional boards, and managers are being reminded of the importance of attending. It will also be picked up at the Divisional Performance Clinics.

The appraisal position has decreased again despite the importance of completion and recording being raised at divisional boards. There is a view from divisions that they may not be recording all appraisals appropriately in ESR, so it is possible that this is slightly under-reported.

ACTIONS FOR IMPROVEMENTS / LEARNING

Further analysis of the reasons for absence will be undertaken. Additionally, Divisional Boards will be invited to cleanse and verify their data for the September submission and this will also be addressed with them at their divisional performance clinics.

RISKS / ISSUES

The decrease in mandatory training is a particular cause for concern, both from a patient safety perspective and also the likelihood of performance notices from our commissioner.

GOVERNANCE DEPARTMENT

QUALITY REPORT

August 2016

EXECUTIVE DIRECTOR: Garry Marsh *Director of Nursing and Clinical Governance*
AUTHOR: Faye Rafferty *Governance Manager*

CONTENTS

1. INTRODUCTION

This integrated Quality Report aims to provide a trust wide overview and assurance relating to patient safety, quality and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham Cross City Clinical Commissioning Group in order to satisfy contractual information requirements.

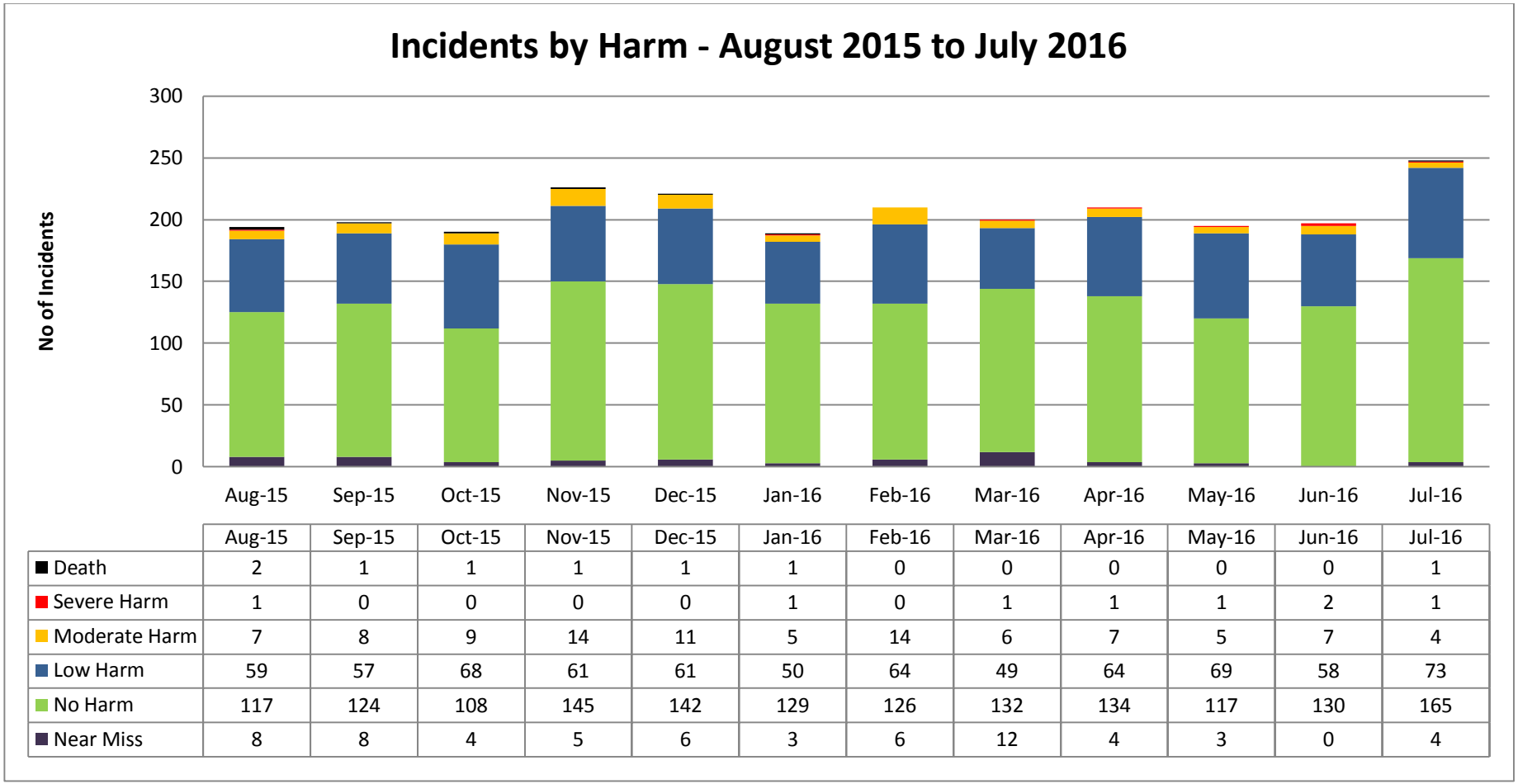
This Quality Report is a dynamic document, the data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this Quality Report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department;

Email: **roh-tr.governance@nhs.net**

Tel: 0121 685 4000 (ext. 55641)

2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Death	2	1	1	1	1	1	0	0	0	0	0	1
Severe Harm	1	0	0	0	0	1	0	1	1	1	2	1
Moderate Harm	7	8	9	14	11	5	14	6	7	5	7	4
Low Harm	59	57	68	61	61	50	64	49	64	69	58	73
No Harm	117	124	108	145	142	129	126	132	134	117	130	165
Near Miss	8	8	4	5	6	3	6	12	4	3	0	4

INFORMATION

There were 248 incidents reported during July 2016, including;

1 Death

1 Severe Harm

4 Moderate Harms

An update to the Ulysses has now been made to ensure the Trust is able to identify and report on incidents that have been reported that relate to Paediatric patients separately as recommended by the Royal College of Paediatrics and Child Health. This information will be included in next month's Quality Report.

ACTIONS FOR IMPROVEMENTS / LEARNING

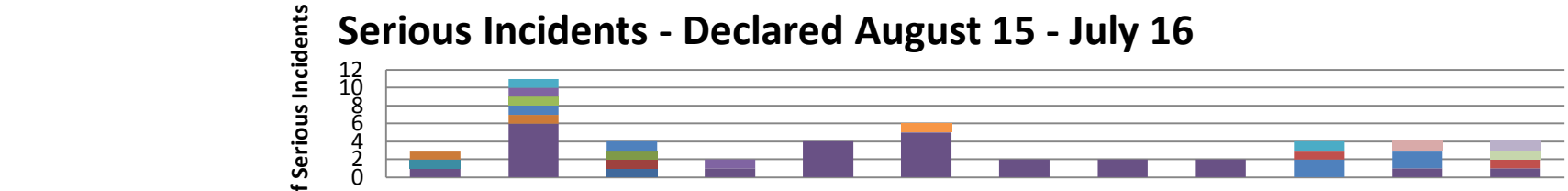
An audit has been completed in the outpatient department in response to CQC findings to assess current knowledge and understanding of the Incident reporting and duty of candour processes. Recommendations have been made. Training sessions for outpatient staff are being delivered through August and September. A roll out programme for other areas will then be developed.

This complements the mandatory training for governance that is delivered to all staff annually

RISKS / ISSUES

There can be delays in the response from incident managers when a request is made to review and amend incidents' harm ratings. Division 2 holds a weekly governance meeting where all incidents rated moderate and above are reviewed. Division 1 will begin to hold regular weekly governance meetings from September. This will ensure incidents are escalated and avoid unnecessary delays.

3. Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Wrong Site Incision												1
Wrong Implant												1
Suspension to services											1	
Delayed diagnosis						1						
Wrong side injection		1								1		
Unexpected deaths		1		1								
Staff conduct incidents		1										
Slips, trips & falls										1		1
Pressure Ulcers		1	1							2	2	
Emergency transfer out of Trust	1	1										
Appointment delay	1											
VTE meeting SI criteria	1	6		1	4	5	2	2	2		1	1
Surgical incident meeting SI criteria			1									
Emergency transfer to HDU			1									
Failure to act on test results			1									

INFORMATION

There were 4 Serious Incidents (SI) declared in July 2016.

All 4 Serious incidents reported to commissioners during July 2016 are currently under investigation within contractual timescales.

ACTIONS FOR IMPROVEMENTS / LEARNING

2 SIs were submitted for closure to Commissioners in July 2016.

- 1 report was in response to a pressure ulcer met the criteria for reporting to commissioners. Details of recommendations are provided in the pressure ulcer section below.
- 1 report was in response to a patient fall that resulted in a fractured radius. Details of actions and recommendations are provided in the falls section of this report.

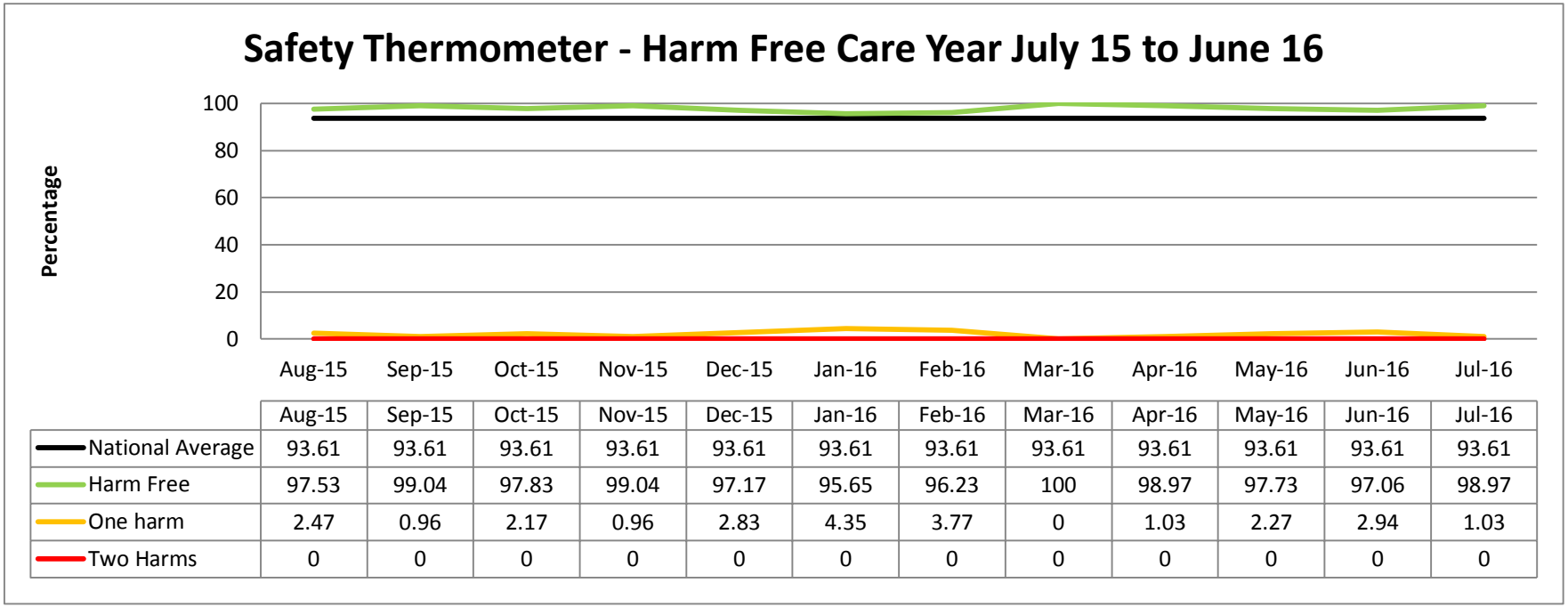
All of the reports and associated action plans submitted to the commissioners during July were closed without further queries being received from the commissioners.

The Trust submitted 1 request for a downgrade of an SI during July. This related to a grade 3 pressure ulcer that was present on admission to the Trust. This downgrade has been agreed by commissioners.

RISKS / ISSUES

None identified.

4. **NHS Safety Thermometer - provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month. In February 2016, a revised standard operating procedure for the collection of data was introduced at ROH. It is of note that ROH continues to perform well against the national average as shown in the table below.**



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
National Average	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61	93.61
Harm Free	97.53	99.04	97.83	99.04	97.17	95.65	96.23	100	98.97	97.73	97.06	98.97
One harm	2.47	0.96	2.17	0.96	2.83	4.35	3.77	0	1.03	2.27	2.94	1.03
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

There was 1 harm reported during July 2016 relating to an inpatient fall that occurred on ward 2.

Children and Young Person's Safety Thermometer

The Trust has started to submit data to the Children and Young Person's Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. Due to the limited number of data points submitted graphical representation of the data is not yet available from the national tool. This report will include information form the tool once available.

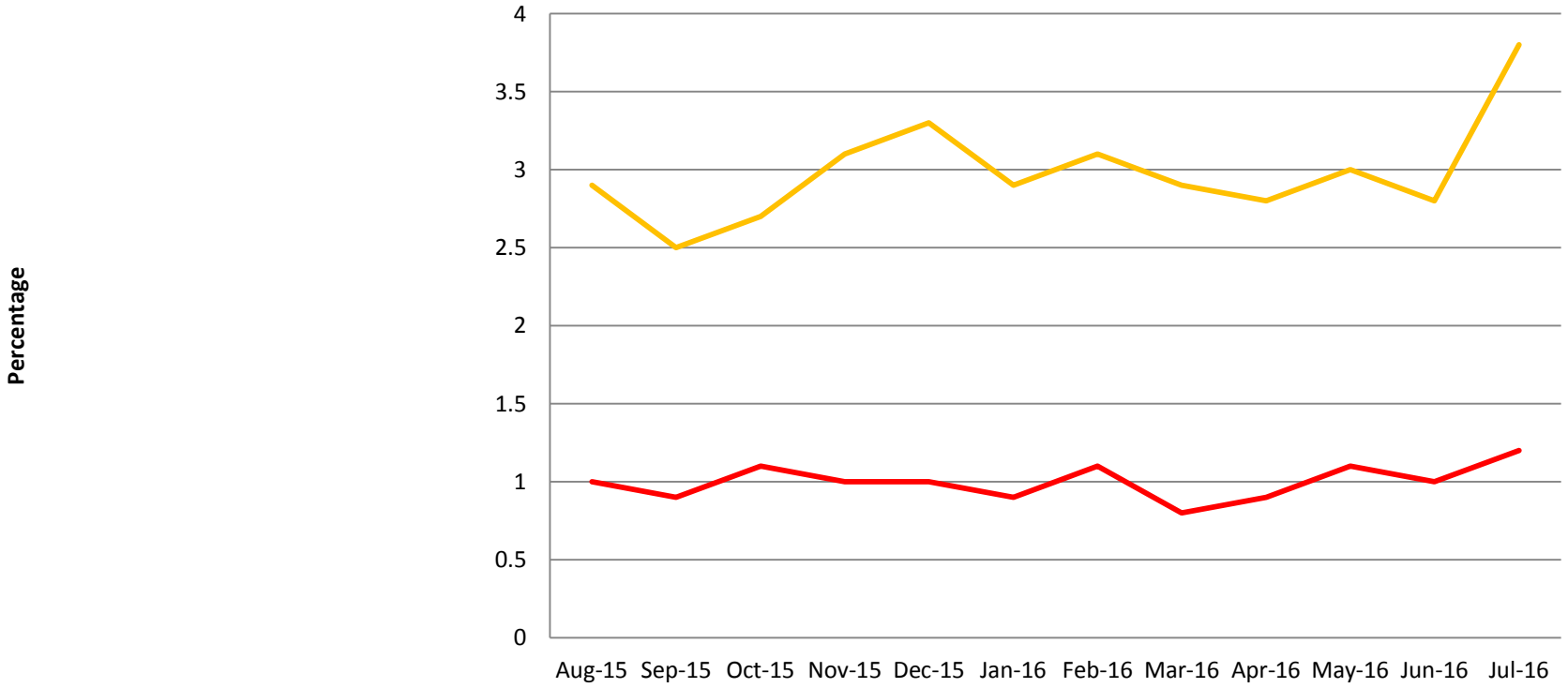
5. **All patient contact and harm – In contrast to the Safety Thermometer which measures the number of harm on one particular day of the month, the following data represents the total number of patient contacts in June 2016 compared to all incidents reported and incidents resulting in harm. Harm includes low harm, moderate harm, severe harm and deaths.**

	Low Harm	Moderate Harm	Severe Harm	Death	Total Incident with Harm	All Incidents Total	Total Patient Contacts
Aug-15	59	7	1	2	69	194	6651
Sep-15	58	8	0	1	67	195	7700
Oct-15	68	9	0	1	78	190	7082
Nov-15	61	14	0	1	76	226	7251
Dec-15	61	11	0	0	72	220	6714
Jan-16	50	5	1	1	57	189	6627
Feb-16	64	14	0	0	78	210	6768
Mar-16	49	6	1	0	56	200	6862
Apr-16	64	7	1	0	72	210	7636
May-16	69	5	1	0	75	195	6528
Jun-16	58	7	2	0	67	197	7037
Jul-16	73	4	1	1	79	248	6426

* This report is written prior to the validation of the total patient contacts. This figure is therefore subject to change following publication.

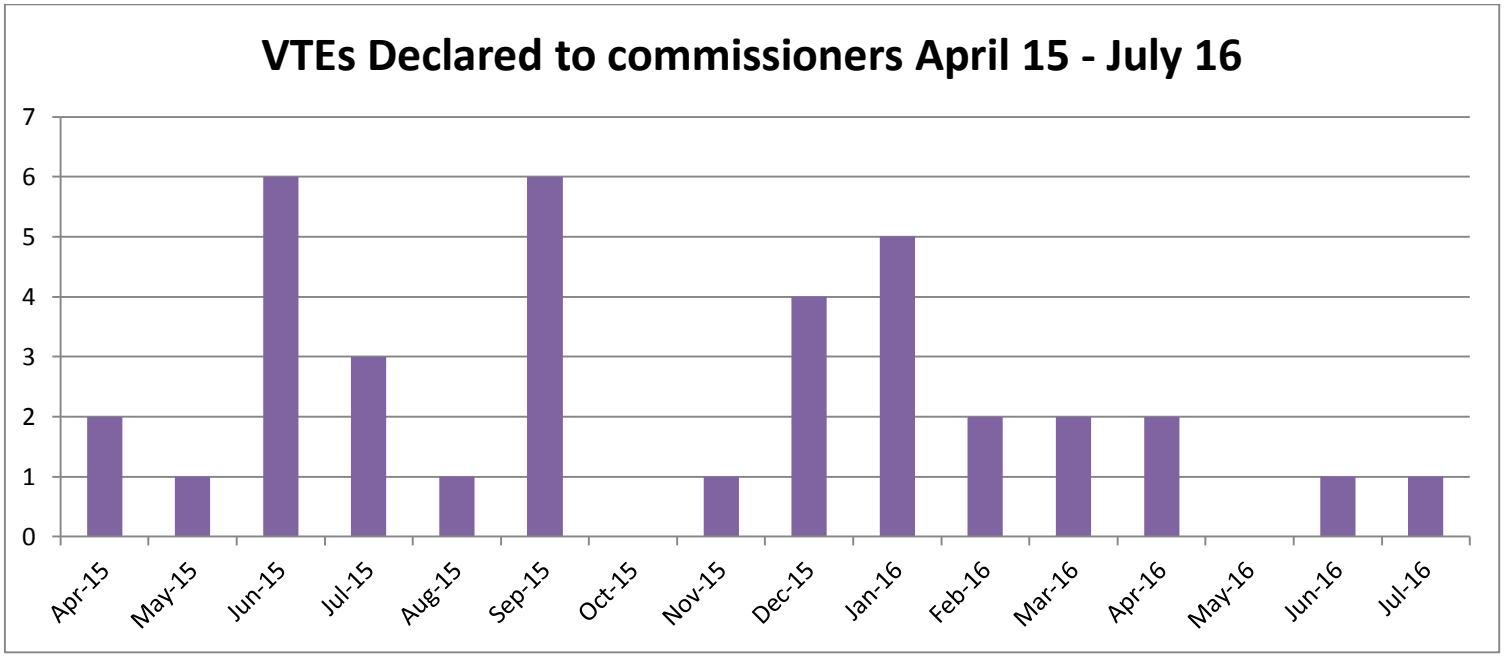
In July 2016, there were a total of 6426 patient contacts. There were 248 incidents reported which is 3.8 percent of the total patient contacts. Of those 248 reported incidents, 79 incidents resulted in harm which is 1.2% of the total patient contact for the month. The Trust is currently reviewing the possibility of benchmarking this data with similar organisations and will include the data as and when it is available.

% of Patient Contact Compared to Number of Incidents and Incidents with Harm August to 15 to July 2016



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
% of Patient Contacts with Incidents Causing Harm	1	0.9	1.1	1	1	0.9	1.1	0.8	0.9	1.1	1	1.2
% of Patient Contact With All Incidents Reported	2.9	2.5	2.7	3.1	3.3	2.9	3.1	2.9	2.8	3	2.8	3.8

6. **VTEs - A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called a venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism).**



INFORMATION

There was 1 VTE incident reported to Commissioners during July 2016. This was discovered post discharge.

ACTIONS FOR IMPROVEMENTS / LEARNING

There were no final investigation reports in response to VTEs due for submission to Commissioners during July 2016.

VTE training continues for student nurses, registered and non-registered staff (clinical update days) and for junior doctors on induction. It is mandatory for clinical staff that have direct patient contact to complete a VTE e-learning module. Targeted learning will take place with individuals identified within RCAs as being none compliant with expected standards.

ROH continues to exceed expected targets set in relation to VTE risk assessment on admission and compliance with Thromboprophylaxis for high risk patients.

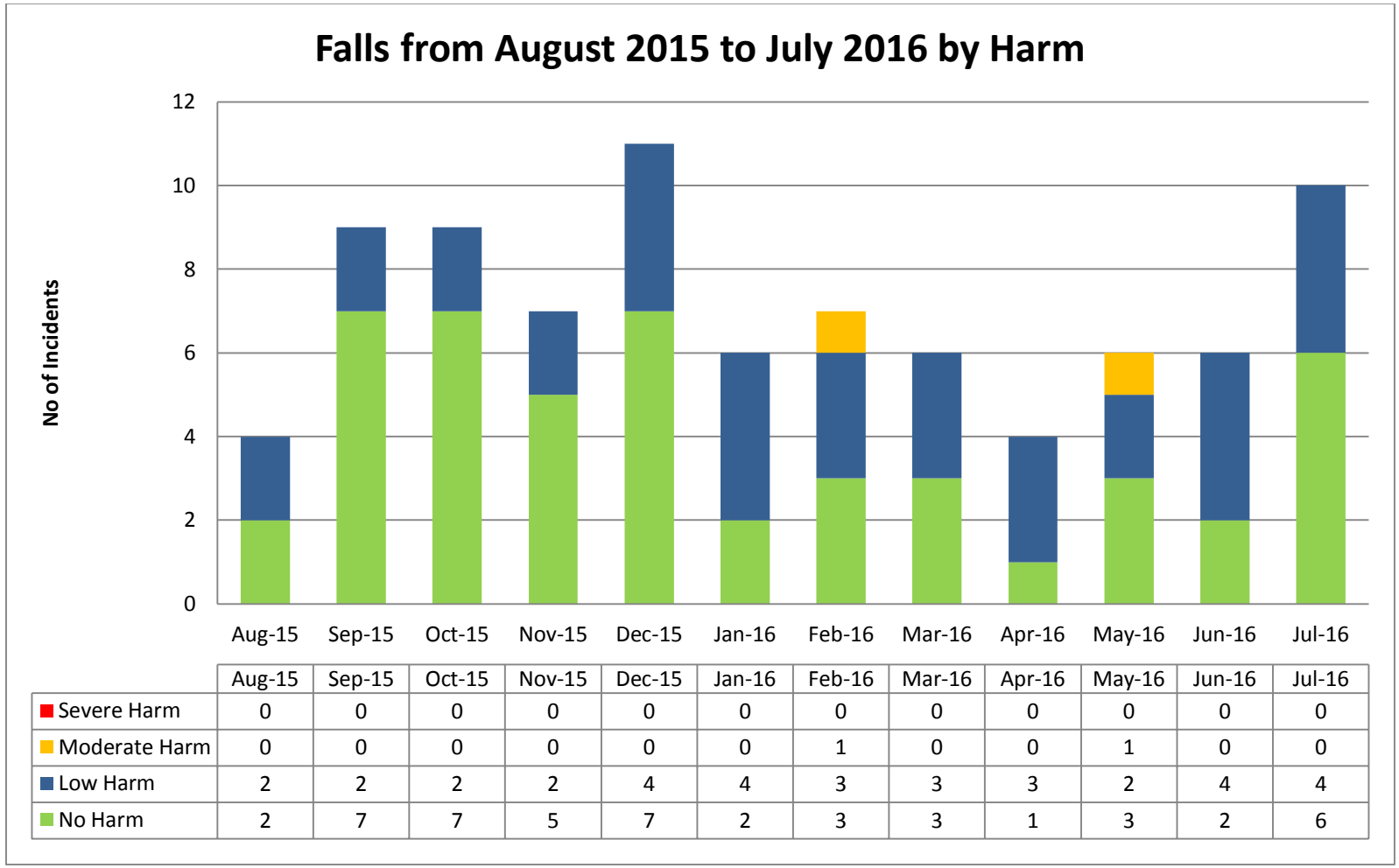
Many of the requirements within the 2016/17 CQUIN have either been achieved or partially achieved. Through outpatients follow ups, the Infection Control hotline and Surgical site 90 day questionnaires the trust is able to identify and review patients who have been diagnosed with a VTE post discharge. Work to fully meet the requirements of the CQUIN will enhance this further.

Following investigation of VTEs a trend has been identified relating to documentation which can sometimes result in potentially unavoidable VTEs being deemed as avoidable particularly around compliance with 24 hour post admission/readmission requirements. Education relating to documentation continues within the Trust.

RISKS / ISSUES

None identified.

7. Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	0	1	0	0	1	0	0
Low Harm	2	2	2	2	4	4	3	3	3	2	4	4
No Harm	2	7	7	5	7	2	3	3	1	3	2	6

INFORMATION

During July 2016, 10 inpatient falls have been reported.

The Head of Nursing will be responsible for reviewing falls within the Trust. Findings from these reviews will be included within future quality reports.

ACTIONS FOR IMPROVEMENTS / LEARNING

A final report in response to a fall that resulted in a fractured wrist was submitted to commissioners during July the investigation of this incident found that

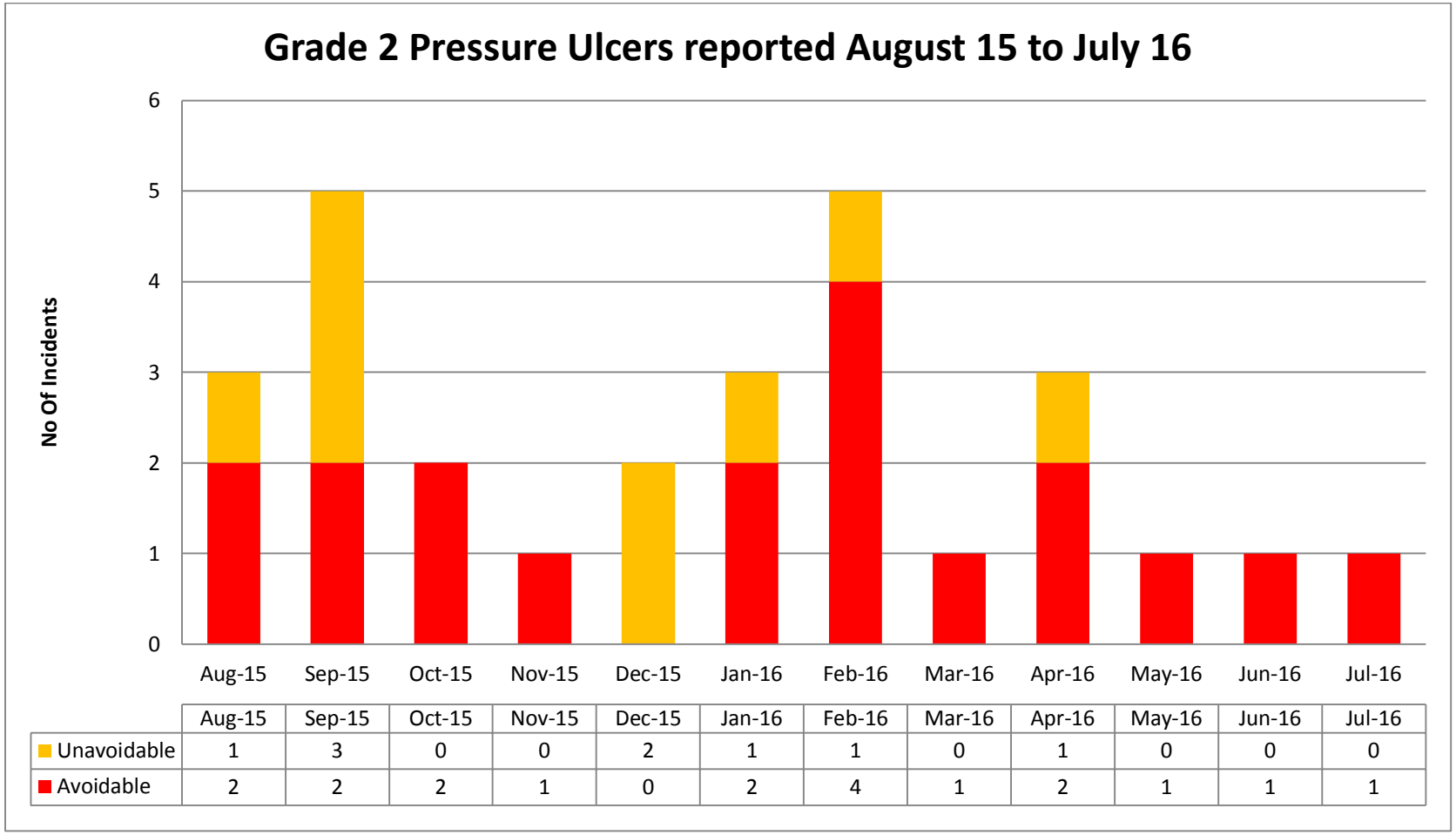
- All risk assessments and care plans were completed appropriately pre- and post-fall.
- The patient had been deemed safe and independent by the therapy team and had been discharged from their input
- This fall was deemed as unavoidable.

Although this fall was deemed unavoidable a recommendation and action has been identified relating to HDU reviewing care plan usage for post-operative patients, in particular, reduced mobility and pain care plans.

RISKS / ISSUES

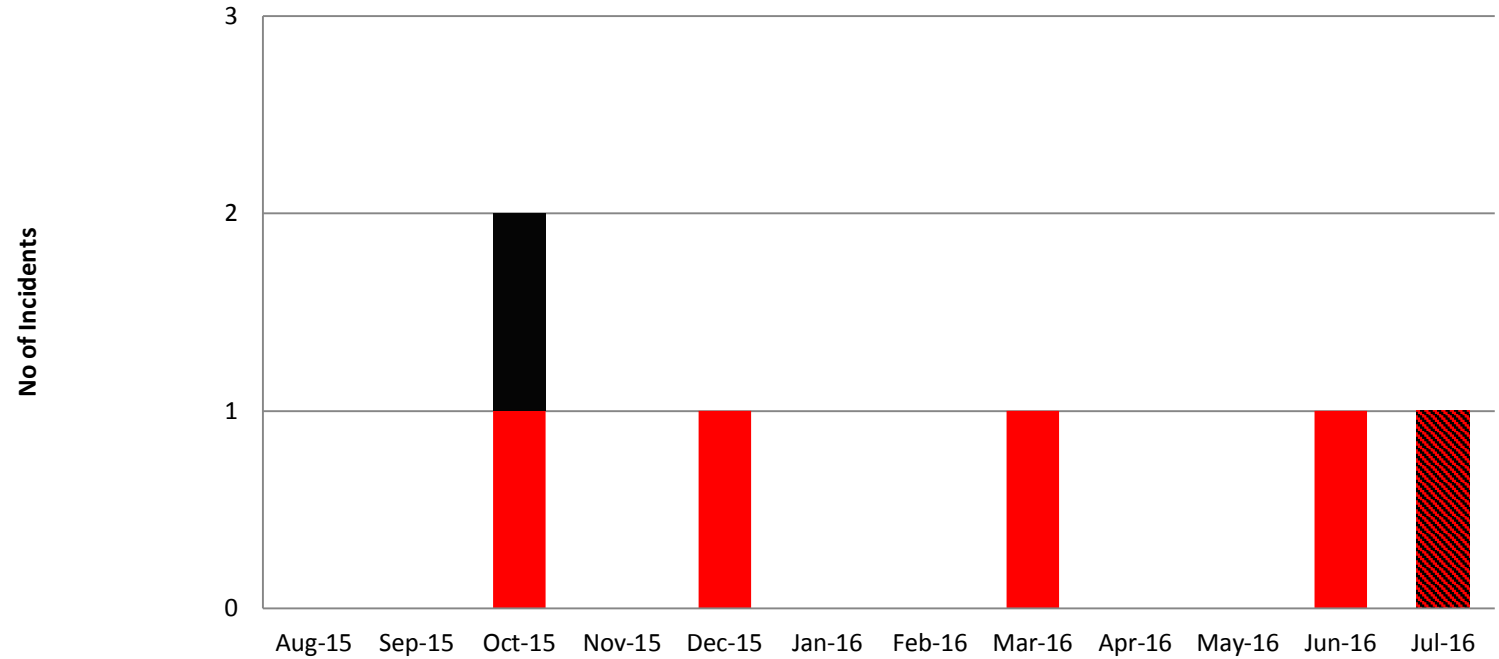
None identified.

8. **Pressure Ulcers - are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.**



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Unavoidable	1	3	0	0	2	1	1	0	1	0	0	0
Avoidable	2	2	2	1	0	2	4	1	2	1	1	1

Grade 3 & 4 Pressure Ulcers reported August 15 to July 16



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Under investigation												1
Grade 4 (Avoidable)			1									
Grade 3 (Avoidable)			1		1			1			1	

INFORMATION

During July there was 1 avoidable grade 2 pressure ulcer reported.

There was 1 Grade 3 pressure ulcer reported during July. The RCA is ongoing to determine avoidability. This incident has been reported to commissioners and will appear in the next month's report under the SI section as this was reported externally in August.

ROH contractual limit for Pressure Ulcers in 2016/17
Grade 2 Avoidable Limit is 15 - at July 2016 = 5 avoidable
Grade 3 Avoidable Limit is 0 - at July 2016 = 2. 1 has been deemed avoidable the remaining 1 is currently under investigation.
Grade 4 Avoidable Limit is 0 - **at July** 2016 = 0

ACTIONS FOR IMPROVEMENTS / LEARNING

A pressure ulcer reduction plan has been developed in order to reduce the number of grade 2 pressure ulcers and eliminate all grade 3 and grade 4 pressure ulcers for 2016/17. There are 10 actions of which all have been commenced and are ongoing.

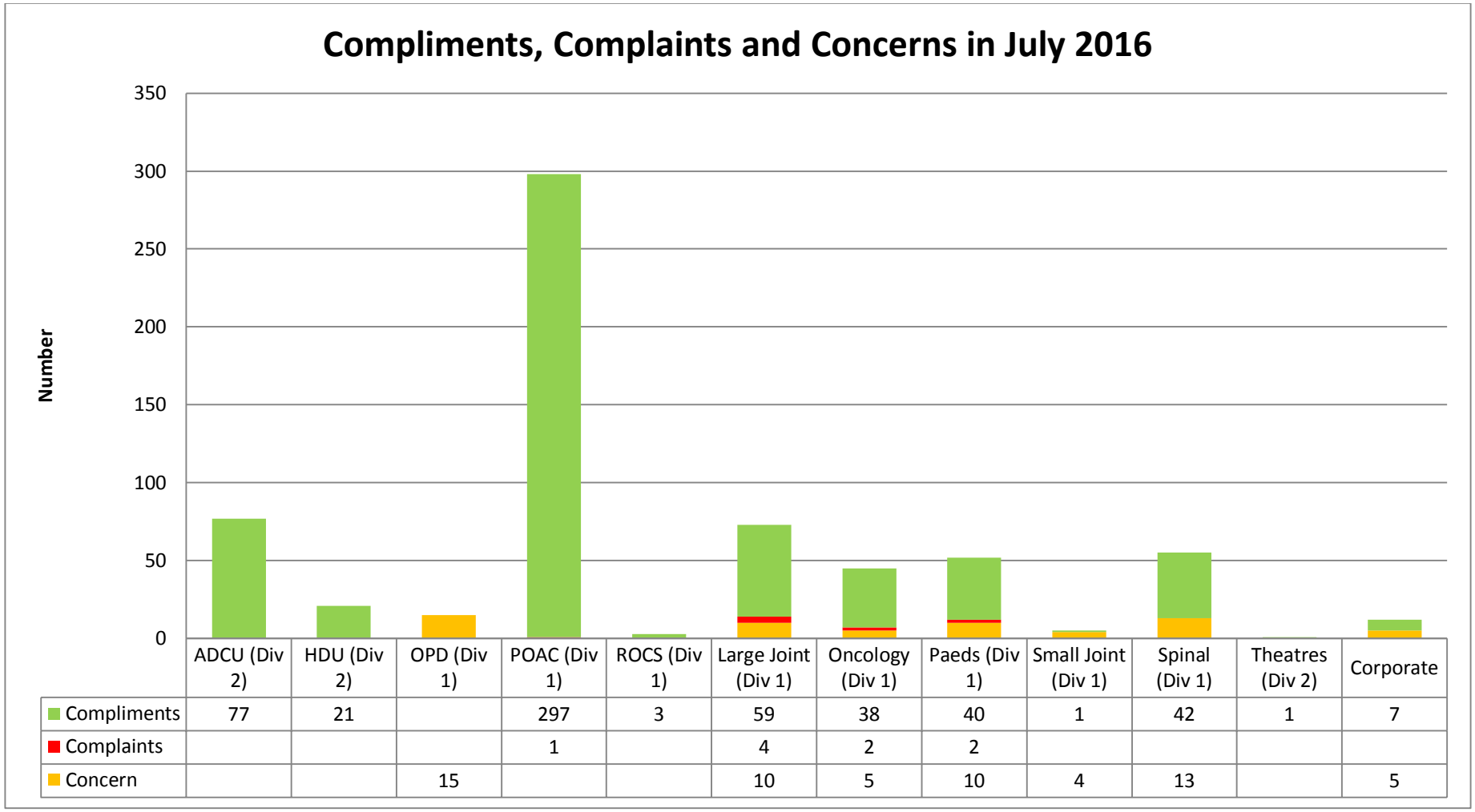
A report was submitted to commissioners in response to a grade 3 pressure ulcer. This pressure ulcer was deemed to be unavoidable. Actions identified following investigation included –

- Plaster care to be recorded on a plaster care plan team to be reminded and compliance monitored
- Ward team to be reminded at ward meeting and compliance to be monitored

RISKS / ISSUES

There is a risk of a financial penalty to the Trust by the Commissioners as ROH have exceeded the contractual threshold set relating to the number of grade 3/4 pressure ulcers reported during 2016/17. The fines associated with pressure ulcers within this year's contract are as follows
Grade 2 first 3 pressure ulcers reported above the 15 threshold = £1000
Grade 3 first 3 reported - £1000
Grade 4 first 2 reported - £1000

9. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



	ADCU (Div 2)	HDU (Div 2)	OPD (Div 1)	POAC (Div 1)	ROCS (Div 1)	Large Joint (Div 1)	Oncology (Div 1)	Paeds (Div 1)	Small Joint (Div 1)	Spinal (Div 1)	Theatres (Div 2)	Corporate
Compliments	77	21		297	3	59	38	40	1	42	1	7
Complaints				1		4	2	2				
Concern			15			10	5	10	4	13		5

INFORMATION

In July there were 9 complaints, 62 concerns and 586 compliments received.

ACTIONS FOR IMPROVEMENTS / LEARNING

4 complaints were closed in July 2016, all of which were closed within the agreed timescales. This gives a 100% completion on time and meets the KPI.

Of the 4 complaints closed in July 2016:

- 2 were upheld
- 0 were partially upheld
- 2 were not upheld

The two complaints upheld relate to the lack of demonstration of the Trust's expected values and behaviours when dealing with patients.

Learning identified and actions taken as a result of complaints closed in July 2016 include:

- Patients and General Practitioners are not always aware of the BMI threshold for knee and hip surgery
  Action: Head of Commissioning is writing to patients and GP's who have been inappropriately referred.

- Attitude of contracted member of staff inappropriate
  Action: Professional Conversation undertaken and individual will not be returning to work at the Trust.

- Clinical treatment by member of staff not as would be expected
  Action: Appropriate monitoring and action being taken

There have been no complaints referred to the Parliamentary Health Service Ombudsman during July 16.

There are currently 2 complaints with the Ombudsman.

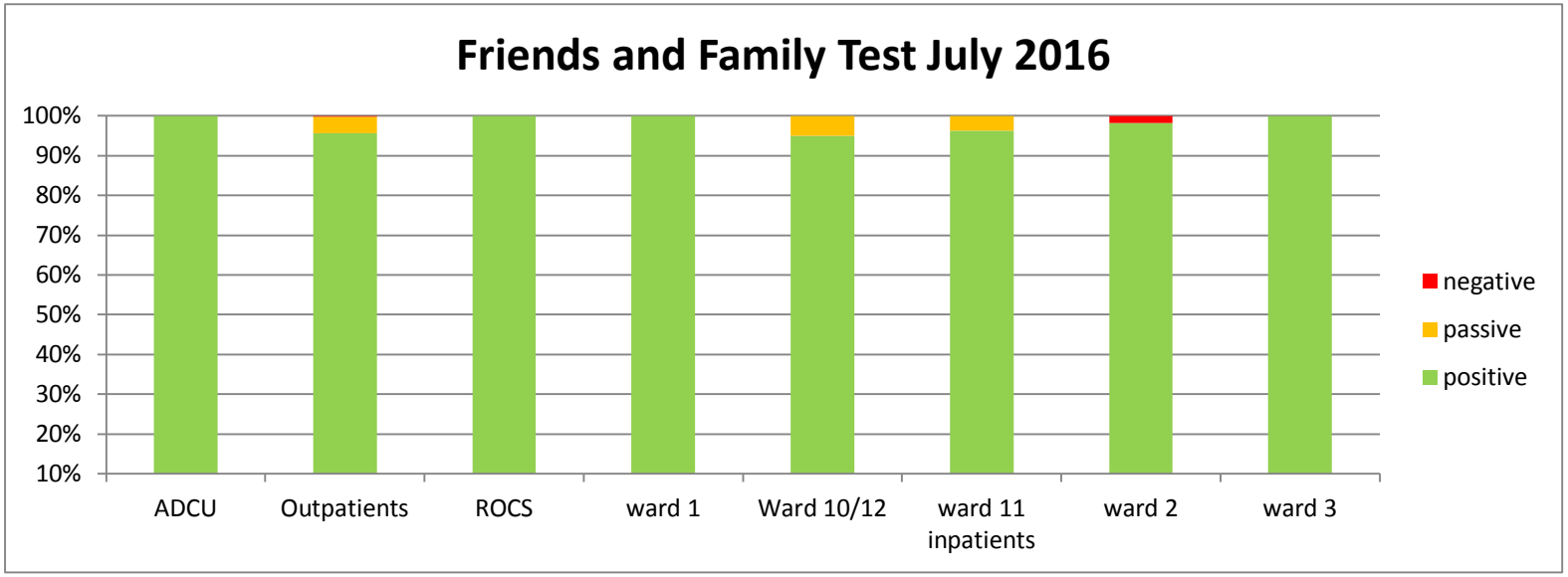
RISKS / ISSUES

None Identified

10. Friends and Family Test Results - The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

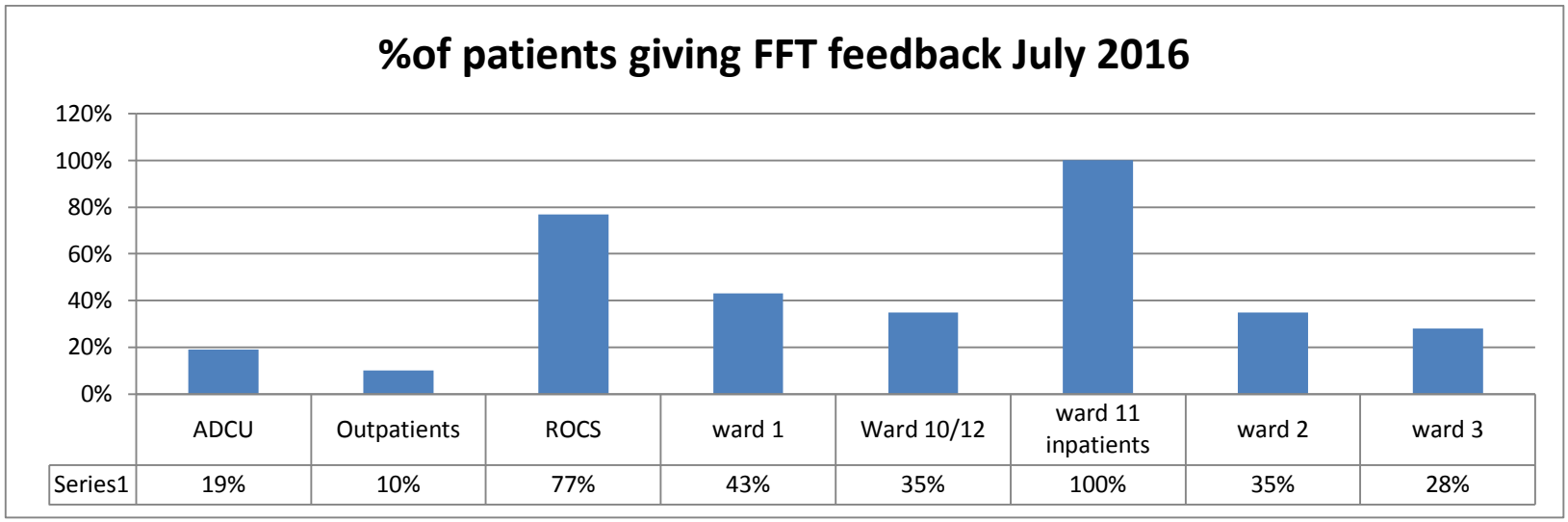
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting patient choice

This is a positive percentage score and it can be seen that almost all patients that we care for would recommend ROH to their family and friends.



The Scores for Friends and Family are calculated using a straightforward percentage response to the question 'How likely are you to recommend this area to friends or family if they require similar care or treatment?' Any patients answering the question as Extremely Likely / Likely are classified as Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely/Extremely Unlikely are classified as negative.

The percentages for all inpatient activity for July 2016 are 97% of those who responded would promote ROH.



Department	Positive	Passive	Negative	satisfaction rate	Eligible	Completion rate
ADCU	106	1	0	99%	558	19%
Outpatients	645	29	5	95%	6833	10%
ROCS	98	1	0	99%	128	77%
ward 1	41	4	0	91%	105	43%
Ward 10/12	39	2	0	95%	118	35%
ward 11 inpatients	37	0	0	100%	37	100%
ward 2	39	1	0	98%	115	35%
ward 3	30	1	1	94%	115	28%

There is an improvement plan in place for the Communications Department to increase the level of responses in the OPD and ADCU. Actions include having extra forms available for patients to complete and prompting staff members to ask patients to complete the forms. The possibility of implementing additional software to aid this process is also being explored.

11. Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.

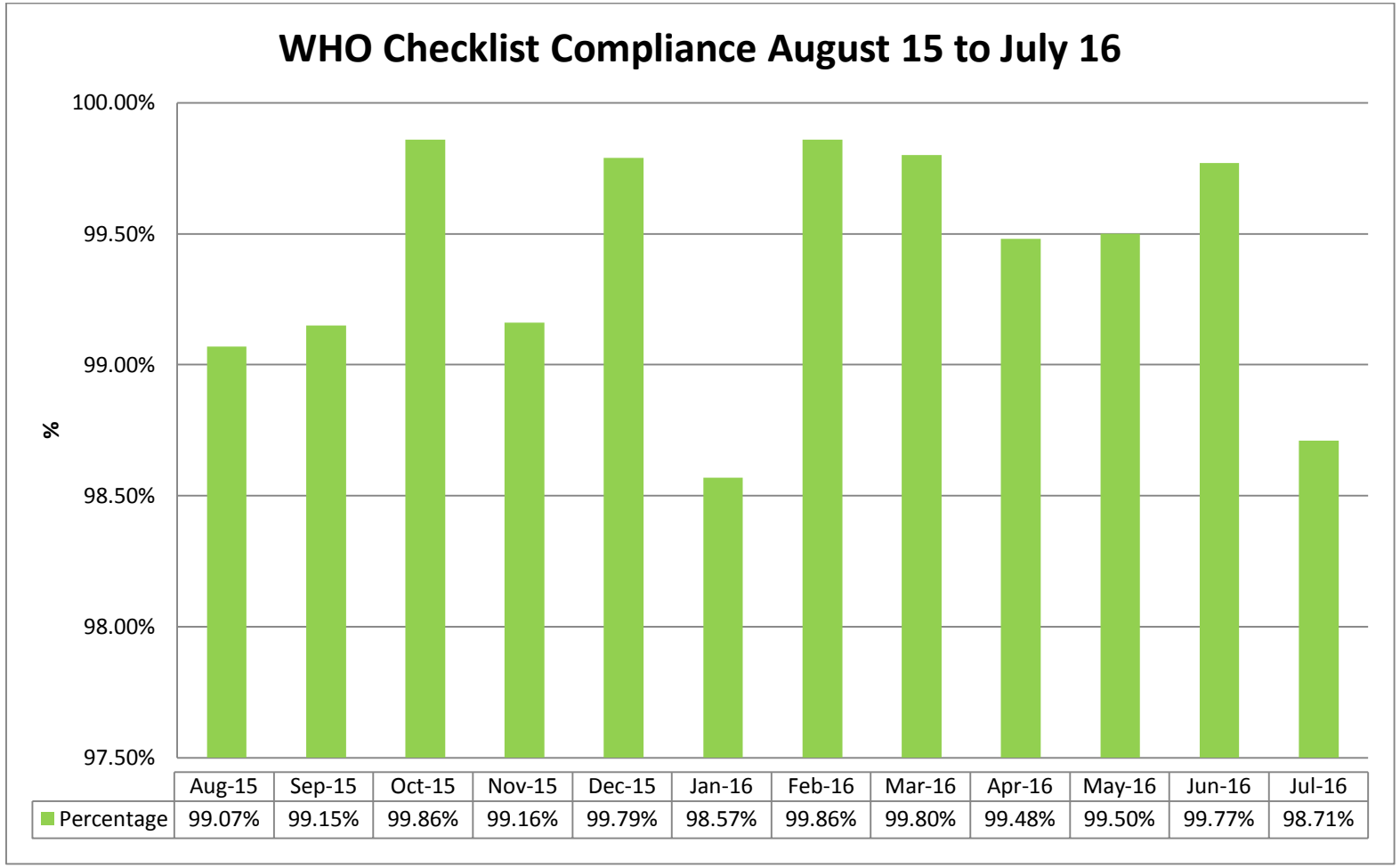
There are currently 17 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

An internal audit has been completed to review arrangements for demonstrating compliance with Regulation 20 with a particular emphasis on the robustness of internal tracking of compliance with the Duty of Candour. The Trust awaits the final report and recommendations following this audit.

12. Litigation

- The Trust is handling two new claims.

13. **WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases of perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
Percentage	99.07%	99.15%	99.86%	99.16%	99.79%	98.57%	99.86%	99.80%	99.48%	99.50%	99.77%	98.71%

INFORMATION

Total Cases in July 2016 = 543

Total Non-Compliance = 7

Total Compliance = **98.7% Total**

An external review of the Trust's safety processes within theatres has been commissioned for assurance and learning.

ACTIONS FOR IMPROVEMENTS / LEARNING

The following recommendations are made following the audit collation:

1. Quarterly report to be disseminated to the Medical director, Clinical Directors, Clinical Leads, Consultants and Team Leaders.
2. Directorates with consistent 100% compliance to share best practice.
3. Continue with weekly and monthly reporting to the Medical Director and Director of Nursing &Clinical Governance.
4. Monthly reporting to the Commissioners.
5. Non-compliance percentages and incomplete sections and areas of the WHO Patient Safety Checklist to continue to be emailed directly to the Consultant and the staff member involved.
6. Audit results are also discussed as a standing agenda item at the Theatre User Group meetings

RISKS / ISSUES

None identified.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Friday 09 September 2016

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 September 2016 at 1400h to transact the business detailed on the attached agenda.

Members of the press and public are welcome to attend the public part of the agenda which commences at 1440h.

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

Notice of Public Board Meeting on Wednesday 5 October 2016

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 5 October 2016 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.

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** 5 October 2016: 1100h – 1300h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair & Non Executive Director	(TP)
HH Frances Kirkham	Non Executive Director	(FK)
Prof Tauny Southwood	Non Executive Director	(TS)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Rod Anthony	Non Executive Director	(RA)
Mrs Jo Chambers	Chief Executive	(JC)
Mr Andrew Pearson	Medical Director	(AP)
Mr Paul Athey	Finance Director	(PA)
Mr Garry Marsh	Director of Operations, Nursing & Clinical Governance	(GM)
Prof Phil Begg	Director of Strategy & Transformation	(PB)

In attendance

Mr Richard Phillips	Associate Non Executive Director	(RP)	
Ms Anne Cholmondeley	Director of Workforce & OD	(AC)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies – None	Verbal	Chair
	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
	3	Patient story	Presentation	GM
	4	Minutes of Public Board Meeting held on the 7 September 2016 *for approval*	ROHTB (9/16) 015	Chair
	5	Trust Board action points: *for assurance*	ROHTB (9/16) 015 (a)	SGL
	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (10/16) 002 ROHTB (10/16) 002 (a)	YB/JC
	7	Nominations Committee (Executive Directors) terms of reference: *for approval*	ROHTB (10/16) 003 ROHTB (10/16) 003 (a)	SGL
QUALITY & PATIENT SAFETY				
	8	Patient Safety & Quality report: *for assurance*	ROHTB (10/16) 004 ROHTB (10/16) 004 (a)	GM

	9	Safe Staffing Report: *for assurance*	ROHTB (10/16) 005 ROHTB (10/16) 005 (a)	GM
	10	Infection Control annual report: *for assurance*	ROHTB (10/16) 006 ROHTB (10/16) 006 (a)	GM
	11	Complaints annual report: *for assurance*	ROHTB (10/16) 007 ROHTB (10/16) 007 (a)	GM
FINANCE AND PERFORMANCE				
	12	Finance & Performance overview: *for assurance*	ROHTB (10/16) 008 ROHTB (10/16) 008 (a)	PA/GM
COMPLIANCE & RISK MANAGEMENT				
	13	Self assessment against the NHS England Core Standards for Emergency Preparedness, Resilience & Response (EPRR) *for assurance*	ROHTB (10/16) 009 ROHTB (10/16) 009 (a) ROHTB (10/16) 009 (b)	PB
	14	Quarter 2 2016/17 – Board Assurance Framework *for information*	ROHTB (10/16) 010 ROHTB (10/16) 010 (a)	SGL
ASSURANCE UPDATES FROM THE BOARD COMMITTEES				
	15	Quality & Safety Committee	ROHTB (10/16) 011	KS
	16	Finance & Performance Committee	ROHTB (10/16) 012	TP
	17	Charitable Funds Committee minutes	ROHTB (10/16) 013	FK
	18	Update from the Council of Governors	Verbal	YB
	19	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 2nd November 2016 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.

MINUTES

Trust Board (Public Session) - DRAFT v0.3

Venue Boardroom, Trust Headquarters **Date** 7 September 2016: 1100h – 1300h

Members present

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair	(TP)
Mr Rod Anthony	Non Executive Director	(RA)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mrs Jo Chambers	Chief Executive	(JC)
Mr Paul Athey	Director of Finance	(PA)
Mr Andrew Pearson	Medical Director	(AP)
Mr Garry Marsh	Director of Operations, Nursing & Clinical Governance	(GM)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(ACh)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

	Paper Reference
1 Apologies	**Verbal**
The Trust was joined by two representatives from DePuy Synthes. Board members introduced themselves. Apologies for absence were received from HH Frances Kirkham, Professor Tauny Southwood and Professor Phil Begg.	
2 Declarations of Interest	**Verbal**
No Declarations of Interest had been received since the last meeting and no declarations were made in connection with any item.	
3 Patient Story	**Presentation**
A patient and her partner joined the meeting to present an account of her experience while in the care of the Trust. The story included some poor practice around the care of the individual while on the ward and difficulties with accessing follow up advice once she had returned home. It was noted that the patient did not wish to register a formal complaint.	

The patient was thanked for her story. It was acknowledged that the patient review process had fallen down, however aside from this the medical care had been good. It was suggested that the administration processes and planning could have been improved, taking into account that the treatment related to a routine procedure. The equipment issues were noted to be of concern and it was suggested that the process by which equipment was accessed needed to be streamlined. It was highlighted that there was some work underway to ensure that there were sufficient pillows. The 'wedge' pillow was highlighted to be most beneficial for use early after surgery and it was noted that it had been appropriate to have been removed from the patient when it was. It was noted to be disappointing that the redirection from the Surgical Site Infection team was not handled well. The PALS contact had also not been well managed. Food hygiene training was being improved and was a focus of attention. Post-operative nausea was also an area of focus at present, through the administration of anti-emetic drugs. Overall it was noted that although the patient's experience had not been of a standard expected, had the individual run into clinical issues, then the medical and nursing support would have addressed the concern. The Chair of Quality & Safety supported this view, however expressed a concern that there was no available bed post-surgery, thereby necessitating a protracted stay in recovery. It was agreed that the issues were process-related and the end to end process was currently being handled through the Transformation Committee. This would take some time to get right but good progress was being made. The CEO apologised for the parts of the experience that had not gone well and advised that the Trust was already sighted on some of the issues reported. It was noted that when lots of issues occurred during one spell there was a disappointing overall patient experience. The patient was thanked again for her presentation and it was noted that the story would be directed to PALS which would keep her up to date and provide explanations for the areas of experience.	
4 Minutes of the Public Board 6 July 2016	**ROHTB (7/16) 020**
The minutes of the public meeting were accepted as a true and accurate record of discussions held, subject to some minor comments.	
AGREEMENT: The minutes of the previous meeting were approved	
5 Trust Board action points	**ROHTB (7/16) 020 (a)**
The Associate Director of Governance & Company Secretary reported that: • Work continued on the 'Paperless Board' solution and Information Governance issues relating to those with a non-Trust iPad were still being working through • Dementia was to be discussed by the Quality & Safety Committee in October • The Board Assurance Framework was to come to the October meeting of	

the Board	
6 Chairman's and Chief Executive's update	**ROHTB (9/16) 002** **ROHTB (9/16) 002 (a)**
The Chief Executive reported that the Trust continued to operate in a difficult context. She elaborated on this point and then guided the Board through some key points of discussion at the recent Trust Management Committee (TMC), which included some concerns expressed around Mandatory Training compliance; progress with development work in the High Dependency Unit; the cost pressure incurred as a result of the national apprenticeship levy; and challenges in terms of IT which would be given oversight by the IM & T Programme board. The Board's attention was drawn to the Single Oversight Framework briefing attached as an appendix to the main report. It was reported that the Sustainability and Transformation Plan was due to be submitted in October 2016 and much work continued with STP partners to develop this submission. The feedback from NHS Improvement on the 2016/17 plan was noted NHSI had also changed the Trust's governance rating from 'Under Review' to 'Green' which was positive news. The Chairman reported that: • She had been involved in the Birmingham Oncology and Arthroplasty Meeting which had been held to mark the retirement of Professors Simon Carter and Rob Grimer. They were thanked for their contributions over their extensive time at the ROH. Exit interviews were planned for the individuals. • A meeting with the Chair & CEO of Robert Jones & Agnes Hunt NHS FT had been held on 23 August; discussions were underway around potential shared training opportunities for the Council of Governors of both organisations. • The Annual Members Meeting was planned for 14 September at 1700h in the Max Harrison Lecture Theatre. All Non Executives were invited to the Council of Governors meeting beforehand (1400h – 1600h). • A round of Non Executive recruitment had taken place on 22 July and a candidate has been offered and accepted a position, subject to agreement by the Council of Governors on 14 September. The interviews for the clinical NED post were to be on 19 September.	
7 Safe staffing report	**ROHTB (9/16) 003** **ROHTB (9/16) 003 (a)**
The Director of Operations, Nursing & Clinical Governance presented the routine safe staffing report. It was reported that fill rates of 90% had been achieved in most areas, with some small pockets being below this threshold. The Trust continued to operate at nurse staffing levels above the national requirements. The Royal College of Nursing (RCN)	

was noted to make a recommendation on skill mix and this had been achieved on all wards, including the Oncology ward. E-rostering roll out would provide better sight of paper-based rotas from October, with Ward 3 being the first environment to adopt the system. It was reported that the Trust had moved bank staff onto e-rostering to provide greater visibility of bank use. It was noted that the spending on agency had been improved but needed to reduce further. The Board was advised that the paper had been scrutinised by TMC previously, which had requested greater detail on the nurse staffing incidents. The case for nurse staffing above minimal levels was discussed. It was reported that by operating above the recommended levels, there was an expectation that performance against nursing quality indicators would be improved. This also helped to cover unexpected sickness absence. Weekend work needed to be considered. It was noted that there was a challenge around HDU to ensure that fundamental control around agency usage was not lost as a result of the Royal College of Paediatric and Child Health requirements. It was noted that by staffing above, mandatory training should be better than it was, given that there was an assumption that the flexibility would enable staff to join courses. It was suggested that the staffing incidents could be picked up at Quality & Safety Committee in future.	
ACTION: **Present the detail of nurse staffing incidents at a future meeting of the Quality & Safety Committee**	
8 CQC action plan update	**ROHTB (9/16) 004** **ROHTB (9/16) 004 (a)** **ROHTB (9/16) 004 (b)**
The Board considered the updated CQC action plan. It was highlighted that there appeared to be a number of elements which were off track. Work was underway to harmonise the colours in the action plan and the layout would be revised in future. Concerns remained around block bookings outpatient clinics and associated waiting times. A delivery plan to address these was in place and would be given close scrutiny through the divisional management board meetings and TMC. It was noted that some of the current clinics might be more appropriately described as being 'one stop' rather than true outpatient clinics, a matter which might need to be reviewed. 'In Touch' had been installed but output reports needed to be refined. The Learning Disability strategy remained to be developed; the Board was advised that conversations around learning disabilities occurred in the Safeguarding Committee, however a strategy needed to be developed. A job description had been developed around Learning Disability nurse. It was noted that there was a	

need to have a Learning Disability nurse within the organisation given that there were patients in the system who were affected by learning disabilities. It was also noted that there was currently non-compliance with the Accessible Information Standard which was linked to this. In terms of the High Dependency Unit (HDU), building work had started with a planned completion date of January 2017. The rotation programme for nurses was in place and a transitional care policy had been developed. The CQC plan would be owned by the Governance Improvement Manager. A replacement Deputy Director of Nursing & Clinical Governance had been recruited who would provide oversight of progress.	
9 Performance reports	**ROHTB (9/16) 005** **ROHTB (9/16) 005 (a)** **ROHTB (9/16) 005 (b)**
The Director of Finance reported that the financial position of the Trust was currently a £2.2m deficit, driven largely by under recovery of clinical income. This position was likely to deteriorate below plan for Month 5. A recovery plan had been developed which identified the steps to close the gap. The Chair of the Finance & Performance Committee underlined the need for a very clear delivery plan for recovery to be able to monitor progress. Performance against the 18 week Referral to Treatment Time and cancer treatment target was on track. Time of patient discharge was discussed and it was highlighted that too many patients were discharged beyond 1600h. It was noted that this would be of focus for the Length of Stay forum that had been recently set up. In terms of the Quality & Patient Safety report, it had been discussed by Quality & Safety Committee and TMC. The patient death reported was an expected death, however the detail of the discussions around appropriateness of the clinical treatment was being investigated. Investigations into the Never Events were approaching closure. The number of pressure ulcers was of concern and the Oncology ward manager & matron had been invited to the next meeting of the Quality & Safety Committee. It was questioned as to whether the Trust was being sufficiently focussed on avoiding pressure ulcers. It was noted that any shortfall in care was classed as being avoidable which may be different to other organisations. A Trustwide action plan was in place but needed to be made locally applicable. The Chair of the Quality & Safety Committee noted that professional accountability for pressure ulcers would be considered by the Quality & Safety Committee Last year's information trends would be added to future reports.	

10 Quarter 1 2016/17 – NHS Improvement governance submission	**ROHTB (9/16) 006** **ROHTB (9/16) 006 (a)** **ROHTB (9/16) 006 (b)**
The declaration was received and noted.	
11 Quality & Safety Committee	**ROHTB (9/16) 007**
The key points of discussion at the assurance meeting on 30 August were presented. Further assurance was needed on the use of the WHO checklist to ensure that it was used robustly. It was noted that engagement with the checklist was paramount. The external review of Never Events would also create additional focus and provide an understanding of the reasons for non-compliance with the use of the WHO checklist. It was noted that the patient safety walkabouts were operating well. Monitoring of actions to create improvement would be implemented. The process around the Friends & Family Test, particularly in Outpatients was to be discussed at a future meeting.	
12 Finance & Performance Committee	**ROHTB (9/16) 008**
The Board was advised that the report covered two meetings, both of which had been positive and constructive. The scale of the challenge to recover the finance and activity position was recognised. It was noted that a clear delivery plan was needed and additional focus was needed on the actions that would generate most improvement. The income attached to theatre utilisation was also discussed. There were reported to be some quick wins around product cost and procurement which needed to be considered and clear focus was needed on Cost Improvement Plans. It was agreed that an update on recovery needed to be presented to the Governors at their next meeting. It was suggested that the plan needed to be communicated in terms of patient numbers and cost or as a graphic and there was a need to create better focus on the patients waiting to be admitted. The Communications Department needed to be proactive in creating these messages.	
ACTION: Present an update on financial and activity recovery to the Council of Governors	
13 Any Other Business	
The Medical Director reported that the Junior Doctors strike would not occur this month, however the others cross Autumn and Winter were still planned. There were reported to be some issues around doctors in training which presented a risk for the organisation. The likely impact of the strike compared to other	

organisations was noted to be minimal, however discussions might be needed around whether a major incident was declared internally and the implications of this. The intent would be to continue with surgery but not outpatient clinics and therefore there would be an impact on new inpatient numbers.	
Details of next meeting	**Verbal**
The next meeting would be held on 5th October 2016 at 1100h, Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting:5 October 2016, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

7 September 2016, Boardroom @ Trust Headquarters

Members present: Yve Buckland (YB), Tim Pile (TP), Rod Anthony (RJA), Kathryn Sallah (KS), Jo Chambers (JC), Paul Athey (PA), Garry Marsh (GM), Andrew Pearson (AP)

In Attendance: Anne Cholmondeley (AC)

Apologies: Tauny Southwood (TS), Frances Kirkham (FK), Phil Begg (PB)

Secretariat: Simon Grainger-Lloyd (SGL)

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
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	~~03/02/2016~~ 6-July-16 Review again in Dec-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. Further development work currently underway. Names of individuals suggested to trial the system have been put forward, however delay due to resolution of Information Governance issues for those wishing to use non-Trust iPads.	
ROHTBACT. 014	Patient Case – an illustration of the work we do	Presentation	06/04/2016	Quality & Safety Committee to consider the future plans for screening dementia patients	SGL	~~25/05/2016~~ 28/09/2016	Included on the agenda of the ~~September~~ October meeting	
ROHTBACT. 020	Board Assurance Framework	ROHTB (5/16) 009 ROHTB (5/16) 009 (a)	04/05/2016	Update the BAF to include risks to the sustainability of the organisation agreed at the Board strategy day	SGL	~~06/07/2016~~ ~~1/10/2016~~ 11/01/2017	Updated BAF as at Quarter 2 included on the agenda of the October Board meeting. Further work planned to update the BAF with any new risks arising from the strategy refresh which will be included in the Quarter 3 update. Next update due in January 2017.	

ROHTBACT. 007	Safe Staffing report	ROHTB (9/16) 003 ROHTB (9/16) 003 (a)	07/09/2016	The detail of nurse staffing incidents to be presented to a future meeting of the Quality & Safety Committee	GM	26-Oct-16	Included on the agenda of the October meeting	
ROHTBACT. 012	Finance & Performance Committee	ROHTB (9/16) 008)	07/09/2016	An update on financial and activity recovery to be presented to the Council of Governors	TP	14-Sep-16	Presented to the Council of Governors at their meeting on 14/09/16	
KEY:								

	Verbal update at meeting
	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

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:	**5 October 2016**

EXECUTIVE SUMMARY:

This report provides an update to board members on the national context and key local activities not covered elsewhere on the agenda.

The report also provides a summary of key discussions and decisions taken by the Trust Management Committee since the Board last met.

REPORT RECOMMENDATION:

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

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:

The contents discuss a number of developments which have the potential to impact on the delivery of a number of the Trust's strategic ambitions

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 5 October 2016

1 EXECUTIVE SUMMARY

1.1 This paper provides an update on a number of key priorities for the Trust, as well as stakeholder and partnership engagement activities undertaken since the last Trust Board meeting on 7 September 2016.

2 NHSI – RECOVERY PLAN

2.1 The Trust's financial recovery plan is being reviewed by NHSI to provide assurance that the Trust has a credible and deliverable plan capable of delivering its control total. This plan includes the impact of the unplanned theatre closure in June which requires mitigating actions to recover lost activity.

2.2 Following the first phase of their Financial Improvement Programme, NHSI have released a framework for Trusts to use which focuses on the top ten opportunities for savings that were identified as part of their initial engagement. It is intended that this framework is used by ROH to drive and monitor progress, with clearly assigned leads and dates for delivery.

3 ENGAGING STAFF IN OUR RECOVERY PLAN

3.1 The Trust is committed to delivering its recovery plan, and all staff have a role to play. The Medical Director held an evening event for Clinical Leaders on 27 September to engage colleagues on the challenge faced by the Trust, and sought to empower teams to make improvements across clinical, operational and financial platforms. This message was reinforced at the CEO Question Time event on 30 September, attended by over 100 staff.

3.2 Going forward, there will be regular communication with managers to ensure that improvements are being driven at the pace they are required.

4 SINGLE OVERSIGHT FRAMEWORK

4.1 In line with the briefing provided in last month's update, notification has been received from NHS Improvement that the Single Oversight Framework is to be launched from 1 October 2016. This will replace the separate regulatory frameworks currently in place for NHS trusts under the Trust Development Authority and the Risk Assessment Framework used to regulate NHS Foundation Trusts. The notification

mentions that the exercise to determine into which segment each Trust will fall will take place over the near future and discussions concerning this will occur between organisations and their NHS Improvement relationship manager over coming weeks.

5 MANAGING CONFLICTS OF INTEREST IN THE NHS – CONSULTATION

5.1 Earlier this year, NHS England set out plans to design a stronger, more consistent approach to managing potential and existing conflicts of interest across the system. Sir Malcolm Grant has chaired a cross NHS task and finish group, which has been working to develop a full set of rules. A consultation on the proposed rules is now available and feedback can be provided until midnight Monday 31 October.

6 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

6.1 In addition to routine business meetings with partners, other key stakeholder and partnership engagement activities over the period include:

- Chaired the Leadership Transformation Theme Group
- Attended an Exceptional STP System Board meeting
- STP Progress meeting with Chairs and CEOs
- Birmingham and Solihull STP meeting

7 UPDATE FROM TRUST MANAGEMENT COMMITTEE

7.1 Since the last meeting of the Board on 7 September 2016, the Trust Management Committee (TMC) was held on 28 September 2016.

7.2 TMC considered the following items to be of note to the Board:

- TMC discussed the 2016-17 Delivery Programme papers that were reviewed at the September Finance & Performance Committee. There was agreement that communicating the Trust's financial position would need to be done openly and transparently, with a focus on empowering staff to act now so that improvements can be made.
- TMC discussed the immediate action required to address Trust's mandatory training compliance (including safeguarding training) as there is a risk that the Trust will be issued with a Contract Performance Notice if compliance does not improve (against the required trajectory).
- Paediatric nurse recruitment remains challenging, with no successful appointments at the recent assessment day. This is a particular risk due to the agency spend that is currently in place to mitigate these vacancies.
- The Trust failed to meet its RTT target (92%) in August 2016 which poses a risk to achievement of our quarterly compliance.
- TMC members discussed the concept of holding 'A Perfect Week', an improvement methodology used by many Trusts to intensely focus on improving patient flow through the hospital. During this week, all staff are engaged in ensuring that every piece of the patient pathway operates at maximum efficiency, and improvements

are communicated to all staff on a daily basis. This will be taken forward by the Operations team in the coming weeks.

7.3 The following policies were reviewed by TMC and recommended for approval:

- Work Experience Policy
- Massive Transfusion Policy and Urgent Transfusion Policy (Adult Patients) – this is subject to reformatting and amending the policy's review date to August 2019

7.4 The Corporate Risk Register was reviewed and a number of additional risks were proposed for addition.

8 RECOMMENDATION(S)

8.1 The Board is asked to discuss the contents of the report, and

8.2 Note the contents of the report.

Jo Chambers
Chief Executive
30 September 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (10/16) 003

TRUST BOARD

DOCUMENT TITLE:	**Nominations Committee (Executive Directors) – Terms of Reference**
SPONSOR (EXECUTIVE DIRECTOR):	**Dame Yve Buckland, Trust Chairman and Chairman of the Nominations Committee**
AUTHOR:	**Mr Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**5 October 2016**

EXECUTIVE SUMMARY:

The attached revised terms of reference were considered and supported by the Nominations Committee (Executive Directors) at a meeting held on 7 September 2016.

It is a requirement of the Trust's constitution that the terms of reference are reviewed annually and updated where appropriate.

The changes to the terms of reference are minor in that the secretariat to the Committee has been amended to be the Associate Director of Governance & Company Secretary and the format of the document has been amended to be consistent with the terms of reference of other Board Committees.

REPORT RECOMMENDATION:

Trust Board is asked to approve the revised terms of reference for the Nominations Committee (Executive Directors.

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		Equality & Diversity		Workforce	X

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Delivered by highly motivated, skilled and inspiring colleagues

PREVIOUS CONSIDERATION:

Considered by the Nominations Committee (Executive Directors) at a meeting held on 7 September 2016.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Nominations Committee (Executive Directors)
Terms of Reference
September 2016

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:

- The authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee;
- 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

The Chair of the Committee shall be the Trust Chairman. 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

Associate Director of Governance/Company Secretary.

11 In attendance, by invitation

Director of Finance & Performance
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

Nominations Committee:	September 2016
Trust Board:	October 2016

16 Date of review

September 2017

ROHTB (10/16) 004

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Quality and Patient Safety Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Operations, Nursing and Clinical Governance**
AUTHOR:	**Ms Faye Rafferty, Governance Manager**
DATE OF MEETING:	**5th October 2016**

EXECUTIVE SUMMARY:

The Quality and Patient Safety Report aims to increase accountability and drive quality across the Trust by triangulating a number of data sources including incidents, litigation and complaints. Through this report areas for improvement will be identified together with risks to the Trust.

Its purpose is to provide assurance to the Trust Board that action is being taken in response to recommendations identified.

REPORT RECOMMENDATION:

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

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:

Aligns to strategic intentions
BAF Risk 16

PREVIOUS CONSIDERATION:

Quality and Safety Committee on 28 September 2016

GOVERNANCE DEPARTMENT

QUALITY REPORT

September 2016

EXECUTIVE DIRECTOR: Garry Marsh *Director of Nursing and Governance*
AUTHOR: Faye Rafferty *Governance Manager*

CONTENTS

1. INTRODUCTION

This integrated Quality Report aims to provide a trust wide overview and assurance relating to patient safety, quality and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham CrossCity Clinical Commissioning Group in order to satisfy contractual information requirements.

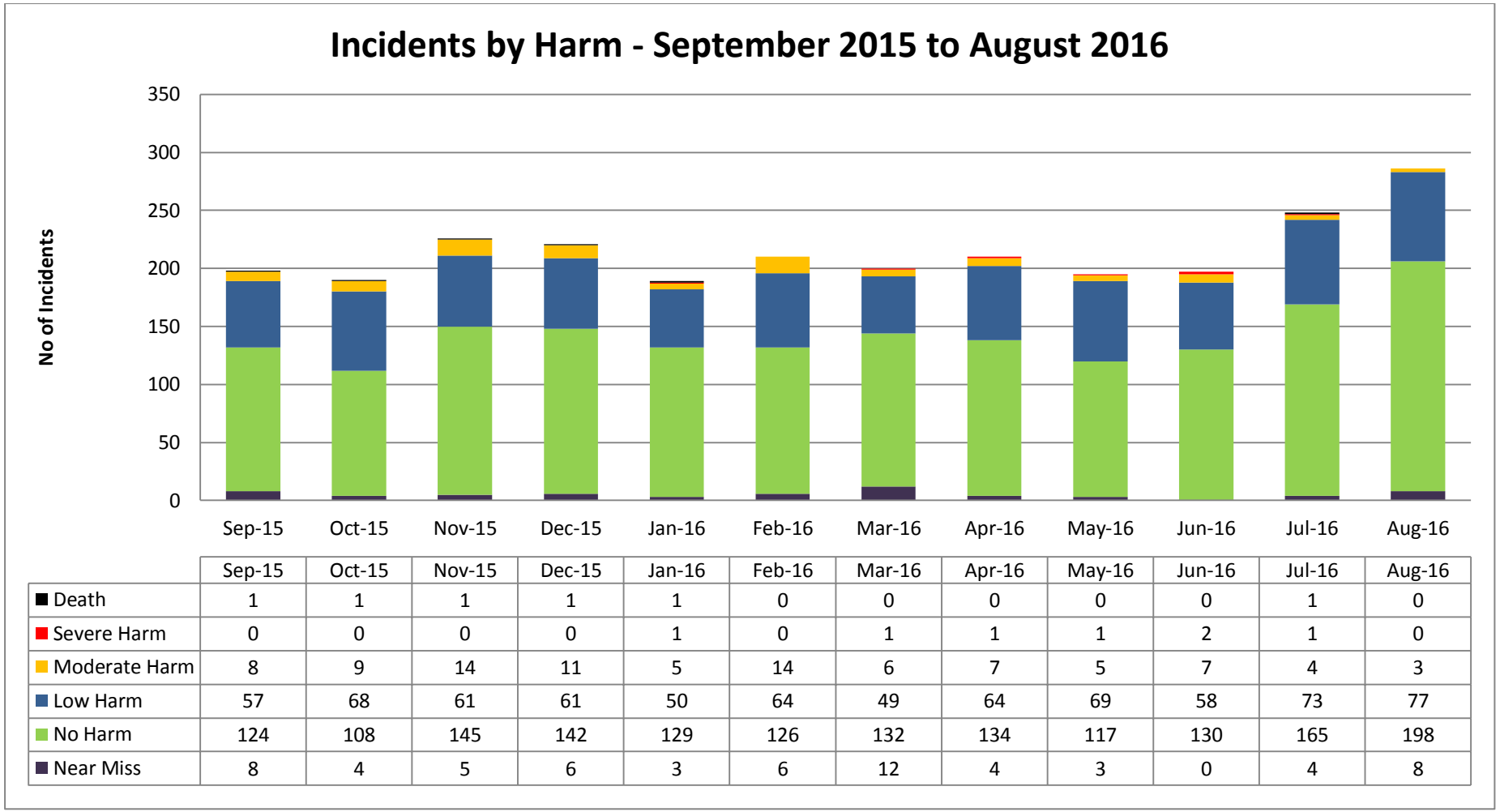
This Quality Report is a dynamic document, the data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this Quality Report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department;

Email: **roh-tr.governance@nhs.net**

Tel: 0121 685 4000 (ext. 55641)

2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.



	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Death	1	1	1	1	1	0	0	0	0	0	1	0
Severe Harm	0	0	0	0	1	0	1	1	1	2	1	0
Moderate Harm	8	9	14	11	5	14	6	7	5	7	4	3
Low Harm	57	68	61	61	50	64	49	64	69	58	73	77
No Harm	124	108	145	142	129	126	132	134	117	130	165	198
Near Miss	8	4	5	6	3	6	12	4	3	0	4	8

INFORMATION

There were 286 incidents reported during August 2016;

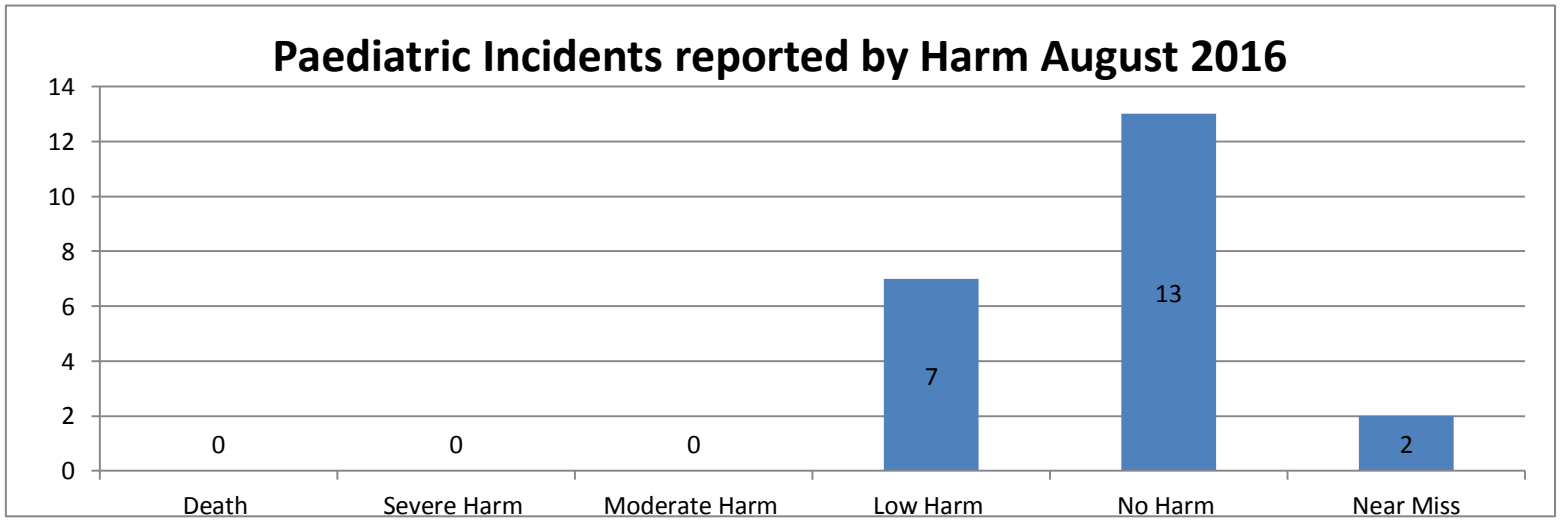
3 Moderate Harms

- Patient has been diagnosed with a VTE post discharge from ROH following a total knee replacement.
- Patient has been diagnosed with a VTE post discharge from ROH following hip re-surfacing procedure.
- Patient has been diagnosed with PE post discharge from ROH following a total knee replacement.

All 3 VTEs meet the criteria for reporting as a serious incident and have therefore been reported to commissioners and are currently under investigation.

Paediatric Incidents

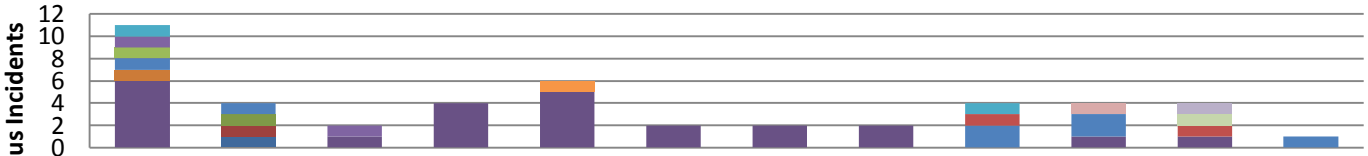
A total of 22 incidents were reported during August that involved a paediatric patient.



ACTIONS FOR IMPROVEMENTS / LEARNING
An update to Ulysses has now been made to ensure the Trust is able to identify and report on incidents that have been reported that relate to paediatric patients separately as recommended by the Royal College of Paediatrics and Child Health. This information will be reported to the Children's committee monthly for review, trend analysis in relation to incident numbers and harm will be provided in this report. A log of ongoing incidents that are currently under investigation will be reported at the Children's board together with findings from investigations. This will also be shared at Divisional Management Boards.
RISKS / ISSUES
None Identified

3. **Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.**

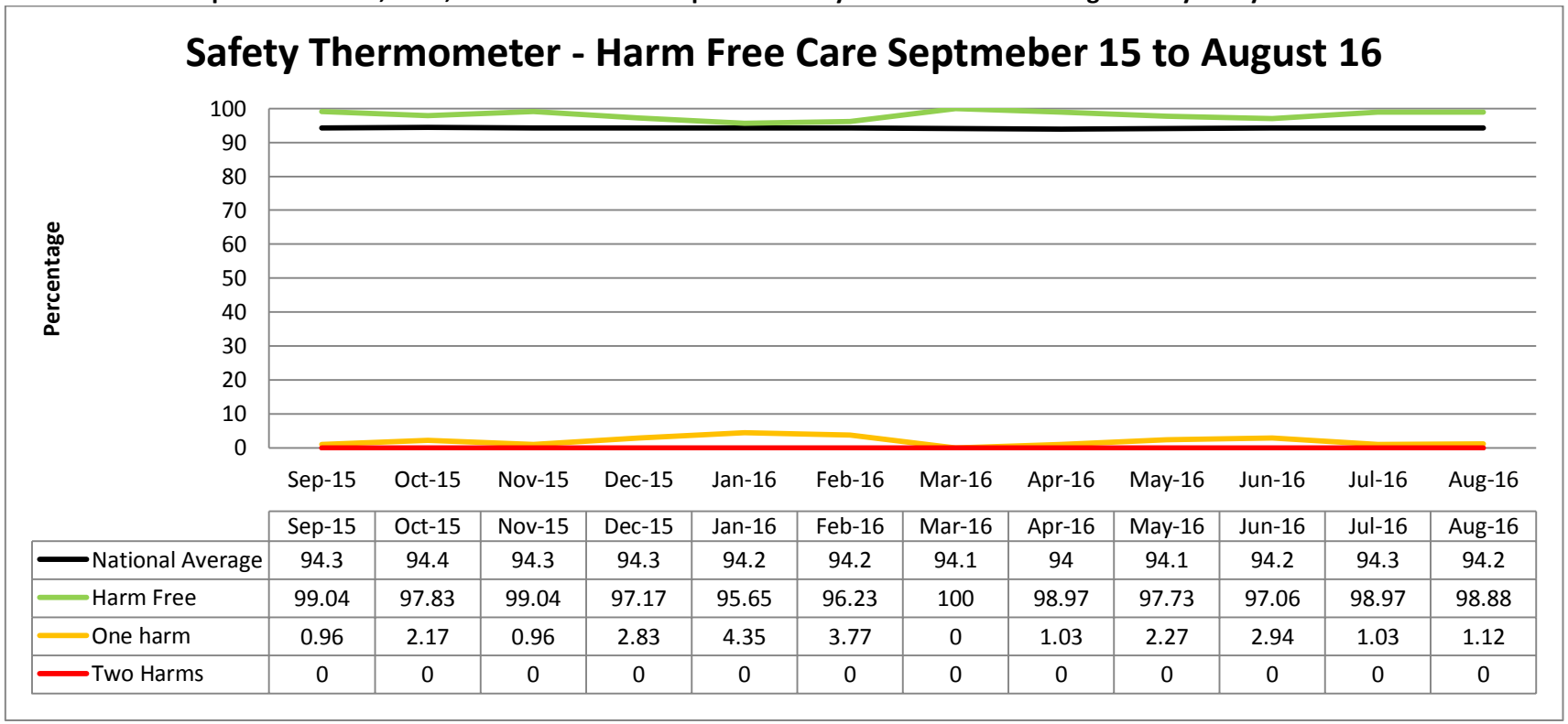
Serious Incidents - Declared September 15 - August 16



	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Wrong Site Incision											1	
Wrong Implant											1	
Suspension to services										1		
Delayed diagnosis					1							
Wrong side injection	1								1			
Unexpected deaths	1		1									
Staff conduct incidents	1											
Slips, trips & falls									1		1	
Pressure Ulcers	1	1							2	2		1
Emergency transfer out of Trust	1											
VTE meeting SI criteria	6		1	4	5	2	2	2		1	1	
Surgical incident meeting SI criteria		1										
Emergency transfer to HDU		1										
Failure to act on test results		1										

INFORMATION
There was 1 Serious Incidents (SI) declared during August 2016. Which was a Grade 3 pressure ulcer
ACTIONS FOR IMPROVEMENTS / LEARNING
3 Serious Incident reports were submitted for closure to Commissioners in August 2016. • 2 reports were in response to pressure ulcers that met the criteria for reporting to commissioners. Details of recommendations are provided in the pressure ulcer section below • 1 report was in response to a wrong side block that was reported to commissioners as a never event. Recommendations identified during the investigation of this incident include – • A review of the current SOP can include a more specific step by step description of the correct marking of the block side and block site and the 'Stop before you block' check. The process should be performed as a two person (ODP-Anaesthetist) directed dialogue. • This needs to be embedded into theatre practice with regular teaching and simulations sessions. The entire team needs to be involved in the training; Anaesthetists, anaesthesia assistants (ODPs), Physicians' assistants (anaesthesia) PA (A) s and theatre assistants; all staff must be empowered to speak up and demonstrate the correct procedures. • All new staff should undergo a clearly defined induction, appropriate to their tenure and role. This should include verbal and written elements. • SOPs must be easily accessible to all staff, also preferably via the hospital intranet. • The team in the anaesthetic room should not be interrupted during the process of anaesthesia (general and regional anaesthesia) • There should be three personnel present in the anaesthetic room during the establishment of anaesthesia in its entirety from the sign in procedure to entry into the operating theatre. • Those involved with the incident to sign for copies of this RCA and the new SOP, confirming receipt and understanding.
RISKS / ISSUES
None identified.

4. **NHS Safety Thermometer - provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.**



	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
National Average	94.3	94.4	94.3	94.3	94.2	94.2	94.1	94	94.1	94.2	94.3	94.2
Harm Free	99.04	97.83	99.04	97.17	95.65	96.23	100	98.97	97.73	97.06	98.97	98.88
One harm	0.96	2.17	0.96	2.83	4.35	3.77	0	1.03	2.27	2.94	1.03	1.12
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

There was 1 new harm reported during August 2016 relating to a hospital acquired grade 3 pressure ulcer on ward 3.

Children and Young Person's Safety Thermometer

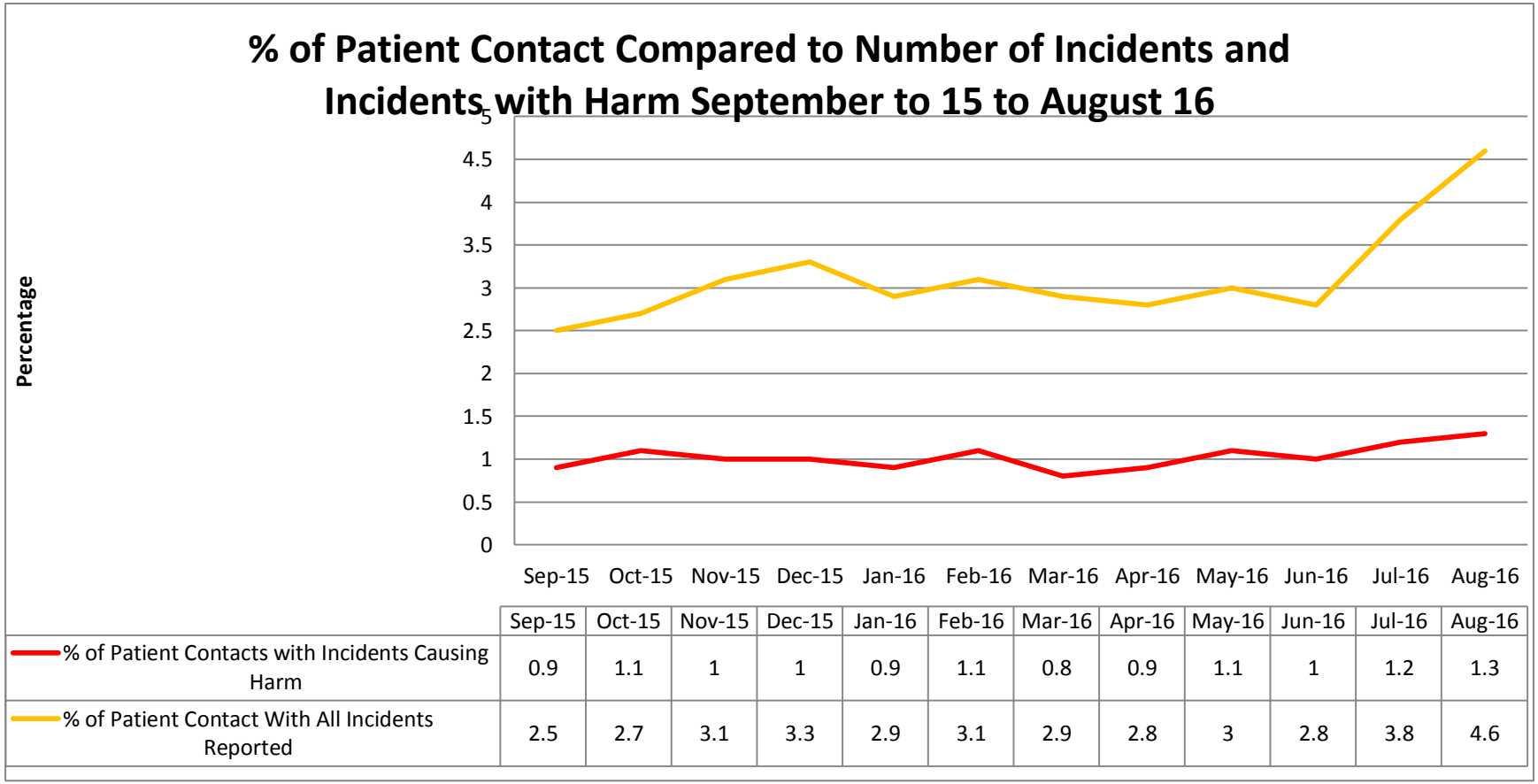
The Trust has started to submit data to the Children and Young Person's Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. Due to the limited number of data points submitted graphical representation of the data is not yet available from the national tool. A meeting is to be arranged with informatics to discuss how this information can be reported and presented in the meantime.

5. **All patient contact and harm – In contrast to the Safety Thermometer which measures the number of harm on one particular day of the month, the following data represents the total number of patient contacts in June 2016 compared to all incidents reported and incidents resulting in harm. Harm includes low harm, moderate harm, severe harm and deaths.**

	Low Harm	Moderate Harm	Severe Harm	Death	Total Incident with Harm	All Incidents Total	Total Patient Contacts
Sep-15	58	8	0	1	67	195	7700
Oct-15	68	9	0	1	78	190	7082
Nov-15	61	14	0	1	76	226	7251
Dec-15	61	11	0	0	72	220	6714
Jan-16	50	5	1	1	57	189	6627
Feb-16	64	14	0	0	78	210	6768
Mar-16	49	6	1	0	56	200	6862
Apr-16	64	7	1	0	72	210	7636
May-16	69	5	1	0	75	195	6528
Jun-16	58	7	2	0	67	197	7037
Jul-16	73	4	1	1	79	248	6426
Aug -16	77	3	0	0	80	286	6274

* This report is written prior to the validation of the total patient contacts. This figure is therefore subject to change following publication.

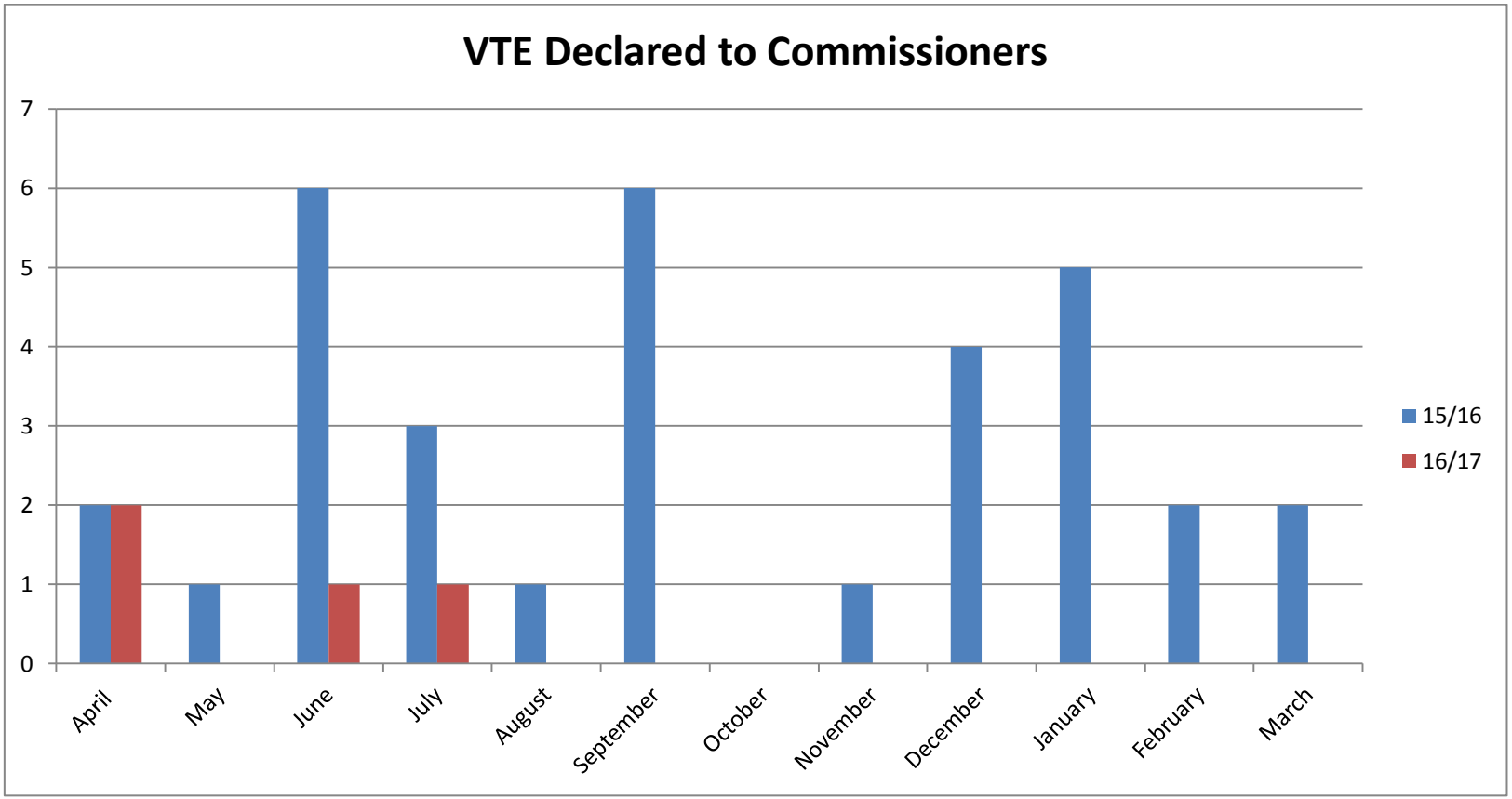
In August 2016, there were a total of 6274 patient contacts. There were 286 incidents reported which is 4.6 percent of the total patient contacts. Of those 286 reported incidents, 80 incidents resulted in harm which is 1.3% of the total patient contact for the month.



	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
% of Patient Contacts with Incidents Causing Harm	0.9	1.1	1	1	0.9	1.1	0.8	0.9	1.1	1	1.2	1.3
% of Patient Contact With All Incidents Reported	2.5	2.7	3.1	3.3	2.9	3.1	2.9	2.8	3	2.8	3.8	4.6

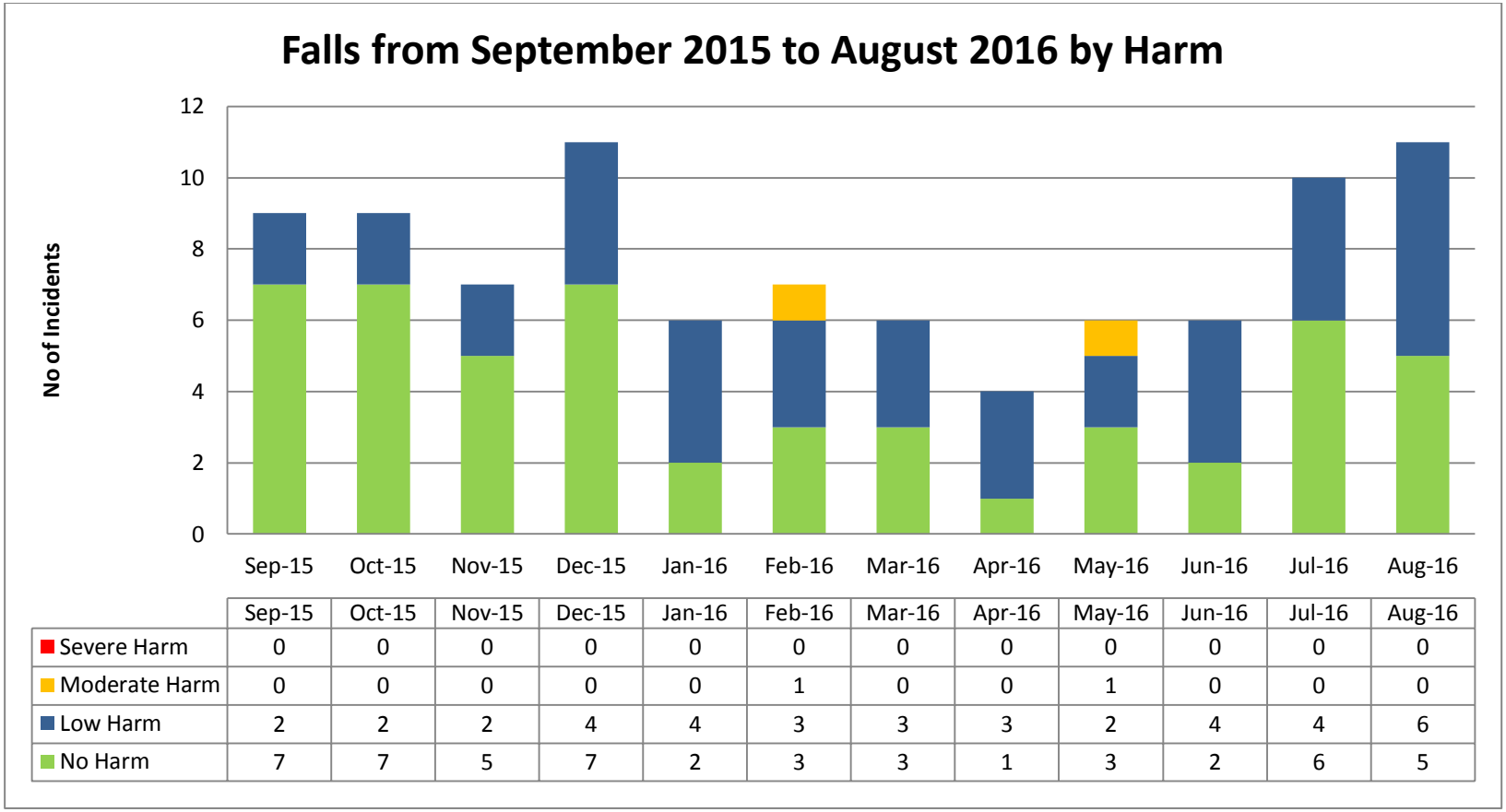
There has been an increase in the number of incidents being reported monthly at the Trust; however no significant increase in the degree of harm caused has been observed. This demonstrates that staff are confident to report incidents and the Trust is able to demonstrate an open reporting culture.

6. **VTEs - A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called a venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism).**



INFORMATION
There were no VTE incidents that were reported to Commissioners during August.
ACTIONS FOR IMPROVEMENTS / LEARNING
There were no final investigation reports in response to VTEs due for submission to Commissioners during August 2016. The Trust is progressing well against CQUIN requirements in relation to the VTE CQUIN entitled "Monitor, review and action plan all VTE occurrences up to 90 days post discharge, aiming to reduce VTE occurrence" All Quarter 1 requirements were met and progress against quarter 2 milestones is underway. The VTE Committee sits every other month with the next scheduled meeting being in September.
RISKS / ISSUES
None identified.

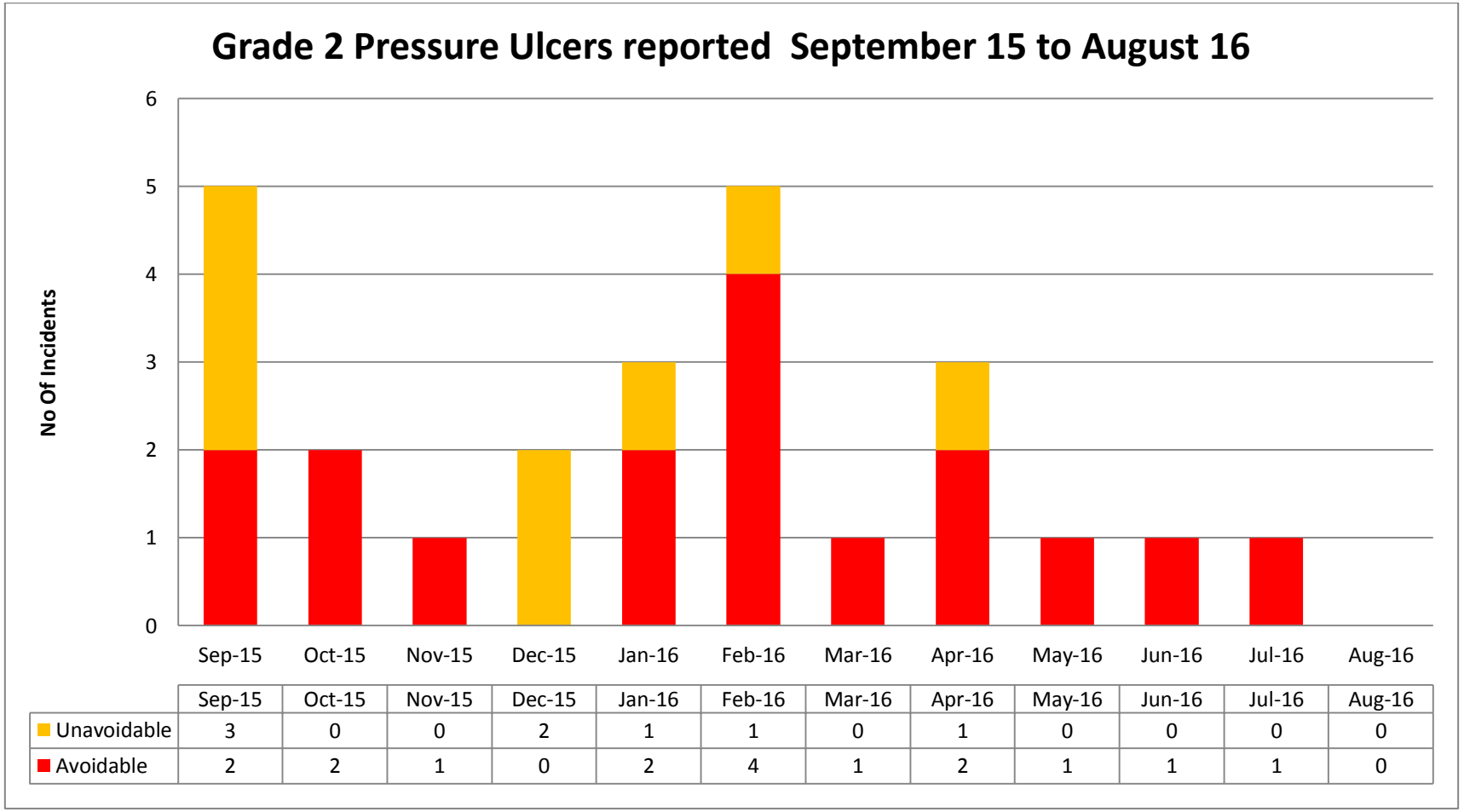
7. Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident



	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	1	0	0	1	0	0	0
Low Harm	2	2	2	4	4	3	3	3	2	4	4	6
No Harm	7	7	5	7	2	3	3	1	3	2	6	5

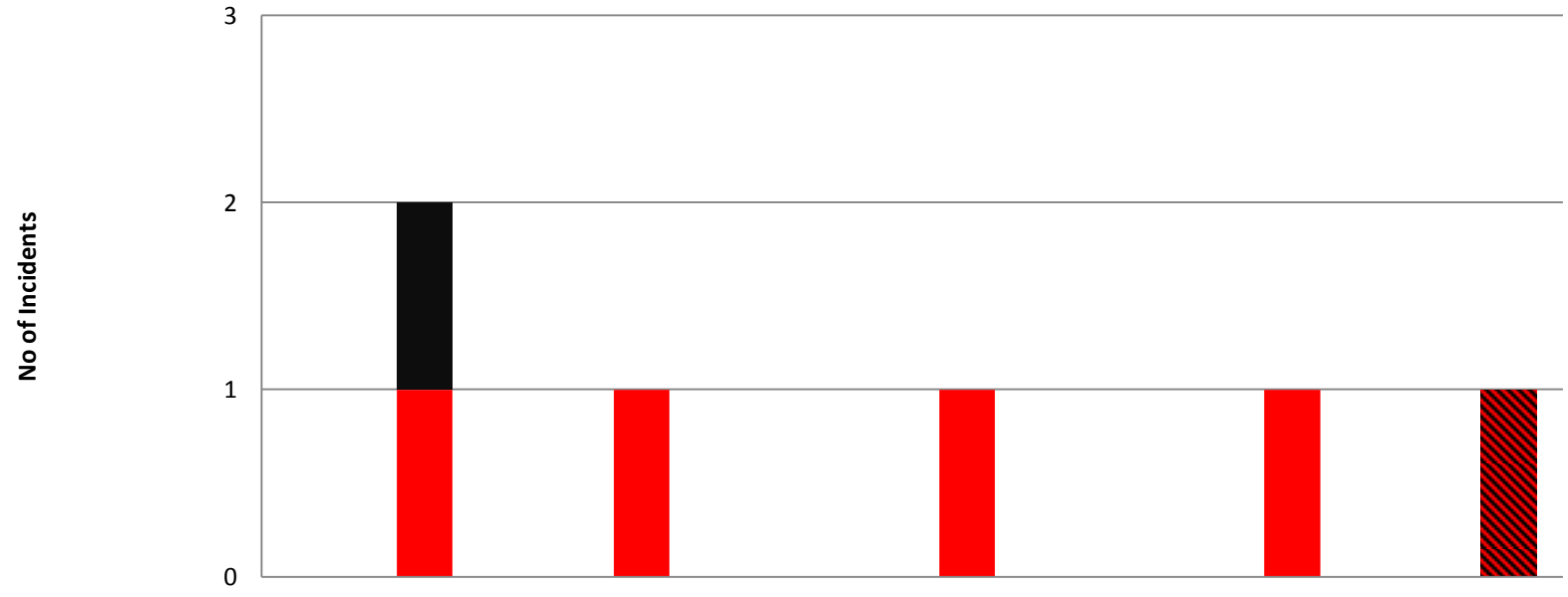
INFORMATION
During August 2016, 11 inpatient falls have been reported.
ACTIONS FOR IMPROVEMENTS / LEARNING
The Head of Nursing will be responsible for reviewing falls within the Trust. A review of falls that have been reported during June, July and August is currently being undertaken. Findings of this review will be included in the quality report once available.
RISKS / ISSUES
None identified.

8. **Pressure Ulcers - are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.**



	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Unavoidable	3	0	0	2	1	1	0	1	0	0	0	0
Avoidable	2	2	1	0	2	4	1	2	1	1	1	0

Grade 3 & 4 Pressure Ulcers reported September 15 to August 16



	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Under investigation												1
Grade 4 (Avoidable)		1										
Grade 3 (Avoidable)		1		1			1			1		

INFORMATION

There has been 1 Grade 3 pressure ulcer reported during August.

ROH contractual limit for Pressure Ulcers in 2016/17
Grade 2 Avoidable Limit is 15 - at August 2016 = 5 avoidable
Grade 3 Avoidable Limit is 0 - at August 2016 = 2. 1 has been deemed avoidable the remaining 1 is currently under investigation.
Grade 4 Avoidable Limit is 0 - at August 2016 = 0

ACTIONS FOR IMPROVEMENTS / LEARNING

2 final reports were submitted to commissioners during August in response to Pressure Ulcers meeting the SI criteria.

Case 1:
Recommendations

- A review of the availability and frequency of mandatory clinical skills updates.
- Continuation of the Tissue Viability drop-in sessions relating to pressure area care to include advice on accurate completion of ROH documentation.
- A review of the arrangements within POAC for the assessment of patients with complex needs.
- HDU to utilise care plans in-line with the other departments within the Trust for specific issues such as Plaster of Paris not covered within the HDU Care Chart.

Case 2:
Recommendations

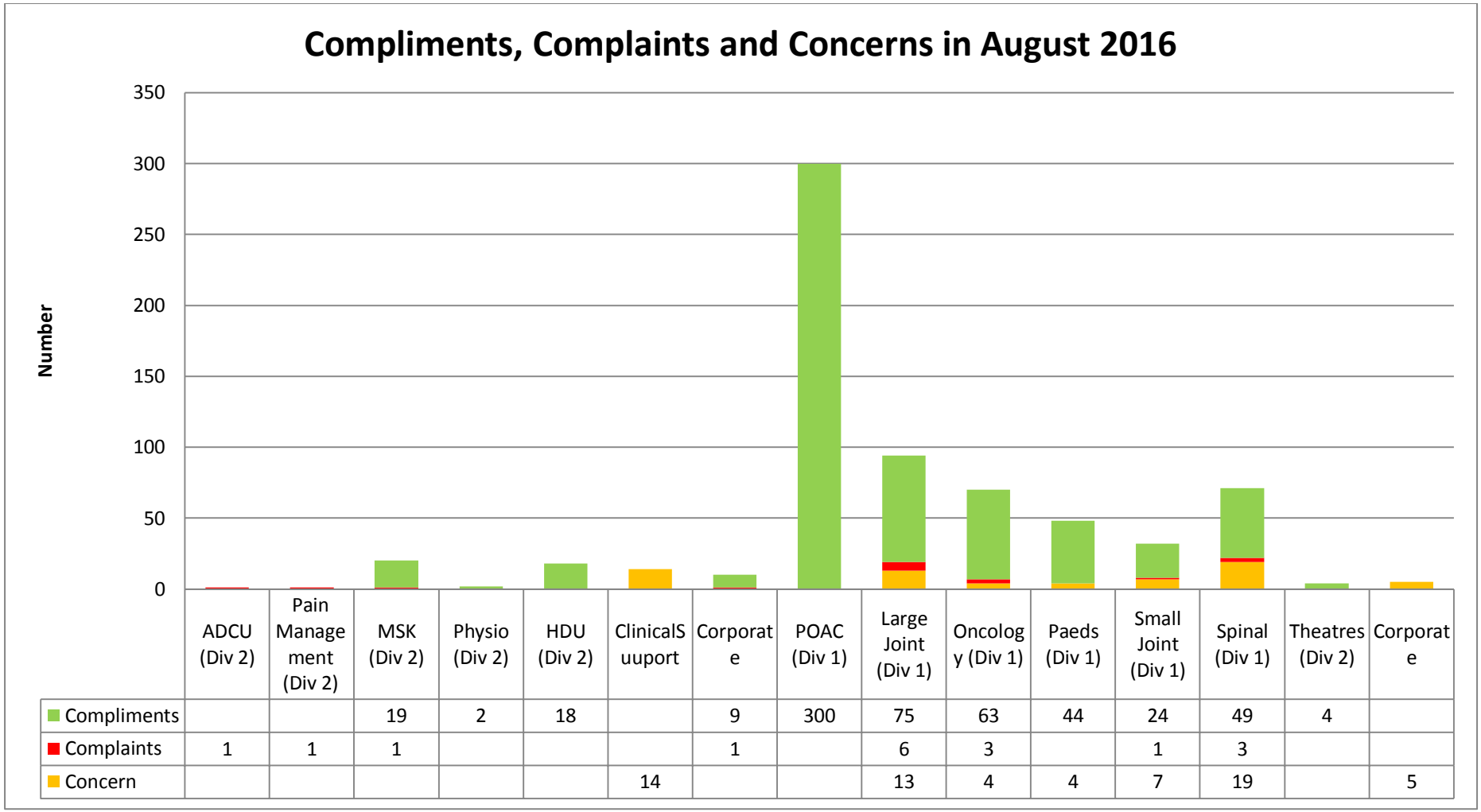
- All nursing assessments must be completed or updated 6 hours of admission or transfer and reviewed on a regular basis and / or as condition changes.
- Accurate completion of documentation in regards to potential warning of pressure area breakdown, skin condition and preventative actions of care to ensure deterioration is reduced or prevented.
- Accurate assessment and evaluation of preventative measures to ensure that the correct and proper care is implemented.
- That any breeze mattress ordered that does not arrive within the allotted time frame should be investigated and escalated appropriately, with completion of incident report.
- All patients admitted with previous skin damage should have this recorded within the nursing notes.

- To ensure that Registered Nurses are aware of their professional obligation to ensure that documentation by Student Nurses is correct and appropriate.
- To ensure that Student Nurses are appropriately mentored during their placements within the ROH.
- To ensure that Ward 3 staff attend care of plaster cast sessions to provide learning opportunities to reduce or prevent pressure area breakdown of areas under casts.
- To ensure that patients that have a cast applied during their admission receive both verbal and written information on care of their cast and escalation of issues on application of cast and on discharge from the ROH.

RISKS / ISSUES

There is a risk of a financial penalty to the Trust by the Commissioners as ROH have exceeded the contractual threshold set relating to the number of avoidable grade 3/4 pressure ulcers reported during 2016/17. The fines associated with pressure ulcers within this year's contract are as follows
Grade 2 first 3 pressure ulcers reported above the 15 threshold = £1000
Grade 3 first 3 reported - £1000
Grade 4 first 2 reported - £1000

9. **Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.**



	ADCU (Div 2)	Pain Management (Div 2)	MSK (Div 2)	Physio (Div 2)	HDU (Div 2)	ClinicalSuuport	Corporate	POAC (Div 1)	Large Joint (Div 1)	Oncology (Div 1)	Paeds (Div 1)	Small Joint (Div 1)	Spinal (Div 1)	Theatres (Div 2)	Corporate
Compliments			19	2	18		9	300	75	63	44	24	49	4	
Complaints	1	1	1				1		6	3		1	3		
Concern						14			13	4	4	7	19		5

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

INFORMATION

In August there were 17 complaints, 66 concerns and 607 compliments received.

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 10 complaints closed in August 2016, all of which were closed within the agreed timescales. This gives a 100% completion on time rate and meets the KPI

Of the 10 complaints closed in August 2016:

- 5 were upheld
- 2 were partially upheld
- 3 were not upheld

All upheld complaints had elements of poor communication that had caused misunderstanding or difficulty for the patients involved.

Learning identified and actions taken as a result of complaints closed in August 2016 include:

- The process for managing private patients when a patient is initially an NHS patient is not explicit
  Action: This is currently under review and new guidance will be issued.

- GPs and external NHS staff still don't appear to understand the BMI guidance for hip and knee surgery
  Action: Information will continue to be sent to GP Practices.

- Staff are not always aware of how to deal with hospital phobic patients
  Action: highlighted to the Equality Manager and Learning Disability Lead

There have been no complaints referred to the Parliamentary Health Service Ombudsman during August 16.
There are currently 2 complaints with the Ombudsman

RISKS / ISSUES

None Identified

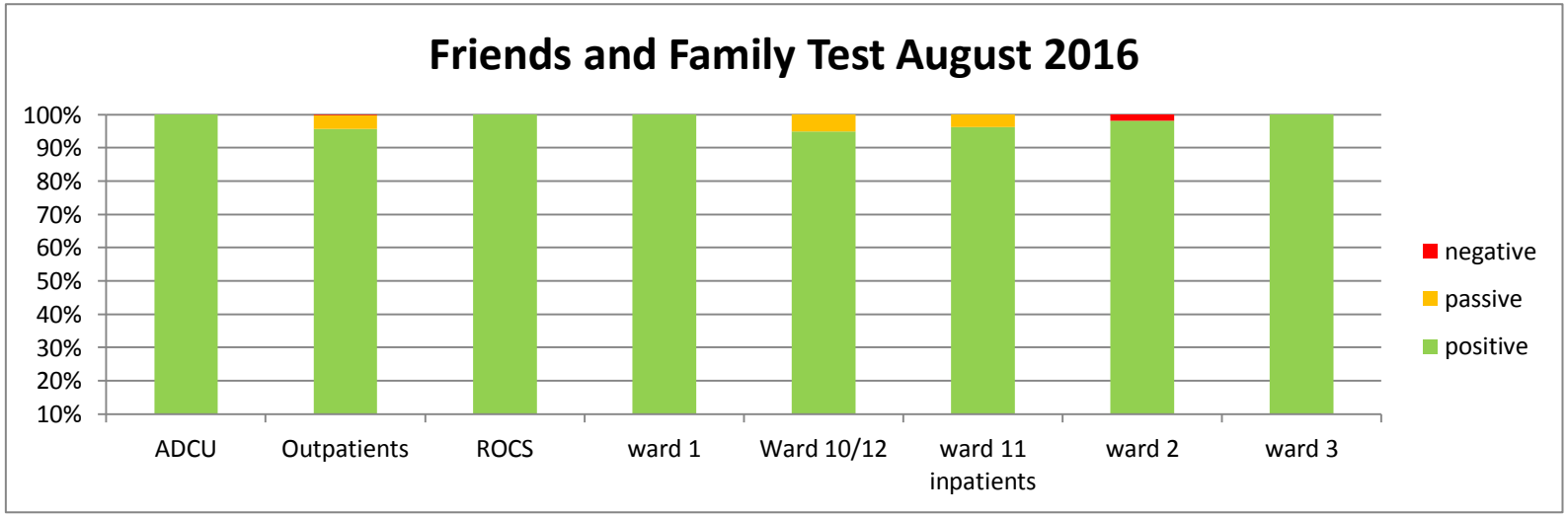
RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

10. Friends and Family Test Results - The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

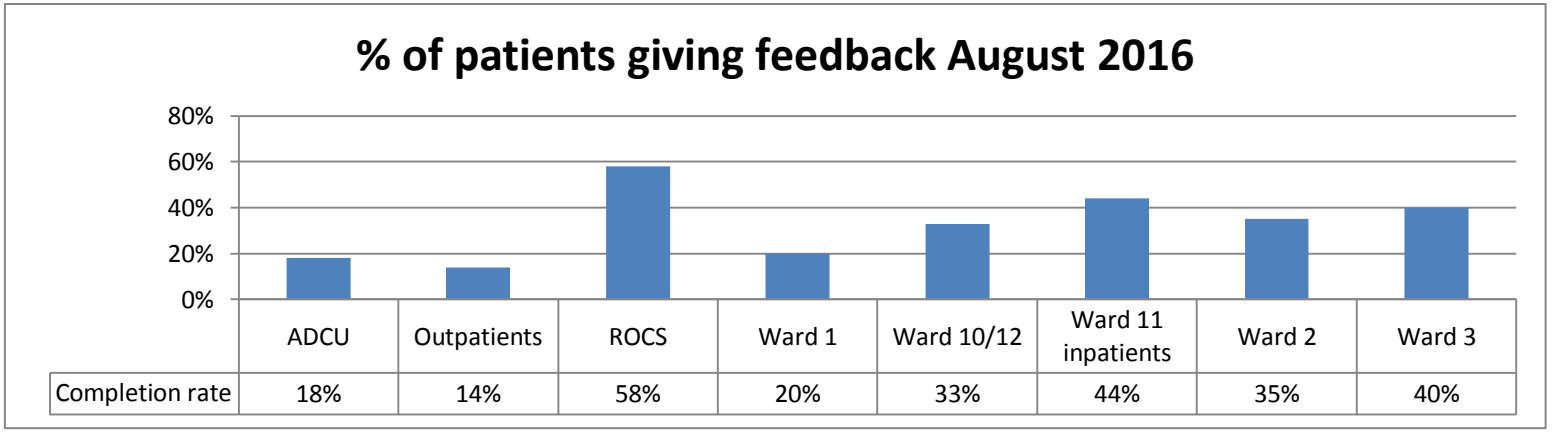
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting patient choice

This is a positive percentage score and it can be seen that almost all patients that we care for would recommend ROH to their family and friends.



The Scores for Friends and Family are calculated using a straightforward percentage response to the question 'How likely are you to recommend this area to friends or family if they require similar care or treatment?' Any patients answering the question as Extremely Likely / Likely are classified as Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely/Extremely Unlikely are classified as negative.

The percentages for all inpatient activity for August 2016 are 95% of those who responded would promote ROH.



Department	Positive	Passive	Negative	satisfaction rate	Eligible	Completion rate
ADCU	79	2	0	98%	445	18%
Outpatients	1003	34	7	96%	7342	14%
ROCS	75	0	0	100%	130	58%
Ward 1	12	4	1	71%	85	20%
Ward 10/12	35	2	0	95%	113	33%
Ward 11 inpatients	40	0	1	98%	94	44%
Ward 2	33	0	0	100%	95	35%
Ward 3	34	0	1	97%	88	40%

All areas receive a detailed breakdown of the friends and family data received relating to their areas together with the free text comments that patients have completed. All areas also receive ward level displays including information about FFT scores, response rates, numbers of complaints and compliments received and individual examples of key feedback received during the previous month.

11. Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.

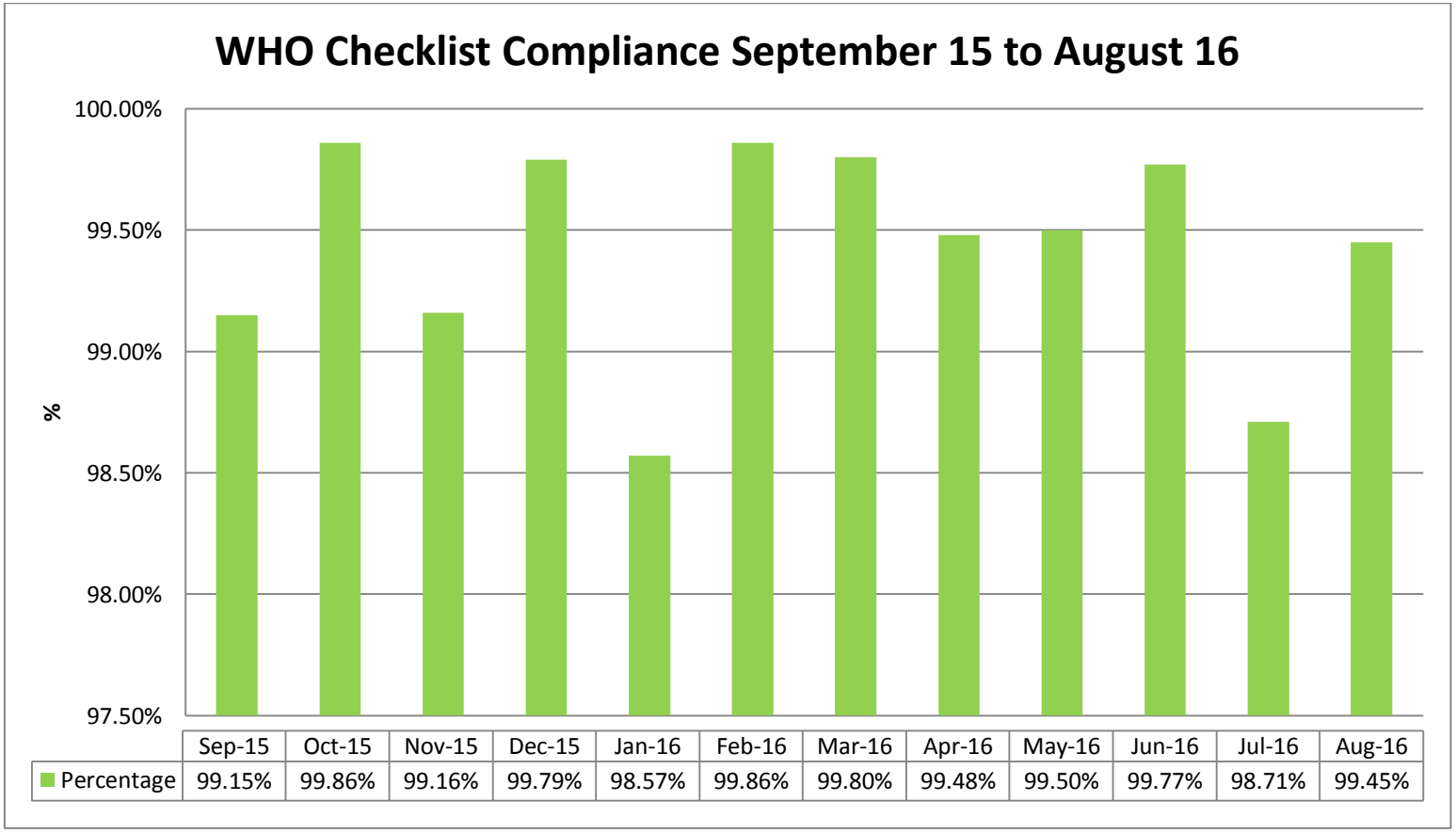
There are currently 20 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

An internal audit has been completed to review arrangements for demonstrating compliance with Regulation 20 with a particular emphasis on the robustness of internal tracking of compliance with the Duty of Candour. A draft report has been received by the Trust and is currently being reviewed for factual accuracy.

12. Litigation

There have been no new litigation cases in August and no cases closed.

13. **WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases of perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**



	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
Percentage	99.15%	99.86%	99.16%	99.79%	98.57%	99.86%	99.80%	99.48%	99.50%	99.77%	98.71%	99.45%

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

INFORMATION

Total Cases in August = 546

Total Non-Compliance = 3

Total Compliance = **99.45% Total**

An external review of the Trust's safety processes within theatres has been commissioned for assurance and learning a draft report has been received by the Trust which is currently being reviewed for factual accuracy.

ACTIONS FOR IMPROVEMENTS / LEARNING

The following recommendations are made following the audit collation:

1. Quarterly report to be disseminated to the Medical director, Clinical Directors, Clinical Leads, Consultants and Team Leaders.
2. Directorates with consistent 100% compliance to share best practice.
3. Continue with weekly and monthly reporting to the Medical Director and Director of Nursing & Governance.
4. Monthly reporting to the Commissioners.
5. Non-compliance percentages and incomplete sections and areas of the WHO Patient Safety Checklist to continue to be emailed directly to the Consultant and the staff member involved.
6. Audit results are also discussed as a standing agenda item at the Theatre User Group meetings

RISKS / ISSUES

None identified.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (10/16) 005

TRUST BOARD

DOCUMENT TITLE:	**Nurse Staffing Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Operations, Nursing and Clinical Governance**
AUTHOR:	**Mrs Sue Smith, Head of Nursing – Patient Services Division**
DATE OF MEETING:	**5 October 2016**

EXECUTIVE SUMMARY:

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. This paper provides the Trust Board with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for August 2016.

REPORT RECOMMENDATION:

The Trust Board is asked to note:

- Fill rates across ward areas are greater than 90% with the exception of Health Care Support Workers on Ward 3. Ward 3 continues to experience long term sickness which is being managed in line with Trust Policy. It is anticipated that the sickness rate will reduce over the next month.
- CHPPD is the principle measure of nurse deployment recommended by NHSI. It should therefore be a key measure in future nurse establishment reviews.
- Good progress has been made in appointing to adult nurse and health care support worker vacancies with the last assessment centres resulting in 12 offers to adult nurses and 7 to Healthcare support workers, all awaiting start dates
- Children's Nurse recruitment remains challenging with an assessment centre planned for October
- The Safer Nursing Care Tool (SNCT) was used across the Trust in late June/early July 2016. It is recommended that the SNCT should be repeated in November 2016 with much greater attention paid to quality assuring data collection.
- Agency use has risen this month, driven by an increase in agency use in theatres and HDU. The increase in agency usage has not been driven by a high level of Annual leave having been granted across the wards in August.

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		

ROHTB (10/16) 005

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial		Environmental		Communications & Media	
Business and market share		Legal & Policy	X	Patient Experience	X
Clinical	X	Equality & Diversity		Workforce	X

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. The provision of a monthly Safe Staffing report supports compliance CQC regulation.

PREVIOUS CONSIDERATION:

The report will be circulated to all matrons, general managers and ward sisters. It is an agenda item on the monthly Ward managers meeting and will be added to Divisional board Meetings from August 2016. The report was considered by the Trust Management Committee on 28 September 2016.

ROHTB (10/16) 005 (a)

Nurse Staffing Report

REPORT TO TRUST BOARD: August 2016 data

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 continued commitment to providing open, honest and transparent nurse staffing information through the publication of this data both on the Trust and NHS Choices Websites. This report provides details of Care hours Per Patient Day (CHPPD) which has become the principle measure of nurse deployment in line with NHSI (2016) requirements.

The paper provides the Trust Board with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for August 2016 with additional information relating to vacancy and plans for recruitment to vacant posts.

2.0 Workforce Information: Trust Overview of Planned Versus Actual Nursing Hours

The overall nurse staffing fill rate for August 2016 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. The actual staffing levels for August 2016 were manually entered into the data collection spreadsheet by the nurse in charge of the shift and subsequently verified by the senior sister and matron. Planned staffing hours are based on funded establishment which provides a minimum ratio of 1 to 8 on day shifts for all adult in patient wards. The planned hours are adjusted each month to allow for the number of days in the month.

Table 1 below provides further detail regarding nurse staffing fill rates for August 2016. The Unify upload for August 2016 is provided in Appendix 1. In the absence of national guidance, ROH will RAG rates each ward against a locally agreed framework as follows: Green - where actual available hours are within 5% of planned; Amber -within 5 and 10% and Red where the difference is greater than 10.

Table 1: Detailed Ward Breakdown

	Day		Night	
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
1	91.9%	98.2%	97.8%	96.8%
2	100.5%	98.5%	100.0%	90.3%
3	92.0%	86.2%	104.8%	85.1%
12	95.4%	94.7%	100.0%	102.8%
11	95.8%	95.4%	96.8%	-
HDU	99.6%	130.2%	104.3%	100%

- There has been little change in the fill rates on ward 3 with improvement in fill rates for Registered Nurses sustained into August 2016 although the fill rate for care workers on both and night shifts is low. The ward continues to manage a high level of sickness in this staff group with sickness/absence processes in place. It is anticipated that the sickness rate amongst this staff group will reduce over the next two months due to anticipated conclusion of sickness management processes.
- The fill rate for non-registered care staff on HDU, day and night, reflects the need for 1 patient to receive enhanced care over a 24 hour period for 4 days in August 2016

2.1 Care Hours per Patient Day (CHPPD)

Following the publication of the Carter Review (2016**)** NHS Improvement have issued new guidance which requires all Trusts to report Care Hours per Patient Day. From May 2016 CHPPD will become the principle measure of nursing and care support deployment. CHPPD provides a single consistent metric of nursing and healthcare support worker deployment on inpatient wards and units.

During August 2016, CHPPD were calculated by ward as detailed in Table 2 below, with the totals in brackets representing July results.

WARD	Table 2: Care Hours Per Patient Day (CHPPD) AUGUST 2016			
	Cumulative count over the month of patients at 23:59 each day	**Registered midwives/ nurses**	**Care Staff**	**Overall CHPPD**
1	441	5.5	3.5	9.0 (6.3)
2	507	4.3	3.1	7.3 (5.7)
3	515	4.5	3.0	7.4 (6.6)
12	640	4.8	3.3	8.2(7.1)
11	193	10.8	1.7	12.5 (18.2)
HDU	147	22.1	2.0	24.1 (17.5)

Benchmarking data is not currently available but it can be seen that there is variation in the number of CHPPD recorded over the past three months. The Carter review (February 2016) notes significant variation in CHPPD in the sample of 1000 wards used to gather the original data source with a range from 6.3 CHPPD to 16.8 CHPPD. On this basis ROH is at the lower end of the spectrum but Carter (2016) notes that we should be mindful of comparing different types of wards and departments and that CHPPD should be used against measures of harm and experience in order to establish ward baselines.

More work is therefore required to understand the optimum number of CHPPD required in a specialist orthopaedic hospital. CHPPD has already been included as a measure on the monthly Ward Healthcheck. CHPPD will be used as one of the measures in staffing establishment reviews and as the data matures it will be possible to compare wards of similar type and activity in order to enable greater understanding of the requirements of patients here at ROH.

2.2 Vacancy Information

Table 3 below shows the rebased ward budgets at Band 5 and 2 for each of the ward areas with the figures in brackets representing the budget before rebase. Note that for HDU the baseline includes Band 6.

Table 3 Band 5 WTE Vacancy (Based on Revised Figures from Matron. August 2016)

Ward/Department	Band 5 Funded Establishment (WTE)	Band 5 Vacancy (WTE)	Band 2 Funded Establishment (WTE)	Band 2 Vacancy (WTE)
OPD	4.43	2.0	8.48	1
POAC	5.6	1.6	3.15	Nil
Ward 1	13.57	1.0	10.32	Nil
Ward 2	13.80	2.0	9.05	Nil

Ward 3	14.16	1.0	7.65	Nil
Ward 12/10	18.61	2.2	13.91	3.0
Ward 11	15.96	2.0	1.8	1.2 (held)
HDU (Includes Band 6)	23.32	2.27	1.8	Nil
Totals	109.45	14.47	56.16	5.2

A number of key actions are in place to address recruitment at the Trust and are listed below:

- The Nursing Workforce group is now meeting monthly. The group is responsible for the development of targeted recruitment campaigns and the introduction of accurate vacancy monitoring across the Trust. Good progress has been made against the establishment of a Trust wide recruitment plan with OPD/POAC and ADCU joining the generic assessment centres and conforming to the recruitment calendar for HCAs. Further work will be undertaken with the theatre team over the next three months to ensure that good practice is shared and where possible Trust wide recruitment events are planned.
- The development of an accurate data set in terms of vacancy numbers remains challenging but a template has been developed that will be completed monthly by Ward sisters/ Charge Nurses to ensure accurate. The introduction of e-rostering will ensure that vacancy data is accurately captured.
- The Paediatric Matron has a planned start date of 1 November 2016.
- A further assessment centre for Children's nurses is planned for October 2016 (advert closes 6th Oct)
- Vacancies in OPD have been fully recruited to
- A further recruitment campaign for both Registered Nurses and Health Care Assistants will take place in October 2016. This will maximise the opportunity to attract the student nurses due to graduate in January 2016 and ensure that the next stage of Health Care support worker recruitment takes place in line with planned care certificate programme dates

2.3 Acuity data

Trust Board is asked to note that Division 1 team have supported the use of the PANDA tool and costings have been agreed. The next step is to identify the IT requirements and agree timescale for implementation. An update will be provided at the next Children's board in October then reported in the next staffing paper in October.

There are a number of caveats to using this single data source to draw conclusions about safe staffing levels on in patient wards:

- The Safer Nursing Care Tool which forms the basis of the data collection was not intended to be used on a daily basis because it is recognised that patient acuity will vary over time
- The tool is not completed at the same time each day.
- Variation is normal and the Safer Nursing Care tool makes clear that this should be expected.

Nevertheless, whilst we continue to use this tool it is recommended that change in demand must be kept under review over the next three months. As we move towards the introduction of e-rostering in October 2016, we will also enable the use of a Safer Staffing tool connected to the software which will enable recording of staffing numbers against acuity in real time.

2.4 Safer Nursing Care Tool:

The next audit should be repeated in November 2016

2.6 Skill Mix

The minimum skill mix recommended by the RCN (2014) is a ratio of 65/35 registered nurses/clinical support workers. All in patient wards at ROH meet this requirement within a percentage point and the ratio on Ward 3 is 70:30 Registered Nurse:Health Care support worker. Under no circumstances should the skill mix reduce below the RCN recommended level.

2.7 Safe Staffing and Efficiency

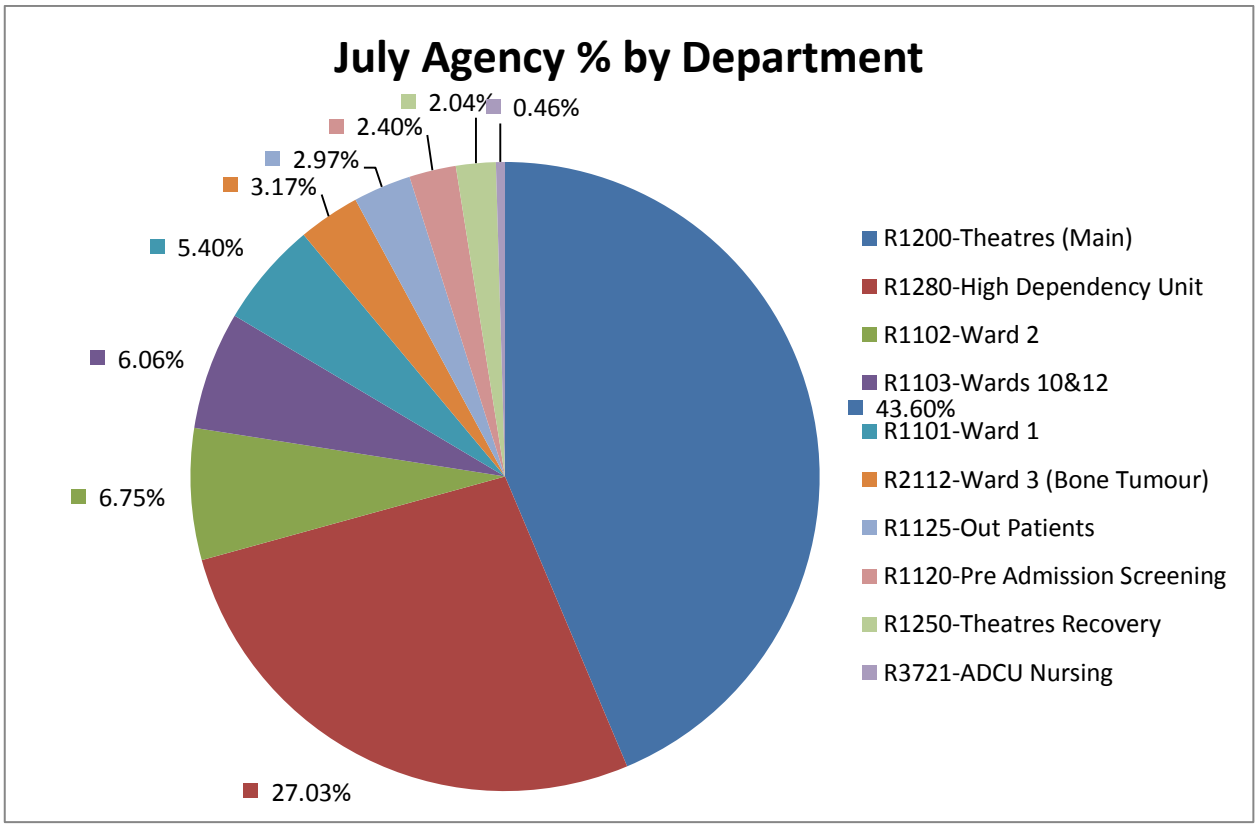
Caps on agency spend for Registered Nurses, mandated by NHS Improvement, have been in place at ROH since 1 October 2015. The ceiling for ROH has been set at 10% which is a reflection of the relatively high use of agency staff at the Trust. During August 2016 overall nurse agency use at ROH was 17% which is a significant increase of 4.6%. Table 8 shows total nurse agency use across the Trust since July 2015.

Table 8: Registered Agency use as a % of total cost (Whole Trust)

July 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	April 16	May 16	June 16	Jul 16	Aug 16
11.6%	12.3%	15.3%	20.9%	13.5%	15.9%	13.7%	14.2%	10.7%	11.2%	10.9%	8.6%	12.4%	17%

Table 9 presents agency use by area as a total of agency spends across the Trust.

Table 9: Agency use (as a percentage of total spend)



The use of agency staff in theatre is the primary cause of the agency spend across the Trust. The high use in HDU continues to be driven by the requirement to staff all shifts with paediatric nurses and by the vacancy factor in HDU.

The SLA with Birmingham Children's Hospital to enable use of their staff bank became operational in August 2016 and provides access to additional children's nurses at lower cost than agency use.

None of the in- patient ward areas have agency use of greater than 10%.

3.0 Progress against E–Rostering at ROH

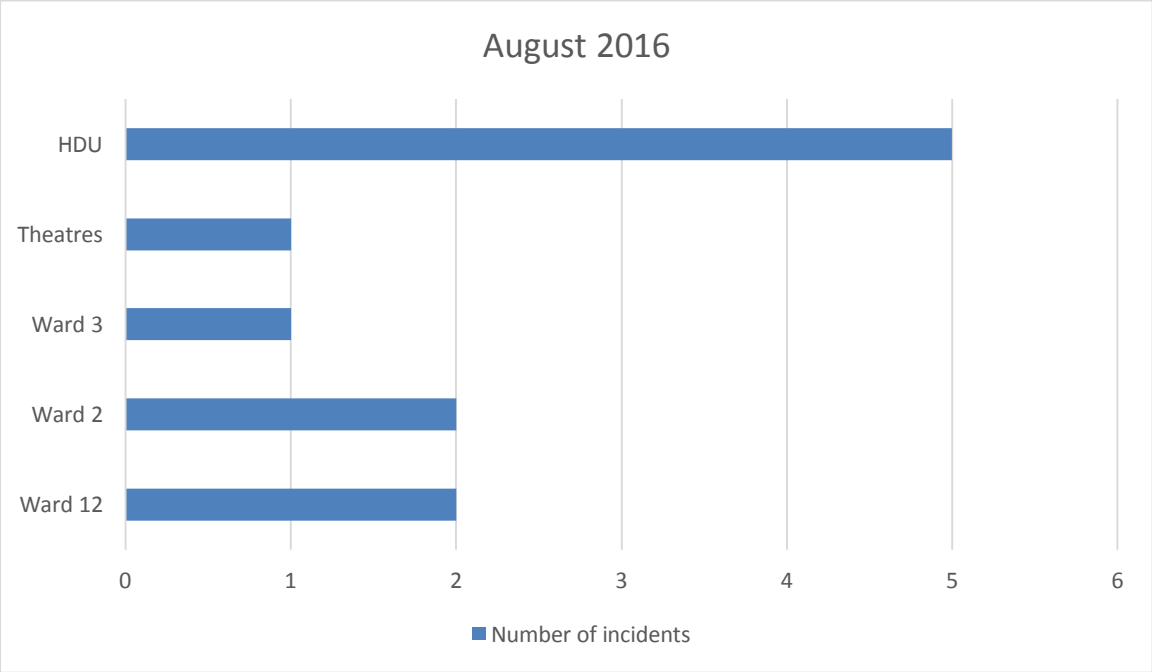
- The commencement date for the roll out has been confirmed as 10th October 2016
- A temporary system administrator will commence in post prior to roll out
- Ward 3 and Ward 11/HDU will be the first wards involved in roll out with the others coming on board on a weekly basis from end October 2016
- The Project team and Project Board are established

4.0 Incident Reporting and Levels of Harm

In addition to the Safer Nurse Staffing tool being used and interpreted, clinical areas are encouraged to report all Safe Staffing incidents. In August 2016, a total of 11 staffing incidents were reported. This compares to a total of 8 reported in July.

Of the 11 incidents reported 1 were graded as 'low harm' with the remaining 16 staffing incidents graded as 'no harm'. Table 7 provides detail of incidents by area

Table 7



Red Flag Shifts June 2016

One of the 11 reported incidents, none met the criteria for NICE Red Flag. Details of all reported staffing incidents can be found at Appendix 2.

5.0 Conclusion and Recommendations.

The Trust Board is asked to note:

- Fill rates across ward areas are greater than 90% with the exception of Health Care Support Workers on Ward 3 and Ward 11. Both wards are experiencing long term sickness which is being

managed in line with Trust Policy. It is anticipated that the sickness rate will reduce over the next two months.

- CHPPD is the principle measure of nurse deployment recommended by NHSI. It should therefore be a key measure in future nurse establishment reviews.
- Good progress has been made in appointing to adult nurse and health care support worker vacancies with the last assessment centres resulting in 12 offers to adult nurses and 7 to Healthcare support workers
- Children's Nurse Recruitment remains challenging with further interviews being carried out in October.
- The Safer Nursing Care tool was used across the Trust in late June/ early July 2016. The SNCT should be repeated in November 2016 with much greater attention paid to Quality assuring data collection.
- Agency use has risen this month, driven by an increase in agency use in theatres and HDU.

Garry Marsh
Director of Operations, Nursing & Clinical Governance

30 September 2016

Appendix 1: Incident Details August 2016

Site	Department	Incident Date	Reported Date	Incident Number	Cause Group	Cause 1	Actual Impact	Incident Type	Reporting Person Job Title	Feedback	Status Type	Details Of Incident
Wards	Ward 12 - Short Stay	11/08/2016	11/08/2016	18499	Staffing	Lack Of Suitably Trained / Skilled Staff	1 - No Harm	Staff Incident	Nurse			Received a call via sister with the Bleep requesting to move x1 staff nurse from our regular staffing levels down to ADCU as ADCU would be staying open to accommodate x 4 patient. Advised sister with the bleep that the current staffing levels involved x2 regular staff and x2 agency staff, one of whom had not worked on the ward previously. Removing a further regular staff member would further compromise the wards dependency if we would have A replacement of a further agency nurse who does not know the ward. So this would leave the ward with x3 agency nurses and x1 regular nurse and 2 of those agency nurses had not worked on the ward before. The sister with the bleep stated she would call other wards prior to confirming moving of any staff. Approx. 1 hour later the ward was called by the bleep holder to inform them that they would have to go ahead with the move of a regular qualified staff member. The ward tried to assist and compromise as there had been x1 male side room and x2 side rooms on ward 12 one which could be bleached and the other which could be piggy backed in to (due to x1 late discharge day case, late transfer of patient to Hereford hospital and a patient transfer to HDU) however the bleep holder stated this was not sufficient for the requirements of the patients in ADCU as they required 4 beds and only 3 had been available to them. I requested for the night bleep holder to base self on ward 12 as although the staffing levels had been met in numbers the quality of the skill mix was not ideal.

Wards	Ward 12 - Short Stay	24/08/2016	30/08/2016	18661	Staffing	Difficulty In Contacting Appropriate Staff	1 - No Harm	Staff Incident	Nurse		Completed By Managers	I was expecting one of our regular bank staff to come on shift at 1500hrs. When she had not arrived by 1515 I called nurse bank and spoke to jade. She said that the bank nurse had cancelled her shift the previous day but that the shift had been covered by outside agency and she gave me a name. I asked where the outside agency staff was as the shift had already started. She said she did not know and would call her agency to find out. She said she would call me back in 5 mins. When she did not call back I tried to call her. Over half an hour I tried her 4 times as we were very busy and needed our full quota of nurses. In the end my colleague went to her office and she had gone home. I am highlighting this incident because I feel communication could have been better: We were not aware that the bank nurse had cancelled. Our paperwork had not been updated. We had not been given a new name. We were given no explanation as to where the other nurse was. Nurse bank staff went home without calling back to tell us what was happening.
Wards	Ward 2	01/08/2016	03/08/2016	18415	Staffing	Lack Of Suitably Trained / Skilled Staff	1 - No Harm	Staff Incident			Completed By Managers	Ward 2 short staffed. Bleep holder requested that a trained member of staff from ward 12 (not agency) go to ward 2 at 00:45 to work with outside agency staff after twilight staff member went home. This left ward 12 short staffed with3 qualified staff one of whom was outside agency
Wards	Ward 2	13/08/2016	13/08/2016	18513	Staffing	Lack Of Suitably Trained / Skilled Staff	1 - No Harm	Staff Incident	Nurse		Completed By Managers	On the day of 12/08/16 at 20:00 I started a night shift where there was just me (and 2 A grades) present at handover. The twilight nurse had already started at 6pm and would be finished at 1am. Once 1am was over I would be on my own. Very kindly the nurse agreed to stay until she had finished all the writing and jobs for the blue side as I was on the red side she didn't leave until 3 am. However, once 3am had come it was just me a relatively junior staff nurse in charge on my own of a ward of 22 patients. if an emergency arise or pain relief or antibiotics were due to be given I couldn't deal with it on my own and the bleep sister although did have to come to the ward each time a pain relief was due she did refuse to base herself on the ward which left me feeling very unsupported and quite scared just in case anything was to happen. This is very dangerous given that the safe staffing should be around 1:8 especially as there were 3 post ops and 1 HDU.

Wards	Ward 3	18/08/2016	19/08/2016	18577	Staffing	Lack Of Suitably Trained / Skilled Staff	1 - No Harm	Staff Incident	Staff Grade	.	Completed By Managers	Agency nurse for night shift did not arrive.
HDU	H D U	07/08/2016	07/08/2016	18449	Staffing	Lack Of Suitably Trained / Skilled Staff	1 - No Harm	Other - I.E. Non-Patient Related	Nurse		Waiting For Managers Form	HDU HAVE TWO STAFF BAND 6 FOR TWO PATIENTS, ONE NURSE HAS TO HAVE THE HOSPITAL BLEEP .PHILL BEGG MADE AWARE BY THE BLEEP HOLDER PETER GIBBONS .PHILL BEGG IS HAPPY FOR HDU TO TAKE THE BLEEP AND ONLY TO ANSWER EMERGENCY CALLS .UNABLE TO GET EXTRA STAFF TO COVER HDU .NO PAEDIATRIC COVER FOR THE NIGHT DUTY THIS HAS ALSO BEEN OUT TO THORNBURY SINCE SATURDAY AFTERNOON .NO CHILDREN ON HDU AT THE MOMENT.
HDU	H D U	14/08/2016	15/08/2016	18523	Staffing	Lack Of Suitably Trained / Skilled Staff	2 - Low Harm	Staff Incident	Nurse		Waiting For Managers Form	Paediatric nurse cover for the night
HDU	H D U	16/08/2016	16/08/2016	18545	Staffing	Lack Of Suitably Trained / Skilled Staff	1 - No Harm	Staff Incident	Staff Grade	.	Under Review	All HDU staff on the unit are agency staff except the bleep holder for the hospital on the night shift on 16/08/2016.
HDU	H D U	16/08/2016	16/08/2016	18547	Staffing	Lack Of Suitably Trained / Skilled Staff	1 - No Harm	Staff Incident	Nurse		Under Review	Arrived on duty on HDU to discover not only did I have the hospital Bleep, that the only staff on the shift were agency nurses.
HDU	H D U	27/08/2016	27/08/2016	18649	Staffing	Staff - Level Of Support To Pt	1 - No Harm	Staff Incident	Manager		Waiting For Managers Form	No paediatric cover on the late shift today and no paediatric cover on the e or the late shift tomorrow 28/8/2016. DOM informed (MP) agencies called to cover no availability at time of writing the incident. Substantive member of HDU staff unable to do night shift leaving only agency staff on duty. Informed MP DOM have called round HDU staff and now covered this shift.
Theatres	Theatre - Other	27/07/2016	02/08/2016	18414	Staffing	Lack Of Suitably Trained / Skilled Staff	1 - No Harm	Staff Incident	Nurse			The clinical standards Lead in theatres, had to be involved in the scrub role count due to short staffing within the department....leading to Clinical standards duties being neglected and uncompleted.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (10/16) 006

TRUST BOARD

DOCUMENT TITLE:	**Infection Prevention & Control – annual report 2015/16**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Operations, Nursing and Clinical Governance**
AUTHOR:	**Ms Sarah Mimmack – Nurse Lead for Infection Prevention & Control**
DATE OF MEETING:	**5 October 2016**

EXECUTIVE SUMMARY:

The attached is the annual report into Infection Prevention and Control (IPC) for the financial year 2015/16.

The report provides detail on:

- The team structure and governance arrangements in relation to IPC
- Infection Prevention and Control activity over the year
- Surgical Site Infection information
- An update on the work of the Bone Infection Unit

REPORT RECOMMENDATION:

The Trust Board is asked to receive and accept the report and note the assurance it provides on the management of Infection Prevention and Control practice in the Trust.

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	X	Communications & Media	
Business and market share		Legal & Policy	X	Patient Experience	X
Clinical	X	Equality & Diversity		Workforce	X

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Safe efficient processes that are patient centred. The Corporate Risk Register and Board Assurance Framework currently contain a number of risks associated with infection prevention and control.

PREVIOUS CONSIDERATION:

The Quality & Safety Committee receives a quarterly update from the Infection Control Committee. The attached report was considered by the Infection Control Committee in July 2016.

The Royal Orthopaedic Hospital
NHS Foundation Trust

Infection Prevention and Control Annual Report

2015-16

Contents

Introduction

The Infection Prevention and Control Service was brought in house in 2007. Prior to that it was purchased from a large Trust situated nearby via a service level agreement. The service has grown significantly over the past 8 years and now encompasses the following:

Infection Prevention and Control
Surgical Site Infection Surveillance
Wound Infection Helpline
Bone Infection Unit
Tissue Viability Service

Having started as a team of 2 nurses; it now consists of the following whole time equivalents (WTE):

WTE	Band	Job Title
1.0	Band 8B	Lead Nurse
0.5	Band 7	IPC Nurse Specialist
1.5	Band 6	IPC Nurse
0.84	Band 6	Data analyst and epidemiologist
1.0	Band 4	Office Administrator
1.0	Band 3	SSI Surveillance Officer
0.6	Band 2	Office Assistant

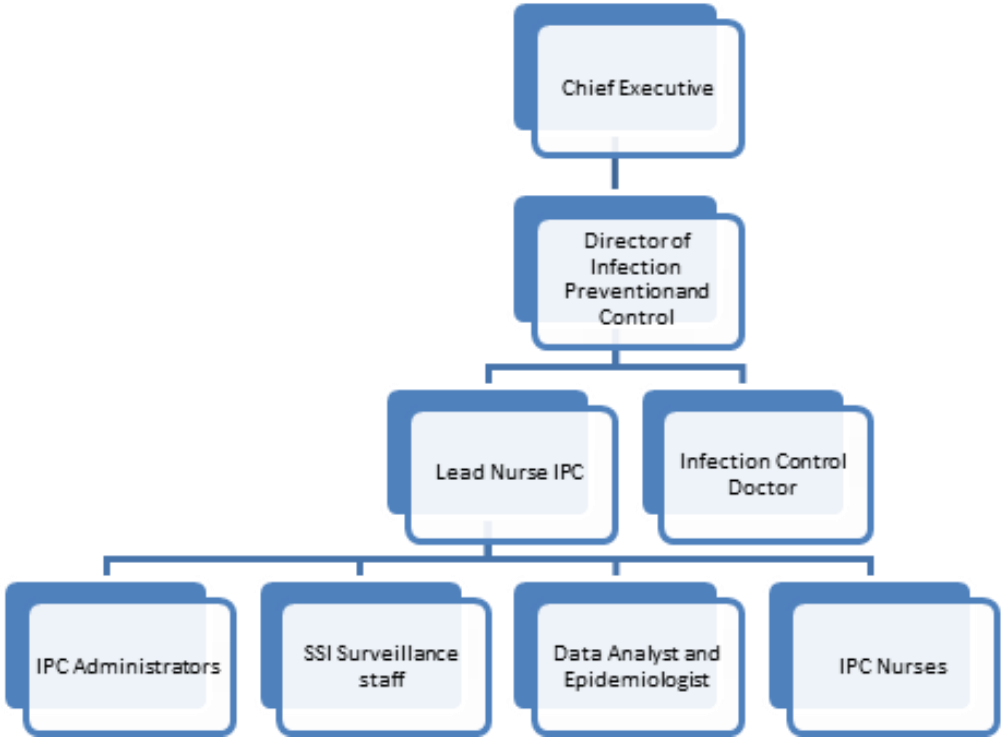
Prior to December 2014, there was a full time band 7 IPC specialist Nurse in post. In order to ensure good succession planning a new part time band 6 training post was introduced, and so the band 7 was replaced with 0.5wte band 7 specialist nurse and a 0.5wte band 6 IPC nurse who is keen to undertake her training in IPC in order to become a specialist nurse.

In addition, 4 pa's of a Consultant Microbiologist who is the Trust's Infection Control Doctor and the lead Microbiologist for the Bone Infection Unit are purchased from a large tertiary referral hospital nearby.

The Director of Infection Prevention and Control is Mr Garry Marsh, Director of Nursing and Clinical Governance at ROHFT.

The Team structure is shown overleaf:

IPC Team Structure 2015-16



Infection Prevention and Control

Budget:

Pay Budget: £354,941

Non Pay Budget: £102,028

At the end of the year the overall budget was £10,673 underspent due to the decision not to backfill maternity leave between November and the year end. Plans are in place to recruit to this gap at the beginning of the new financial year.

Reporting arrangements:

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

Director of Infection Prevention and Control /Director of Nursing & Clinical Governance (Chair)

Clinical Microbiologist / Infection Control Doctor

Lead Nurse IPC / Bone Infection Unit – (Deputy Chair)

Consultant Orthopaedic Surgeon x2

Consultant Anaesthetist

Birmingham Cross City CCG, Infection Prevention Practitioner

Public Health England representative

Head of Estates and Facilities

Decontamination Lead

Theatres Representative

The committee reports to the Quality and Safety Committee which in turn reports to the Trust Board. The Terms of Reference were reviewed and agreed in February 2016. Several significant changes have been made:

- The DIPC role has moved from the Medical Director to the Director of Nursing and Clinical Governance.
- The meeting is now attended by a Matron who collates a formal report from all divisional matrons for scrutiny by the committee.
- The Facilities Manager provides a comprehensive report and cleanliness is monitored very closely by the committee as a standing agenda item.

An Operational Group link meeting is held every two months and is chaired either by the Lead Nurse for Infection Prevention and Control (IPC) or the IPC Specialist Nurse. The Operational Group consists of link workers from all clinical departments and representatives from facilities. They are supported by the ward or departmental managers who ensure they are given protected time each month to complete the audits required.

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

agreement.

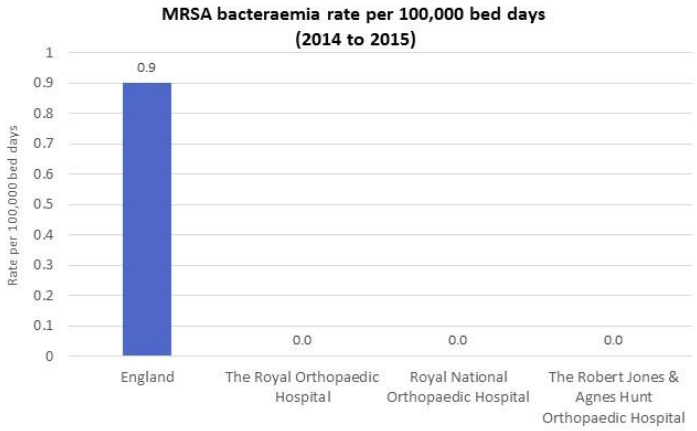
Mandatory Surveillance of Healthcare Associated Infections (HCAI)

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 methicillin-resistant *Staphylococcus aureus* (MRSA) and methicillin- sensitive *Staphylococcus aureus* (MSSA) bacteraemias as well as *Clostridium difficile*, *E.coli* and glycopeptide-resistant enterococcus (GRE). There is a surveillance scheme for monitoring Surgical Site Infections (SSI) and this is covered in more detail within the SSI section of this report.

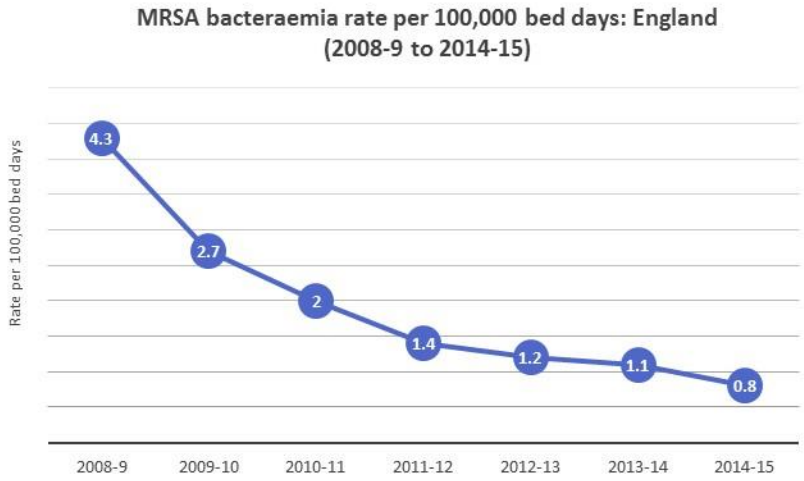
The graphs in this section show the organisms that have a mandatory reporting mechanism attached to them and highlight ROH in orange, all England rates and other specialist orthopaedic trusts are in blue and these have been included to give context and to enable benchmarking.

In 2015-16, all targets were achieved for mandatory surveillance once avoidability had been agreed by the lead commissioners for the Trust (Birmingham Cross City Clinical Commissioning Group).

- **MRSA**



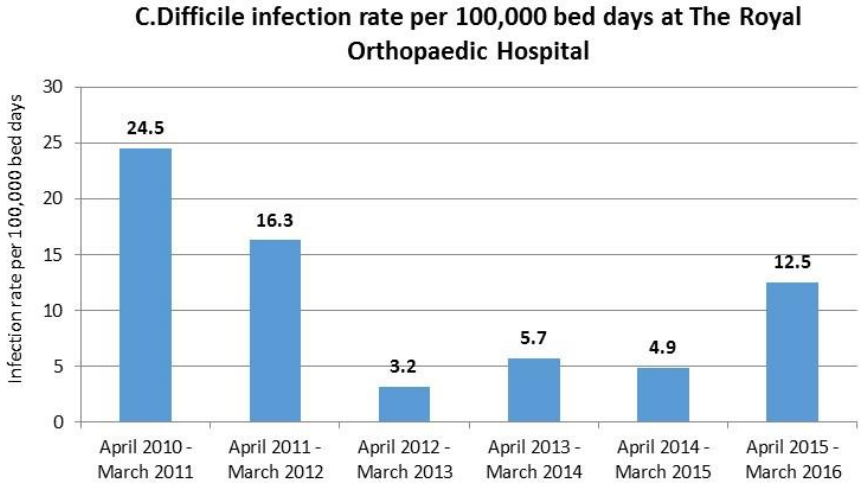
Source: Public Health England (2015 c.)



There have been no MRSA bacteraemias at ROHFT since May 2008. This is against a national picture of a continual year on year reduction of MRSA bacteraemia cases across England. In 2014-15, there were just 320 cases of MRSA bacteraemia reported in England.

- ***Clostridium difficile***

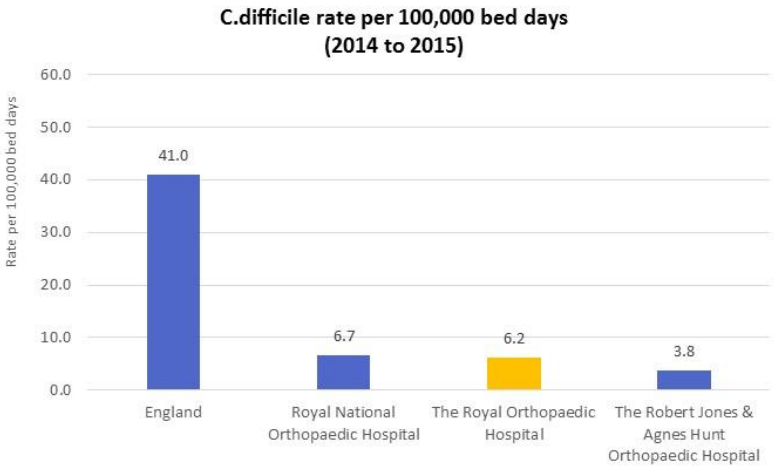
97 faecal samples were sent from patients with diarrhoea and in 6 cases these were toxin positive for Clostridium difficile and were therefore reportable. These six cases reported by the Trust this year, were all were fully investigated and avoidability was discussed with the lead commissioners, who deemed that all cases were unavoidable. All patients received appropriate antimicrobials according to the Trust antimicrobial policy throughout their stay.



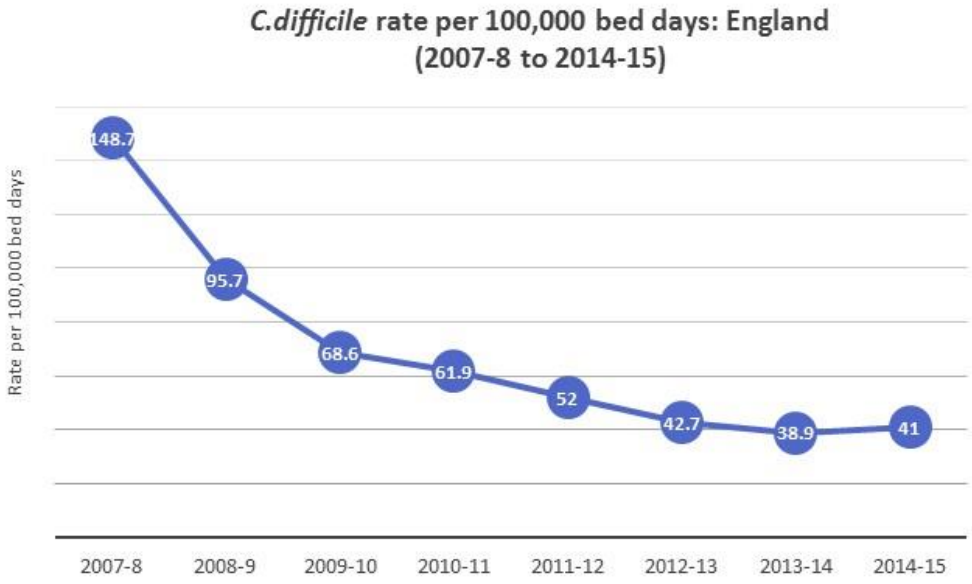
Source: Public Health England (2015 b.)

The graph above details the rate per 100,000 bed days over the past 6 years.

The graph below shows the previous year's data as 2015-16 national *C.difficile* data will not be published by the Office for National Statistics until July 2016. This compares ROH with other Trusts including other Specialist Orthopaedic Trusts and the England rate is also included, for context. ROH is identified in orange.



Source: Public Health England (2015 b.)



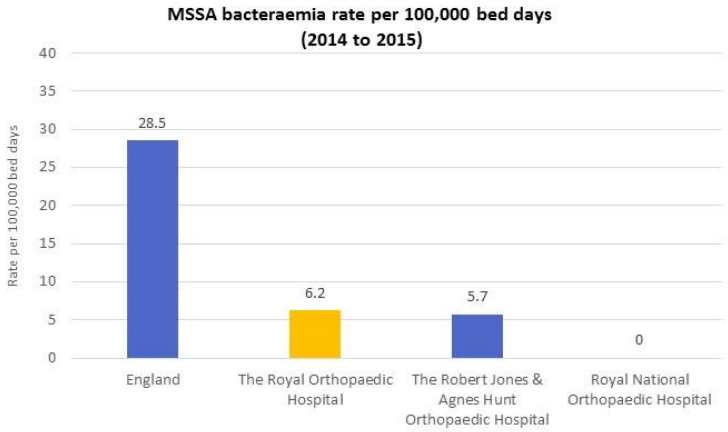
The graph above shows the overall reduction in *C.difficile* cases reported in England between 2007-8 to 2014-15. Rates of infection have consistently fallen year on year until 2012-13 where rates have maintained at a rate of around 40.0 cases per 100,000 bed days nationally.

A total of 14,165 cases of C. difficile infection were reported across the NHS between April 2014 and March 2015 (2014/15). This represents a 6.0% increase compared to the number of cases reported in 2013/14 when 13,361 cases were reported. This is the **first annual increase** in *C. difficile* infections since the enhanced mandatory surveillance of *C. difficile* infections was initiated in 2007[1]

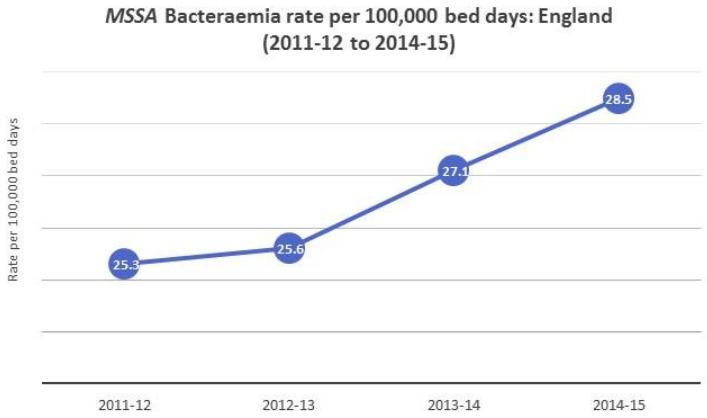
- ***MSSA***

[1] Public Health England (2015) **Annual Epidemiological Commentary:** Mandatory MRSA, MSSA and *E. coli* bacteraemia and *C. difficile* infection data, 2014/15, [Online],Accessed: 26/04/2016 Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/442952/Annual_Epidemiological_Commentary_FY_2014_2015.pdf

There was 1 pre 48 hour MSSA bacteraemia reported in May 2015. This was investigated and avoidability was difficult to determine due to some gaps in documentation at a ward level.



Source: Public Health England (2015 d.)

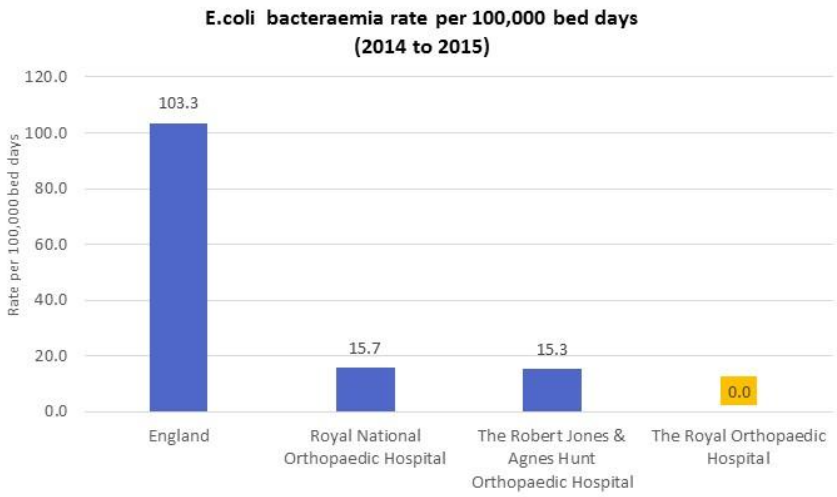


There has been a year on year increase in MSSA bacteraemias reported in England since this was included in Mandatory Surveillance. Perhaps most interestingly it has been reported nationally that 71.6% of all MSSA bacteraemias are classified as non-hospital onset[2], this could be suggestive of a higher rate of carriage of this microorganism within the community. It has been reported that approximately 1 in 5 MRSA and MSSA bacteraemias are associated with skin and soft tissue infection[1]. Public Health England have reported that more work needs to be undertaken, particularly in the wider health economy to focus on reducing the carriage rate within the wider community.

- ***E.coli***

There were 3 E.coli bacteraemias reported at ROH this year, 2 cases (May and October) were deemed avoidable due to gaps in documentation at a ward level and a further unavoidable case occurred in March 2016.

[2] [2] Public Health England (2015) **Annual Epidemiological Commentary:** Mandatory MRSA, MSSA and *E. coli* bacteraemia and *C. difficile* infection data, 2014/15, [Online],Accessed: 26/04/2016 Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/442952/Annual_Epidemiological_Commentary_FY_2014_2015.pdf



Source: Public Health England (2015 a.)

- **GRE**

There were no cases of GRE reported at ROH this year.

Compliance with Contractual requirements

Environmental audit results

The Trust implemented the Infection Prevention Society (IPS) Quality Improvement Tools (QIT) in April 2014. These amalgamate the requirements of all significant national documents and incorporate the guidance described within these documents, including the Department of Health (DH) Saving Lives guidance, DH Health Technical memorandums and Health Building Notes; Association for perioperative practice (AfPP); the national specifications for Cleanliness in the NHS; EPIC and many other national guidance documents. The Trust purchased an electronic system in the hope that it would reduce the administration time associated with these audit tools, but unfortunately the system has not proved to be easy for link workers to use, despite repeated attempts at teaching. The IPC team data analyst and epidemiologist has the skill to build intuitive, easy to use databases and is working on an alternative system that is simple to use, it is hoped that this will be ready to use by the end of the summer 2015.

The facilities team is managed by the Head of Estates. The service is managed in house and includes a 'Blitz team' who provide enhanced cleaning to all inpatient areas once a week in addition to the usual level of cleaning. The Facilities team utilise the credits for cleaning system for auditing their activities.

Themes identified via the IPS QIT tools:

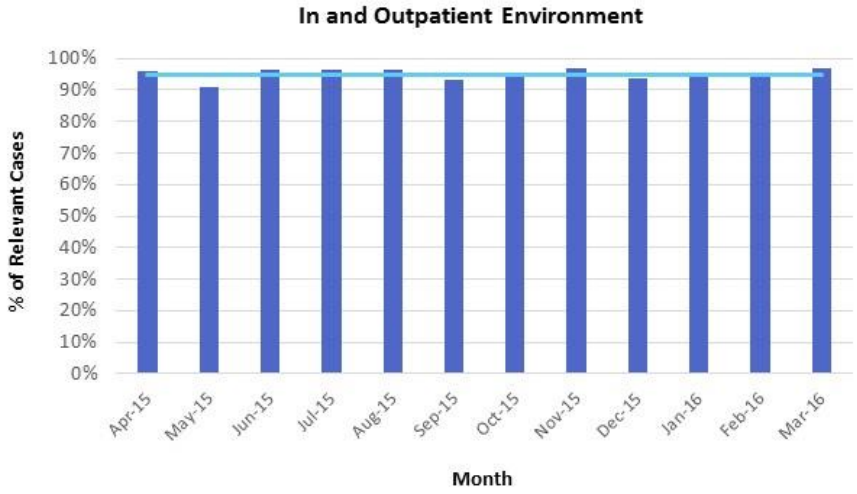
- Lack of storage in some areas resulting in equipment being stored on the floor.
- Some estates issues relating to damage to walls / floors/ work surfaces
- Sharps bins – temporary closure mechanisms not always utilised

- Some areas have fabric chairs in staff areas, rather than the impermeable fabric required by IPC.
- A lack of replacement programme for some equipment e.g. Bins.
- Some nursing equipment found to be dusty e.g. suction equipment, drip stands, fans, keyboards

The contractual requirement for environmental standards (as determined by the IPS QIT tools completed by the link team in all clinical areas) is 95%. This has been difficult to achieve consistently throughout the year and is not assisted by the subjective nature of the issue.

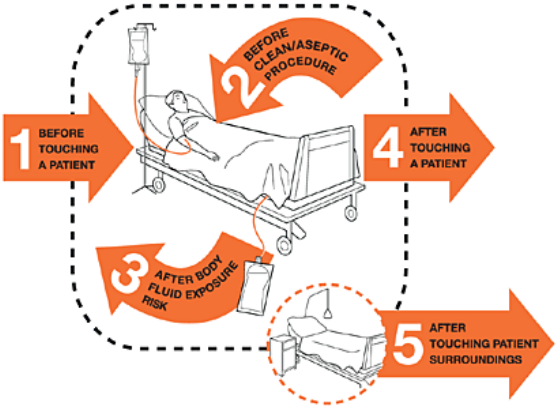
There are 2 levels of audit utilised at ROHFT. The rapid improvement tool (RIT) audits are undertaken by the link team; these are relatively quick tools to complete which provide a good overview of the environmental standards. A more thorough, in-depth tool is utilised twice a year in inpatient areas (and once a year in outpatient areas) by the Infection Prevention and Control Team as suggested by the Infection Prevention Society in their guidance when the tools were launched in 2014. This process improvement tool (PIT) looks more closely at all aspects of the environmental standards, encompassing estates issues etc.

The graph overleaf shows the scores reported to the commissioners throughout the year:

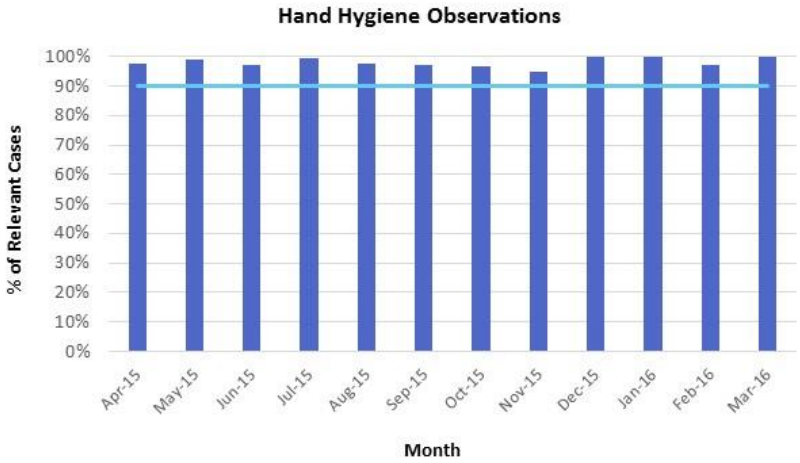


Hand Hygiene audit results:

Hand Hygiene is taught and audited according to the World Health Organisation's 5 Moments (shown below). This method concentrates on ensuring good practice at the point of care, therefore improving outcomes for patients by reducing cross infection.



The graph below details the scores achieved across all clinical areas throughout the year:



Themes identified during Hand Hygiene Audits:

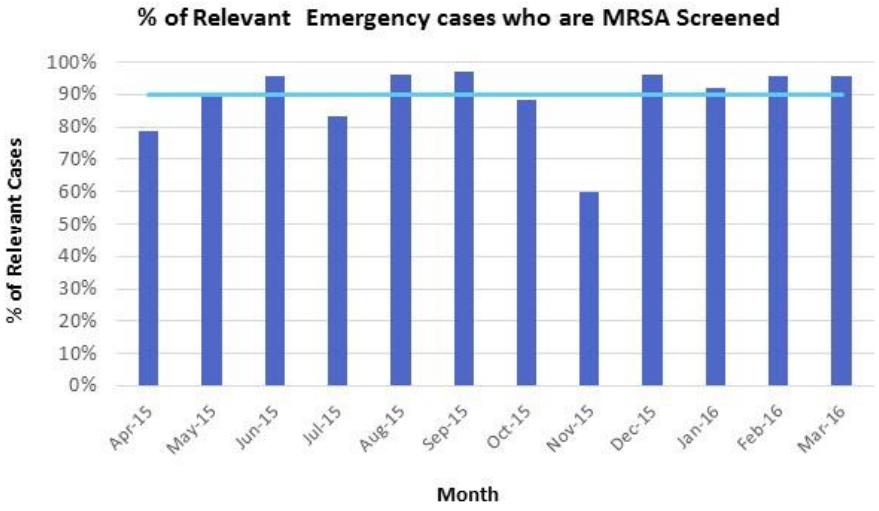
Not all staff observe bare below the elbow;

- Wristwatches and stoned rings are still seen.
- Not all medical staff adhere - wearing long sleeves with cufflinks / jackets
- Not all staff adhere to the 5 moments at all times

The Deputy Director of Nursing is currently reviewing the Trust's Uniform Policy – this clarifies the Trust's exact requirements for all staff and will strengthen the management of any non-compliance.

<u>MRSA screening – emergency admissions</u>

All emergency admissions are required to be isolated and screened on admission. Once a clear screen is obtained there is no need to continue their isolation. The number of emergency admissions is relatively small each month (less than 20 patients) and so each case is individually reviewed and where necessary the admitting nurse and ward manager contacted if a deficiency is noted.



MRSA screening for elective cases is undertaken utilising a risk assessment approach. An assessment tool is completed at the 'Rapid' stage of pre-operative assessment and if required a screen is undertaken.

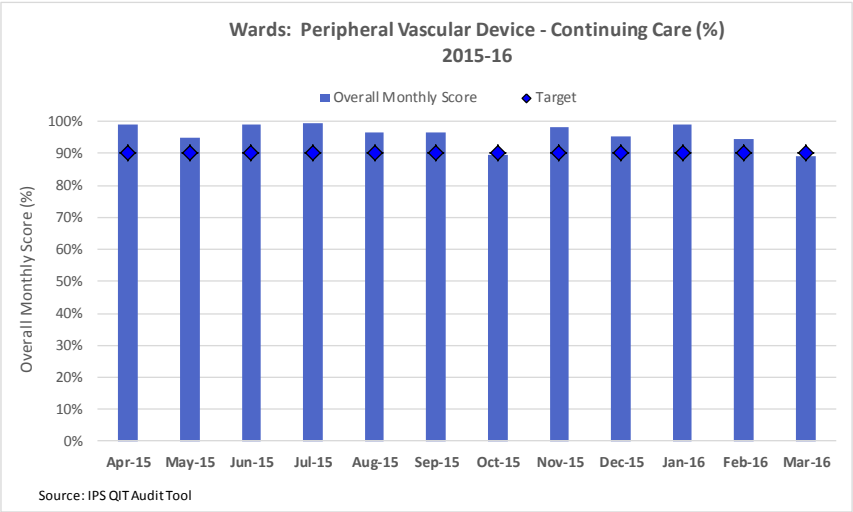
As a baseline all patients meeting the following criteria are screened prior to admission patients requiring overnight stay

- Any patients where metal work is due to be inserted (no matter how small)
- Patients from a nursing home or residential care
- Patients who work in healthcare or who have contact with carers at home

Any positive cases are decolonised wherever possible ahead of admission and surgery.

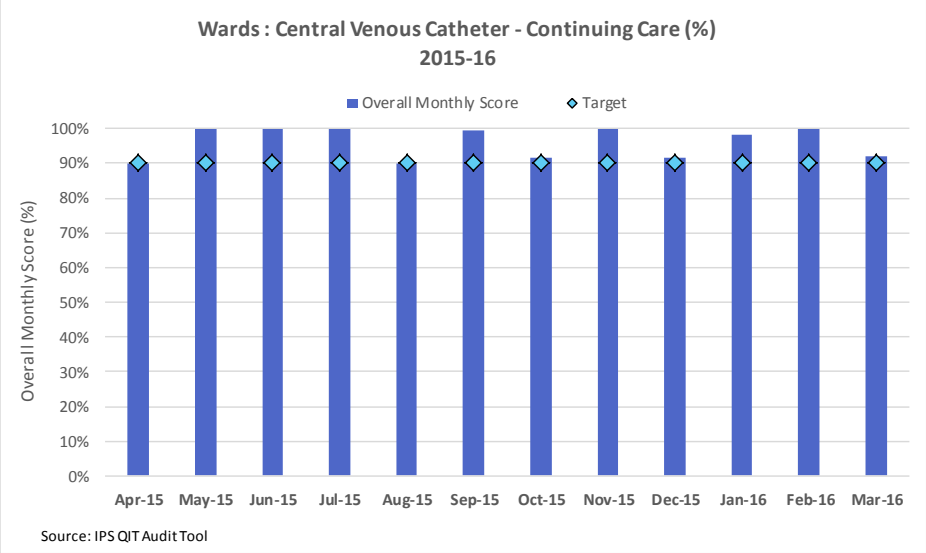
<u>Peripheral venous cannulae care:</u>

Care of peripheral cannulae is audited each month in all inpatient areas where it is applicable. A target of 90% against the IPS audit tool is required.



Central Venous Catheter care:

Care of central venous catheters is audited each month in all inpatient areas where applicable. A target of 90% against the IPS audit tool is required, and a minimum of 20 observations must be submitted per month. Unfortunately the Trust was the subject of a Contract Performance Notice due to failure to submit enough observations each month. Following the implementation of additional scrutiny compliance was consistently achieved and the contract performance notice was lifted. The required information has been consistently submitted and the standards maintained. The graph below shows that the compliance with the care provided was maintained although the number of observations fell below the contractual target.



Hygiene Code Compliance:

The Trust was last fully inspected by the Care Quality Commission in June 2014. The full report can be accessed using this link: http://www.cqc.org.uk/sites/default/files/new_reports/AAAA2989.pdf

Their findings included the following statements:

'Staff followed good infection control practices. The hospital was clean and well maintained, and infection control rates in the hospital were low.'

'The number of pressure ulcers, falls and catheter related infections were significantly lower than the England average…'

There is always room for improvement and a capital expenditure plan is in place to ensure the upgrade of theatres continues.

An updated version of the Hygiene code (Health and Social Care Act 2008 – Regulations 2015 came into force in March 2015, the requirements of this formed the basis of the Trust's 2015-16 Infection Prevention and Control annual plan as outlined in Appendix 1 on page 38.

Estates Update - Information provided by Stuart Lovack - Head of Estates

- **Plaster Room Relocation:** The Plaster Room which was located adjacent to Theatre 4 has been relocated outside of the Theatre Complex. The new facility has been designed with full medical gas provision and is serviced by an independent supply and extracts system. This has helped reduce some of the unnecessary staff and patient movement within the theatre complex.

- **Alcohol Hand Gel placement:** Following the most recent visit from the CQC additional alcohol hand gel was provided within the outpatient department. Although it was available at the point of care in every part of the department, the inspectors requested additional gel was provided for use in public areas.

- **Theatre Improvement Works:** The relocation of the Plaster room has enabled theatre improvement works to be undertaken. The works will be completed in phases, phase one will include the provision of new Male Staff Change facilities, phase two will be the provision of new Female Staff Change facilities. The final phase will provide improved Blood Bank, Theatre Office and Welfare facilities. This work will continue into 2016-17.

- **Replacement X-ray Equipment:** All the X-ray equipment over the last 18 months has been replaced including the CT Scanning machine and Fluoroscopy machine. The X-ray Department has full digital capability.

- **Legionella Works**: Improvements to the water distribution systems on site have taken place based on our legionella risk assessment.

- **Asbestos Removal:** Asbestos containing material has been removed from the site using an approved asbestos contractor, the main area of focus being Block 07.

- **Demolitions**: Old Ward 7 and the Gymnasium have now been demolished; the area has been levelled and is really for any future development.

- **Lift Replacement:** A new fully compliant bed / passenger lift is being installed in Block 27, the work is programmed to complete in the summer of 2016.

- **Replacement Windows**: A phased window replacement programme is underway, new windows continue to be fitted to our guest accommodation in the Nurses Home.

- **External Works:** Improvements have been made to the external areas of the estates which include re-surfacing works to footpaths and roadways including Entrance A and the area adjacent to our High Dependency Unit. DDA works have been undertaken to make access areas and points more user friendly and extensive works have been undertaken to our trees, grounds and gardens.

- **Cadbury's House:** A refurbishment programme has been completed to improve the accommodation in the Management building (Block 07)

- **Theatre Maintenance Programme**: A maintenance programme of works has been carried out in our Theatres complex; Theatres 1, 2 and 4 have been recently completed. The works have included additional works associated with replacement operating lights and new floor coverings to Theatre 1.

- **Ward 3:** Due to some movement of the sectional building within the Treatment centre, cracks developed in the flooring along the length of the orthopaedic oncology ward. This was replaced following closure of the ward to enable the works to take place safely.

Decontamination – Information provided by S. Johnson – Decontamination lead

The Royal Orthopaedic Hospital NHS Trust has a decontamination unit consisting of a R.O plant (Reverse Osmosis) washer, Autoclave and endoscope unit. The unit is primarily used for Loan Kits and dropped Instruments or breached trays; all other items used are decontaminated by B Braun Sterilog based in Kings Norton. It complies with CFPP 01 and CFPP 06.

The management and compliance of this department is overseen by the Trust AED Keith Shuttleworth who undertakes an annual audit to monitor compliance. This is managed by Estates and Theatres.

In order to gain assurance regarding the management and usage of the reverse osmosis plant, and washer disinfector a formal review of the onsite decontamination service is due to take place in early 2016-17.

Surgical Site Infection Surveillance

Introduction

Surgical Site Infections are a particularly important Healthcare-associated Infection (HCAI) because they can increase a patient's length of stay in hospital and *"are associated with considerable morbidity and it has been reported that over one-third of postoperative deaths are related, at least in part, to SSI. However, it is important to recognise that SSIs can range from a relatively trivial wound discharge with no other complications to a life-threatening condition"* NICE (2008)[3].

Guidelines for the prevention of SSI were issued by the National Institute for Heath and Clinical Excellence (NICE) in the UK, updated in 2013, and accompanied by a High Impact Intervention (HII) from the Department of Health. These guidelines are outlined in the following table. Since 2011, many of these recommendations have been implemented at ROHFT with further additional adjustments made that go above and beyond the National Guidance; the wound care helpline is a good example of this.

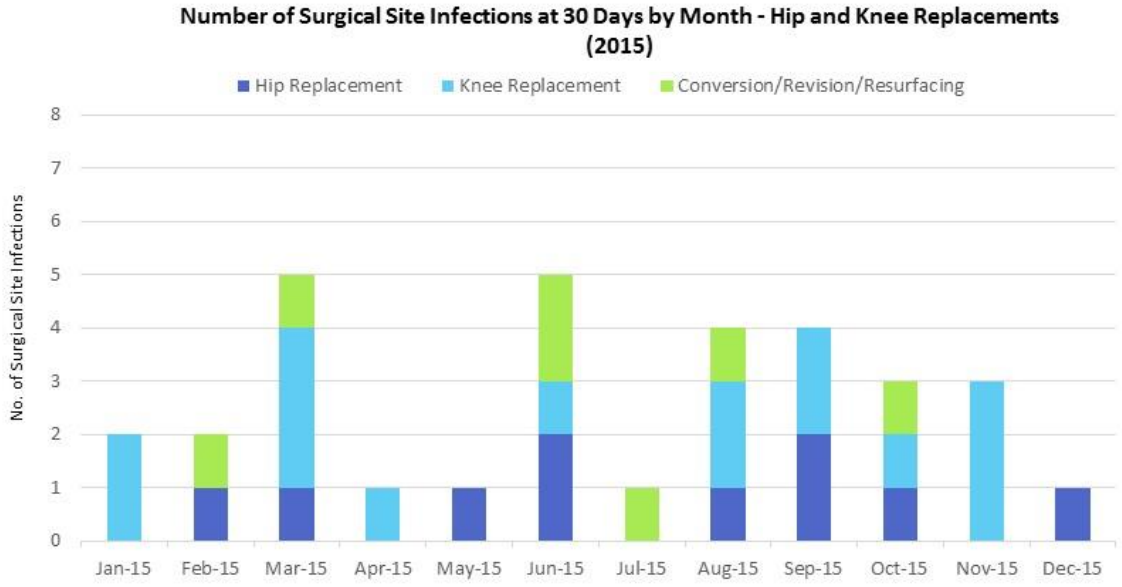
Period	Action	Evidence
Pre-operative	Showering	+ / -
	S.aureus decolonisation	+ / -
Peri-operative	Antibiotic prophylaxis	+
	Skin preparation	+
	No shaving with razors	+
	Theatre environment/procedures	+
	Surgical technique	+
	Normothermia	+
	Glucose control	+
Post-operative	Wound management	+ / -
	Surveillance and feedback of rates	+

Primary arthroplasty surgery is constantly reviewed and monitored as part of the SSI surveillance programme at The Royal Orthopaedic Hospital NHS Foundation Trust (ROHFT). Surgical Site Infection (SSI) surveillance is routinely carried out according to Public Health England (previously the Health Protection Agency – HPA) protocol at the point of discharge from hospital and at 30 days post primary hip and knee replacement surgery and has received close attention since 2009 when the 30 day surveillance was introduced.

The data presented within this report is a combination of Mandatory surveillance data for Surgical Site Infections identified following Hip and Knee Replacement surgery carried out between January and December 2015 and wider analysis surgical site infections in other specialties where it is available. In addition to this there is also in-house data collected by the Infection Prevention and Control Team, which looks at a number of other areas of interest. This enables the team to gain an informed understanding of Surgical Site Infections across all directorates and the potential for them to have longstanding implications for patients and significant financial implications for the trust.

[3] NICE (2008) "**Surgical site infection prevention and treatment of surgical site infection",** [Online] Available from: https://www.nice.org.uk/guidance/cg74

Surgical Site Infection Surveillance 2015: Primary Hip and Knee Replacements



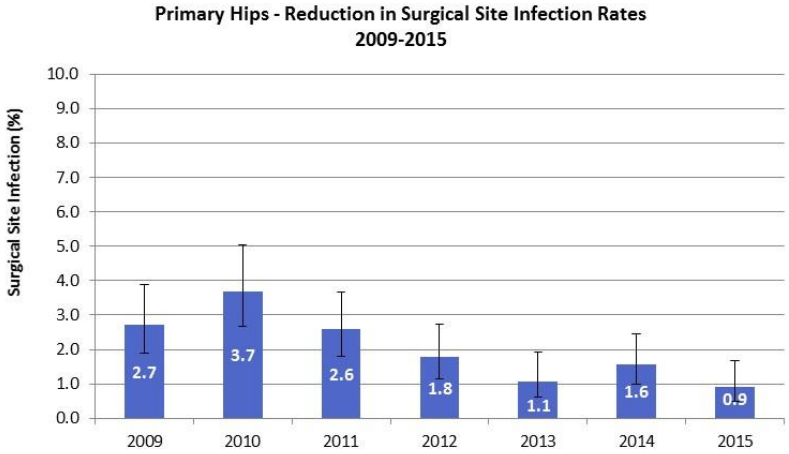
There were a total of 32 Surgical Site Infections in patients who underwent Hip and Knee replacement surgery at the Royal Orthopaedic Hospital NHS Foundation Trust between January and December 2015. The highest number of SSIs were seen in the months of March (n.5) and June (n.5) which accounted for 31.2% of all infections overall. There were consistently higher numbers of Surgical Site Infections reported between August and November 2015.

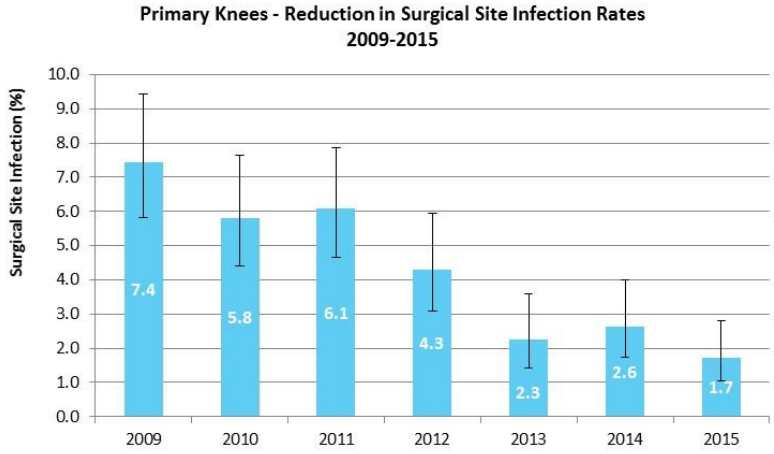
There are a small number of patients who fit the criteria for an SSI set by Public Health England (PHE) but on further investigation, either through a visit to the SSI clinic, visit at home by the Royal Orthopaedic Community Service or through discussion with the GP it is suspected that these cases were not 'True SSIs'. An area of concern is that GP's sometimes prescribe antibiotics as a precautionary measure and this makes the classification of SSIs difficult on some occasions as they fit the PHE criteria for an SSI because they have been prescribed antibiotics yet the antibiotics were 'precautionary' rather than for an active infection.

Similarly, there have been some instances where SSIs have been incorrectly classified as 'stitch abscesses', which under current PHE guidance are not to be included in the mandatory surveillance. There is some debate as to whether these should be monitored as the team feel that these are infection because they can relate to the subcutaneous layers and not the skin as the PHE criteria suggests. The team plan to monitor stitch abscesses to ascertain whether these patients present as deep infections further down the line.

A stitch abscess is classified by PHE as being *"Minimal inflammation and discharge confined to the points of suture penetration and localised infection around stab wound"* however some surgeons class patients as having a stitch abscess when the subcutaneous sutures cause the skin layer to open, requiring a washout to clear residual collections. Clarification is required to ensure that the correct term is utilised, as these appear to be SSI's, not stitch abscesses.

ROH Surgical Site Infection: Primary Hip and Knee Replacements Only – 30 Day Rate





In 2015, a total of 25 Surgical Site Infections for Primary Hip and Knee replacements were reported. 2015 has seen the lowest rates of infections in Primary Hip and Knee Replacements at 30 days since surveillance began in 2009.

There has been a significant reduction in SSI's for Primary Hip Replacements where rates have fallen from 2.7% (CI: 1.9 to 3.9) in 2009 to 0.9% (CI: 0.5 – 1.7) in 2015, which equates to a reduction of 65.5% over a seven year period. In Primary Knee Replacements rates have fallen from 7.4% (CI: 5.8 – 9.4) in 2009 to 1.7% (CI: 1.0 – 2.8) in 2015, which equates to a reduction of 75.8% over a seven year period. However, overall there are still a higher number of SSIs for Primary Knee Replacements when compared to Primary Hip Replacements. This needs careful correlation with the separate deep infection rate information discussed later in this report.

The team feel that the reduction in SSIs is reaching an irreducible minimum based on the multitude of interventions that have been put in place as recommended in national guidance. The focus this financial year is to look continue improving standards in Theatres and to review surgical practice to improve SSI rates further.

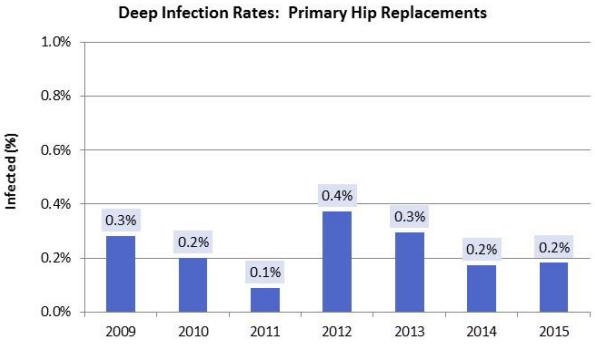
A range of measures were introduced at different times to reduce the rate of SSI rates at the ROHFT. This included the introduction of antimicrobial sutures, 2% chlorhexidine, antimicrobial ioban incise drapes and Aquacell dressings, introduction of Wound Care Helpline, as well as providing training and education to all clinical staff to raise awareness of SSI prevention in conjunction with an improvement in monitoring and surveillance of SSIs would have contributed towards the reduction in SSI rates.

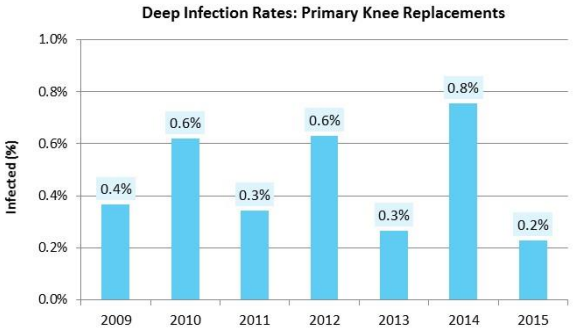
Infection Type: Deep/Superficial – Primary Hips and Knees

Surgical Site Infections are classified as either Superficial or Deep infections based on the criteria used for the mandatory Surveillance of Surgical Site Infection produced by Public Health England[4].

> ***Superficial incisional infection:*** *a surgical site infection that occurs within 30 days of surgery and involves only the skin or subcutaneous tissue of the incision, and meets at least one of the PHE criteria for superficial incisional infection.*
>
> ***Deep incisional infection:*** *a surgical site infection involving the deep tissues (i.e. fascial and muscle layers) that occurs within 30 days of surgery if no implant is in place, or within a year if an implant is in place and the infection appears to be related to the surgical procedure, and meets at least one of the PHE criteria for deep incisional infection.*

The proportion of deep infections for Primary Hip replacements at 30 days have remained static from 0.2% in 2014 and at 0.2% in 2015. It is encouraging to see that the proportion of deep infections for patients who have undergone Primary Knee replacement, decreased from 0.8% in 2014 to 0.2% in 2015.





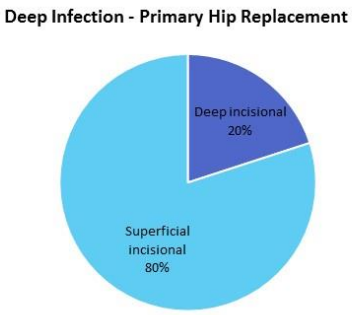
No. of Deep Infections	2009	2010	2011	2012	2013	2014	2015
Primary Hip Replacements	3	2	1	4	3	2	2
Primary Knee Replacements	3	5	3	5	2	6	2
No. of Procedures	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Primary Hip Replacements	1068	1004	1123	1074	1017	1160	1098
Primary Knee Replacements	821	808	873	793	751	795	873
Deep Infection Rate	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**
Primary Hip Replacements	0.3%	0.2%	0.1%	0.4%	0.3%	0.2%	0.2%
Primary Knee Replacements	0.4%	0.6%	0.3%	0.6%	0.3%	0.8%	0.2%

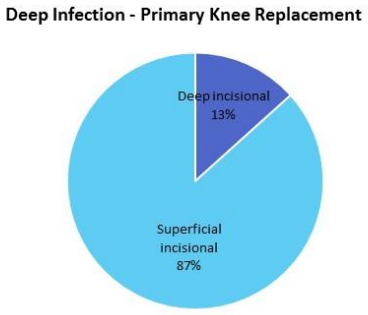
The average (median) age of all patients who had a deep infection following Primary Hip Replacement or Primary Knee Replacement was 65 years old (range: 59-77) all patients were male. The average length of stay for patients during their primary surgery was 6 days (median, Range: 3-14).

There were a total of 4 deep infections (16%) and 19 superficial infections (76%). There were differences in the number of deep infections seen by procedure type. Around 20% of patients had a deep infection following hip replacement surgery, compared to 13% of patients who had primary knee replacement surgery. Overall the proportion of deep infections in Primary Hip and Knee replacement surgery at 30 days has seen a decrease from 21% in 2014 to 16% in 2015.

4 Public Health England (2013) Protocol for the Surveillance of Surgical Site Infection, Surgical Site Infection Surveillance Service Version 6, [online], Available from: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SurgicalSiteInfection/SSISurveillanceProgramme/

Infection Type: Deep/Superficial – Primary Hips and Knees (Continued)





Category Name	Deep incisional	Superficial incisional	Total	Deep incisional (%)	Superficial incisional (%)
Hip replacement	2	8	**10**	20%	80%
Knee replacement	2	13	**15**	13%	87%
Total	**4**	**21**	**25**	**16%**	**84%**

Of the four patients who had a deep infection, two patients had a Washout and Debridement and two had a DAIR (debridement and Implant Retention) procedure performed.

All patients were admitted under the care of the Bone Infection Unit and were prescribed an appropriate and specific treatment regime based on the organisms they grew from cultures. One patient grew a single microorganism from samples taken at the time of surgery on readmission. The remaining three patients had a polymicrobial infection. One patient had a multi-drug resistant organism.

A detailed anonymised breakdown of patients is provided on the following page for information.

Deep Infections - Breakdown

Case No.	Age	Gender	Month & Year	Time to Readmit	BIU	Readmit	Primary LOS	Readmit LOS	Primary Surgery	Primary Theatre	Readmission Surgery	Organisms	Discharge Treatment Plan
1	77	M	02_2015	18	Y	Y	14	17	Primary THR	Theatre 2	Washout & Debridement	*MRSA*	Ciprofloxacin & Rifampicin,
2	64	M	08_2015	14	Y	Y	3	21	Primary THR	Theatre 3	DAIR	*Enterococcus faecalis, Staphylococcus aureus*	Rifampicin & Co-amoxiclav
3	67	M	03_2015	17	Y	Y	4	12	Primary TKR	Theatre 2	Washout & Debridement	*Coagulase negative Staphylococcus, Staphylococcus lugdunensis*	Doxycycline & Clindamycin
4	59	M	08_2015	8	Y	Y	8	18	Primary - TKR	Theatre 1	DAIR	*Coagulase negative Staphylococcus (MDR)*	Linezolid

Note:

LOS - Length of Stay **MDR** - Multi Drug Resistant;

Readmissions within 30 Days – Primary Hip and Knee Replacements

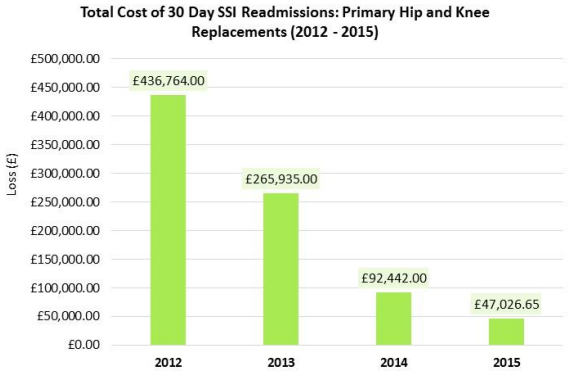
All 4 patients who had a deep infection and who had a Primary Hip and Knee replacement were unplanned readmissions to the Royal Orthopaedic Hospital NHS Foundation Trust within 30 days of their operation with patients returning on average within 16 days (Median, Range: 8-18) of having their initial surgery. The average length of stay following readmission was 18 days (Median, Range: 12 -21). This often has a devastating impact upon the patient, requires an unexpected further lengthy stay at the hospital. This affects the patient in a number of ways including the obviously poor outcome from primary surgery, potential loss of income or earnings and the potential to be put at greater risk to acquiring other Healthcare associated infections (HCAI) whilst an inpatient.

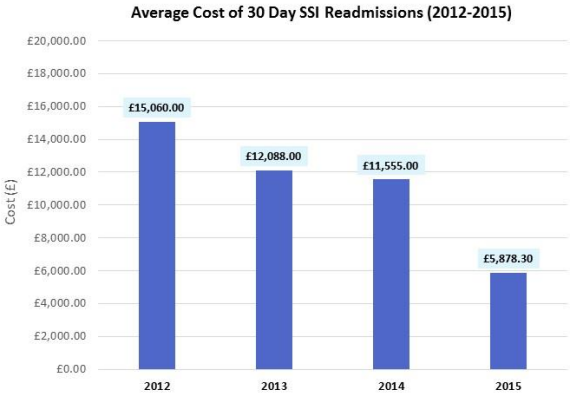
The costs of treating infections (deep and superficial) have reduced significantly over the past 3 years, this is probably due to rapid, targeted treatment being utilised and the BIU and ROCS ensuring that much of the treatment occurs in the community.

Treatment Protocols may be a sensible step to introduce, they would provide some reassurance that all patients are receiving the most appropriate treatment, no matter whose care they are under. By utilising the expertise within the BIU, as well as the existing surgical expertise, this would offer all healthcare professionals involved some protection from litigious action.

Readmissions within 1 year post-operatively – Primary Hip and Knee

There were a total of 18 readmissions for patients within 1 year following Primary Hip and Knee replacement surgery. The total cost for readmissions totalled £96,680.15 with a range of £308.50 between £33,043.13. The patient with the most costly readmission required multiple washouts and debridement and eventually a complete revision of her infected knee replacement, this patient was readmitted for 76 days.





Caveats:

Please note that this data is missing one inpatient spell who is currently an inpatient, it is estimated that this inpatient episode will be of significant cost to the trust as this patient has had a complex joint infection with a particularly resistant polymicrobial infection, which has required multiple washouts and debridement's. At the time of writing this report this patient has been an inpatient at the trust for approximately 148 days. Therefore, the overall figure quoted above for 2015 will be higher, once this data becomes available.

Readmissions within 1 year – All Readmissions for Infection

Under current contacting arrangements, patients who are readmitted as an emergency within 30 days of their discharge from hospital, do not generate income for the trust as the primary episode of care will not be paid for, neither will the inpatient spell following readmission. This ultimately results in a significant loss of income for the trust. Based on 2013, patient level costing figures the average cost of a patient readmitted with infection was £12,088 although if a two stage revision is required this costs around £52,000 per case.

Patient level costings for 2015 identify that all patients readmitted within 1 year of their primary surgery with an infection cost a total of £371,712.09 to treat. This varied between the minimum cost of £70.74 and the maximum of £60,306.99; with the average cost of a readmission for infection being £7,2883.47.

Readmissions with Infections – All Specialties

The Infection Prevention and Control Team monitor all patients who are readmitted with an infection or for suspected infection within 30 days and again within 1 year for all patients.

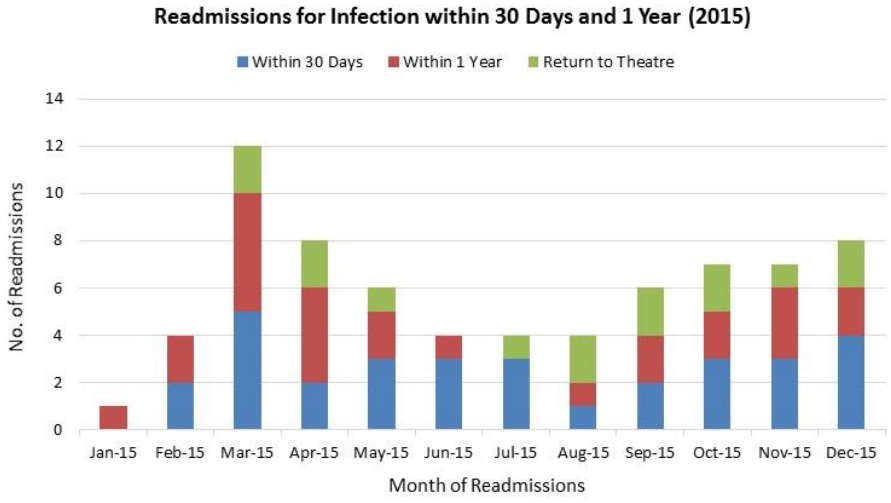
The criterion that has been used to identify patients that were readmitted for an infection or suspected infection is as follows:

1) **Infection was not present at the time of primary or initial surgery**

2) **Patients who had washouts +/- debridement or who had a readmission for infusion of IV antibiotics.**

3) **Points 1 and 2 above and those patients who were readmitted within 1 year and who had metalwork inserted.**

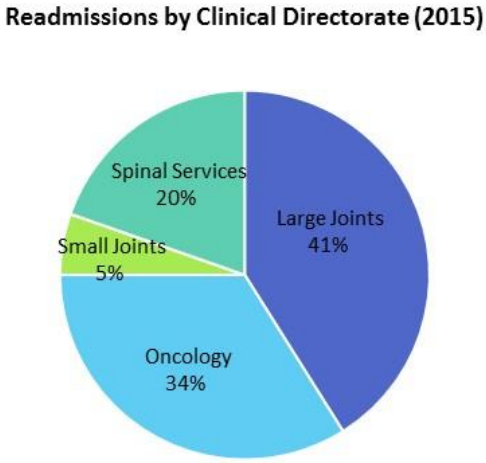
All specialties are included and readmissions are examined in this way to monitor for any emerging problems or issues that are occurring outside the mandatory surveillance of Primary Hip and Knee replacement surgery. At the current time there is no mandatory surveillance for other specialties but this is an area that the team are investigating and a business case has been submitted to extend the service to other clinical specialties.



In 2015, there were a total of 56 patients who were readmitted for infections across all specialties, where Infection was not present at the time of primary or initial surgery. Almost 55.3% of patients were readmitted

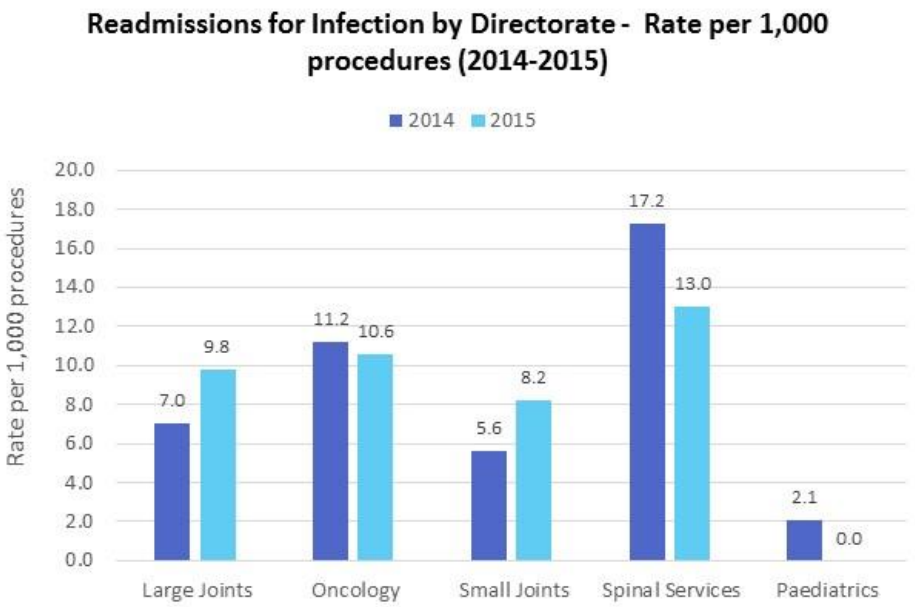
within 30 Days (n.31) and 25 patients were readmitted within 1 year (44.6%). Around 75% of patients were readmitted within 90 days (n.42).

Readmissions by Clinical Directorate – All Specialties

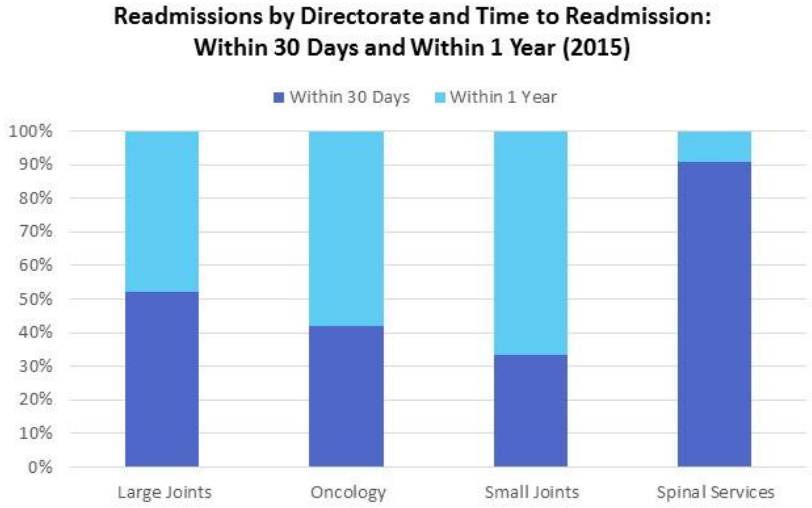


The distribution of readmissions by clinical directorate shows that the largest proportion of readmissions were for the Large Joints Directorate (41%). Around a third of patients who were readmitted were in the Oncology Directorate (34%) and approximately one in five readmissions were for patients in the Spinal Services Directorate.

It is important to consider the number of procedures that are undertaken by each directorate as this will impact upon the numbers of readmissions seen by directorate. The chart below illustrates this finding; when data is analysed by directorate and includes the number of inpatient spells† against the number of readmissions we see a different representation. The chart below shows that the rate of readmissions per 1,000 inpatient spells by directorate for 2014 and 2015. Spinal services had the highest rate of readmissions at 13.0 per 1,000 procedures carried out followed by Oncology with 10.6 readmissions per 1,000 procedures and Large Joints 9.8 per 1,000 procedures. We have noted an increase in readmissions for Small Joint infection from 5.6 per 1,000 procedures in 2014 to 8.2 per 1,000 procedures in 2015.

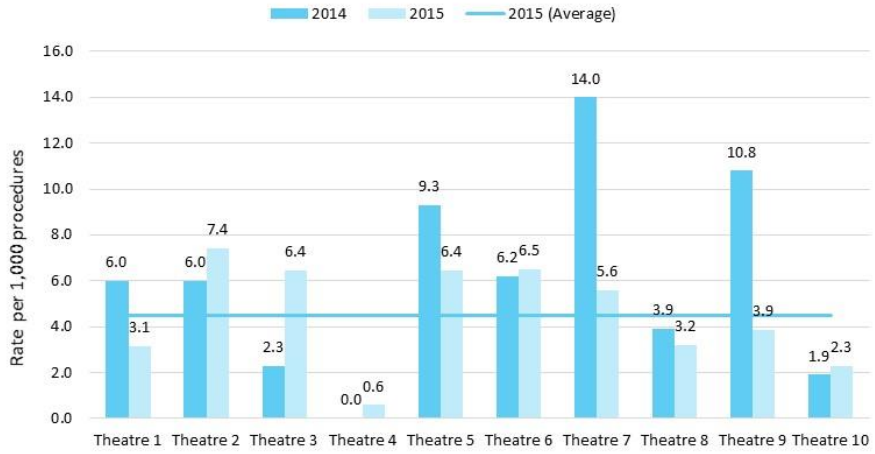


Note: †Inpatient Spells - All patients with an overnight stay **and** who had a procedure carried out. This excludes injections.



Just over half of all patients who are readmitted for infection do so within 30 days (55.3%, n.25) A 'within group comparison' showed that there were differences between clinical directorates with regards to readmissions. 90.9% of patients who were readmitted with a spinal infection were readmitted within 30 days, compared to oncology patients where around 42% of patients were readmitted within 30 days.

Readmissions with Infections: All Specialties - Rate of Readmissions by Theatre and Month (2015)



The chart above shows the rate of readmissions per 1,000 procedures (numbers of readmissions against the total number of procedures) carried out in each operating theatre, to gain a better understanding of areas of potential concern. The highest rates of readmission for infection in 2015 were in Theatres 5, 6 and 7 and also those who were operated on in Theatres 2 and 3. There has been a significant improvement in the rate of infections seen in Theatre 5, 6 and 7 compared to 2014. The IPC team arranged for the sluice door to be closed in Theatre 5 during July/August 2015, this may be one of the reasons for the reduction in infections for this particular area. However, rates of readmission for infection still remain higher within barns theatre compared to other areas.

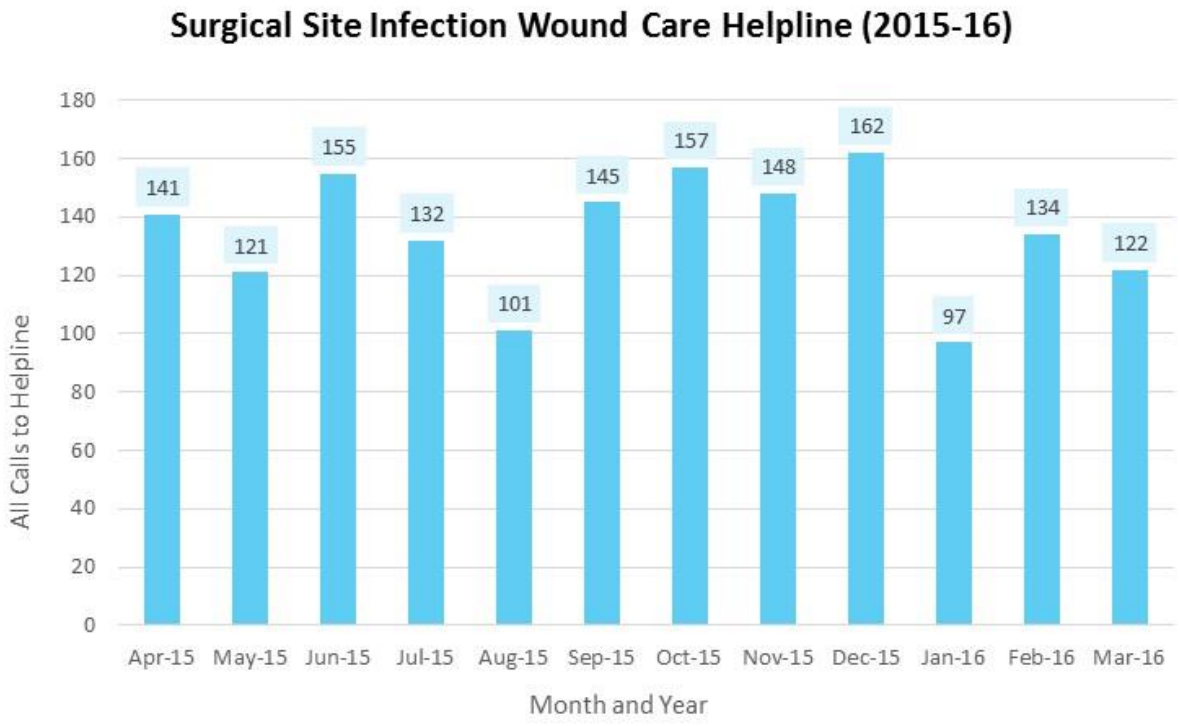
Readmissions data is monitored on a daily basis to identify trends and potential clusters outbreaks. It provides a useful insight into understanding infections at the Royal Orthopaedic Hospital NHS Foundation Trust and where potential issues may exist. However, the operating theatre where patients have their primary surgery is only a small part of the overall picture in identifying a likely source of infection.

Surgical Site Infection Wound Care Helpline

(April 2015 – March 2016)

The data below has been extracted from the Infection Control Information and Surveillance System (ICISS). All telephone calls from patients reporting issues with their wound are logged on the local database to monitor a patient's progress should they have any issues developing.

Between April 2015 and March 2016, there were a total of 1274 calls to the wound care helpline. The average number of calls received each month is 134. The highest number of calls were received in December 2015.

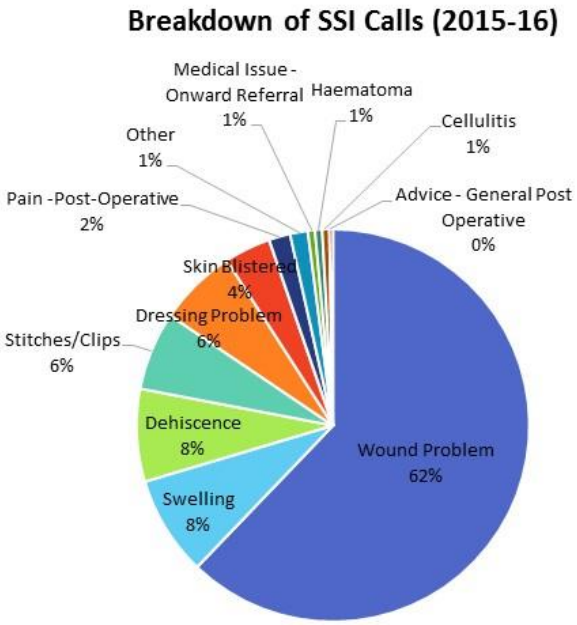


The graph above shows the total number of calls to the Surgical Site Infection helpline. The phone line receives calls about a range of different issues from patients. Patients reporting specific issues with their wounds have been analysed separately in the section below because they are recorded within the database. Calls that are more general in nature are recorded in our telephone book as our contact with that patient is usually in an advisory capacity or to signpost to another department in the Trust, nonetheless these calls do represent a workload for the team and as such have been included.

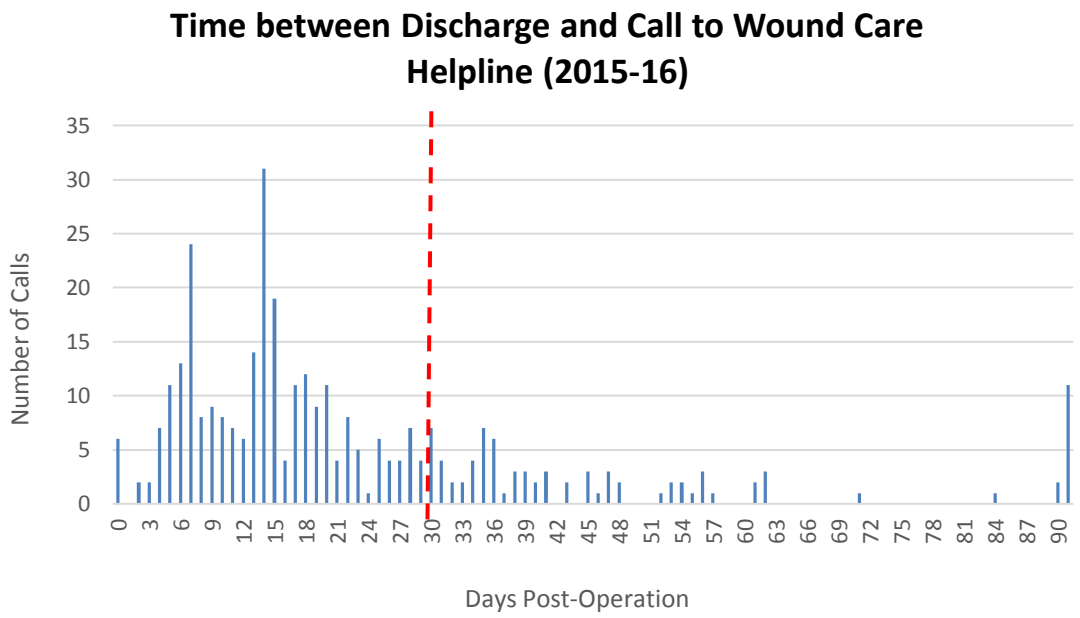
Surgical Site Infection Wound Care Helpline (Continued)

SSI Helpline – Issues with Wounds:

A total of 343 patients telephoned the SSI helpline with an issue specifically relating to their wound post-operatively. Approximately 62% of patients who experienced problems with their wound had issues that included Oozing, Redness, Heat, Pain, Swelling and Inflammation. Around 8% of patients reported post-operative swelling for which advice was given surrounding post-operative care and exercises. 6.5% of patients reported a problem with their dressing which included ooze onto dressing, dressing had fallen off, dressing was wet, there was blood staining on dressing. Around 8% of patients reported that their wound had dehisced. A small proportion of patients were referred onwards to their GP or Consultant for a medical issue that was not related to their post-operative wound. The wound care helpline regularly receives a number of calls that are unrelated to wound care or surgical site infection.



Issue	% Reporting
Wound Problem	62.2%
Swelling	8.2%
Dehiscence	7.6%
Stitches/Clips	6.5%
Dressing Problem	6.5%
Skin Blistered	3.8%
Pain -Post-Operative	1.8%
Other	1.5%
Medical Issue - Onward Referral	0.6%
Haematoma	0.6%
Cellulitis	0.6%
Advice - General Post-Operative	0.3%



- The average time between discharge and contacting the wound helpline was 27 Days. The median was 17 days.

- 19.5% were post 30 Days (67/343) - of the 67 calls post 30 Days, 70.1% were calls relating to problems with wounds or infection (47/67). This is interesting to note because around a quarter of patients (23.0%) are reporting issues with their wound after 30 days, which falls outside of the 30 day surveillance period as per Public Health England guidance. Without the wound care helpline there could be a potential for patients to receive incorrect advice or inappropriate treatment, particularly with the use of broad spectrum antibiotics to treat an infection. Surveillance has now been extended to 1 year in order to capture this data and ensure patients get the correct treatment whenever it is required.

Bone Infection Unit

Introduction

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 other infected metalwork such as pins and plates.

There have been significant advances in orthopaedic treatments including arthroplasty, endoprostheses and the surgical correction of deformities in the past decade. 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%[5]. The number of joint replacements being performed is increasing and this means that the absolute number of prosthetic joint infections is increasing this was highlighted in the report 'Getting It Right First Time' (Briggs, 2012).

The development of the Bone Infection Unit (BIU) was driven by the desire to improve the quality of care and experience for patients undergoing treatment for bone infection. The BIU operates as a 'virtual' unit and manages patients both in the hospital and in the community from all over the UK, and even abroad.

The management of prosthetic joint infection is 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. Each patient requires a tailored approach because they may grow different microorganisms in their wounds and require a different surgical and or antibiotic regime from another patient.

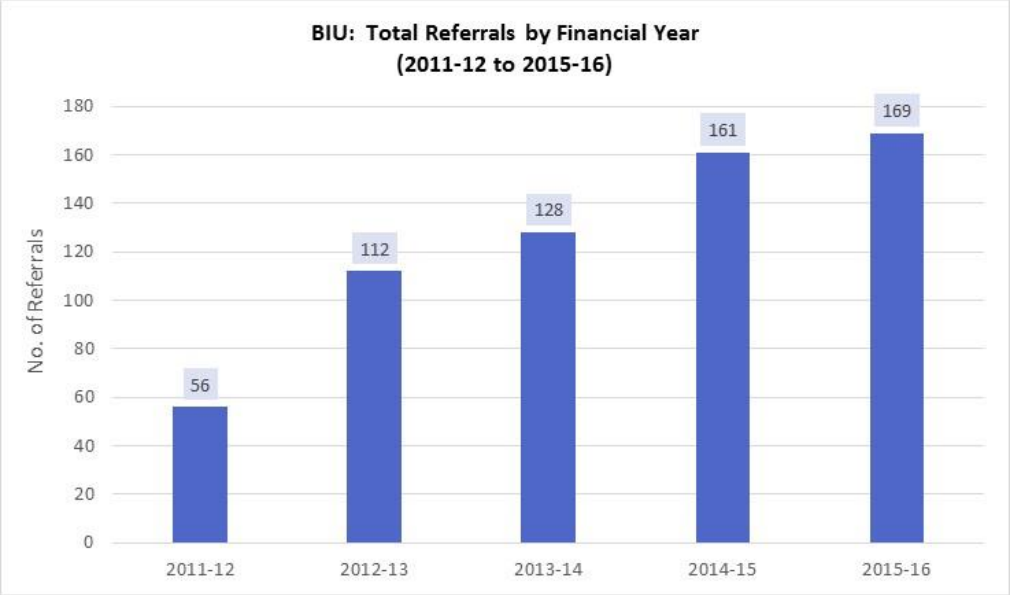
The pathway for each BIU patient is determined at the multidisciplinary meeting held once a week. The team consists of Consultant Clinical Microbiologist, Consultant Orthopaedic Surgeon, Antimicrobial Pharmacist and specialist nurses from IPC and Tissue Viability with access to consultant physicians where necessary. Prior to the introduction of the BIU all patients received a six week course IV antibiotics. Treatment of patients with or 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 a prosthesis to receive six weeks of antibiotic therapy and those with a retained prosthesis a three month course of antimicrobial therapy. Both of these pathways begin after an initial period as an inpatient receiving IV antibiotics for 2 weeks. The complexity of dealing with biofilm is the primary reason for the differentiation.

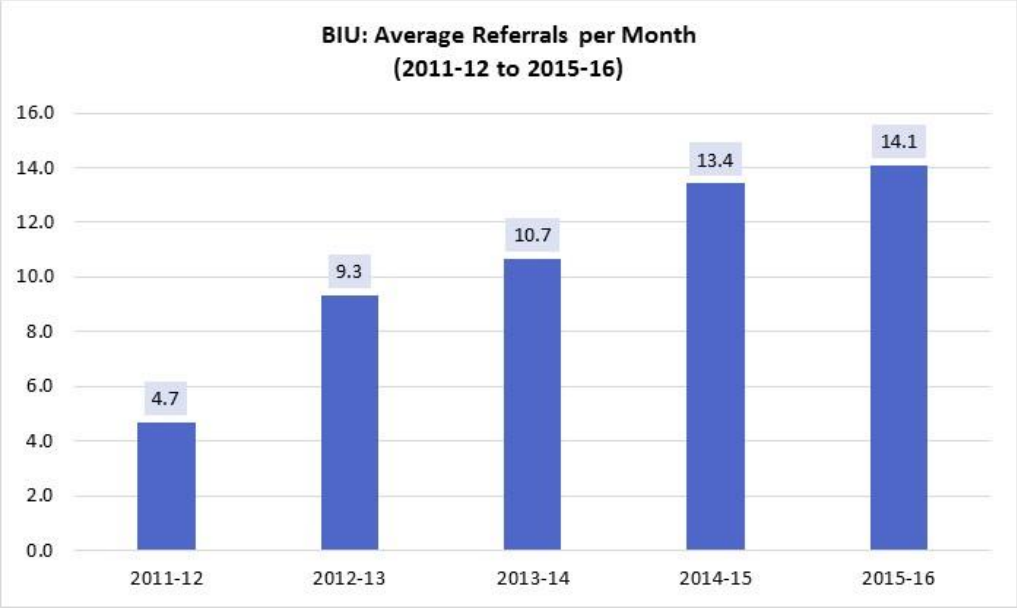
This year the team has made considerable strides, increasing knowledge surrounding Prosthetic Joint and Bone Infection. There has been an increase in understanding of risk factors for infection, as well as understanding the psychological impact of dealing with an infection.

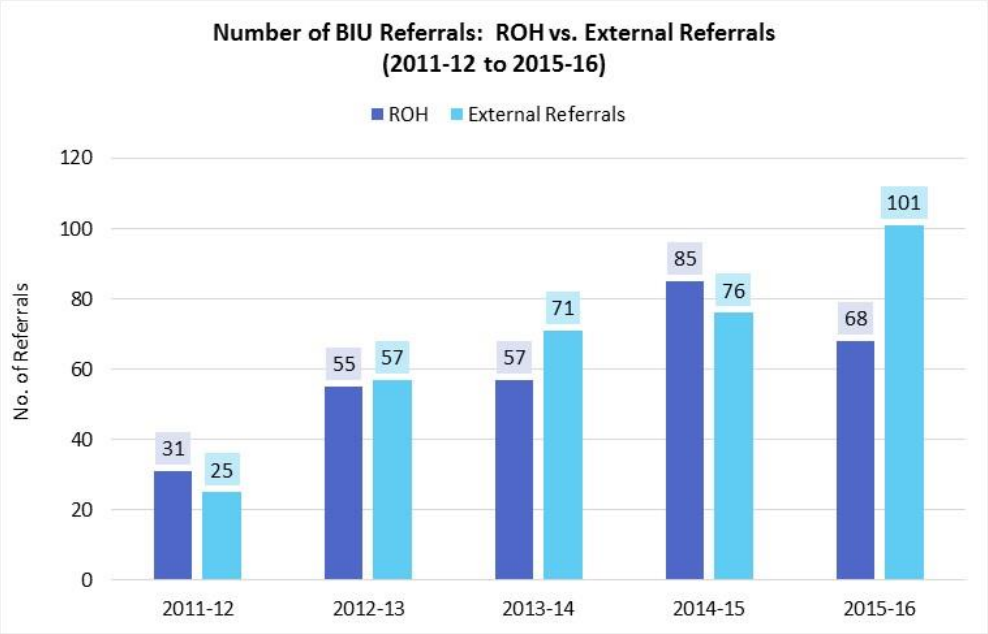
5 Sixth report of the mandatory Surveillance of Surgical Site Infection in Orthopaedic Surgery http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1287147699571 (Accessed 7/9/12)

Bone Infection Unit Activity (2011 - 2016)

There were a total of **626** patients who were under the care of the Bone Infection Unit (BIU) between April'11 and March'2016. There has been a steady upward trend in patients who are referred to the BIU, in 2015-16 has been the busiest since its inception with a total of 169 patients being cared for by the team. In 2012-13 there were an average of 9 patients referred to the BIU per month, 11 patients per month in 2013-14 and 13 patients per month in 2014-15 and in 2015-16 we are seeing around 14 referrals per month. We have also identified that in 2015-16, the team have seen a large increase in referrals from outside the trust. One reason for this is that Sandwell Hospital are no longer undertaking revision surgery and such cases are beginning to be referred here.







The Royal Orthopaedic Community Scheme (ROCS) are an essential part of the BIU service undertaking home visits and providing wound care, IV antibiotics and monitoring for patients. This reduces the need for patients with complex mobility problems to return to the hospital and enables them to complete their treatment in the comfort of their own home, rather than isolated in a side room in hospital. During 2015-16 ROCS undertook 2467 visits for BIU and the surgical site infection service.

Publications / Conference presentations:

Poster presentation at Oxford Bone Infection Conference (OBIC) 2015: Prosthetic joint and endoprosthetic infections caused by vancomycin-resistant enterococci (VRE): Experience at the Royal Orthopaedic Hospital Birmingham 2011-2014. Jumaa P, Mimmack S, Reeves N, Pearson A.

Poster presentation for the European Federation of National Associations of Orthopaedics and Traumatology (EFORT) 2015: Superficial Surgical Site Infections following Hip & Knee Arthroplasty – The positive impact of telesurveillance. U Ahmed, F Wong, N Reeves, S Mimmack, D Dunlop, A Pearson.

There are a variety of abstracts being produced for publication and presentation during 2016, these including nursing issues, surgical intervention, microbiology and the multidisciplinary approach to providing care.

Indications for One Stage vs. Two-stage Exchange†

	Irrigation and Debridement	Single Stage Revision	Two Stage Revision
Indication	• Infection <3 Months of Primary Procedure • Acute haematogenous infection • Stable Implant • Healthy soft tissue envelope • Symptoms < 3 weeks	• Viable soft tissues with adequate coverage • Surgeon able to perform flaps and have adequate soft tissue coverage	• Patient with a systemic manifestation of infection • Infection appears obvious but no organism isolated • Multidrug resistant or difficult to treat organisms • Presence of draining sinus tract • Inadequate and non-viable tissue coverage**
Not Indicated	• Presence of draining sinus tract • MDR Organisms or Fungi • Polymicrobial Infection • Immunocompromised	• Presence of draining sinus tract • Presence of Generalised Sepsis • No Microbiological Cultures • MDR Organisms or Fungi • Presence of severe soft-tissue deficiency over the joint • Compromised skin flaps incl. multiple separate incisions and recent multiple surgery	

Source: †Adapted from Parvizi & Gehrke (2013)

Best Practice

1. Preoperative optimisation of patient
2. Good visualisation and thorough debridement
3. Obtaining culture samples
4. Copious irrigation 6-9L of the joint
5. Explantation of the prosthesis if indicated

Best Practice

1. Preoperative optimisation of patient
2. Control of patient and wound comorbidities

Best Practice

1. ** The use of tissue expanders, musculocutaneous flaps and repeat debridement may all be indicated. In addition to this, further time between resection and implantation may also be required.

Appendix 1

Annual Plan 2015-16

Annual Plan 2015-16 - Infection Prevention and Control

Issue Identified	Intended outcome	Risk Score April 2015			Local assurance	Board assurance	Action Plan	Lead	Due date	Current Risk Status			Risk Score from Previous Review	STI
		C	L	R						C	L	R		
Improve Theatre's compliance with Hygiene Code	Within constraints of the physical environment improve the standards and compliance with the code	4	3	12	Monthly IPC inspections in conjunction with Theatre Management, Estates and Facilities	Infection Control Committee reports Bi-annually and by exception to Clinical Governance Committee	•Ensure the position of HDU remains on the risk register, and forms part of any capital Estates plans. •Storage needs close management by Theatre management team. •IPC to support and advise Theatre management in order to ensure standards are outlined in policy and maintained.	Theatre manager supported by SM/ GM	Ongoing	3	3	9	⇔	1,2,3,4,5
Status Update - End Q4 2015-16: Executive support is in place. Monthly inspections are undertaken highlighting some improvement although the existing department has some fundamental flaws in the physical environment that make full compliance very challenging (1 sluice for 10 theatres, waste streams that cannot be separated completely etc.) All risk are identified on the ICC Risk Register and have been escalated to Quality and Safety Committee (previously CGC). This is an amalgamated risk taking into account several seperate risks in the ICC risk register. Links between the Theatre management team and IPC have been formalised and theatres are intending to employ a band 7 IPC nurse to concentrate on their issues specifically.														
Ensure gaps in updated Hygiene Code (Regulations 2016) in areas outside theatres are closed.	Compliance with Health and Social Care Act 2008 (Regulations 2015) is maintained	2	3	6	Reported to ICC and Commissioners monthly	Infection Control Committee reports Bi-annually and by exception to Clinical Governance Committee	•Annual audit programme completed: RITs undertaken monthly by link team. PITs undertaken by IPCT according to risk rating of the area bi-annually. •Estates and facilities to work closely with IPC regarding Cleanliness, Management of water, Food hygiene and Capital plans for the Estate	SM/ SL / WM's	Ongoing - to be completed by end December 2015.	2	2	4	⇩	1,2,3,4,5
Status Update - End Q4 2015-16: Compliance in ward areas is variable, although links with facilities are much improved. Work is ongoing regarding waste streams and Estates and IPC collaboration continues to improve. Matrons now have more input into cleanliness on wards and departments, ensuring the variability in compliance improves. An independant review of decontamination services at the Trust is planned for early May 2016. A formal policy to ensure compliance with HBN 00-09 is out for consultation this will strengthen compliance and reduce clinical risk where estates / IT work is required throughout the site.														
Extend SSI surveillance to Foot & Ankle service highlighted as an area of interest via analysis of SSI helpline.	Enable clear identification of Trust infection rates in specialties outside arthroplasty.	2	3	6	Results reported at ICC and to Consultants at audit every 6 months.	Quarterly reports to ICC regarding 30 day data as it becomes available.	•Discuss with foot & Ankle Team where they see the priority as business case for expansion of the SSI service was declined. •Once priorities are agreed, implement 30 day surveillance initially as far as is possible within manpower constraints. •Continue to monitor and report SSI wound helpline for Foot & Ankle cases	SM/ JM	Ongoing - likely to continue into 2016-17	2	3	6	⇔	1,2,3,4,5,6,7
Status Update - End Q4 2015-16: Unfortunately there has been no additional manpower agreed to extend surveillance. Maternity leave has further depleted the current service so this development is on hold at present. However, analysis of the patients calling the SSI helpline continues to offer some data to the Foot and ankle team although this is not true surveillance. this does not increase the risk but does not enable it to improve.														

Issue Identified	Intended outcome	Risk Score April 2015			Local assurance	Board assurance	Action Plan	Lead	Due date	Current Risk Status			Risk Score from Previous Review	STI
		C	L	R						C	L	R		
Avoidable exposure to influenza due to low levels of vaccination	To implement a robust vaccination programme and increase uptake to 75% of all staff as per DH guidance	2	4	8	Progress reported to and monitored by Emergency Planning Committee	Uptake reported to Integrated Governance Committee	•HR are providing the service via OH purchased via an SLA with HEFT •Incentivised scheme is recommended to increase uptake	HR dept. & OH dept.	Complete March 2016	2	4	8	⇔	1,2,3,4
Status Update - End Q4 2015-16: Uptake at the end of the flu campaign was 42.8% of frontline staff have been vaccinated. this is the highest uptake seen at ROH since 2011. The link nurses have given the majority of the vaccinations (229 out of a total of 422). The Trust failed to meet the 75% target set by the Department of Health despite the best efforts of all staff involved in the vaccination programme. 1 case of flu was reported amongst patients although this did not adversely affect the patient's journey at ROHFT.														
Develop new IT system for IPS audit tools - existing system is not fit for purpose	To devise a new web based system that can be utilised throughout the Trust. This is intended to become a viable commercial opportunity for the Team and the Trust. This new system will improve the variable reporting seen across the Trust.	C	L	R	Audit data is reported to WM's/ matrons/ Commissioners monthly. Also reported at ICC bi-monthly	The audit data is reported but the system used to collect it is poor. The creation of a new system will not affect the final reporting but will save clinical time in undertaking and reporting audit.	•IPC Data Analyst & Epidemiologist to complete Web training course •Build and test new system internally •Protect IP with assistance from R&D department •Consider commercial possibilities once system is fully tested.	SM / NR	Aim to complete internal elements by end March 2016. Commercial potential may roll into 2017.	C	L	R	⇔	1,3,4,5,6,7
		1	2	2						1	2	2		
Status Update - End Q4 2015-16: The IPC data analyst and epidemiologist completed the course to enable her to design the tool at the end of July; work began in Sept 2015 but the impact of not covering the team's maternity leave has meant that the progress is slower than anticipated. However, it is still very much the plan for the future.														
Strengthen Link Team knowledge in both Tissue Viability and Infection Prevention & Control	Raise the standard of wound care throughout the Trust and reduce the pressure on the IPC/ TV team who have limited resources and cover 5 days a week, not 7 at present.	C	L	R	Monthly IPC and TV report sent to WM's and Commissioners Incident reporting information Post Infection Reviews for readmissions with infection	SSI information reported quarterly and reported to ICC and CGC.	•Work closely with industry to assist the team provide specialist training in NPWT and irrigation Vac systems. •Devise an 'in house' Training day that is dedicated to care of infected wounds, and the importance of early detection and Treatment as well as prevention. •Consider running this course and offering it to other orthopaedic providers (EOC have requested assistance with this) •Ensure issues are escalated appropriately allowing Matrons/ Directorate Managers to assist IPC in ensuring patient care is appropriate.	SM / JT	Ongoing	C	L	R	⇩	1,2,3,4,5,6,7
		3	4	12						3	2	6		
Status Update - End Q4 2015-16: Tissue Viability provide short updates on a drop in session basis each month in addition to the formal teaching they routinely provide. IPC have presented 2 sessions on an internal seminar training programme set up by the research and teaching department. Each link nurse meeting includes a section of training provided by the IPC Specialist Nurse on a varety of topics depending upon current issues.														

Issue Identified	Intended outcome	Risk Score April 2015			Local assurance	Board assurance	Action Plan	Lead	Due date	Current Risk Status			Risk Score from Previous Review	STI
Strengthening of Antimicrobial stewardship within the Trust	Reduced inappropriate use of antimicrobials in order to limit resistance issues and improve patient outcomes.	2	3	6	A quarterly audit to be undertaken - using Trust antimicrobial guidelines as the standard - reports submitted to ICC	Inform Board via ICC report	•Pharmacy will undertake quarterly audits and report to ICC •EPMA will assist with antimicrobial stewardship and will aid policing and compliance	SB	Ongoing	2	3	6	⇔	2,3,5
Status Update - End Q4 2015-16: New guidelines devised, ratified and disseminated. Audit is undertaken by pharmacy. No Post Infection Reviews (PIR's) have identified a deficiency in antimicrobial prescribing. The weekly Bone Infection Unit ward rounds help maintain close surveillance for the more complex patients.														

Report Conclusion

In conclusion, the Infection Prevention and Control team have continued to provide an essential service to the Trust, they are unique; encompassing far more than the usual Infection Prevention and Control service seen in most Acute Trusts with the Bone Infection Unit, Surgical Site Surveillance, the wound infection helpline and tissue viability all coming under the team's remit in addition to the statutory requirements of the Health and Social Care Act (updated 2015).

The role of Director of Infection Prevention and Control has moved from the Medical Director's portfolio to lie with the Director of Nursing and Clinical Governance. A review of the terms of reference for the Infection Control Committee has strengthened the group with much closer inclusion of Facilities and Matrons; with cleanliness as a key priority.

There have been no MRSA bacteraemias at the Trust since May 2008 and rates of Clostridium difficile remain very low compared to national data with no avoidable cases recorded during 2015-16.

A number of interventions have been put in place over the years and as a result SSI rates have seen a significant downward trend. There has been a significant reduction in SSI's for Primary Hip Replacements where rates have fallen from 2.7% (CI: 1.9 to 3.9) in 2009 to 0.9% (CI: 0.5 – 1.7) in 2015, which equates to a reduction of 65.5% over a seven year period. In Primary Knee Replacements rates have fallen from 7.4% (CI: 5.8 – 9.4) in 2009 to 1.7% (CI: 1.0 – 2.8) in 2015, which equates to a reduction of 75.8% over a seven year period. The Trust monitors patients actively for 12 months post-surgery and has identified a deep infection rate of 0.2% in both Primary hip and Primary knee replacements.

The costs of treating infections (deep and superficial) have reduced significantly over the past 4 years, this is probably due to rapid, targeted treatment being utilised and the BIU and ROCS ensuring that much of the treatment occurs in the community. Patient level costings allow the Trust to understand the true financial burden of treating infections and managing this group of complex patients. The practice and environment within theatres is of critical importance in the prevention and control of surgical site infection and as such continued surveillance to monitor readmissions with infection/suspected infection by theatre will continue.

Research and understanding about the treatment of Prosthetic Joint Infection is continuing to grow all the time and in light of this it is important that patients are treated according to protocol. It is also important that once a patient is identified as having an infection action is taken swiftly to decide on a treatment plan for them. Cohorting of the patients under the care of the Bone Infection Unit (BIU) is a key priority for the team; this will enhance the ability to provide protocol based care and will enable the provision of specialist nutrition and psychological care in particular. This is designed to ensure that patients get the best chance of a positive outcome following an infection.

There will be several new developments in the coming year which will improve the current in-house database, this will allow the data to be used in a more efficient way and ensure it is accessible to consultants and other staff via a web based system.

The service continues to develop and change as does the healthcare climate. Ensuring that the Royal Orthopaedic Hospital NHS Foundation Trust is at the leading edge of care for this complex group of patients is vital not only to the whole health economy but to our patients themselves.

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ROHTB (10/16) 007

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual Complaints report 2015/16**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Operations, Nursing and Clinical Governance**
AUTHOR:	**Mrs Lisa Kealey, Public and Patient Relations Manager**
DATE OF MEETING:	**5th October 2016**

EXECUTIVE SUMMARY:

This report will provide the Trust Board with assurance that the requirements of the NHS Complaint Regulations 2009 have been met, through the production of an annual report, to be submitted to the CCG and subsequently to the Trust Board.

This report provides an overview of the complaints process, the numbers and trends in complaints, actions taken as a result of and learning from complaints. It will also provide a summary of achievement against the complaint priorities for 2015/16 and outline the complaints priorities for 2016/17.

Of note, there has been a slight increase in complaints during the year to 113, compared with 105 the previous year

The level of satisfaction with the way we have handled complaints has increased from 40% in 2014/15 to 76% in 2015/16. This is believed to be due to changes in personnel and process within the complaints department.

Successful resolution, smooth handling and learning from complaints will improve the quality of services that the Trust provides. Accurate adherence to the Policy, based on Good Practice guidelines and changes to the regulatory and monitoring processes will minimise reputational and financial risks to the Trust as a result of complaints.

REPORT RECOMMENDATION:

The Board is asked to

- Note the annual complaints report
- Agree to the improvement plans for 2016/17

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	x
Business and market share		Legal & Policy	x	Patient Experience	x
Clinical	x	Equality and Diversity	x	Workforce	x
Comments: [*elaborate on the impact suggested above*]					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
Delivering exceptional patient experience and world class outcomes
PREVIOUS CONSIDERATION:
Clinical Quality Group on 23 September 2016 and Quality & Safety Committee on 28 September 2016.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Annual Complaints Report 2015/16

REPORT TO THE TRUST BOARD – 5 OCTOBER 2016

1.0 Introduction

The Trust deals with complaints in accordance with its PALS and Complaints Policy and the NHS Complaints Regulations of 2009.This report provides information with regard to complaints received by the Royal Orthopaedic Hospital NHS Foundation Trust between 01/04/2015 and 31/03/2016. It provides data in regard to the number of complaints received and identifies trends in relation to issues raised with the Trust. The priorities for the complaints service during 2015/2016 were agreed as listed below:

- Creation of a monthly summary complaint report to be posted onto the Trust website
- Formal complaint investigation and response training for Divisional Staff where required
- Link more closely with Governance to ensure that trends across all areas are clearly identified
- Simplify the complaints reports to comply with the K041 categories to make benchmarking across the Trust and with other comparable organisations easier.
- Review of the structure of the Public and Patient Service Department
- Achieve the KPI of 80% of complaints completed within the agreed timescale
- Reporting of complaints to Divisional Leaders at the monthly Divisional Governance meetings
- The additional of risk assessment information to the complaint reporting processes

Progress against each of these priorities is covered in Appendix A

2.0 Definitions

Formal Complaint: Any expression of dissatisfaction, where the complainant wishes to have a fully investigated response in writing. These are likely to take longer than 2 working days to resolve, but may also include issues that are resolvable quickly, where the complainant expresses a wish for the complaint to be dealt with formally.

Informal Complaint: A concern that is raised by the complainant where the issue can be resolved either immediately or to the complainant's satisfaction within 48

hours. It also applies to issues raised verbally through the Patient Advice and Liaison Service or the Complaints Department where the complainant indicates he/she does not require a written response from the Trust or does not wish to proceed with the formal complaint, once resolved to their satisfaction. These are not formally reported via the complaints data.

PALS Enquiry: A general enquiry that does not raise any matters of concern, but the individual merely requires information. These are not formally reported and are resolved within 2 working days.

PALS Concern: An enquiry that requires contact with other staff to resolve and a response verbally or in writing to the individual providing answers to specified questions. There are not formally reported and are resolved within 5 working days.

3.0 The PALS and Complaints Team

The team comprises 2.0 WTE – Public and Patient Relations Manager (1.0 WTE) and PALS Manager (1.0 WTE).

The Public and Patient Relations Manager is responsible for the day to day operational management and performance of both services.

The team reports directly to the Deputy Director of Nursing and Governance and the Director of Nursing & Clinical Governance is the Executive Officer with overall responsibility.

4.0 Data Collection and analysis

All complaints data is entered into the Customer Service Module within the Ulysses Safeguard system retrospectively. In October 2015, a new system for recording and logging complaints and actions taken was implemented. This has enabled more accurate and responsive monitoring and evaluation of actions taken as a result of complaints. The new system allows for analysis against a defined set of categories which enables a more detailed analysis of themes. This has, in turn, supported Divisional teams to identify and embed learning and change across the organisation.

5.0 Number of complaints

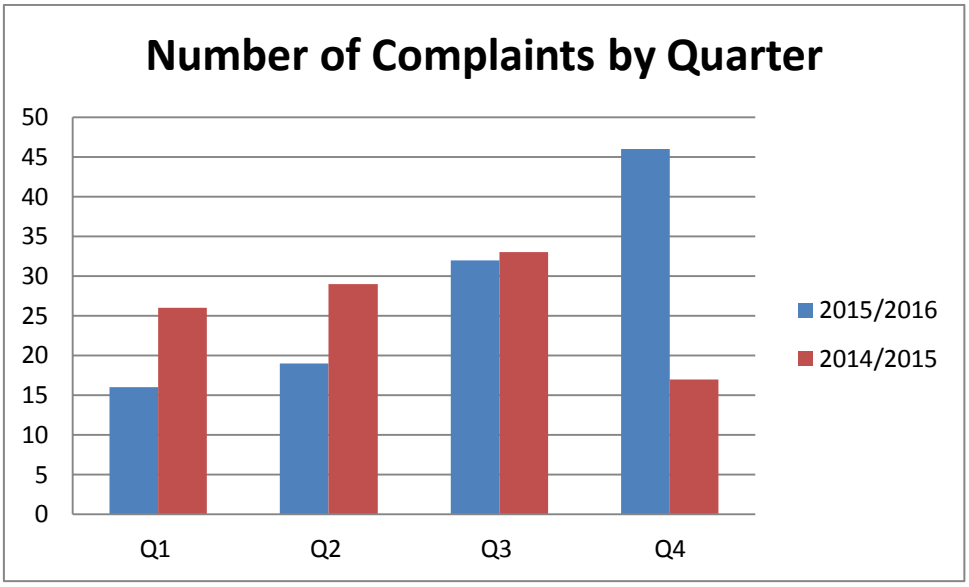
In 2015/2016, ROH received 113 formal complaints, 1 of which was withdrawn following discussion with the patient (although formally answered and still logged in the complaints process as this had been investigated at the point of withdrawal) Figure 1 below shows the total number of formal complaints received over a three year period. Figure 2 details the number of complaints by quarter in 2015/16 with the previous year's data for comparison.

Figure 1: Numbers of complaints received 2014/2015

Formal Complaints	2013/2014	2014/2015	2015/2016
	146	105	113

Formal complaints experienced a slight increase during the year after a steady decline over the previous 3 years.

Figure 2: Number of complaints by quarter

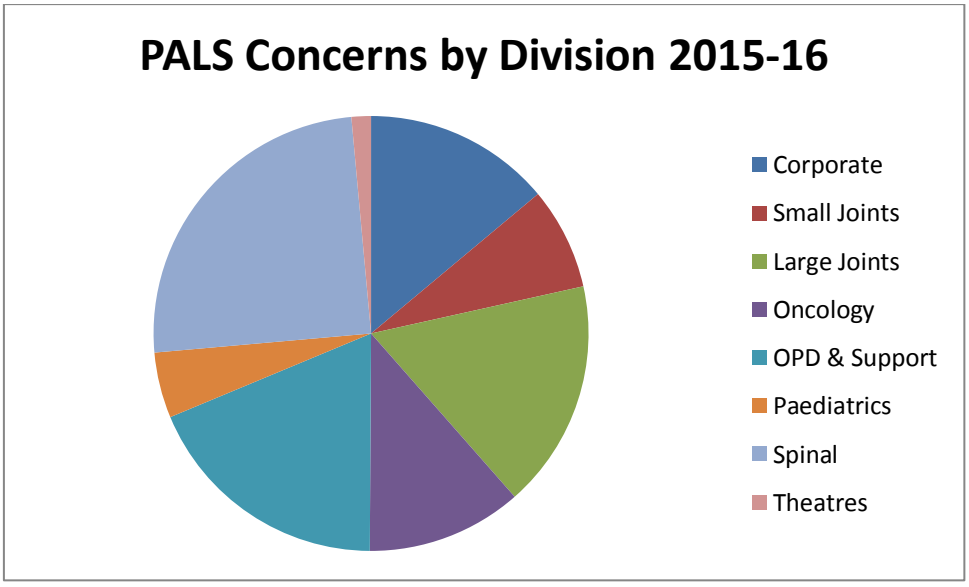


The number of complaints has increased each quarter during the year. This coincides with an increase in activity level over the same time period. The obvious change in Quarter 4 of this year relates to a substantial increase in complaints about the Spinal Directorate. Details of this are included in Section 8.0.

6.0 PALS Contacts during 2015/2016

There were 1029 contacts with the Patient Advice and Liaison Service this year of which 553 were concerns. The most frequent concern expressed via PALS was for patients accessing spinal services, which correlates to the formal complaints logged in the year. Other concerns related to repeated cancellations of appointments as well as waits for surgery dates. Most concerns raised via this method were caused by a lack of information about what was happening.

Figure 3: Number of PALS Concerns by Division



The PALS Service has also provided support to patients with identified needs to access appointments and treatment where this has been possible,

7.0 Formal Complaints numbers measured against Trust activity

Figure 4: Complaints against Trust Activity 2015/2016

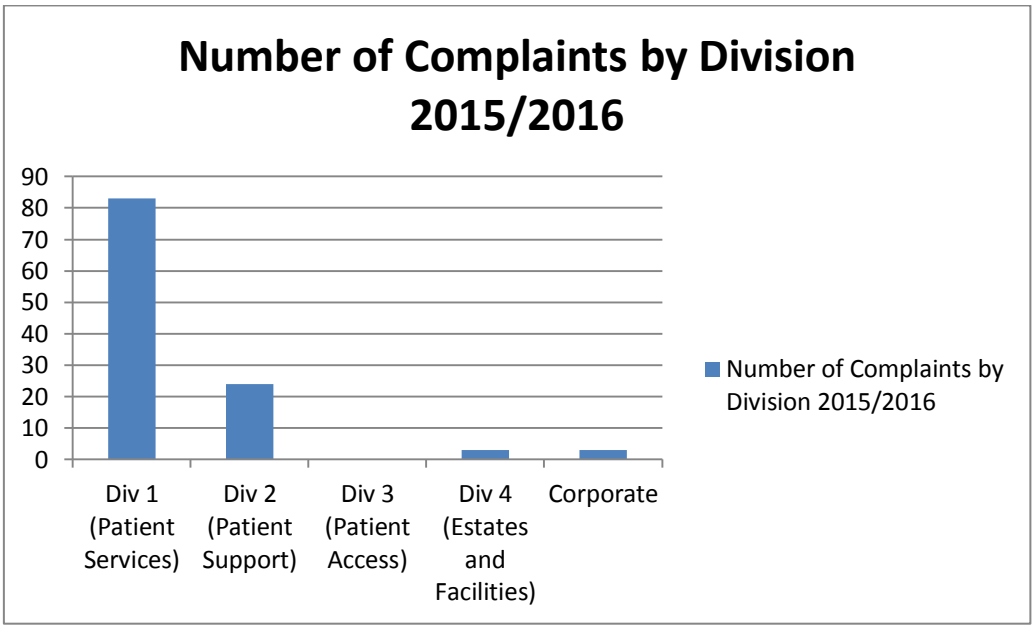
	2015/2016	2014/2015
Inpatient Attendances		
Inpatient Complaints	45	62
Inpatient Episodes	14954	14379
Complaints per 100 inpatient episodes	0.30%	0.43%
Outpatient Attendances		
Outpatient Complaints	68	38
Outpatient Episodes	69253	68586
Complaints per 1000 outpatient attendance	0.10%	0.05%

It can be seen that whilst the total number of complaints has increased slightly over the last year, the greatest rise in complaint numbers is in out- patient areas with a rise in complaint numbers from 38 to 68 over this time period. The ratio of complaints to patient episodes has reduced in respect of in patient complaints.

8.0 Number of Complaints by Division

Figure 5 below illustrates the number of formal complaints by Division in 2015/2016.

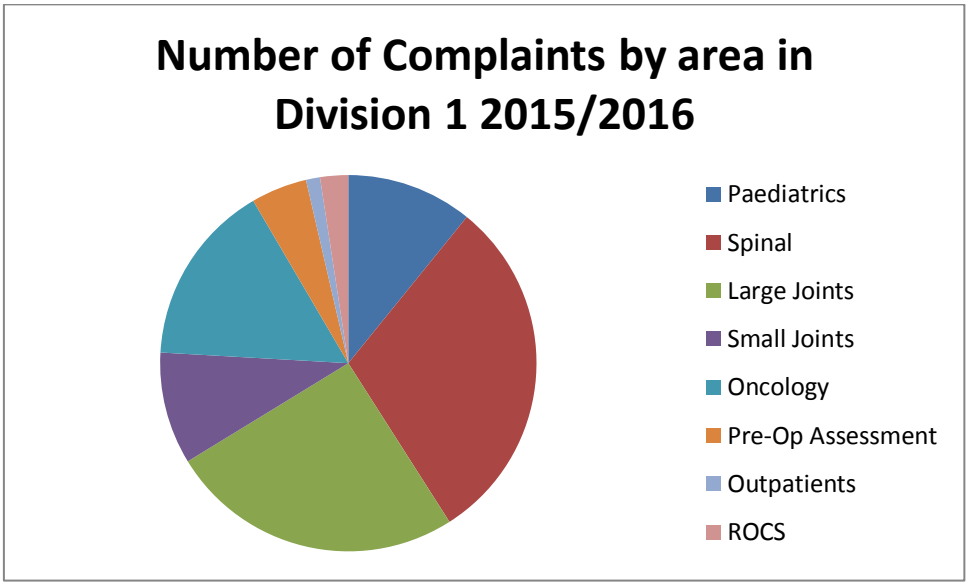
Figure 5: Number of Complaints by Division 2014/2015



The majority of complaints (73%) relate to the Patient Services Division which is to be expected since this Division oversees all inpatient and outpatient activity. There is no direct comparison available against last year's figures as the Divisional Structure has changed over this time period. The area with the highest number of complaints in 2014/15 was the Large Joint Division which is now included in the Patient Services Division.

Figures 6 below provides an in-depth breakdown of complaints within Division 1

Figure 6: Number of Complaints by area in Division 1 2014/2015



8.1 Spinal Service complaints

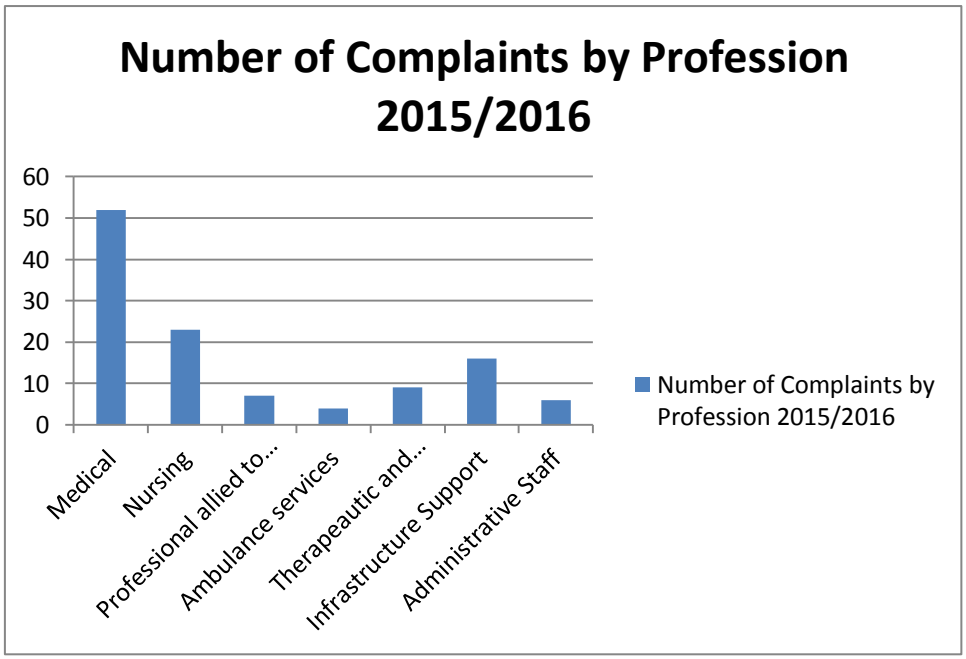
The largest numbers of complaints in Division 1 relate to delays within the spinal service (22% of all complaints this year), relating to all aspects of the service, including clinical and administrative. The most significant concern raised (48% of spinal complaints) was about delays to receiving planned treatment. Also of concern was repeated cancelled clinic appointments (20%), cancellation of planned surgery at short notice (20%) and communication (20%). One of these complaints generated a Serious Incident Investigation.

The spinal deformity service in Birmingham is under significant pressure due to the high volume of referrals received into the service and numbers of patients requiring care and treatment. The demand on the service significantly outweighs our resources, particularly with respect to children. In response to our growing waiting lists the Divisional Leads for Spinal Services and the Director of Operations have been in regular discussion with NHS England and our commissioners to escalate the critical status of our service. In addition we have been working with other healthcare organisations to secure additional capacity to reduce our waiting times. Although not all patients are clinically suitable to be treated elsewhere, we are looking into various options to try and reduce our waiting times. In addition, a review of the administrative processes within the service has commenced. The number of complaints regarding

issues relating to the Spinal service will continue to be monitored and used as a guide as to the effectivity of the interventions taken.

9.0 Complaints by Profession

Figure 7: Number of Complaints by Profession 2014/2015



It can be seen that most complaints received relate to aspects of medical care which is reflective of the type and nature of activity carried out in a specialist orthopaedic Trust The complaints received during this time period raise concerns about surgical outcome, complications and clinical treatment options. This is similar to last year. although the number of complaints relating to infrastructure support within the hospital has shown a marked increase, which relate to the cancellation of spinal deformity surgery due to lack of paediatric intensive care availability.

10.0 Complaints by Subject

Figure 8: Complaints by Subject 2015/2016

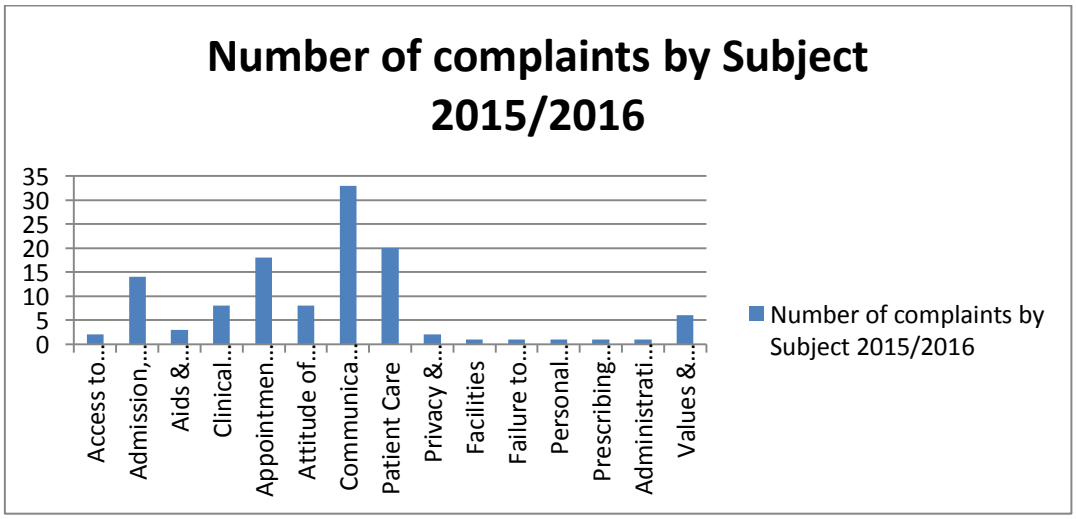
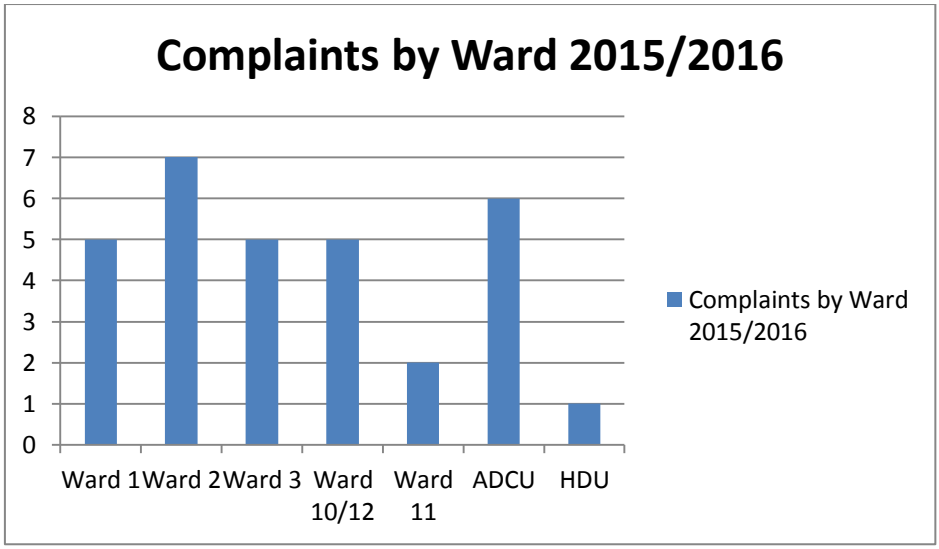


Figure 8 shows the main causes for complaints in 2015/2016, with communication with patients, patient care and delays or cancellation of appointments being the highest reasons. This is a change from the previous two years where all aspects of treatment was the highest reason for complaints; however the new thematic coding has resulted in more defined areas of concern enabling the Trust to gain a clearer picture of patients areas of concern.

Trends and individual issues identified from complaints are monitored more effectively and evidence of actions to drive improvements has started to be more widespread within the Divisions. There is still only limited recorded evidence of Trust wide learning from trends identified across the organisation. The governance and complaints teams are working on addressing this with Divisional Managers as part of the improvement objectives for 2016/2017.

11. Complaints by Ward during 2015/2016

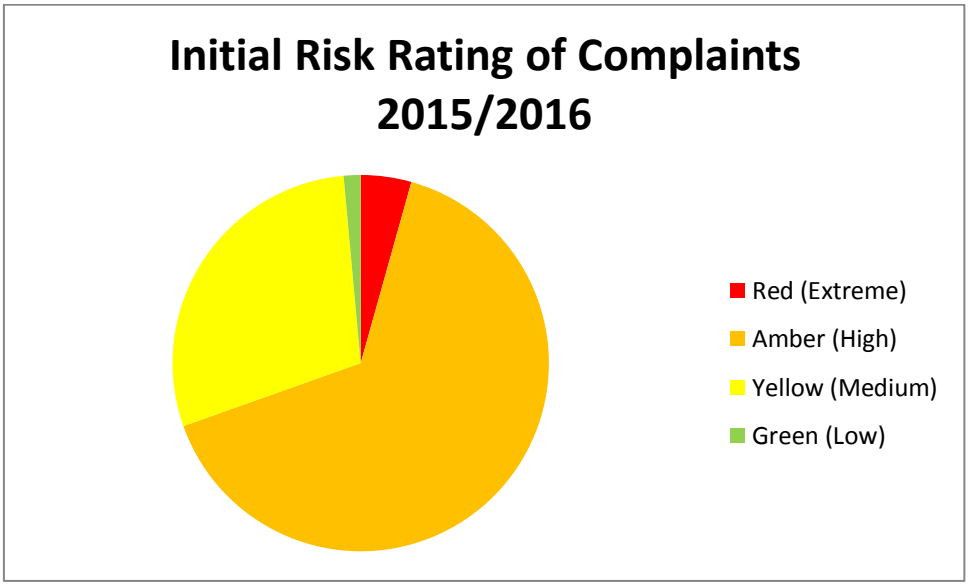
Figure 9: Complaints by Ward 2015/2016



The new recording and reporting system has enabled the analysis of ward involvement in complaints since October 2015. Concerns about aspects of ward care or treatment has been mentioned in 45% of complaints since implementation. The data is scrutinised, together with other ward performance data in Quality Summit meetings for each area which were implemented as part of the Quality Nursing Agenda during the year. This has helped to identify specific performance improvements in individual wards as well as operational issues that can affect nursing care. For example, the data suggested that there may have been an issue with the approach of the night staff on a specific ward. Discussion during the Quality Summit and ward visit enabled clarification of these issues and action to be taken. This will continue to be monitored throughout 2016/2017 as a means of assurance that improvements are implemented and sustained.

12. Risk Ratings of Complaints during 2015/2016

Figure 10: Initial Risk Rating of Complaints 2015/2016



The Trust implemented a more robust system of tracking and monitoring complaints from October 2015 as previous indicated. Part of this tracking involves the logging of an initial risk rating. The Deputy Director of Nursing & Governance monitors these risk ratings and reviews all complaints that are initially rated Red or Amber, to ensure Duty of Candour requirements have been discussed and met where required. The Trust Risk Scoring Matrix can be found in Appendix B.

The results of this monitoring clearly shows that most of the complaints that represent a lower risk to the Trust are handled via different processes within the Trust, such as PALS or informally, as the number of complaints assessed as green or low risk are relatively few. A review of the formal complaints assessed in this risk category shows that in each case, the complainant had expressed a preference for their concerns to be made formal. This is indicative that the trust is handling complaints in accordance with the Department of Health Complaint Regulations 2012 – that the complainant is able to determine how their concerns are managed.

13.0 Performance against Key Performance Indicators (KPI)

During 2015/16 the Trust had 3 contractual complaints KPI's which were reported to the Trust Board and the Commissioners on a monthly basis. In addition, there were an additional 2 internal performance measures within the PALS and Complaints Policy. These are:

- Verbal acknowledgement within 2 days if possible (95%)
- Written Acknowledgement within 3 days (95%)
- Response within timescales agreed with complainant (90% KPI – contractual requirement)

Compliance against these KPI's is recorded in Sections 13.1 and 13.2

13.1 Acknowledging complaints

The NHS complaints procedure states that an acknowledgement should be made within 3 working days of receipt by any method.

The Trust's Policy states that all attempts should be made to contact the complainant

by telephone within the first two days of receipt and this conversation informs the acknowledgement letter sent out by day 3. If there is no telephone number available or the complainant does not answer/return the calls, then the letter is sent within the same timescale.

100% of complaint letters received during the 2015/2016 were acknowledged verbally or by e-mail within the correct timescale, thereby meeting the KPI.

97% of complaint letters were formally acknowledged by letter within the agreed timescale. This remaining 3% were acknowledged within 5 working days. This was due to concerns and immediate actions needing to be verified and completed in all of the exceptions except for 1 case and these were documented. The remaining case was not acknowledged in error.

13.2 Responding to complaints within the agreed timescale

The PALS and Complaints Policy was updated in January 2015 and revised in March 2016. It states that the timescale for response should be agreed with the complainant. In the event of not being able to contact the complainant and speak to them directly, the Trust sets a provisional response date of 25 working days for routine/lower risk complaints and 40 working days for complex/higher risk complaints (dependant on discussion with the Deputy Director of Nursing & Clinical Governance, the Designated Complaint Investigator and the complainant as to the complexity of work required).

In line with ROH Policy, it is permissible to discuss an extension with the complainant. If they are in agreement with the extension, the complaint will be deemed to have been completed within agreed timescales. Any complaint can only be extended once.

Annual Compliance with the contractual reporting requirement of 80% (for Q1-Q3) and 90% (for Q4) has been met.

14.0 Outcome of complaints made in 2015/2016

Figure 11: outcome of complaints 2015/2016

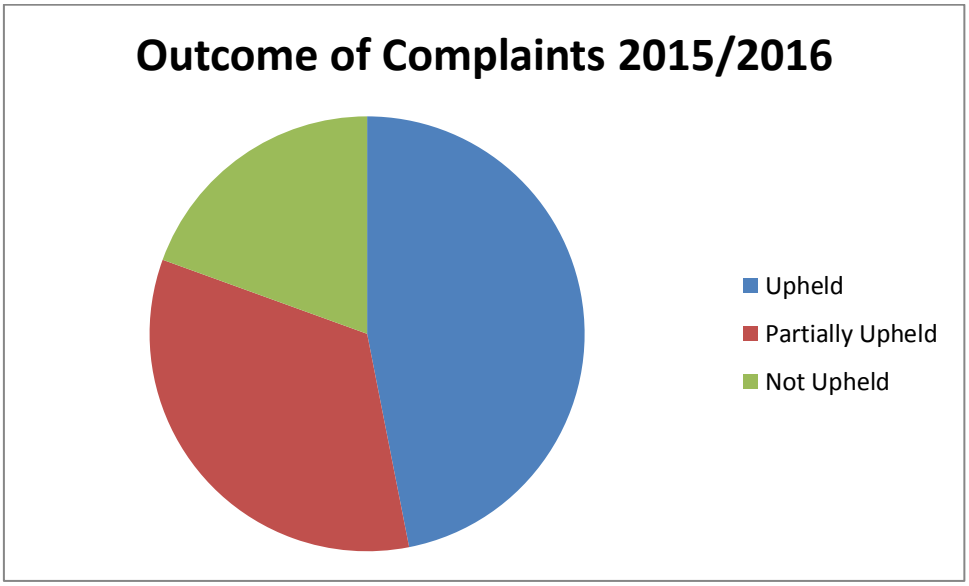


Figure 11 shows the outcome of complaints made in 2015/2016. The Trust upheld some aspects of 81% of the complaints made in this year, which represents a substantial increase from 57% in the previous year. A review of this difference shows more robust investigation and clearer expectations of good service provision across the Trust, which is being defined by the changes to the operational structure, the Quality Agenda priorities and the 5 year strategic plan to transform our services. 90% of the complaints that were partially upheld were due to communication issues.

15.0 Satisfaction with the Complaints Service

During 2015/2016, a total of 36 satisfaction surveys were returned by complainants representing 32% of all complainants. The questionnaire is seeking to understand the complainant's perception of how their complaint has been handled,

The number of people satisfied with the outcome of their complaint has increased from 40% last year to 75% this year, which is the highest satisfaction level recorded at the Trust. Respondent satisfaction with the time taken to respond to their concerns has improved dramatically from 38% to 83%. In addition, 92% of respondents felt that the complaints staff were helpful and professional. This is evidence that the changes made from the previous year have been embedded into the service and are well received by those who have needed to complain.

The information from the full satisfaction survey will continue to be reviewed and used to inform further improvement work in 2017/2018.

16.0 Complaints referred to the Parliamentary Health Service Ombudsman (PHSO)

We aim to resolve complaints by undertaking a thorough investigation, providing a comprehensive response and offering all complainants the opportunity to discuss further concerns with us. Generally the Trust is successful with this, but sometimes it is not always possible to achieve a resolution which satisfies the complainant.

Under the NHS complaint Regulations, any complainant who remains dissatisfied with the response has the right to request an independent review of their case with the PHSO. Every response contains this information together with the contact details for the PHSO.

During 2015/2016, the PHSO requested information about 2 complaints made to the Trust. One complaint was made in 2011/2012 and the other was made in 2012/2013. One is still under investigation currently and the outcome of is not yet known. The other was partially upheld and required the Trust to send a further letter of explanation to the Complainant. The aspects upheld relate to administrative processes rather than the clinical care given.

17.0 Listening and Learning from Complaints

Patient Story

Mr X made a formal complaint about the time it had taken to process his wife's referral as he felt that she had waited too long for her procedure. Investigation revealed that although the time from referral to treatment was well within appropriate limits, there had been a delay for the referral to be authorised. The hospital acknowledged that treatment could have been undertaken sooner had the referral been processed within the guidelines of the Patient Access Policy and some immediate changes were made to the handling of the Consultants referrals. In addition, discussions with divisional staff identified that audits of referral authorisation times were not routinely undertaken. There was therefore no information to assure the Trust that referral delays were the exception rather than the rule. As a result, the hospital is undertaking the first audit of this in June 2016 and will use the results of this audit to identify any further work that needs to be undertaken.

Mr X was mostly happy with the Trusts response to his concerns but was anxious to ensure that should his wife need further treatment, he would know that there would be no delay to the processing of the request. He was advised to contact the hospital should she require further treatment at the point of referral in order to assure him that the new processes implemented as a result of his complaint worked effectively.

Complaints are reviewed and signed off at senior level within ROH to ensure that:

- Complaints are well managed and contain accurate, helpful responses
- Any serious issues are identified and escalated appropriately
- Trends can be identified and acted upon

The clearest theme from complaints received in 2015/2016 continues to relate to communication, particularly about communication of progress and delays or changes of appointments in services where there is higher demand that current capacity.

This issue was reviewed in depth when developing the ROH 5 year strategy and helped to shape the direction of two particular work streams:

- Exceptional Patient Experience every step of the way; Anonymised data is provided to the transformation team to be used as learning material and examples for improvement
- Safe and Efficient Processes: A review of compliance with the new requirements for efficient safe handling of complaints after the Francis Report was undertaken. Changes to the process were made and shared with the transformation team.

As part of the changes made in October 2015, identified learning points from investigations has been formulated into action plans where necessary and monitored within Divisional Governance meetings in a similar manner to serious incident investigation action plans. A total of 21 action plans have been created since then, ensuring changes are implemented which include:

Learning	Action
There was no written process for on the day surgical cancellation of a patient	Process has been developed with the manager of the day now responsible for informing the patient
Changing room in ADCU can be cold	Temperature is being monitored and action taken when it is cold
Staff do not apply the access policy consistently in all departments	Appropriate Staff received refresher training in waiting list management
A primary cause of delayed discharge is the wait for take home medicines	Discharge process has been reviewed and medicines are being requested a day earlier to ensure that they don't delay the process
Attitude of a member of staff (sub-contracted to ROH) was unacceptable	Member of staff removed from ROH and disciplinary action taken by provider
ROH process not followed for checking of patients' medication for discharge	Professional conversation with staff member and shared as a learning exercise at departmental meeting

Learning	Action
Opening hours of Café Royale may not suit patients, visitors and staff at weekends	Review of all feedback of use of canteen has been undertaken with a view to reassessing need.
Staff require more training in managing patients with mental health conditions such as Obsessive Compulsive Disorder	Added to the work plan of the safeguarding team and training initiated
Gap identified in pre-operative checking process where results could be missed if notes are removed	Patients results are now cross checked with clinic list as well as notes to prevent this occurring again. Nurses are now required to fully document actions taken on test results in patient records.
Information about relevant previous history not always included in referral	Patient Access Team to review sample notes and evaluate level of issue.
Specialist Nurses need to be fully involved where patient has pre-existing medical condition that could affect surgery or outcome	Information taken to Senior Nurse forum to discuss how to embed
Patients may not understand the eligibility criteria for using hospital transport.	Information has been fed into the transformation team work about patient information
Approach and manner of a member of staff has been identified as not acceptable	Professional conversation has been undertaken and performance management process has been implemented
Repeated cancelled appointments is becoming a bigger issue	Divisional Leads are working with Patient Access to reduce appointment changes
GP's are not necessarily aware of BMI restrictions for hip and knee surgery	Letters are being sent explaining the restrictions where needed
There is a communication issue in the process whereby a Consultant books leave and this is passed to the relevant departments (appointments in particular), which is resulting in late cancellation of clinics	This has been passed to the Patient Access team to review and alter.
There is no audit currently of the number of days taken to accept or process a referral	Audit is planned for June 2016

17.0 Looking ahead to 2016/2017

The Department is continuing to look at the process of handling complaints, particularly with a view to further the work of embedding complaint investigation within the new Divisional Structure. The PALS and Complaints Policy has been reviewed and will be signed off by the Chief Executive in July 2016 and a new roll-out programme will be implemented during this year.

Other improvements planned for 2016/2017:

- A centralised system for monitoring and completing action plans for complaints will be developed.
- Actions Plans will be sent out with complaint responses and a final letter will be sent to complainants when they are complete. This will ensure that complainants are reassured that the hospital has done what it said it will do.
- Complaint investigation and report writing training will be undertaken for all staff involved in investigating and responding to complaints where the need is identified.
- In conjunction with the Governance department, an agreed process for sharing of Trust wide learning from complaints will be created and evaluated.
- Achieve the KPI of 80% of complaints completed within the agreed timescale
- A review of current staffing provision for PALS and Complaints will be undertaken

18.0 Conclusion

At the ROH, we remain committed to investigating, learning from and taking action from complaints where it is confirmed that mistakes have been made or services can be improved. We recognise that the process of improvement is continual and that transparency and honesty are vital when things go wrong.

Garry Marsh
Director of Operations, Nursing & Clinical Governance

30 September 2016

Appendix A

Progress against 2015/2016 priorities for the Complaints Department

Priority	Status	Detail
Creation of a monthly summary complaint report to be posted onto the Trust website	Partially Achieved Carried forward to 2016/17	A monthly report has been created which is now sent to all internal and external stakeholders. It has not been published on the website
Formal complaint investigation and response training for Divisional Staff where required	Achieved	Complaints investigation and response training has been undertaken as required
Link more closely with Governance to ensure that trends across all areas are clearly identified	Partially Achieved Carried forward to 2016/17	Trends across Divisions are clearly documented. Trends across the Trust will form part of the priorities for next year
Simplify the complaints reports to comply with the K041 categories to make benchmarking across the Trust and with other comparable organisations easier.	Achieved	complaints now coded against K041 categories
Review of the Public and Patient Service Department	Achieved	Department was reviewed
Achieve the KPI of 80% of complaints completed within the agreed timescale	Achieved	Information included in this report
Reporting of complaints to Divisional Leaders	Achieved	Information shared monthly
The additional of risk assessment information to the complaint reporting processes	Achieved	Information included in this report

Appendix B

Trust Risk Rating Matrix

	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 riskRed = HIGH risk**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Finance & Performance Overview**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Director of Finance & Performance**
AUTHOR:	**Various**
DATE OF MEETING:	**5th October 2016**

EXECUTIVE SUMMARY:

This paper, alongside the Quality & Patient Safety report, replaces the old Corporate Performance report as the mechanism for reporting performance against the Trust's key targets and performance metrics.

The report covers the main performance metrics related to finance, activity, operational efficiency and operational workforce.

The Trust has delivered a cumulative deficit of £2,742,000 as at the end of August against a planned deficit of £1,698,000. In month, the Trust delivered a deficit of £505,000 against a planned deficit of £303,000.

The Trust is therefore £1,043,000 behind plan at the end of M5. During the month of June all operating theatres were closed for a week due to problems with the air filtration canopy system. It is estimated that this closure resulted in a loss of £954,000. Excluding the impact of this closure, the Trust would be behind plan by £89,000. £251,000 of CIP savings were released in August against a plan of £340,000. This increases the overall achievement for the year to date to £1,098,000, £287,000 behind plan

Theatre sessional utilisation has dropped in the first 5 months of this year, and is a key driver for the under-delivery of inpatient activity. This is a focus of the Finance & Activity recovery plan. August saw a significantly increased length of stay, which is in line with increases in casemix. These increases appear to be across the Board, with primary joints also showing a big increase.

August has seen improvements to the vacancy position, staff turnover, sickness absence, and mandatory training versus the July outturn figures.

REPORT RECOMMENDATION:

Trust Board is asked to note this report and discuss actions to be taken with regards to the issues outlined in the 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	**X**	Environmental	**X**	Communications & Media	
Business and market share	**X**	Legal & Policy	**X**	Patient Experience	
Clinical	**X**	Equality and Diversity		Workforce	**X**
Comments:					
ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:					
The Finance & Performance Report, alongside the Quality Report, demonstrates performance against a number of key metrics linked to the delivery of the Trust objectives.					
PREVIOUS CONSIDERATION:					
This report was considered by Finance & Performance committee and TMC in September2016.					

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE REPORT

SEPTEMBER 2016

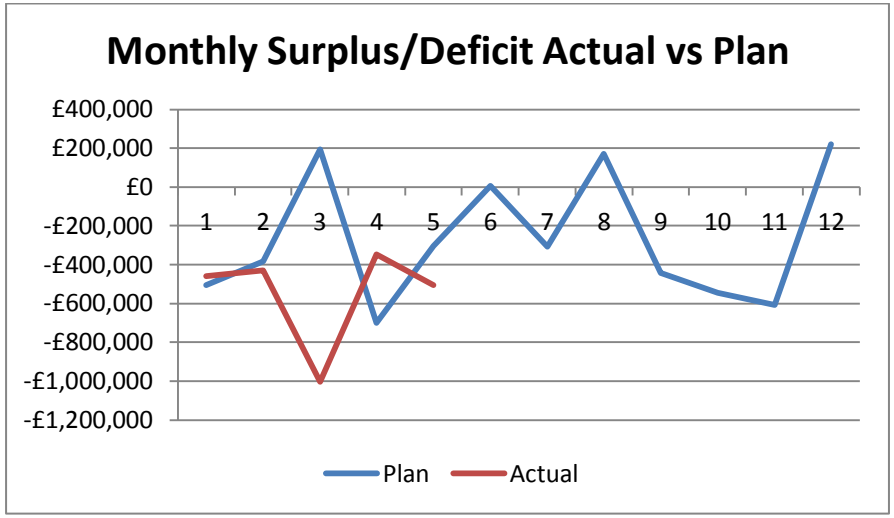
CONTENTS

INTRODUCTION

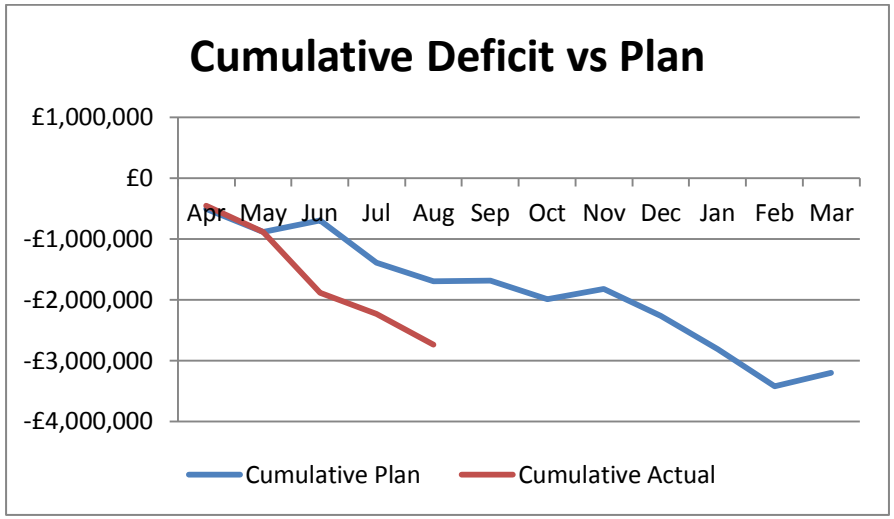
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

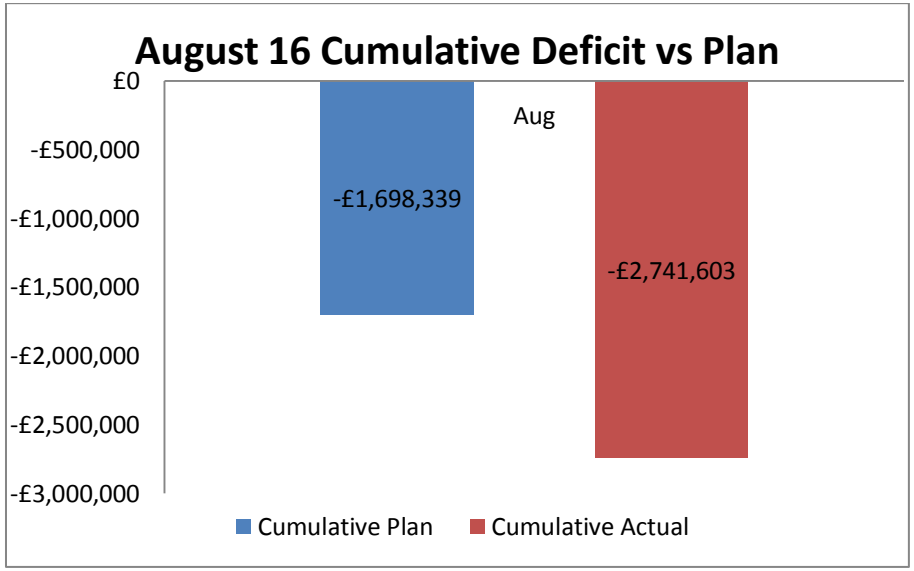
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. **Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Financial Sustainability Risk Rating (FSRR)**



NHSI Financial Sustainability Risk Rating (FSRR)		
	Plan	**Actual**
Capital Service Cover	1	1
Liquidity	4	4
I&E Margin	1	1
I&E Margin – Variance against plan	2	1
Overall FSRR	2	2





INFORMATION

The Trust has delivered a cumulative deficit of £2,742,000 as at the end of August against a planned deficit of £1,698,000. In month, the Trust delivered a deficit of £505,000 against a planned deficit of £303,000.

The Trust is therefore £1,043,000 behind plan at the end of M5. During the month of June all operating theatres were closed for a week due to problems with the air filtration canopy system. It is estimated that this closure resulted in a loss of £954,000. Excluding the impact of this closure, the Trust would be behind plan by £89,000.

Further detail on the key drivers of the financial position is provided in the income and expenditure sections below.

£251,000 of CIP savings were released in August against a plan of £340,000. This increases the overall achievement for the year to date to £1,098,000, £287,000 behind plan.

The deficit position results in the Trust achieving ratings of 1 for our Capital Service Cover, I&E Margin metrics and I&E Margin Metrics against plan. As part of the NHSI Financial Sustainability Risk Rating. The achievement of a 1 in any metric caps the overall performance level for the Trust at a maximum rating of 2, despite receiving the highest available rating for liquidity.

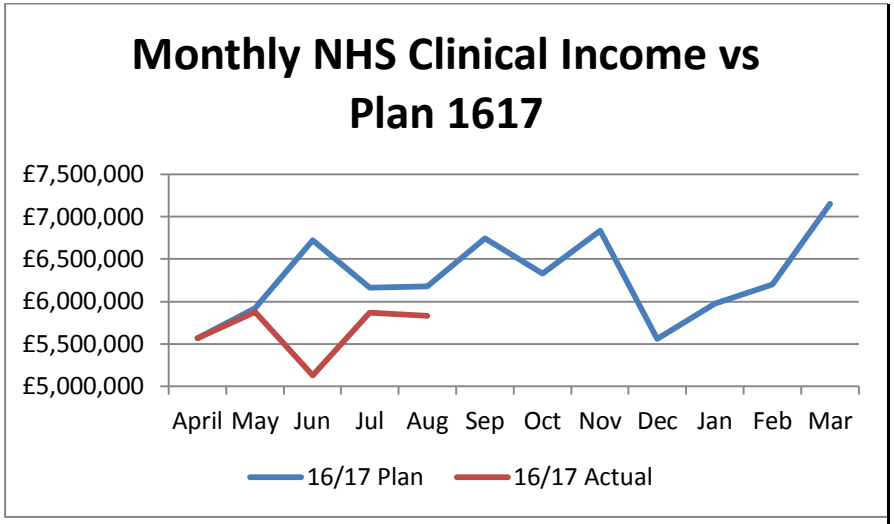
ACTIONS FOR IMPROVEMENTS / LEARNING

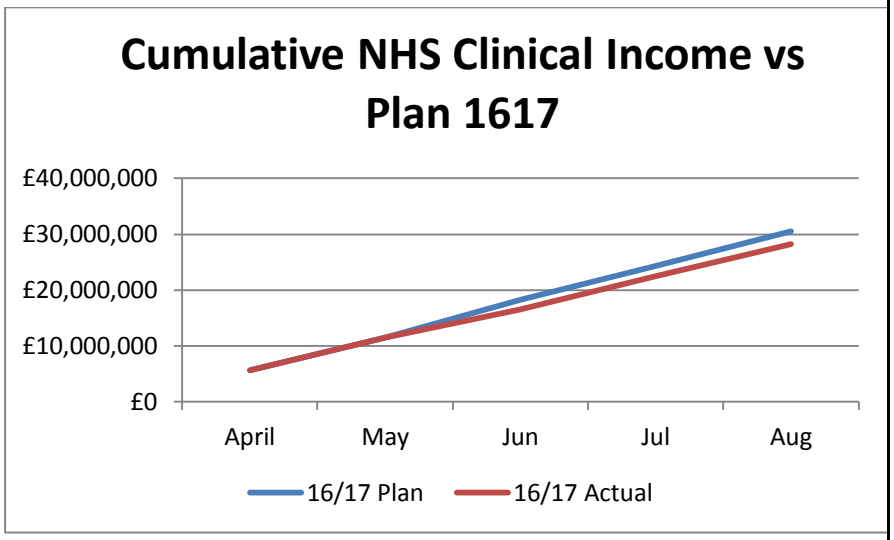
F&P committee in August considered a first stage financial recovery plan, which was also reviewed by NHSI on 13th September. Further work is ongoing to develop clearer actions and milestones against which the recovery will be measured.

RISKS / ISSUES

In order to clawback the shortfall, a significant growth in activity is required moving into the second half of the year. This will put pressure on theatres and wards to ensure that patient flow runs smoothly as there will be no excess capacity in the system. The Trust is not eligible for its £200,000 sustainability funding until our financial position is back in line with our planned trajectory.

2. Income – This illustrates the total income generated by the Trust in 2016/17, including the split of income by category





NHS Clinical Income – August 2016			
	Plan	**Actual**	**Variance**
Inpatients (inc XBDs)	3,217	3,230	13
Day Cases	739	540	-199
Outpatients	677	589	-88
Critical Care	231	291	60
Therapies	228	255	27
Pass-through income	201	157	-44
Other variable income	379	246	-133
Block income	507	527	20
TOTAL	6,161	5,906	(255)

NHS Clinical Income – YTD 2016			
	Plan	**Actual**	**Variance**
Inpatients (inc XBDs)	15,761	14,282	-1,479
Day Cases	3,623	3,185	-438
Outpatients	3,419	3,097	-322
Critical Care	1,132	1,157	25
Therapies	1,154	1,249	95
Pass-through income	1,010	979	-31
Other variable income	1,892	1,804	-88
Block income	2,559	2,635	76
TOTAL	24,373	22,547	(1,826)

INFORMATION

Activity levels were extremely low in August, with inpatient activity underperforming plan by 23%. This was partly due to higher the planned levels of annual leave, but also significantly linked to an increase in casemix. The average tariff for elective inpatients discharged in August was £6,028 against a plan of £5,226 (a 15% increase) and for non-electives, the average tariff was £8,890 against a plan of £6,082 (a 46% increase). At this point, this appears to be an outlier, as the trend for the first 4 months of the year does not support a gradual and continual increase in casemix, however it does provide some rationale for the lower activity numbers achieved in month.

Day case and outpatient numbers also saw a drop in activity linked to higher than planned absence, however this was not offset by any case-mix changes.

ACTIONS FOR IMPROVEMENTS / LEARNING

A full activity recovery plan has been developed to clawback activity shortfalls to date. Actions within this plan include:

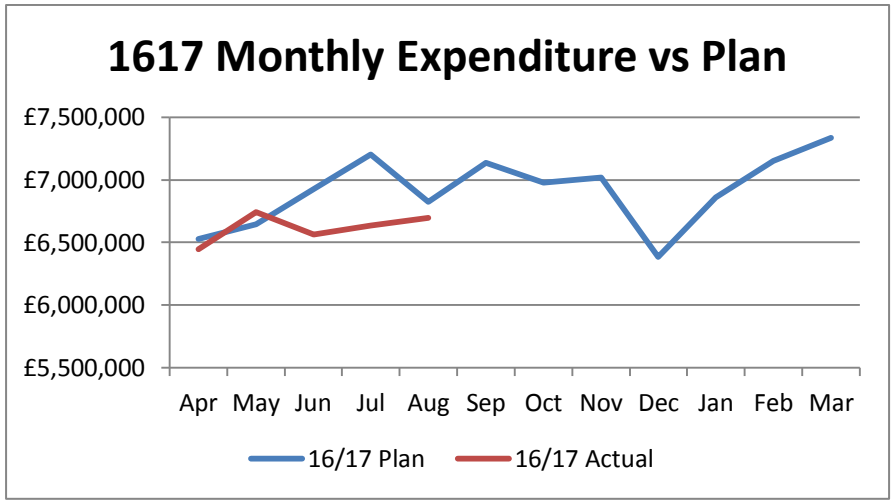
- Improvement in utilisation linked to new recruits (Spinal, Oncology, Pain Management, Radiology)
- Targeted weekend work for those surgeons with 18 week backlogs
- Revisions to the theatre timetable to make more effectiveness and productive use of planned slots
- Targeted work with key firms to increase in-session utilisation
- Focus on pre-op and theatre booking processes to reduce theatre cancellations
- Development of support from clinical teams to support more effective recycling and sharing of lists.

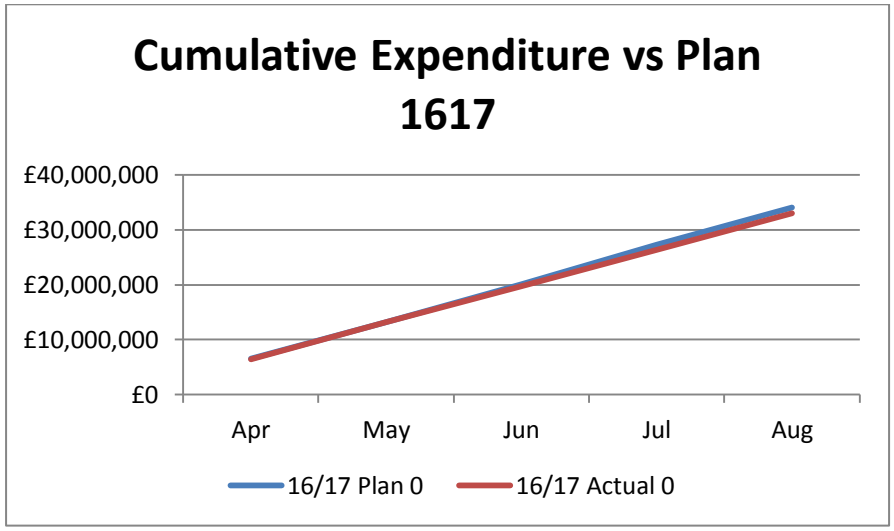
RISKS / ISSUES

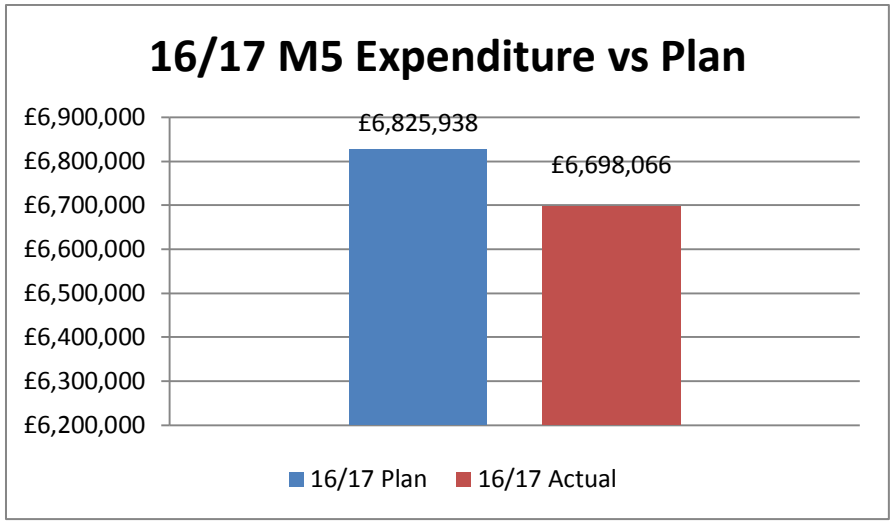
The level of activity required to deliver a full clawback is in excess of the ceiling levels delivered over the last 18 months. There is a major risk that, if enabling actions across other areas of the Trust are not successful, the hospital system will be unable to deliver the range of capacity required to meet planned activity levels.

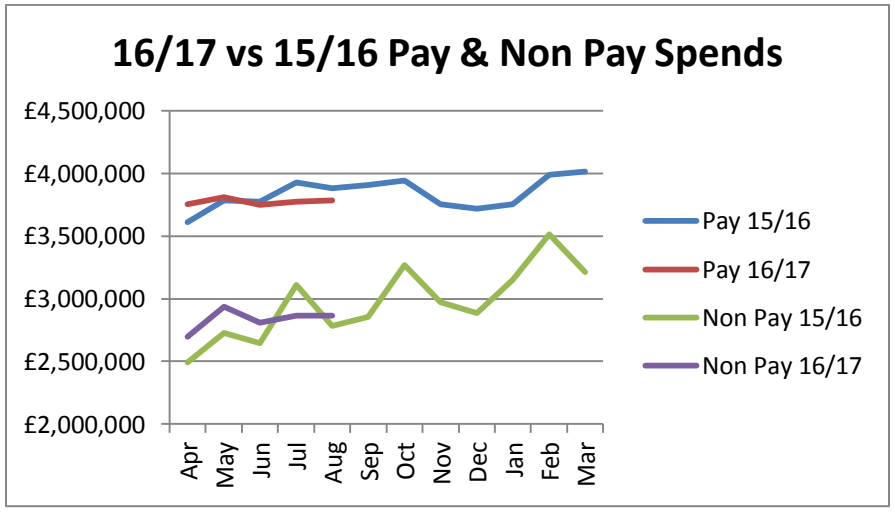
The governance processes around day-to-day challenge of key actions are now in place to attempt to mitigate this risk

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2016/17, compared to historic trends









INFORMATION

Expenditure levels remain reasonably consistent across 2016/17, and continue to deliver below the plan set as the start of the year. For the year to date, expenditure levels are over £1m below plan.

Pay increased slightly in month, despite planning for a slight reduction in line with school holidays. This was driven by an increase in agency spend acros both medical locums and nursing. This is described in more detail in section 4.

Non pay remains stable, however again the planned level of reduction against July's spend was not achieved. This reflects the increased casemix of patients as described in section 3.

ACTIONS FOR IMPROVEMENTS / LEARNING

F&P committee in August considered a first stage financial recovery plan, which was also reviewed by NHSI on 13th September. It highlighted that, whilst expenditure was currently below plan, a combination of activity clawback (some at premium rates) and new costs relating to the RCPCH review are likely to significantly reduce this underspend by the end of the year.

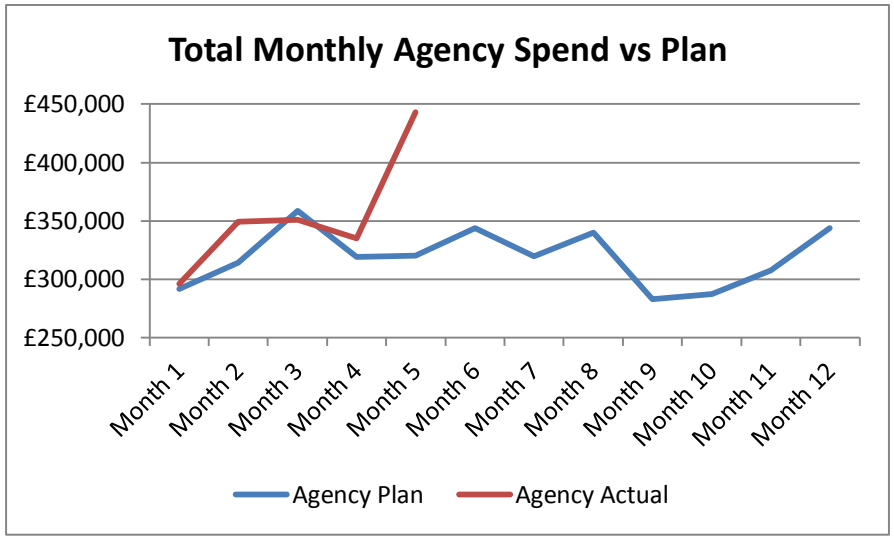
A detailed action plan is in place with regards to agency staffing and overall workforce controls. This is described in section 4.

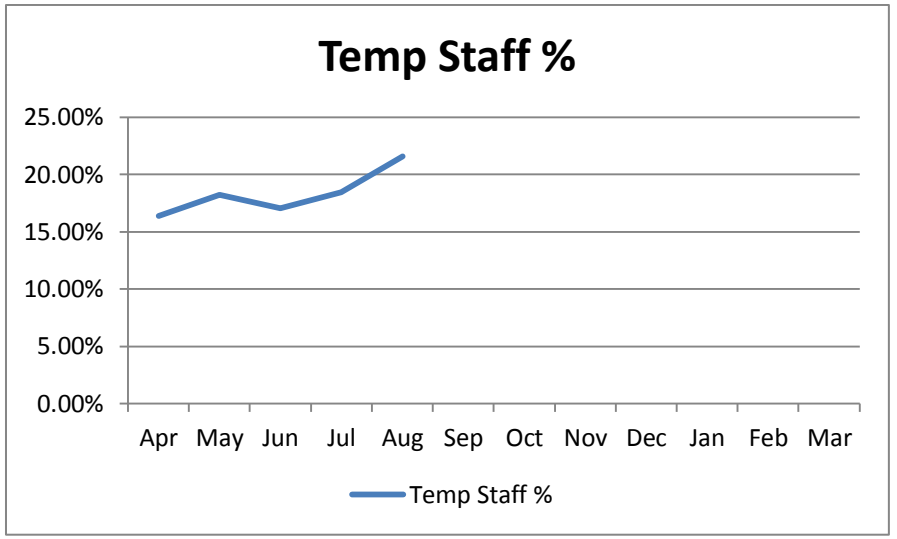
RISKS / ISSUES

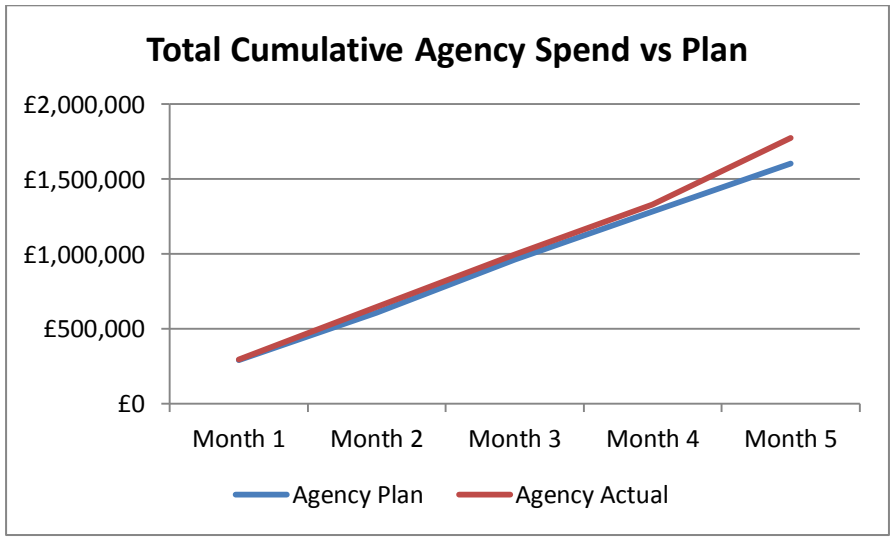
The implementation of recommendations relating to the review into theatre stock control and processes continues, however until full cyclical stock takes are completed, there remains a risk around the robustness of non pay spend within the ledger.

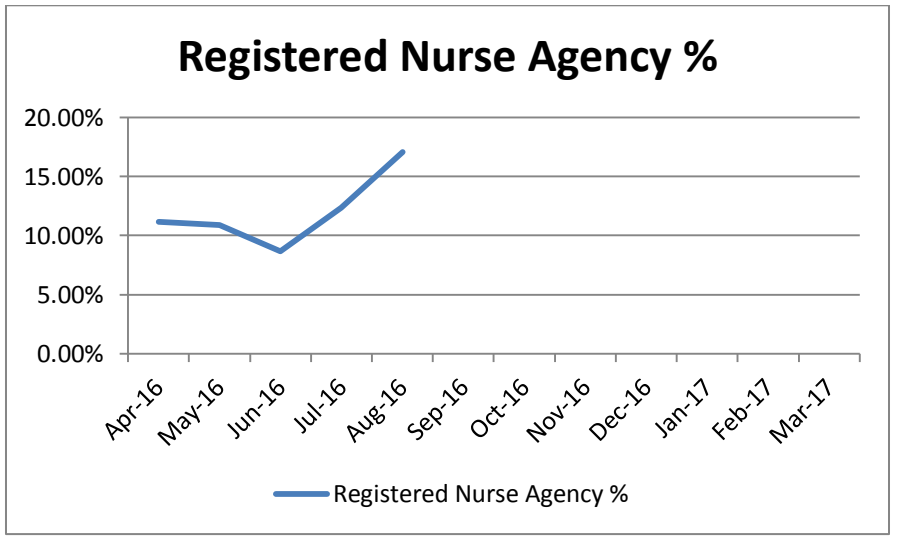
Unplanned pressures in the junior doctor rota are expected to result in a continuation of the overspend against agency trajectories into Q3.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2016/17, and performance against the NHSI agency requirements









INFORMATION

There was a significant increase in the level of agency spend in August, with £443,000 being spend on locum and agency staff against a plan of £320,000.

There were 3 key issues driving the overspend:

- A lapse in controls relating to spend on junior doctors and theatres staff
- Three more locum doctors in month than plan – 1 due to maternity leave (unknown at time of plan as junior doctor), one additional doctor authorised via lapsed controls, one unplanned vacancy (usual supply from military doctor not continued).
- Increased agency usage on wards without obvious cause (sickness and vacancy position is marginally improved).

It has been suggested that an increased number of in-patients needed enhanced care (specialing) during August. The fact and scale of this is to be explored.

ACTIONS FOR IMPROVEMENTS / LEARNING

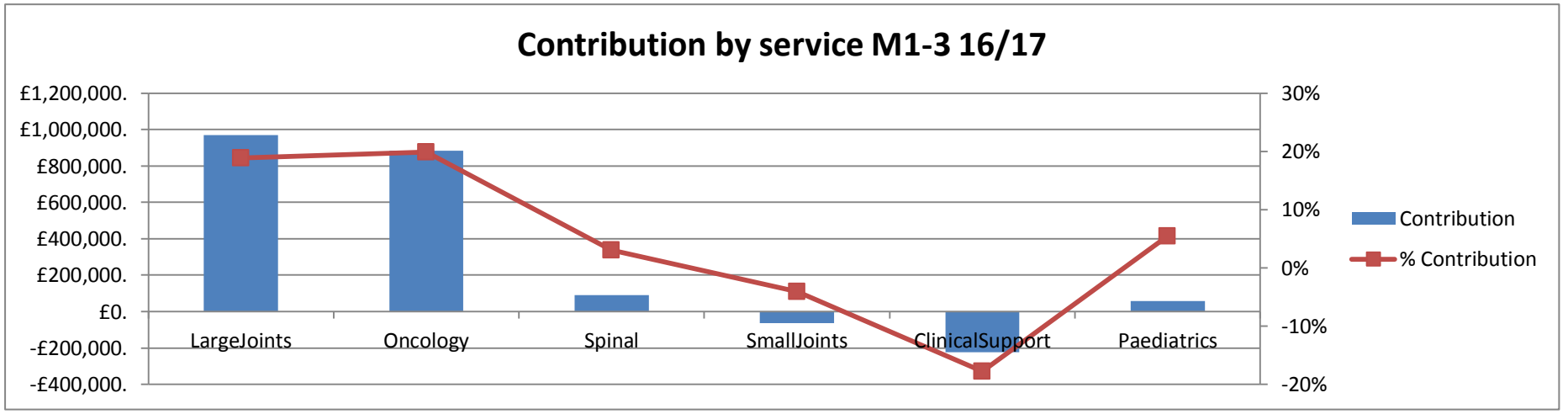
A detailed action plan is in place to address the ongoing trajectory of increased spend. The main actions include:

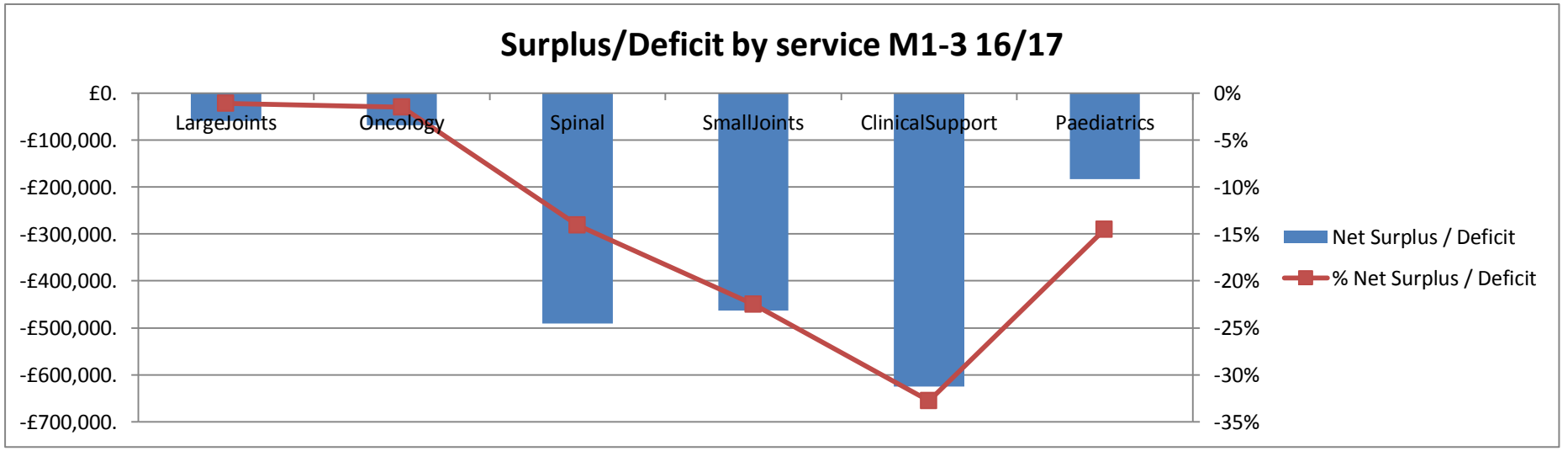
- A reprofiling of expenditure based on known factors
- Enhanced delivery of Healthroster to partially offset variance from plan
- Implementation of the new POAC workforce model from January 2015
- Further review of short term mitigations
- Increasing quantity of substantive clinical workforce
- Improved oversight and governance via the multi-professional agency group, reporting up to Finance and Performance Committee

RISKS / ISSUES

Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is now being built into the Single Oversight Framework from Q3. An overspend against the trajectory will therefore have a direct impact on our regulator ratings.

5. Service Line Reporting – This represents the profitability of service units, in terms of both consultant and HRG groupings





INFORMATION

The graphs above, and the associated narrative, relate to the Quarter 1 of 2016-17.

The first graph is showing the contribution each service is generating, currently the Trust target is set at <20%. Oncology has been the only service to have achieved this set target at the end of the first quarter of the year. Clinical Support and Small Joints are the only services to have provided a negative contribution. Clinical Support's negative contribution has mainly been due to vacancies within the service and the associated premium costs of maintaining waiting time compliance.

The contribution of Spinal services has reduced in month, linked to a number of very high costing procedures undertaken at BCH. The finance team is currently working with spinal surgeons to review the patient costs and ensure that the Trust has been recharged any costs at an appropriate level.

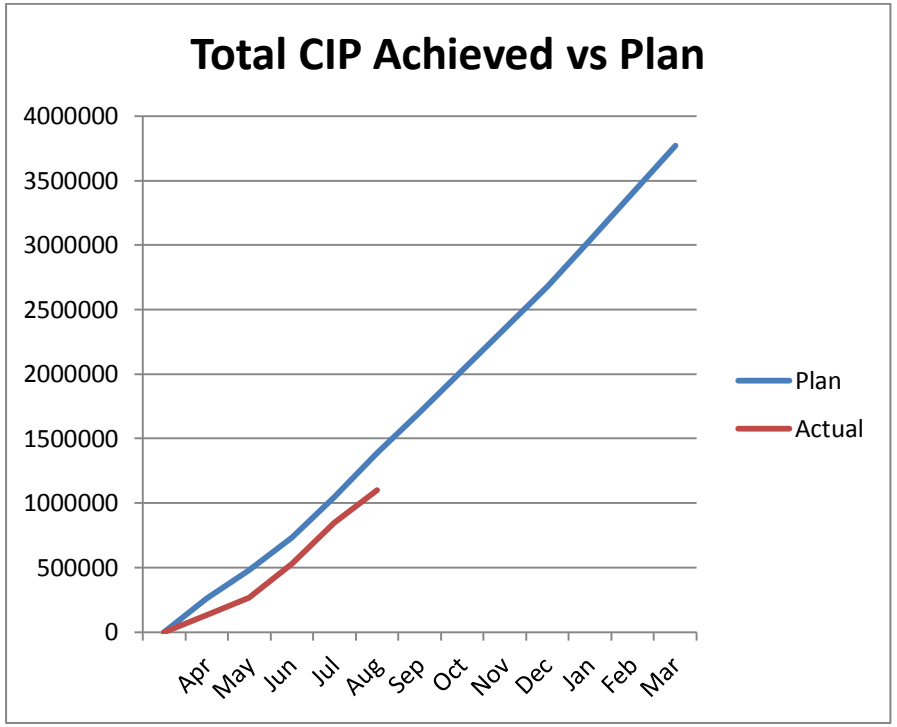
It can be seen that once the finance costs for overheads, depreciation and interest are applied; all service lines are then running at a net loss, this is reflected in the overall Trust position of a £1.89m deficit in the first 3 months of 2016-17. The closure of theatres in June has clearly had an impact on this position.

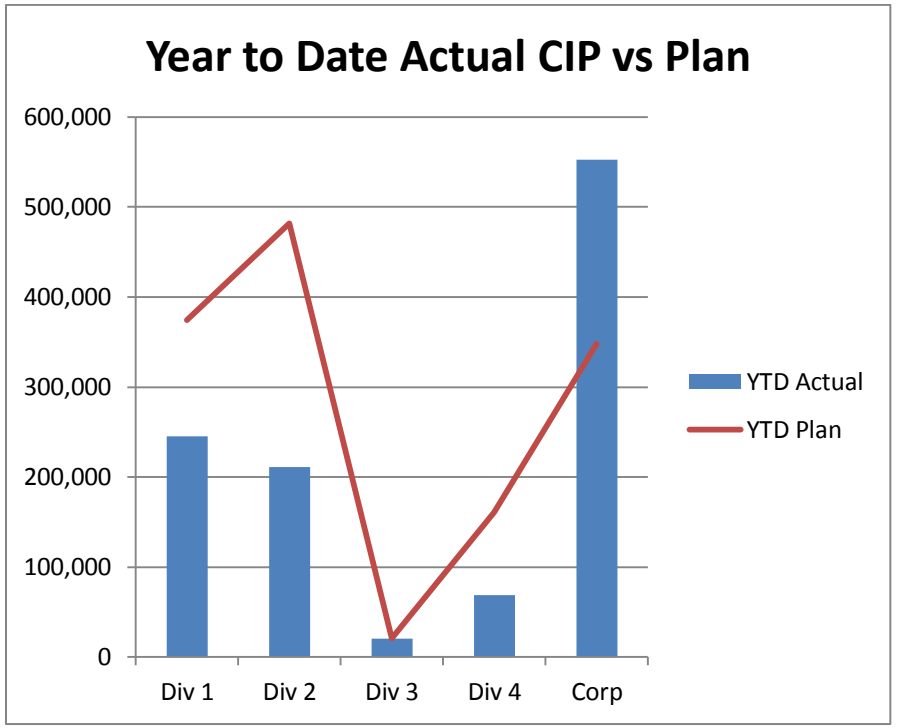
ACTIONS FOR IMPROVEMENTS / LEARNING

It is important that the use of SLR is embedded into the Trust, as this information provides the vehicle to challenge clinical and price variation at all levels. SLR reporting will form part of the divisional reporting moving forwards, and will be challenged at monthly performance meetings.

RISKS / ISSUES

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2016/17





INFORMATION

As at the end of Month 5, the Trust has recognised £1,098k of savings, against a plan of £1,385k. £314k (28%) of savings to date are non-recurrent. The in month savings recognised were £251k against an August target of £340k.

With regards to key schemes, the following actions have been taken or are in the process of being taken to deliver savings through the remainder of the financial year:

- A staffing model has been agreed by a multi-professional group, and job adverts are being placed, to deliver a revised pre-op workforce model for January 2017. This will enable locum doctors to be removed and support the medical staffing CIP.
- Meetings are being held with key implant suppliers on 4th October to gain agreement to costing structure proposed by the Trust.
- A revised offer has been received from NHS Supply Chain will also provides an opportunity for implant savings.
- The Trust is developing the scope for a piece of joint work with UHB and HEFT to review prices paid for a range of clinical products.
- Business cases have been approved and recruitment in ongoing to support the transfer of anaesthetic and theatre staffing costs from agency to substantive.

The majority of undelivered CIP schemes are still rated as medium or high risk in terms of likely delivery. Further work is required by CIP leads to ensure that these schemes are delivered, and that additional mitigation schemes are developed to cover any future slippage. Some of this information is described within the financial recovery plan.

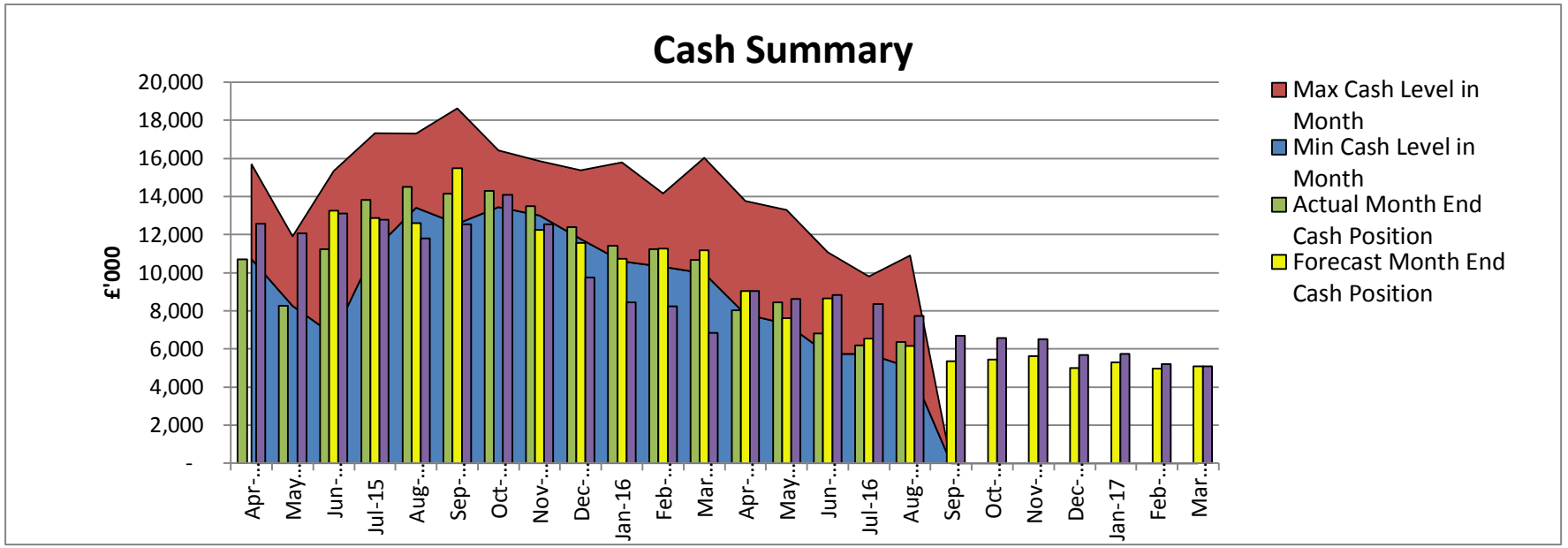
ACTIONS FOR IMPROVEMENTS / LEARNING

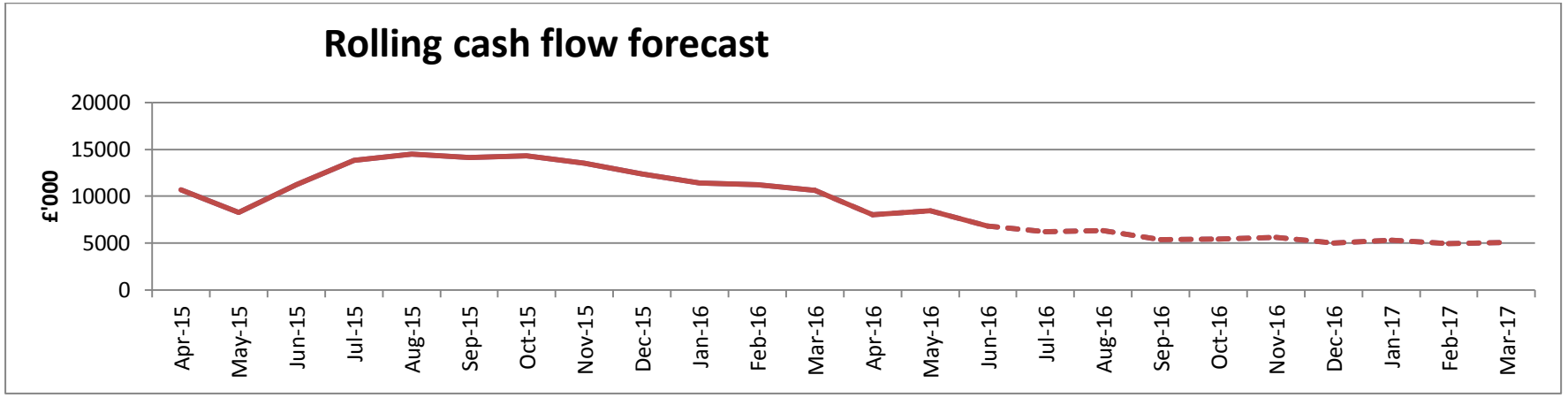
There are still gaps in some areas with regards to the required CIP documentation, largely relating to implementation plans and QIAs however the majority of these relate to newly developed schemes within the Corporate Division. A mid-July deadline was set for this paperwork to be completed and the majority of the QIA's have been received. For the QIA's that are outstanding, all Leads have been reminded to submit their paperwork.

RISKS / ISSUES

The CIP target of £3.67m represents a significant challenge to the Trust. It is vital that we remain on target in the early months as it will not be possible to make significant clawbacks against this level of savings target later in the year.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet





INFORMATION

A cash levels are £1.35m million lower than planned levels at the end of August 2016. The Trust is forecasting an end of year cash balance of circa £5m, which relies upon the delivery of our deficit plan and the control of capital spend within the budget that has been set.

The lower than planned cash position is mainly linked to the increased deficit, with some changes in overall working capital levels.

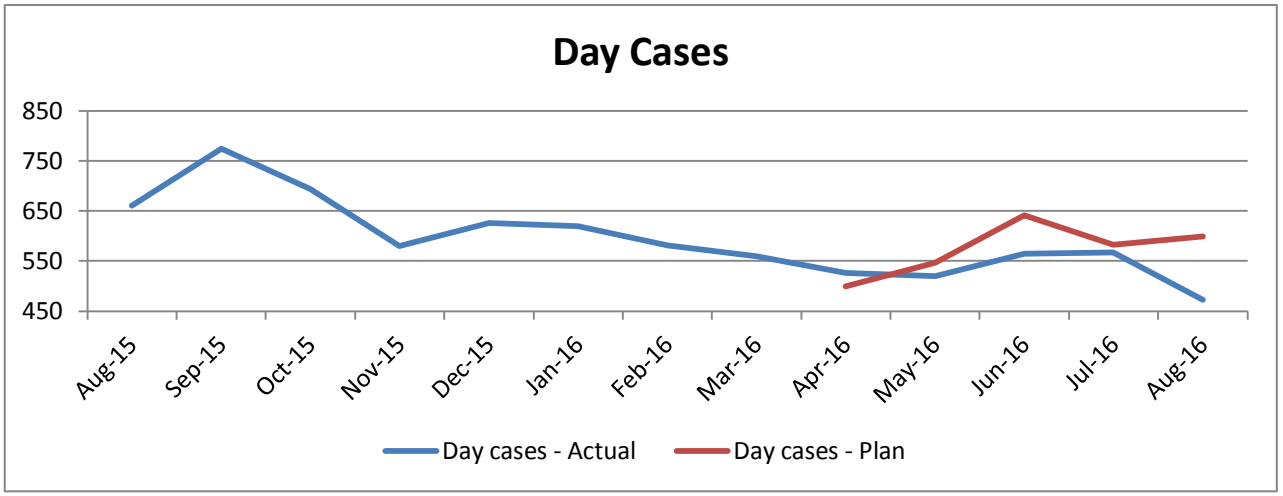
ACTIONS FOR IMPROVEMENTS / LEARNING

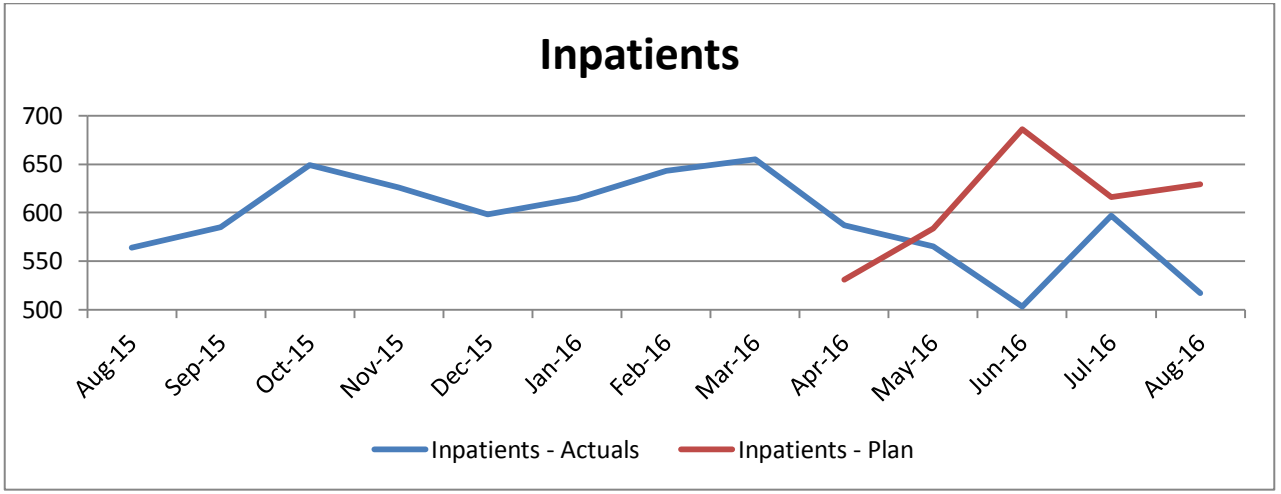
The Financial accounting team are continuing to review opportunities to improve the monitoring and projection of working capital movements, particularly in relation to early warnings around stock purchases and issuing.

RISKS / ISSUES

Given the in-month fluctuation of the cash position, which can potentially hit levels £1m-£2m below month end figures before mandate payments are received, it is vital that financial projections are met to ensure that cash can be comfortably managed within safe tolerances.

8. Activity: Admitted Patient Care – This illustrates the number of inpatient and day case discharges in the month, and year to date

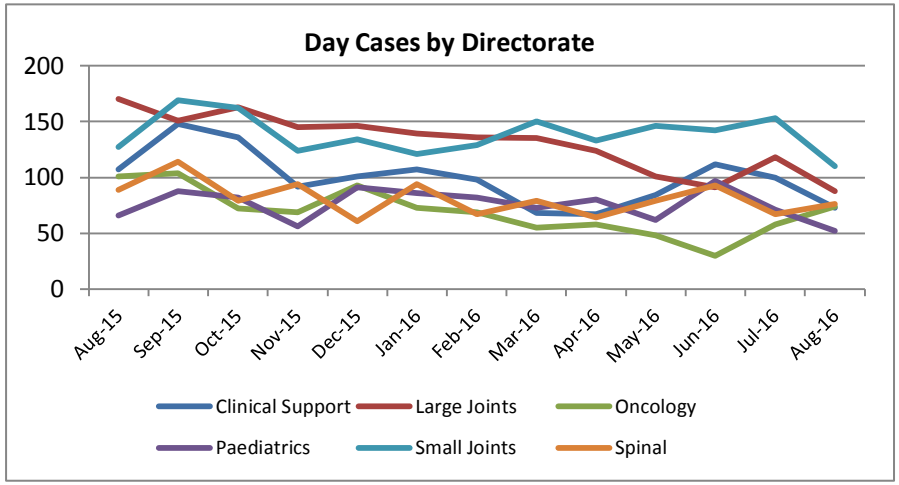


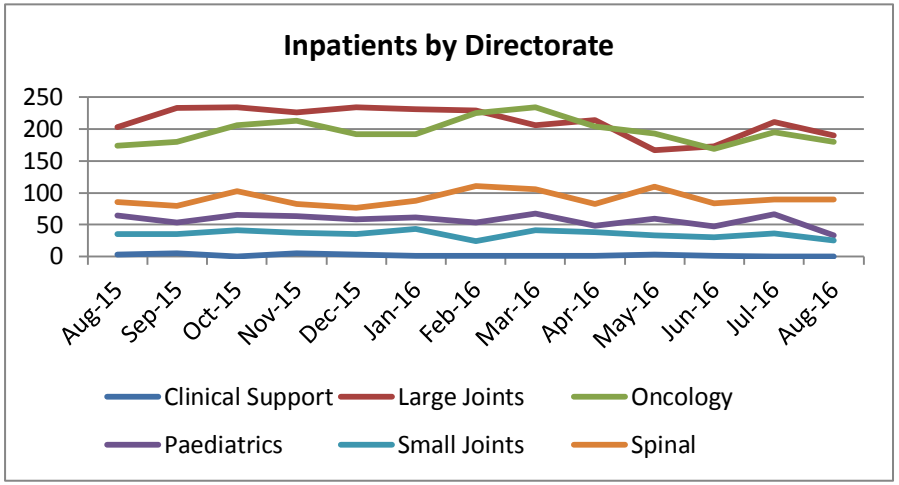


INFORMATION

As stated in Section 3, Inpatient activity was down by 22% against plan in August, with day case activity also down by 21%. As the graph above shows, this was also low compared to the equivalent period in 2015, although case-mix played a major part in the reduction in inpatient numbers.

As the graphs below show, Large Joints activity has shown a particular reduction in the last quarter both in day case and elective numbers. The most notable reductions in August were around small joints and paediatrics, with small joints impacted by the long term absence of a key member of the team.





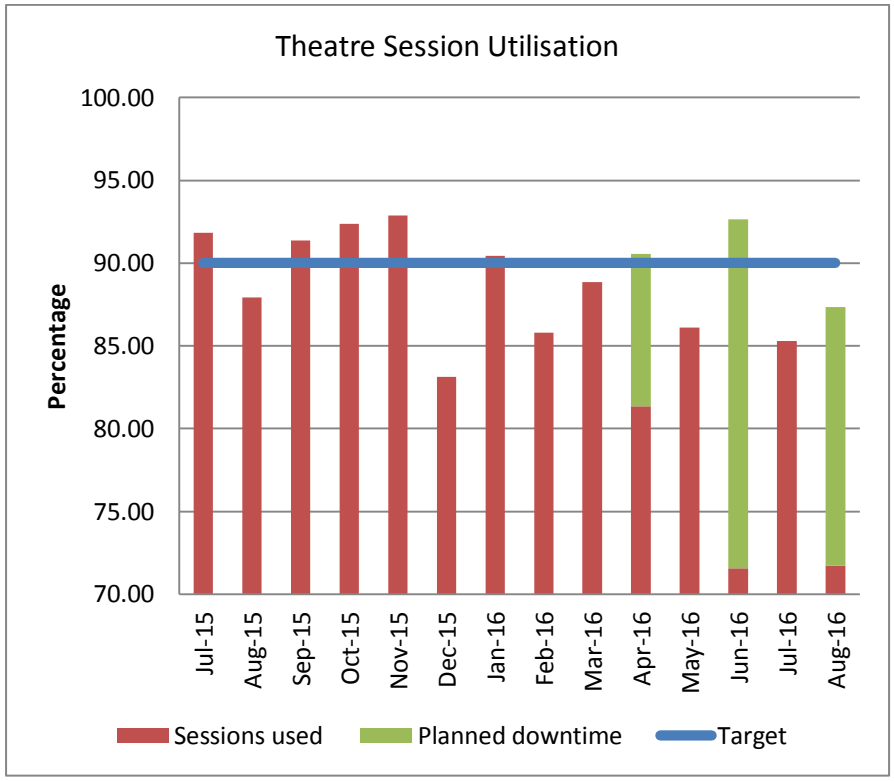
ACTIONS FOR IMPROVEMENTS / LEARNING

See Section 2

RISKS / ISSUES

See Section 2

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

340 sessions were used in August, with a further 74 taken down in a planned way to utilise the opportunities created by low surgeon availability to ensure that key maintenance works were completed. The 74 also includes the full closure of theatres on the Friday before the Bank Holiday weekend to enable building works around HDU to be undertaken.

Overall utilisation was only 72% for August and, even taking into account planned closures, this only reached 87%

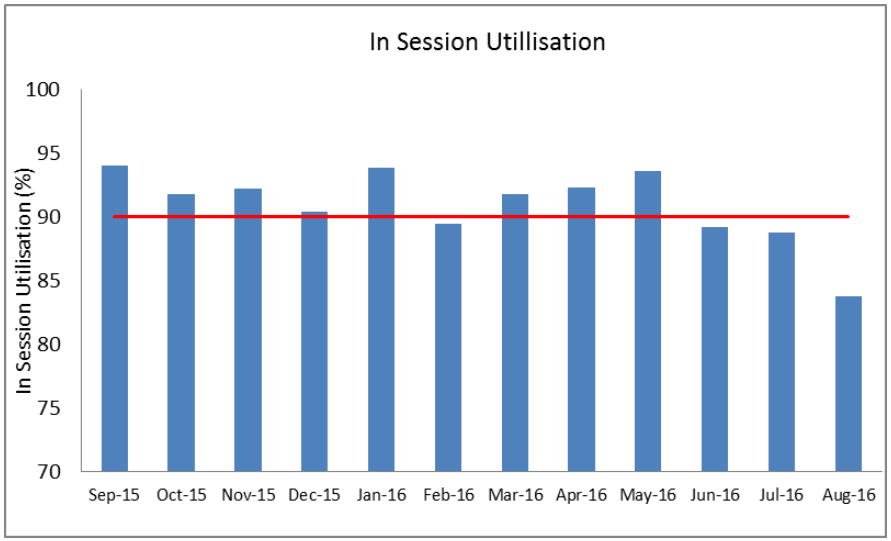
ACTIONS FOR IMPROVEMENTS / LEARNING

A review of theatre timetables as part of the job planning programme has highlighted the potential for changes which could support an increased utilisation of sessions in the second half of the financial year. A number of the new consultant appointments have also agreed a flexible job plan involving one full day "floating" theatre session per week, so that should enable a greater fill-rate of spare sessions.

RISKS / ISSUES

Engagement in the job planning process and delivery of timescales. Notice required to establish buddying timetable arrangements and co-ordination of leave evenly through the year.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



Add graph showing theatre in-session usage by month – may need to wait for Theatreman for this

INFORMATION

Utilisation against this measure had remained consistently above the target 90%. However, the previous measure was flawed in that it included the overrun minutes in the numerator, against the planned time available in the denominator. From June, this has been amended to follow national best practice with overrun minutes not included.

A realistic target against this measure is 85% however for the first time this year, this level was not achieved in August. It is not clear at this point as to why in-session utilisation has reduced, however the increased complexity is likely to play some part given that it is often simple cases that allow sessions to be filled up to an appropriate level.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are a range of actions being undertaken as part of the Patient Journey 2 project to ensure continual improvement in theatre in session utilisation, focussing on start time, turnaround, optimal list composition and the eradication of unplanned overruns.

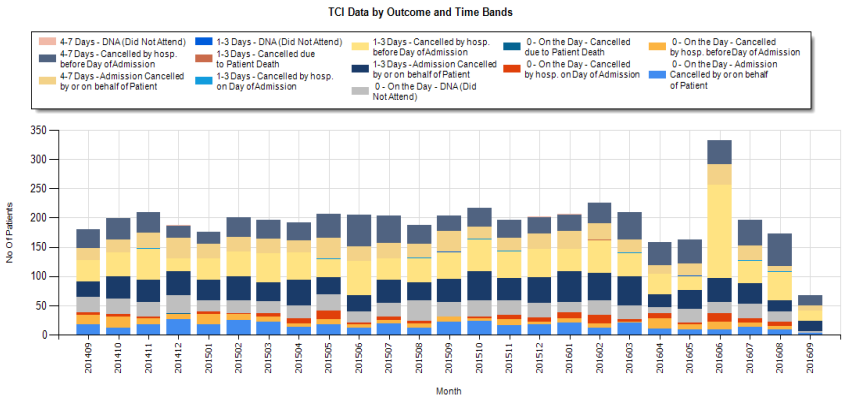
The implementation of the new Theatre Management System (Theatreman) planned for December will be a further vehicle to ensure that lists are optimally booked based on the available time.

RISKS / ISSUES

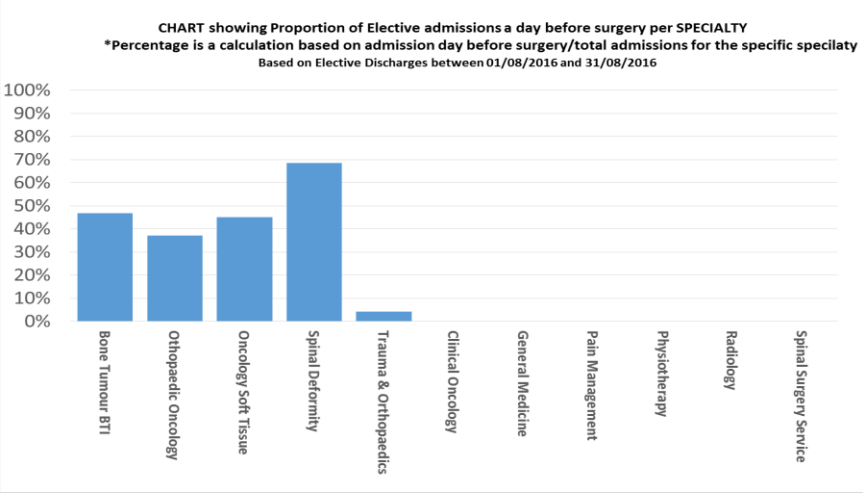
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (eg experience in spinal scrub) to ensure the best possible use of available operating time.

11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

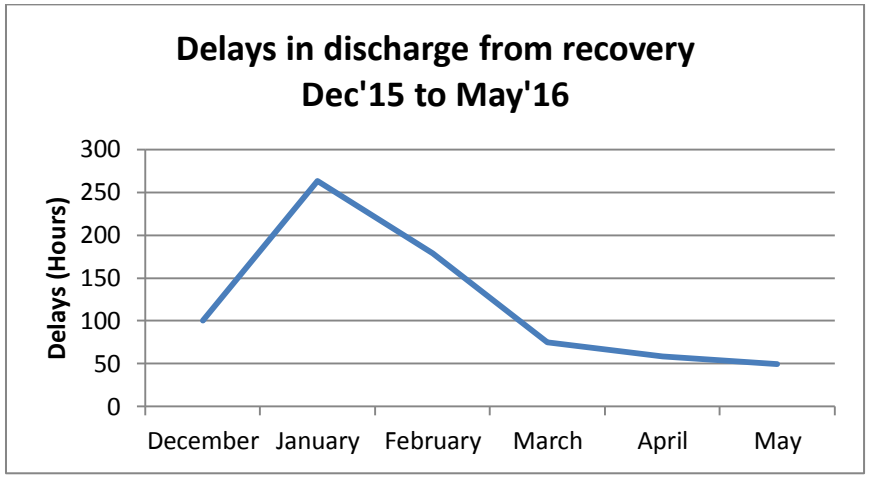
Cancellations by patient / hospital



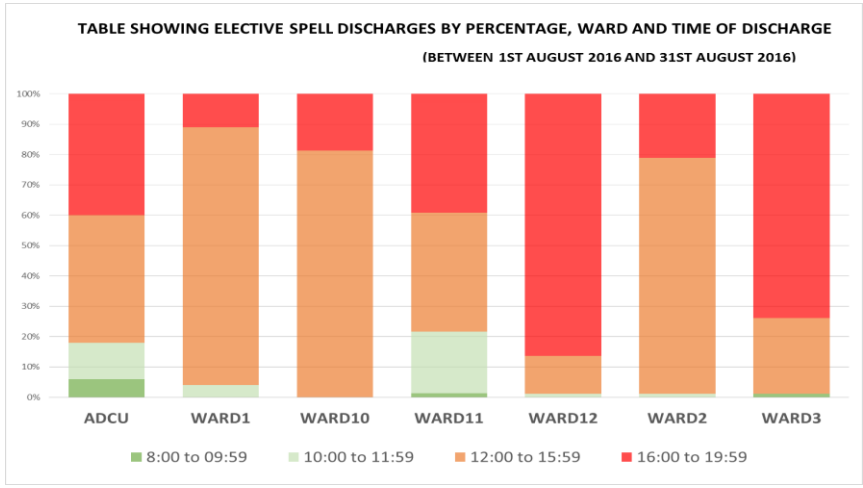
Admission the day before surgery



Delays out of recovery



Time of day patients discharged



INFORMATION

Cancellations have again remained slightly higher than the improved levels noted in April and May, however they continue to be lower than the numbers seen across 2015-16. Some improvements to the booking of equipment following discussions with medical secretaries have been noted in recent weeks, however problems with medical cancellations linked to poor pre-operative processes still remain.

No major changes have been noted with regards to reducing the number of patients admitted on the day before surgery, with almost half of all Oncology patients admitted early. The improvement in Spinal Deformity noted in July also seems to have been an outlier as August performance has returned towards the previously reported levels.

ACTIONS FOR IMPROVEMENTS / LEARNING

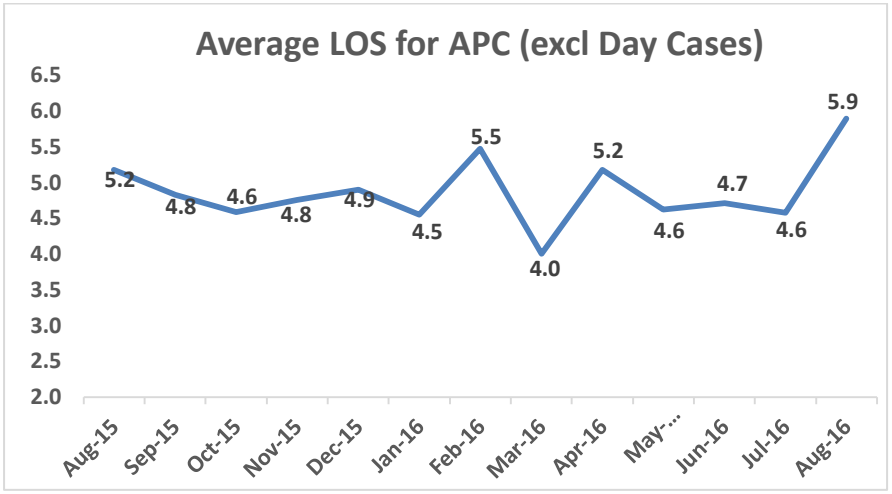
Continued work is required to ensure that all specialties have a pool of patients who are pre-op'd and available to be called in at short notice to fill cancellation slots. A new pre-operative department workforce model has been agreed which, as well as removing expensive medical locums, will also generate some additional slots to enable more patients to be reviewed prior to surgery.

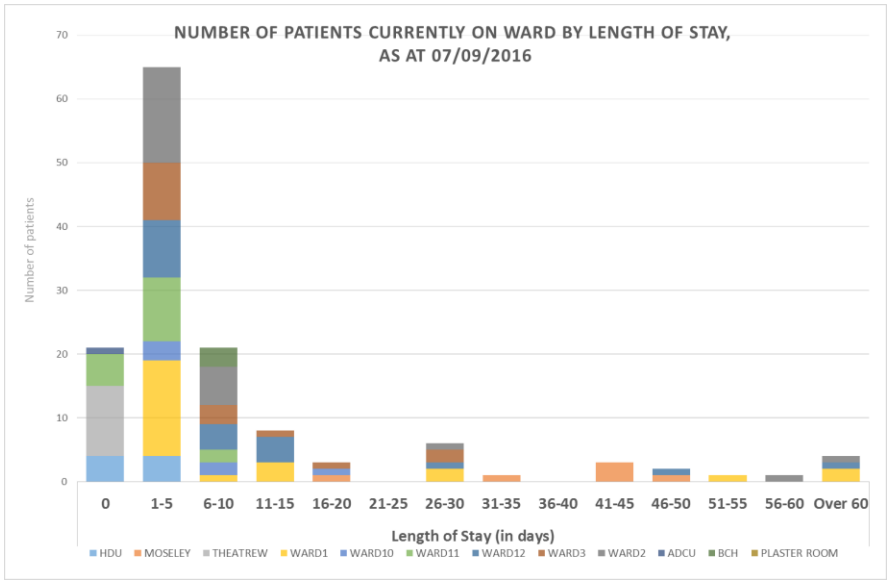
Work is required to draft and agree criteria for admission night before – clinical and social (ie if someone is coming from a long way) for agreement with consultants. This will form part of the new length of stay forum, chaired by the Head of Nursing for Division 1, who will be ensuring actions are in place to support the delivery of the Trust's recovery plan.

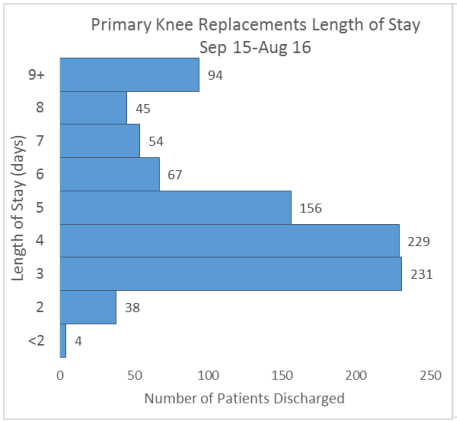
RISKS / ISSUES

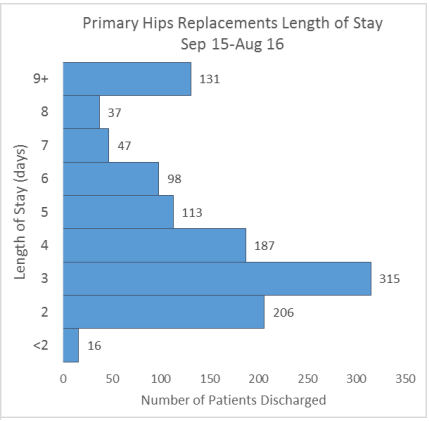
As activity increases in line with the profiled plan, it will become increasingly difficult to sustain admission before the day of surgery, and necessary to achieve a higher level of discharges before midday. This is covered within Patient Journey 2.

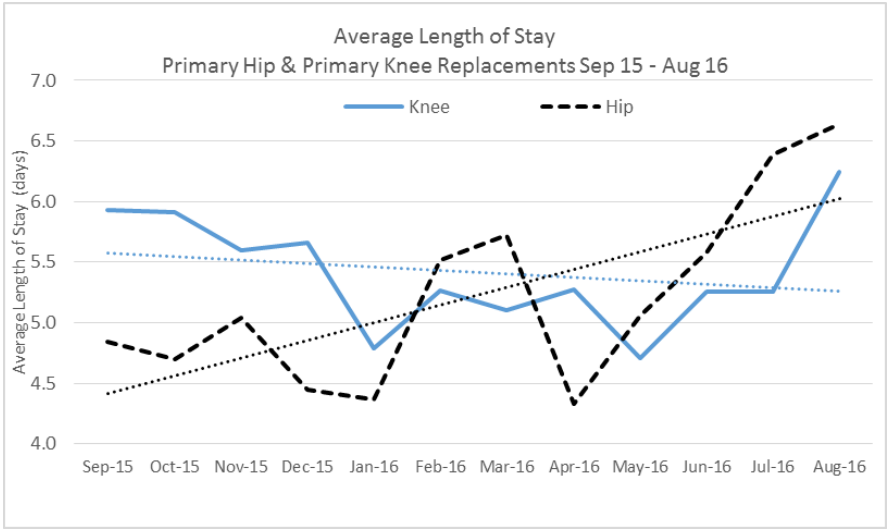
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

August saw a significantly increased length of stay, which is in line with the increases in casemix noted earlier in this paper. These increases appear to be across the Board, with primary joints also showing a big increase. The rapid recovery programme will place particular emphasis on reducing this trend.

Even with some of the long-stay discharges which impacted on the length of stay figures in August, the number of patients in beds for over 40 days at the end of the month increased from 9 to 11. Actions are being taken to review the bed co-ordinator role (which has suffered in recent weeks due to sickness) to ensure that it is working effectively to support discharge for this key group of patients.

ACTIONS FOR IMPROVEMENTS / LEARNING

Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.

The Rapid Recovery project places particular focus on the actions needed to speed up discharge, initially in our primary joint pathways. This is anticipated to have a significant impact on length of stay in this area.

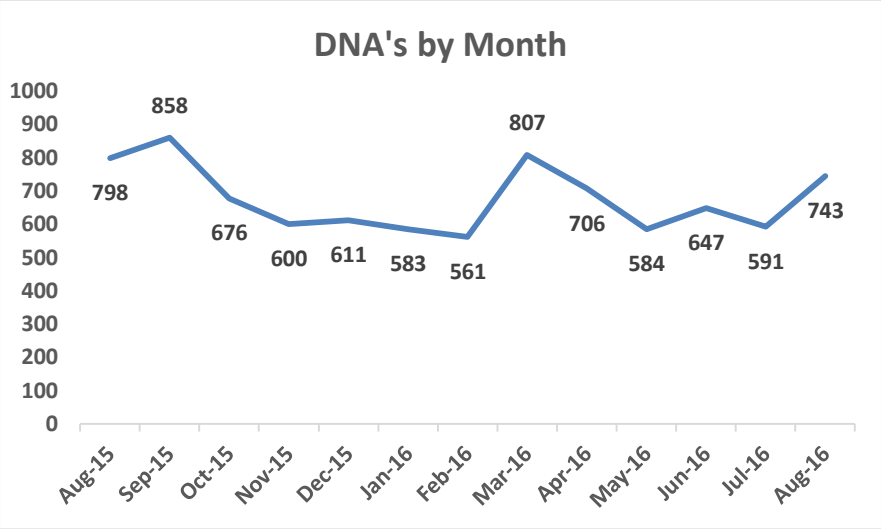
More formalised ward reviews should be part of consultant job planning discussions, which will be helpful in speeding up decision making and therefore shaving days off individual patient length of stay, or bringing discharge earlier in the day so that the bed can be recycled for incoming patients.

A length of stay forum has been set up to ensure delivery of a range of key actions aimed at ensuring sufficient bed capacity is available to meet activity increase.

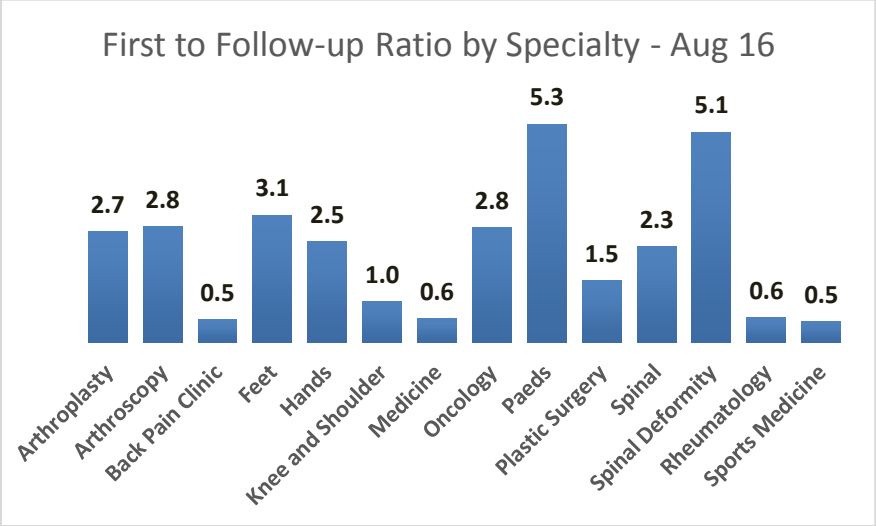
RISKS / ISSUES

With a defined bed stock, these changes need to happen at pace in order to deliver the commissioned level of activity.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients



Graph showing average waiting time in outpatients by month under development



Graph showing under / overbooking of clinic by specialty under development

INFORMATION

DNAs increased in August, although historic data would suggest that there is potentially a seasonal trend here linked to patient availability over the summer holidays.

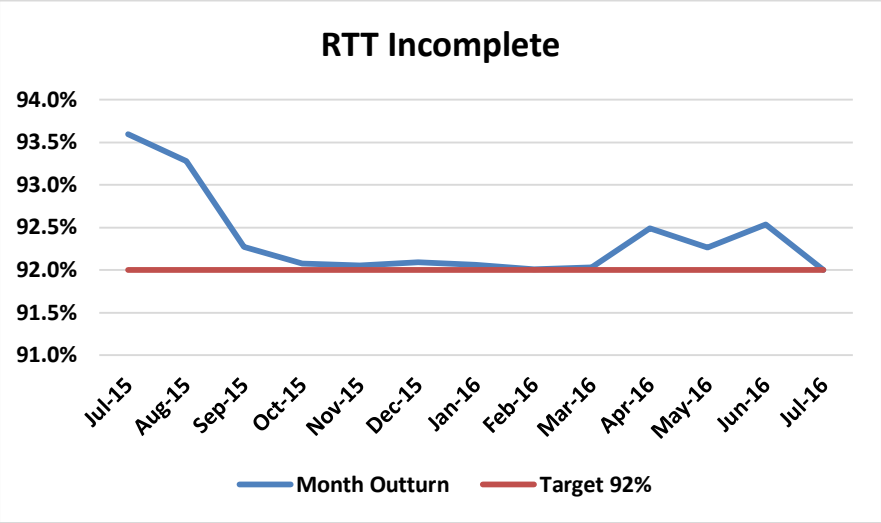
ACTIONS FOR IMPROVEMENTS / LEARNING

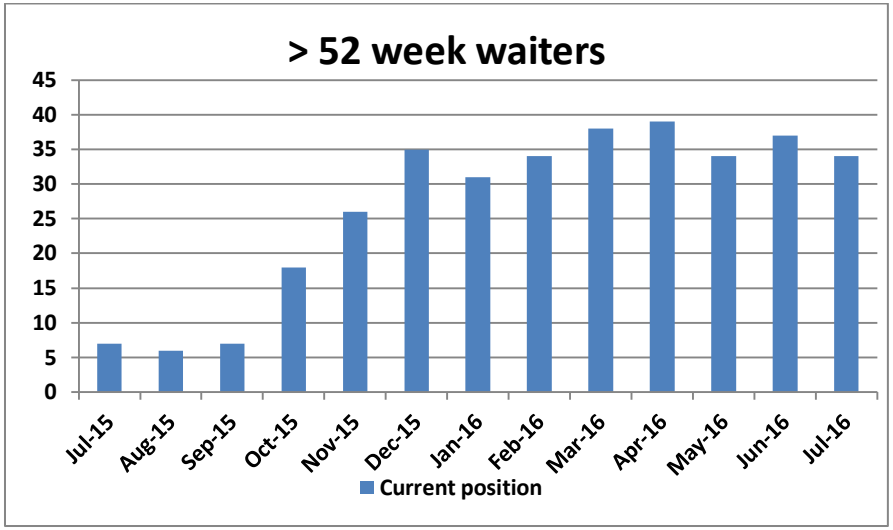
There are a range of actions as part of Patient Journey 2, and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

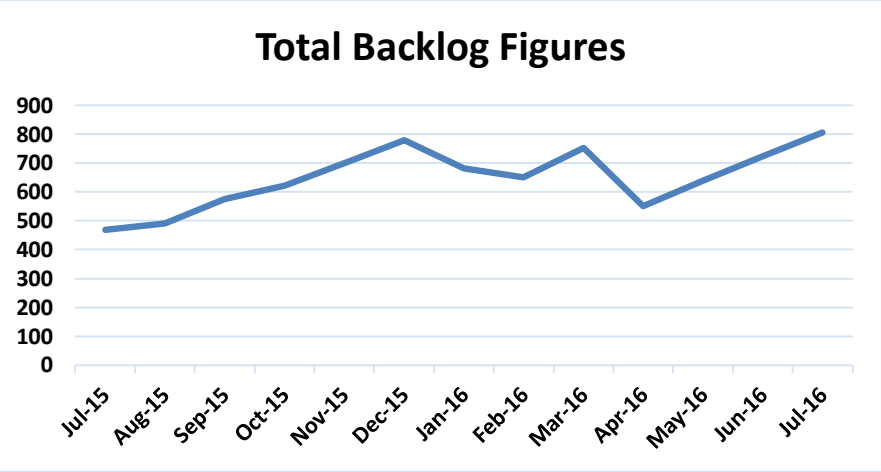
RISKS / ISSUES

Clinical engagement in the redesign of patient pathways.

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets	Target / Trajectory	Actual (July)	Actual (YTD)
52 week waiters	52	34	
18 week RTT	92%	92.00%	
Cancer (2 week wait)	93%	100%	100%
Cancer (31 days from diagnosis for 1st treatment)	96%	91.67%	96.55%
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	94.44%
Cancer (62 days)	85%	N/A	N/A

INFORMATION

This data is not available at the time of writing the report. It should however be noted that the number of backlog patients is continuing to rise, increasing the risk of breaches of the 18 week target.

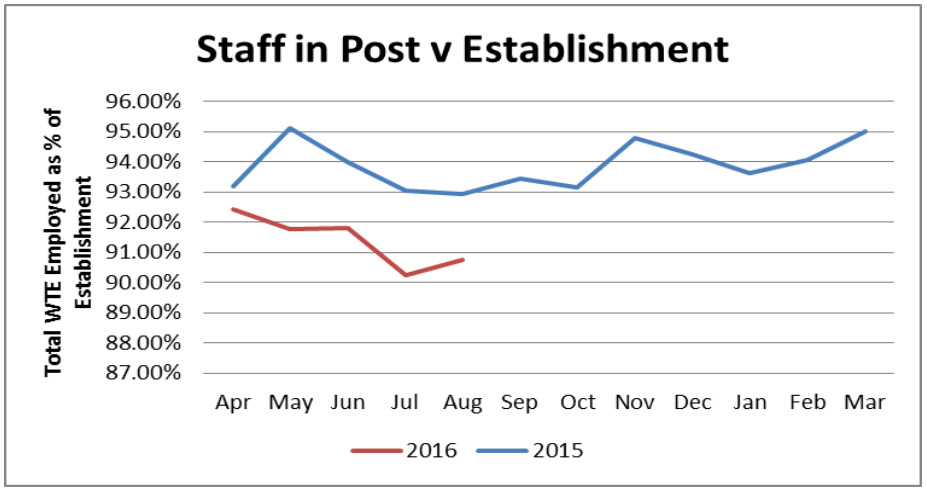
ACTIONS FOR IMPROVEMENTS / LEARNING

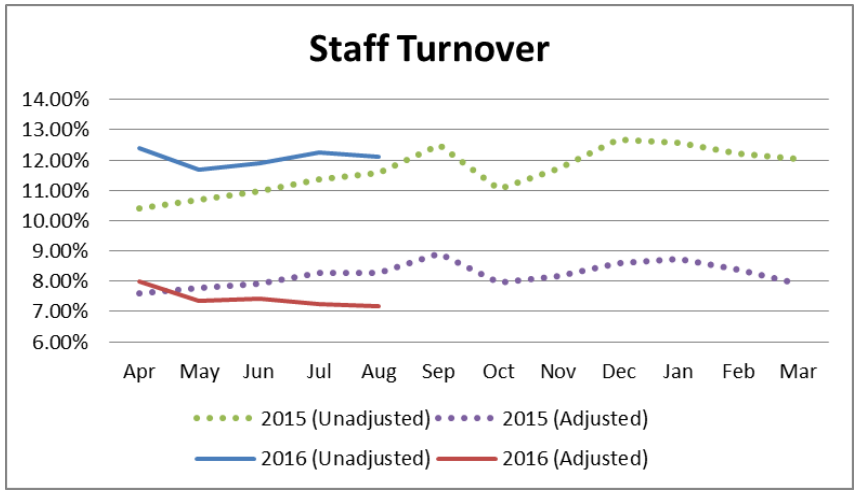
Work continues to refine the joint delivery plan for the additional 26 BCH theatres, which should support the overall management of the spinal deformity service within the 52 week parameters.

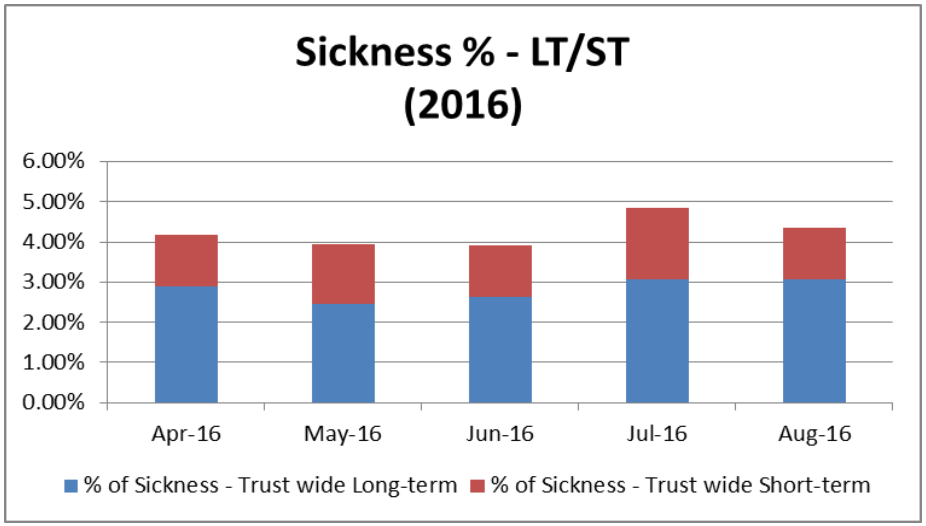
RISKS / ISSUES

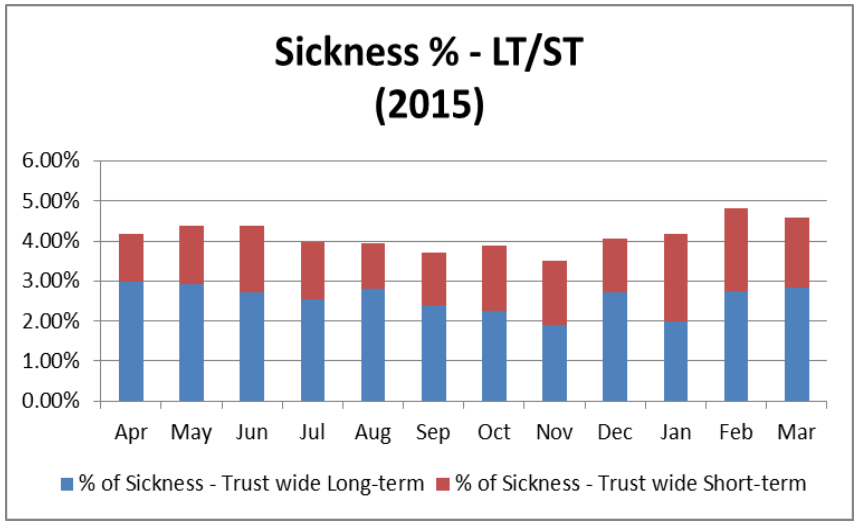
Spinal deformity remains a risk with regard to overall Trust performance, specifically with regards to the fact that the amnesty for 52 week fines is only for the 2016-17 financial year, and that this regime could resume from April 2017.

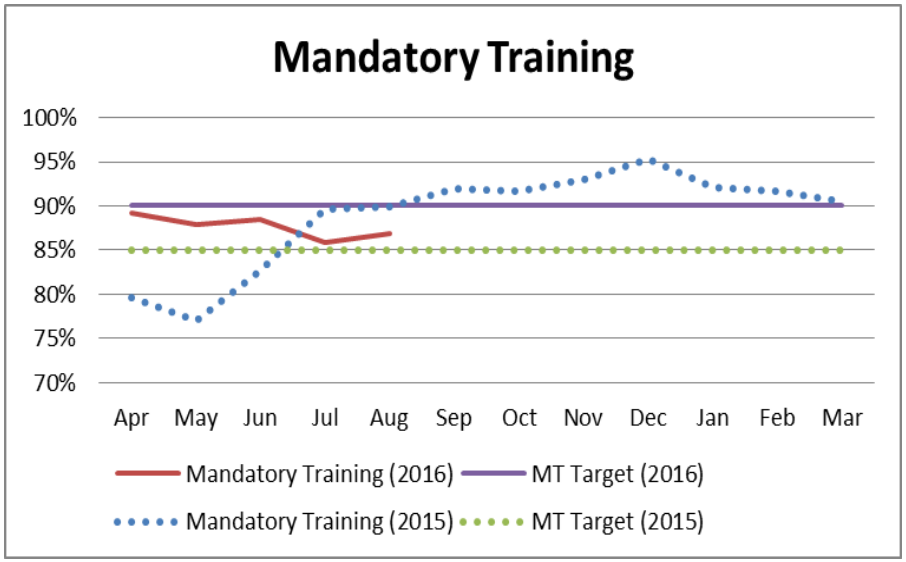
15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training.

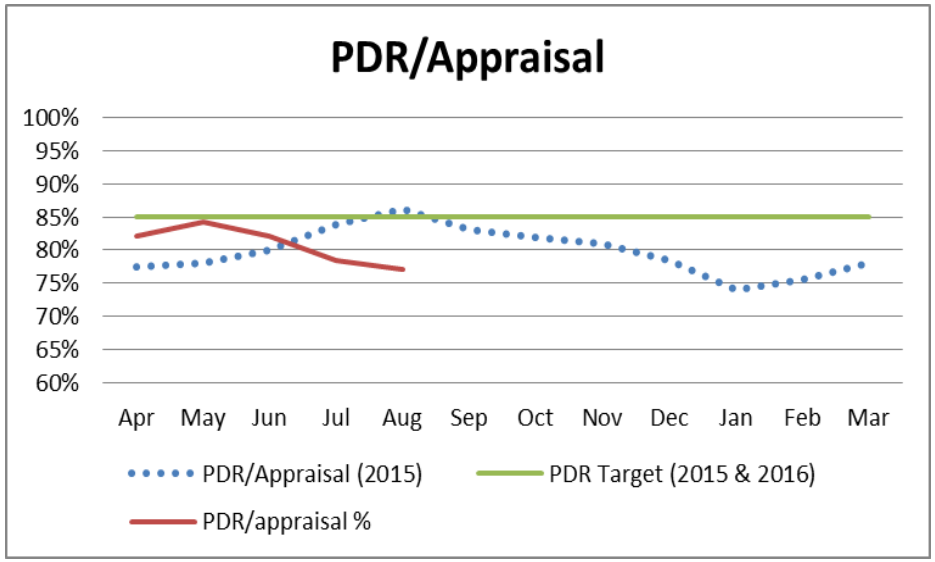









Mandatory Training
100%
95%
90%
85%
80%
75%
70%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Mandatory Training (2016)
MT Target (2016)
Mandatory Training (2015)
MT Target (2015)


PDR/Appraisal
100%
95%
90%
85%
80%
75%
70%
65%
60%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
PDR/Appraisal (2015)
PDR Target (2015 & 2016)
PDR/appraisal %

INFORMATION
INFORMATION

August has seen improvements to the vacancy position, staff turnover, sickness absence, and mandatory training versus the July outturn figures.

Sickness absence has improved and returned to amber this month due in particular to a reduction in short term absence, with long term showing a very slight improvement. Early indications are that this will improve in September's data, however, as several long term staff have now returned to work.

The vacancy position taken from the ledger has marginally improved this month. In context, the staff in post position remains lower than in 2015 while recruitment is undertaken to newly funded posts. This gap is expected to close in the coming months. In August there were an additional 5.54WTE staff in post compared with July's position.

Both turnover figures (all leavers except doctors and retire/ returners, and "true leavers") were lower than July, were in a typical range for ROH and were otherwise unremarkable.

The mandatory training position increased this month by 1%, but the appraisal position has decreased slightly by 1% and remains red this month.

ACTIONS FOR IMPROVEMENTS / LEARNING

Divisions have been asked for specific improvement trajectories for mandatory training, and HR Managers will focus on appraisal performance with their respective Divisional Boards in September.

RISKS / ISSUES

There is a risk of a compliance notice from our commissioners in relation to statutory and mandatory training and appraisal.

ROHTB (10/16) 009

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Emergency Preparedness, Resilience and Response (EPRR) assessment against the 2016 NHS Core Standards profile**
SPONSOR (EXECUTIVE DIRECTOR):	**Prof Phil Begg, Director of Strategy & Transformation**
AUTHOR:	**Mr Stuart Lovack, Divisional General Manager (Division 4 – Estates & Facilities)**
DATE OF MEETING:	**5th October 2016**

EXECUTIVE 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 2016 NHS Core Standards profile.

The review process has identified 34 areas of compliance (Green) and 3 areas of partial compliance (Amber).

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, which may require financial support.

REPORT RECOMMENDATION:

The Trust Board is asked to note the content of this report which has been assessed against the 2016 NHS Core Standards, noting in particular the actions being taken to address the areas where compliance needs to be strengthened.

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	x	Communications & Media	x
Business and market share		Legal & Policy	x	Patient Experience	
Clinical		Equality and Diversity		Workforce	x
Comments: [*elaborate on the impact suggested above*]					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:

Safe, efficient processes that are patient centred

PREVIOUS CONSIDERATION:

Divisional Management Board (Division 4)

NHS England Core Standards for Emergency preparedness, resilience and response

v4.0

The EPRR Core Standards spreadsheet has 7 tabs:

Introduction - this tab,. outlining the content of the other 6 tabs and version control history

EPRR Core Standards tab - with core standards nos 1 - 37 (green tab)

Business Continuity tab:- with deep dive questions to support the review of business continutiy planning for EPRR Assurance 2016-17 (blue tab) with a focus on organisational fuel use and supply.

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and NHS ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard (NHS Ambulance Services only): designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards (NHS Ambulance Services only): designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V4.0. The following changes have been made :

- Inclusion of Business Continuity questions to support the 'deep dive' for EPRR Assurance 2016-17, replacing the Pandemic Influenza tab
- Inclusion of the HART service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Inclusion of the MTFA service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Updated the requirements for primary care to more accurately reflect where they sit in the health economy
- update the requirement for acute service providers to have Chemical Exposure Assessment Kits (ChEAKs) (via PHE) to reflect that not all acute service providers have been issued these by PHE and to clarify the expectations for acute service providers in relation to supporting PHE in the collection of samples

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	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	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	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 and 'Best Practice Assessments' 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	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.) EPRR budget review underway.**			
4	The accountable emergency officer ensures that the Board and/or Governing Body 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	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; • 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	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 • Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	**Risk register process in operation throughout the Trust, local risk register for Emergency Planning developed. Overarching Business Continuity Plan developed. 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.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**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	Y	Y		**Local risks discussed at LHRF and shared with other EPO's to gain understanding and develop mitigations.**			
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		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.	**MI Plan and Emergency Response Pack developed**			
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Business Continuity Plan developed and tested**			
		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y			Y	Y					Y			**No CBRN capability at the Specialist Trust.**			
		Severe Weather (heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Site assessed for climate change, receive DH directives.**			
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y		**Pandemic flu plan developed in conjunction with QEHB and Infection Control Doctor.**			
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y			Y		Y	Y				Y		**SLA in place with QEHB for Infection Control Advice and support.**			
		Mass Casualties	Y	Y	Y			Y		Y	Y				Y		**Hospital Evacuation and Shelter Plan developed incorporating internal mass casualties scenario.**			
		Fuel Disruption	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Fuel Disruption Plan developed.**			
		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		Y	Y		**Specialist elective hospital.**			
		Infectious Disease Outbreak	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y		**SLA agreement with Infection Control Doctor at QEHB.**			
		Evacuation	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y		**Hospital Evacuation and Shelter Plan developed.**			
		Lockdown	Y	Y	Y			Y	Y					Y	Y		**Lockdown procedure in place.**			
		Utilities, IT and Telecommunications Failure	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y		**Business continuity and local hospital arrangements in place to deal with system failures.**			
		Excess Deaths/ Mass Fatalities	Y	Y	Y					Y	Y				Y		**Systems in place to deal with excess deaths.**			
		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												**Not applicable.**			
		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			Y												**Not applicable.**			
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	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	Y	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	**Executive Director On-call Rote 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	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**			
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	Y	Y	• Specifiy 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	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	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 publised competencies are based upon National Occupation Standards .	Y	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 completed 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	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, ICC established on site, ICC activation pack developed.**			
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	Y	Y		**Form part of MI procedures, hot and cold debriefs and lessons learned action 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	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 response would be to contact neighbouring hospital (QEHB) for**			
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												**Radiation Protection Officer contactable 24/7.**			
Duty to communicate with the public																				

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	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.**			

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	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
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	Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	Telephone landlines, mobile telephones including MTPAS enabled, 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 inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes 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	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 for 2016. Trust is signed up to ResilienceDirect.			
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 memebership is quorat.	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		Y	Y	• Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups	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	• 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	Mutual aid arrangements in place through EPRR Locality team for Birmingham, Solihull and the Black Country. Mutual aid handbook developed.			
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	• 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	Not applicable.			
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y						Y				Y	• 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	Not applicable.			
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						Not applicable.			
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						Not applicable.			
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 representation at LHFP and LHRF.			
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	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, communication exercise training undertaken, live exercise training delivered within last 3 yea			
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	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 incidentshave 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 November 2015, Live exercise undertaken in November 2014, tabletop exercise undertaken in April 2016, reports and lessons learnt communicated through committee structures.			
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y	Y	Y			Y	Y	Y	Y	Y			Y		Trust representatives attended multi-agency exercises Dark star and Pandemic Outbreak .			
37	Preparedness ensures all incident commanders (oncall 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			Y		Training to be organised for senior Trust staff to ensures requirements of CPD is maintained.			

Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	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
2015 Deep Dive																			
DD1	Organisation has undertaken a Business Impact Assesment	• The organisation has undertaken a risk based Business Impact Assessment of services it delivers, taking into account the resouces required against staffing, premises, information and information systems, supplies and suppliers • The organisation has identified interdependencies within its own services and with other NHS organisations and 3rd party providers • Risks identified thought the Business Impact Assessment are present on the organisations Corporate Risk Register	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• updated Business Imact Assessment • corporate risk register	**The Trust has a Business Continuity Plan in place, some department have undertaken business impact assessments.**			
DD2	Organisation has explicitly identified its Critical Functions and set Minimum Tolorable Peroiods of disruption for these	• The organisaiton has identified their Critical Functions through the Business Impact Assesment. • Maximum Tolerable Periods of Disruption have been set for all organisaional functions - including the Critical Functions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity plan explicitly details the Critical Functions • Business Continuity plan explicitly outlines all organisations functions and the maximum torlerable period of disrution	**Departments are currently being asked to identify their critical functions.**		
DD3	There is a plan in place for the organisation to follow to maintain critical functions and restore other functions following a disruptive event.	• The organisation has an up to date plan which has been approved by its Board/Governing Body that will support staff to maintain critical functions and restore lost functions • The plan outlines roles and responsibilities for key staff and includes how a disrutive event will be communicated both internally and externally	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• an organisation wide Business Continuity plan that has been updated in the last 12 months and agreed the Board/Governing Body	**The Trust has a Board approved Business Continuity Plan in place.**		
DD4	Within the plan there are arrangements in place to manage a shortage of road fuel and heating fuel	• The plan details arrangements in place to maintain critical functions during disruption to fuel. These arrangements include both road fuel and were applicable heating fuel.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• detail within the plan that explicitly makes reference to shortage of fuel and its impact of the business.	**The Trust has a Fuel Shortage Plan which is part of a suite of documents associated with Business Continuity.**		
DD5	The Accountable Emergency Officers has ensured that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this .	EPRR Framework 2015 requirement, page 17	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		**Some assurance from key suppliers around their business continuity arrangements.**		
DD6	Review of Critical Services Fuel Requirement Data Collection Programme (F1:F18)	Please complete the data collection below - this data set does not count towards the RAG score for the organisations. Please provide any additional information in the "Other comments" free text box.	Y	Y		Y	Y	Y	Y						Y	• NHS Ambulance Trusts have already provided this information in a national collection in May 2016.				

Fuel Demand Summary

When providing information on the fuel requirements for both business as usual and to operate a critical service please ensure the supply and demand balances whereby:

Total Daily fuel use (F1) = own bunkered fuel use (F5) + any 3rd party bunkered fuel use (F6) + any forecourt fuel use (F9)

Section 1: Business as Usual Demand

		Petrol	Diesel	Other (inc LPG, Kerosene
F1	How much fuel do you use daily when providing a business as usual service? (litres)	52	35	

Section 2: Bunkered Fuel

		Petrol	Diesel	Other (inc LPG, Kerosene
F2	Do you hold bunkered fuel **(No)** If no go to F6			
F3	What is the total bunkered fuel capacity? (litres)			
F4	On average, what volume of bunkered fuel do you hold? (litres)			
F5	Do you use your own bunkered fuel when providing a business as usual service? If no go to F6			
F6	Do you access a 3rd party or another service's bunkered fuel when providing a business as usual service? If no go to F8			
F7	If you have answered "Yes" to F6 or have bilateral supply agreements to operate a business as usual service, please provide a description of any agreement(s), amount of supply and companies / organisations involved.			

1) What happens if I have mutual aid agreements with another Critical Service provider to utilise their bunkered stock, do I need to record the bunkered stock or will they?
DECC is requesting that the supplier records the bunkered stock holdings and the user records the demand. As the user of these bunkered fuels in this instance, please record the use of these stocks under the section referring to access to third party bunkered stock.
2) Should we assume that in the build up to an emergency our bunkered stocks would be full, as we would be prioritising deliveries and therefore the days' stock held calculations should be based on full capacity and not average daily stock holdings?
The prioritisation of supply will be dependent on the facts of any fuel shortage scenario, and will be a decision taken at the time. Data provided in the template should provide DECC with a sufficient evidence base to make decisions based on capacity and BAU bunkered stocks. Therefore please fill out the template as requested, providing notes where you think that estimates are required, or where you have had to average data in order to fit the template.
3) Our choice of bunkered fuel supplier varies depending on supply cost or availability. Who do I record as the primary supplier?
Please provide the supplier you get most of your fuel from, but also note that this varies and provide details of the other suppliers and average quantities.
4) The terminal our bunkered fuel is supplied from varies depending on who our supplier is. What should we report?
Please report your largest supplier based on average BAU, but also provide notes on any secondary service providers and average quantities obtained from those providers.

Section 3: Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene
F8	Do you use forecourts to operate a business as usual service? **(No)** If no go to F10			
F9	What is the average daily forecourt fuel use to operate a business as usual service? (litres)			

Critical Service Operation Only

Please refer to question 4 of the guidance notes for further information on how to identify the fuel requirements of a critical service.
During an emergency it is expected that organisations will not be operating as normal and will only be delivering those essential services that are Critical.
Low fuel consumption alternatives should also be explored as part of the Critical Service identification process. For example, if there is the possibility that a Critical Service activity can be carried out remotely, and therefore does not require the use of fuel, this should be removed from the supply requirements to deliver
The below section refers to the fuel requirements to deliver a Critical Service only.

Section 4: Critical Service Demand

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F10	How much fuel would you use daily if you were providing a critical service? (litres)			

Section 5: Critical Service Bunkered Fuel

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F11	Do you have access to either your own or 3rd party bunkered fuel if you were providing a critical service (either from general access or mutual supply agreements)? (Yes/No) If no go to F14			
F12	What volume of your own bunkered fuel would you use daily if you were providing a critical service? (litres)			
F13	What volume of 3rd party or another service bunkered fuel (either from general access or mutual supply agreements) would you use daily if you were providing a critical service? (litres)			
F14	If you have answered "Yes" to F13 or have bilateral supply agreements to operate a critical service, please provide a description of any agreement(s), amount of supply and companies / organisations involved. If no go to F15			

Section 6: Critical Service Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F15	Will you need access to Designated Filling Stations (DFS) if you were providing a critical service? (Yes/No) If no go to F17			
F16	What volume of fuel would you use daily from Designated Filling Stations (DFS) if you were providing a critical service? (litres)			

Critical Service Operation Only

F17 To ensure that there are adequate Designated Filling Stations* (DFS) to meet the demands of all critical users , please detail in the table below the number of vehicles required to operate a critical service
A Designated Filling Station (DFS) is a retail filling station with the purpose of only supplying road fuel for critical use only. The DFS list will be compiled to provide sites giving a good geographic coverage of the UK to meet the predicted regional demand for fuel for critical services.

Vehicles	Number of Vehicles required to operate a critical service		
	Petrol	Diesel	Other (inc LPG)
With NHS Logo			
Without NHS Logo			
Private vehicles			
Total			

F18 If you have answered "Yes" to question 2 (Do you hold bunkered fuel?) please detail which company primarily supplies your bunkered fuel and where known which local or regional supply depot or terminal does the fuel gets delivered from. Please select from drop down list provided or select "other" and please detail.

Who primarily supplies your bunkered fuel? Please Select from drop down list:	If other or multiple suppliers please state:	Which Terminal is your bunkered fuel supplied from? Please Select from drop down list:	If other please state:	Average Number of Deliveries per Month

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental Health care providers		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
Q	**Core standard**	**Clarifying information**						**Evidence of assurance**				
	Preparedness											
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • 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	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	**Not applicable - not a receiving hospital.**			
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	Y	Y	Y	Y	• Site inspection • IT system screen dump	**Not applicable - not a receiving hospital.**			
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	Y	Y	Y	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	**Not applicable - not a receiving hospital.**			
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y			• Resource provision / % staff trained and available • Rota / rostering arrangements	**Not applicable - not a receiving hospital.**			
42	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	Y	Y	Y	Y	• Provision documented in plan / procedures • Staff awareness	**Not applicable - not a receiving hospital.**			
	Decontamination Equipment											
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	**Not applicable - not a receiving hospital.**			
44	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Y				**Not applicable.**			
45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		Y				**Not applicable.**			
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Y				**Not applicable.**			
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y				**Not applicable.**			
	Training											
48	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		Y		Y				**Not applicable.**			
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	**Not applicable - not a receiving hospital.**			
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme.		Y		Y				**Not applicable.**			
51	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y	Y	Y	Y	Y		**Not applicable - not a receiving hospital.**			

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Emergency Preparedness, Resilience and Response (EPRR) Action Plan 2016/17

Monitoring body (Internal and/or External):	NHSE
Reason for action plan:	Non-Compliance with all standards
Date of action plan approval:	September 2016
Executive Sponsor:	Professor Phil Begg
Operational Lead:	Mr Stuart Lovack
Frequency of review:	Quarterly
Date of last review:	New Plan
Expected completion of action plan:	March 2017

EPRR Assurance Process 2016 – Action Plan

Attached is the Royal Orthopaedic Hospital NHS Foundation Trust's action plan based on the updated assessment on the 2016 NHS Core Standards. In assessing against the EPRR core standards, the Trust has identified 34 areas of compliance (Green) and 3 areas of partial compliance (Amber).

Stuart Lovack
Divisional General Manager (Division 4 – Estates and Facilities)

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
1	**Core Standards – Non-compliance**						
Std. 16	**On-Call staff must meet identified competencies and key knowledge and skills for staff** – Training modules will be developed based on best practice with key staff.	PB	SL	March 2017	Staff availability and resources		
Std. 34	**Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergency and business continuity incidents** – it is proposed to further develop staff training plans to enable them to better respond to emergencies and business continuity incidents.	PB	SL	March 2017	Staff availability and resources		
Std. 37	**Preparedness ensures all incident commanders (On-call Directors and Managers) maintain a continuous personal development portfolio demonstrating training and/or incident/exercise participation** – it is proposed to run another table top exercise.	PB	SL	Jan 2017	Staff availability and resources		

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
2	**Business Continuity Deep Dive**						
DD1	**Organisation has undertaken a Business Impact Assessment –** a high level BIA has been undertaken however this needs testing with critical functions.	PB	SL	March 2017	None		
DD2	**Organisation has explicitly these identified its critical functions and set minimum tolerable periods of disruption for –** minimum tolerable periods of disruption need to be further tested.	PB	SL	Jan 2017	None		
DD5	**The AEO has ensured that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this –** further work is required with our key suppliers to ensure they have robust business continuity arrangements in place.	PB	SL	Jan 2017	None		

Key to initials of leads

PB	Professor Phil Begg
SL	Stuart Lovack

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

ROHTB (10/16) 010

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Quarter 2 2016/17 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**5th October 2016**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at September 2016.

On the attached Board Assurance Framework, risks are grouped into two categories:

- Strategic risks – those that are most likely to impact on the delivery of the Trust's strategic objectives. These are entries shaded in blue on the attached.

- Escalated risks – those risks featuring on the Corporate Risk Register that have been added to the Board Assurance Framework on the basis that their pre-mitigated risk scores are sufficiently high to suggest that they could impact on the delivery of the Trust's business and its strategic plans

- The risks agreed for removal by the Board when it last reviewed the BAF have been archived.

- Additional mitigating actions and plans to close any gaps in control and/or assurance have been updated.

- There has been one new risk added to the BAF, which has been discussed by the Trust Management Committee, which agreed that they should be added to the BAF as a new risk:

  Risk 1048 – management of the knowledge & administration of 18 weeks pathway, linked to the findings of the internal audit into 18 weeks RTT management

REPORT RECOMMENDATION:

Trust Board is asked to:

- review the Board Assurance Framework
- confirm and challenge that the controls and assurances listed to mitigate the risks are adequate

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

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

ROHTB (10/16) 010

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial		Environmental		Communications & Media	x
Business and market share		Legal & Policy	x	Patient Experience	
Clinical		Equality and Diversity		Workforce	x
Comments: Pages within the report refer in some manner to all of the key areas highlighted above.					

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:
Trust Board in July 2016

BOARD ASSURANCE FRAMEWORK Q2 2016/17

Risk Ref	Department	Executive Lead	Risk Statement	Strategic Objective/Organisational Goal	Primary Assurance Body	Initial risk			Summary of Risk Controls and Treatment Plan	Assurance Received (Internal, Peer or Independent)	Controlled			Risk movement	Risk controls and assurances scheduled / not in place and associated actions	Completion date for actions	Target risk		
						Likelihood	Severity	Risk Rating (LxS)			Likelihood	Severity	Residual risk rating				Likelihood	Severity	Residual risk rating
803	Finance	Paul Athey	Risk to financial viability through the inability to manage internal costs, deliver key programmes or respond to tariff deductions which could lead to concerns over the Going Concern status of the Trust	Safe and efficient processes that are patient-centred	F & PC	4	5	20	**September 2016** **The Patient Journey II project is moving forwards to provide the platform for change and enable sustainability of the Trust. The Medical Director engaged the consultant body in September to discuss and agree actions on how to move forwards in a timely manner with those drivers. Similar discussions have been held with the wider workforce through a combination of platforms including team brief and the CEO's brief. The 2017/18 tariff has now been received and is being modelled for its financial impact on the Trust by the finance team.**	**F&P Report; Monthly Performance Clinics; Transformation Board Reports; Audit Committee – Review of contract risk; Weekly activity / income reports at Exec Business Meeting** CPR; Monthly Performance Reviews; Transformation Board Reports; Audit Committee – Review of contract risk; CIP Board reports	4	4	16	↔	The Trust continues to pursue transformation efficiency gains through its Transformation Programme. A finance and activity recovery plans has been developed, which will be supported by a clear delivery plan to be monitored through the Finance & Performance Committee on a monthly basis. The Executive will also keep close scrutiny on delivery through the weekly business meetings.	Ongoing	2	4	8
582	Workforce	Anne Cholmondeley	Risk of non-delivery of strategic objectives associated with leaders' ability to lead change, including cultural change.	Highly motivated, skilled and inspiring colleagues	Transformation Cttee	4	4	16	**September 2016:** **Work underway to develop a strategic narrative to describe the vision for the Trust, what needs to change and why.** **Funding agreed for leadership development.** **Review of leadership by Kings Fund has provided feedback which will be incorporated into Leadership Strategy.** **Framework for strategy developed, currently being populated with data and proposed development options.** **People Strategy agreed at Board and Exec Team level. This strategy encompasses the Leadership approach,. Plan to be submitted to Board and Exec Team in December which includes MSP Leadership programme** **Third cohort of staff undertaking MSP will be identified and enrolled before the end of Quarter 3.**	Presentation to Transformation Committee; RF report working group workstation 1 of TP, notes from Workforce & OD Committee. People strategy presented at Trust Board in September & associated minutes detailing the approval.	3	4	12	↔	Delivery plan for the People Strategy is to be presented at the Transformation Committee in October 2016.	Q1-Q2-3 2016/17	2	4	8

798	Workforce	Anne Cholmondeley	The Board and organisation does not have adequate capacity or capability to change or does not organise its resources to change effectively, which could lead to the organisation being slow to respond to changing internal or external influences	Highly motivated, skilled and inspiring colleagues	Transformation Cttee	3	5	15	**September 2016** **Staff engagement strategy presented to Trust Board at its September meeting. Several engagement events have been held in September to outline the changes needed to deliver recovery of the Trust's financial and activity position, underlining the need for wholescale change across the patient pathway from pre-operative assessment through to more efficient discharge processes.** June 2016 Existing work engaging staff in strategy development and communication.	Presentations to clinical leaders and CEO Question Time briefings for September 2016. Staff engagement presentation from September 2016 Trust Board meeting. Recruitment decisions; New Beginnings outputs; medical staff engagement event on 29th June 2015; plans for corporate departments.	3	4	12	↔	People strategy delivery plan to be developed. Financial & activity recovery plan to show signs of traction and improvement.	Q1-Q2-3 2016/17	2	4	8
804	Information	Paul Athey	There is a risk that Information and Business Intelligence is insufficient in quantity, usefulness or reliability to inform key operational decisions and to manage the business on a day to day basis or to help improve services.	Safe, efficient processes that are patient-centred	F & PC	4	2	8	**August & July 2016** **A large majority of the re-mapping work to point at the data warehouse is now complete. Overall the data warehouse now provides the BI team with a great range of information that is updated more frequently. A series of workshops are being held with the BI team to understand the new information sources and how to use them in relation to information requests and building reports.** **Work to recruit a BI report writer is on hold as we are currently attempting to fix some configuration issues with SharePoint/PoweView (a pivot piece of software to enable the viewing the new suite of BI interactive reports). This has caused a delay in the setup of the new BI portal. However, there remains optimism that the new suite and reports will be available by the end of September 2016.**	Daily huddle outputs and ACTION; Weekly 6-4-2 and list review by Director of Operations and review by Executive of weekly activity tracker and governance trackers for complaints, SIs and Duty of Candour incidents; monthly corporate performance report; safe staffing report; Internal Audit reports; Transformation Committee Reports; CQC report & action plan; IM&T Programme Board minutes; ad hoc report through Serious Incident and Root Cause Analysis/Lessons learned communications to staff	3	2	6	↓	**Ongoing development of the Data Warehouse.**	Q2-3 2016/17	2	4	8

801	CEO	Jo Chambers	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.	Delivering exceptional patient experience and world class outcomes	Trust Board	4	3	12	**September 2016** **The Trust is part of a national Vanguard model, which will provide opportunities to develop a quality improvement process and a set of quality indicators.** **The Trust engages in the wider NHS nationally and locally to stay on top of changing context and regulatory requirements. Ensure the organisation 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; STP Planning processes; NHS Confederation; Kings Fund papers. Evidence through CEO and other Director reports to the Board. Evidence of managing operational delivery through Financial overview to Board.	3	3	9	↔	Vanguard & STP will be used to influence the wider Health Economy as it develops and embraces a new way of working collaboratively. 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.	Ongoing	2	3	6
S797	Workforce	Anne Cholmondeley	The Board and organisation 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	Highly motivated, skilled and inspiring colleagues	Trust Board	4	4	16	**September 2016** **People strategy approved by Trust Board in September which includes a focus on learning & improvement. Governance roadshows also underway in Outpatients to share learning from serious incidents and an update on learning is to be presented to Quality & Safety Committee in October 2016.** June 2016 People strategy (Engagement & Leadership) with detailed action plan). Action ongoing to improve engagement - improved communication, staff involvement in improvement activity and increased learning opportunities for whole workforce 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	3	4	12	↔	People strategy (Engagement & Leadership with detailed action plan). Freedom to Speak up Guardian role to be implemented to encourage staff to speak up to enable learning and to coach managers in response to safety incidents. Other actions as detailed in Transformation Programme work stream 1	Q2 2016/17	1	4	4

S799	Strategy	Phil Begg	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	Highly motivated, skilled and inspiring colleagues	Trust Board	4	3	12	**June & September 2016** **A refresh of the Trust's 5-year strategy is underway and will reinforce our commitment to and provide clarify on our objectives for all stakeholders. The 'Our People' section of the strategy will confirm our approach to staff engagement and provide details of the leadership strategy currently in development.** 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. People strategy and staff engagement strategy.	3	3	9	↔	**Delivery of the People Strategy approved by the Board at its meeting in September.**	Q1 Q2-3 2016/17	2	3	6
S802	Chief Executive	Jo Chambers	There is a risk that the Trust's operational model is unsustainable as a result of tariff changes, year on year efficiency requirement and the need to meet the requirements of an increasingly burdensome regulatory environment.	Developing services to meet changing needs, through partnership where appropriate	Trust Board	3	4	12	**June & September 2016** **Effort is directed into continuing to develop the growth strategy and seek multiple opportunities, including those provided by the Vanguard and STP. 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.**	Viable business plan. Key milestones met – growth, expenditure, CIPs, transformation initiatives. Evidence of alignment with commissioner intentions.	3	3	9	↔	Refresh of the Trust's strategic plan and seek new opportunities for collaboration as part of the new Vanguard model. Clinical engagement with the turnaround work, including the pathway changes from pre-op to discharge.	Ongoing	2	3	6
S270	Finance	Paul Athey	National tariff may fail to remunerate specialist work adequately as the ROH case-mix becomes more specialist	Developing services to meet changing needs, through partnership where appropriate	F & PC	4	4	16	**September 2016 – The draft tariff for 2016/17 has been received and is currently being modelled for impact. An update will be provided as part of the Q3 update of the BAF.** June 2016 Completion of reference costs & patient level costing returns. Work as a roadmap partner for NHSI in developing costing standards Monitor 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 given the issues faced with the current year tariff and the first version of next year's tariff which has been seen.	**Reference costs submissions** **Audit report on costing process** 2016/17 NHS contracts 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 technical working group to influence tariff development	3	4	12	↔	**SOA writing to Jim Mackay to ask for support on resolving the long standing problems with the orthopaedic chapter** January 2016: Delay to the publication of the new national tariff, which will allow some stability for the current year.	Mar-17	1	4	4

S800	CoSec/Governance	Simon Grainger/Lloyd/Garry Marsh	Governance structure and processes are poorly understood with a result that they become a barrier rather than a tool for delivery	Safe, efficient processes that are patient-centred	QSC	3	3	9	**September 2016** **Internal audits in relation to the duty of candour process and Serious incident processes have been conducted. A final report has been received response to the Duty of Candour audit. Actions have been identified, monitoring and implementation ongoing. Draft report in response to SI management received currently undergoing factual accuracy check.** **Weekly governance meetings being held in Divisions 1 and 2.** June 2016 Mandatory Training has been reviewed to incorporate DOC and Incident reporting. Divisions now monitor weekly trackers due to heightened compliance and escalate risk to executive team. Governance team structure is now fully filled; clarity over separation of responsibilities between Director of Nursing & Clinical Governance and the Associate Director of Governance & Company Secretary; refinement of processes around incident reporting, policy governance, compliance with CQC Regulation 20 and complaints handling has made the processes more fit for purpose.	Structure chart; TOR; Awareness, understanding application of organisational structure and processes at sub Board level; effectiveness of the new structure; new complaints and Duty of Candour policies; new Policy on Policies; weekly trackers reviewed by Exec Team; Patient Safety & Quality report	2	3	6	↔	**Governance Facilitator to start from 03/10/2016 on a fixed term contract to cover maternity leave.** **Ongoing implementation of action plan in response to internal audit results.** **Ongoing work to ensure robust processes are developed and implemented to ensure learning as a result of governance activity within the Trust can be evidenced.** Continue to embed the new governance structures, including those at Divisional Level. Training to be created for key processes and responsibilities. Audit effectiveness of new clinical governance policies. Maternity leave in governance team with effect from July 2016 to be filled.	Nov-16	1	3	3
S832	Operations	Garry Marsh	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	Developing services to meet changing needs, through partnership where appropriate	Trust Board	3	3	9	**September & June 2016** **Participation in the STP; Membership of SOA; Membership of academic health science network; Membership of regional chief operating officers group, Membership of SDP unit and National Orthopaedic Vanguard.**	Transformation Committee meetings and regular reports to board; Quarterly Commissioner review meetings; Activity Review Group; Business Planning Group	2	3	6	↔	Continue maintaining strategic focus and exploit opportunity for collaborative working and driving quality improvements at a national level through the Vanguard	Ongoing	2	3	6
S796	Nursing	Garry Marsh	The Board and organisation loses its focus on patient care so the ROH is no longer a patient-centric organisation	Delivering exceptional patient experience and world class outcomes	Trust Board	3	3	9	**September 2016** **Governor rep is a routine observer at Quality & Safety Committee meetings.** June 2016 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/TMC. Board members visiting wards and departments speaking directly to patients and staff.	Representation from the CCG at Q&S Committee. Patient quality report to QS every month. Patient Quality Report; CPR; Patient & Carer Council; Quality Meeting; Patient Harm Reviews; FFT feedback; Complaints & PALS review; Patient Stories.	2	3	6	↔	Continued patient stories at Trust Board; improved membership engagement and plans to redevelop the membership & governor engagement plan.	Q3 2016/17	1	3	3

S986	Nursing	Garry Marsh	There is a risk that the Paediatric nurse staffing on HDU is insufficient to meet the needs of Paediatric patients that the Trust cares for	Delivering exceptional patient experience and world class outcomes	QSC	3	4	12	**September 2016** **Since the last update one of the appointed paediatric nurses has pulled out of the post. This now means there are 3 nurses who will have been recruited with the following commencement days** **X 1 Has already commenced** **X1 due to start 03/10/16** **X1 due to start 07/11/16** **Recruitment is still underway to fill the last vacant post and there is further work being done between HDU Senior Nurse and the Director of Nursing to ensure the model is correct post Paediatric HDU completion.**	2 WTE paed nurses have been recruited. CQC action plan; SOPs; critical care passport evidence portfolio; presentation for CQC Quality Summit.	3	3	9	↔	Actions contained within the CQC action plan around recruitment events for Paediatrics staffing and liaising with Birmingham Children's Hospital to develop a programme to access competency based training for all HDU staff. Developing a programme to assess adult nurses against the Paediatric passport and a rotational programme between Ward 11 & HDU by end of Feb 16. Further actions planned to be completed by September 2016.	Q2 2016/17	2	2	4
269	Finance	Garry Marsh	There is a risk that the Trust may fail to deliver the activity targets set out in the Trust's annual operational plan, leading to a shortfall against the agreed Financial Outturn position for the year and potential poor patient experience	Safe, efficient processes that are patient-centred	F & PC	4	4	16	**September 2016:** **Activity recovery plans has been developed which is monitored monthly by the Finance & Performance Committee. An Associate Director of Turnaround is in place to oversee delivery of turnaround. Several engagement events held during Quarter 2 to gather momentum around recovery and clinical support for operational changes needed to be able to deliver the planned activity. Collaboration with Birmingham Children's Hospital FT to deliver improvement in spinal deformity cases.** January 2016: Fines removed for waits in excess of 18 week RTT. Activity rectification plan has been developed and approved by Monitor. Will meet activity rectification plan and anticipate will slight overachieve against it. The plan has been accepted by Monitor, however the action plan will take several months to embed.	Finance & activity recovery plan; minutes of Trust Board, TMC & Finance & Performance Committee; Monthly finance & Performance overview; outputs from daily huddles;	4	4	16	→	Traction with recovery plan is needed to create the step change in activity performance needed. Flow through the organisation is to be improved through creating more efficient discharge processes and slicker end to end in-hospital processes. Turnaround and improvement framework to be further developed.	Q4 2016/17	2	4	8

7	Operations	Garry Marsh	Long waiting times for spinal deformity. Impact of BCH capacity on ROH's waiting list potentially causing delays and poor patient experience & outcomes. This risk has a significant potential financial impact year to date.	Delivering exceptional patient experience and world class outcomes	F & PC	5	4	20	**Sept 16:** **At present ROH are not seeking extra capacity with private partners. Plans progressing with BCH to fully utilise the additional 26 lists agreed from Q3 onwards. Currently 28 patients on the IP WL waiting over 52 weeks and over. The team are currently reviewing all patients waiting for first definitive treatment to define where they will be treated ie BCH or ROH following further discussions and joint working. CSM providing fortnightly action plan update for NHSE and continues with 52 week trajectory and strategic plans for a 3-5 yr service plan.** June 2016 Year 16/17 financial threat significantly less. Q&E risk still significant with patients waiting 18 months. BCH have increased tables from 48 to 72. BCH & ROH are working closely together to improve access ability. BCH have implemented new systems processes in PICU.	Finance & Performance reports to the Board and Finance & Performance Committee on a monthly basis ; correspondence with NHS England and BCH. Notes from Quality Meeting around RCPCH report which include discussions with specialist commissioners on treatment of spinal deformity.	4	4	16	↔	Appointment of additional spinal deformity consultants Active management of waiting list Sourcing additional capacity as required. Working with BCH NHSFT to deliver a model of operation which will treat more patients in a short time.	Q4 2016/17	3	3	9
27	Workforce	Anne Cholmondeley	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.	Delivered by highly motivated, skilled and inspiring colleagues	F & PC	5	4	20	**September 2016** **Agency review group established to provide oversight of control of spend.** June 2016 The 2 PAs were continuing to embed their services within oncology and arthroplasty. A review was taking place of the levels of service provided by the Fellows. The ATRs for the additional junior and senior fellows were nearing completion. Further consideration was being given to recruit ANPs to work within POAC to replace junior doctors. There will shortly be a junior doctor recruitment drive to replace the 8 locums currently being used. Expenditure on management of agency staff likely to increase due to vacancies. Medical staff expenditure likely to increase due to training vacancies. A further PA was expected to be appointed during Q2 2016. No additional PAs would join the Trust during the following year. Amendment to remuneration for discussion at Board	Updates to Transformation Committee on delivery of work stream 1. Minutes from Workforce & OD Committee. Agency staffing presentation to Trust Board workshop on 13 January. Agency staffing cost position as outlined in the CPR received by the Board on a monthly basis.	4	4	12	↑	**Revised workforce model to be implemented into POAC. Continued focus on agency spend given the high level of spend in August 2016. Job planning to deliver benefits from late Q3/Q4 2016/17.**	~~Q4 15/16 – Q1 2 16/17~~ Q4 2016/17	2	4	8

275	Nursing & Clinical Governance	Garry Marsh	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.	Delivering exceptional patient experience and world class outcomes	QSC	4	4	16	**September 2016** **All action plans developed in response to Serious incidents and complaints are disseminated to divisions for review and monitoring.** **Work to include action monitoring within the Ulysses system is ongoing.** **All SIs are reviewed at the Trust Clinical Quality Group to ensure that learning is shared across all Divisions and trust wide communication/learning occurs.** **"Ensuring that learning identified from serious incidents and complaints are embedded in practice" has been identified as a quality priority within the quality account for 16/17. Progress against this priority will be reported quarterly to the Trust Clinical Quality Group.** **All action plans developed in response to Serious incidents and complaints are disseminated to divisions for review and monitoring.**	Patient Safety & Quality Report presented monthly to TMC and Board Clinical Audit meeting shared events/claims/SIRIs/Incidents Directorate Governance meetings	3	4	12	↔	Trust Business and Learning days to continue to provide a platform for sharing lessons learned. Quality & Patient Safety report continues to evolve to encompass assurances over lessons learned from incidents, complaints and claims. Additional communication channels to be identified to share lessons learned and disseminate good practice to other areas of the organisation. Update on dissemination of lessons learned planned for October 2016 to Quality & Safety Committee.	~~01/06/2016~~ Q3 2016/17	2	2	4
414	Medical Director	Andrew Pearson	There is a risk that the Trust may suffer reputational damage owing to its low position for significantly below average for the oxford knee score and index for revision knees	Delivering exceptional patient experience and world class outcomes	QSC	4	4	16	**September & June 2016** **Latest PROMS report shows ROH for primary THR and TKR is above the England average and better than comparator SOA hospitals (RJAH, RNOH and Wrightington).** **Revision TKR report shows insufficient data numbers to calculate an adjusted score. For revision THR the ROH is significantly above the England average.** January 2016: PROMS report presented to QSC in January 2016, which reported that the Trust's PROMs scores for Total Knee Replacements was an outlier against the national average position.	Report to QSC; national comparative data; PROMs scores by consultant	3	3	9	↔	Additional set of metrics identified which will improve PROMS scores, including physiotherapy, enhanced recovery, improved pain management on wards, patient education, review of surgeon techniques & their individual results and organisation wide focus on supporting PROMs work. A further meeting is due to be given in the late Spring on theories regarding measures required to improve the PROMs figures.	~~01/05/2016~~ Q2-3 2016/17	2	3	6
770	Operations	Garry Marsh	Theatres' engineering plant is beyond its normal life expectancy and has a high risk of failure,	Safe and efficient processes that are patient-centred	QSC	4	4	16	**September 2016** **There are no further updates to this risk. The inaccessibility of the plant means that the equipment cannot be replaced. Routine maintenance to the theatres continues to be undertaken further dates have been agreed later in the year for the replacement of Hepa filters but this will not reduce this risk.** June 2016 Motor has been replaced with another motor on standby. Continued enhanced maintenance and scheduling service continuing. March 2016 Annual Maintenance Programme continues but this issue cannot be fully mitigated without full rebuild due to building design air plant. January 2016: Two two-week blocks of maintenance each year. Further estates work planned for the future.	Estates maintenance schedule	4	4	16	↔	Identification of plan for theatre maintenance	~~Q1 2015/16~~ Q2 2016/17	2	2	4

1028	IM & T	Paul Athey	There is a risk that the network bandwidth is insufficient to support all essential network traffic, including access to clinical systems as well as administrative tools	Developing services to meet changing needs	IM&T Programme Board	4	4	16	**September, August & July 2016** **Risk reviewed but, subject to IM&T Programme Board view, risk rating unchanged.** June 2016 Request submitted to upgrade network bandwidth of NHS net connection but funding not currently approved. Request submitted to implement network monitoring software so that network traffic can be analysed and limited in a managed way, funding not currently approved.	IM & T Programme Board minutes	4	4	16	↔	Reprioritisation of IM & T Programme. Resolution of resources available to support the IT Infrastructure work.	Q4 2016/17	2	4	8
1030	Finance	Garry Marsh	Limited capital funding available for 2016/17 to replace equipment that is beyond its useful life meaning that there is a risk that patient care might be compromised.	Safe and efficient processes that are patient-centred	TMC	4	5	20	**September 2016** **Risk assessments completed, covering both service risk and clinical risk. Meeting held (Director of Finance, DGM & AMD) on 15/8. Original list of 13 equipment bids to be re-prioritised on this basis to define absolute bare minimum 'must dos' for 2016/17 and this will be further considered by Executive Team in context of available funds across whole capital programme. Some individual risk scores may increase as equipment becomes so old that no manufacturer maintenance cover or spare parts are available.**	Funding requests. TMC minutes.	4	4	16	↔	Further consideration of the priorities in the capital programme considered by the Executive Team and the Board at its meeting in October 2016.	Q3 2016/17	2	2	4
1031	Operations	Garry Marsh	There is a risk that the Trust does not currently have an electronic inventory management system. Whilst there are now plans in place to procure one, the implementation will not commence until September 2016. This means that the financial risks associated with the control of stock in Theatres that were identified as part of the 2015-16 year and stock take and the risks to day to day efficient operational delivery and care to patients due to not having the correct implants or other consumable items, will persists part way into 2016/17.	Safe and efficient processes that are patient-centred	TMC	4	4	16	**September 2016** **All preparatory work is in place in advance of EDC Gold commencing on site on 5/9/16. Based on planned implementation it should be possible to reduce this risk score by February 2017. Further issues in relation to provision of a single implant store have materialised and are being worked through. Work to rationalise the number of suppliers is still required to achieve full benefits and planned financial savings.**	Minutes of TMC	3	4	12	↔	An action plan has been developed following receipt on the RSM audit and recommendations with regard to stock management. Work is being co-ordinated between Division 2 and Finance. A Project Board will be set up to assure delivery of the recommendations.	Q4 2016/17	2	2	4

971	IM & T	Paul Athey	There is a risk that the IT network infrastructure, including wireless connectivity (wi-fi) will prove unreliable and breakdown. This could result in disruption to core Trust Services and potentially creating patient safety issues and loss of income.	Developing services to meet changing needs	IM & T Programme Board	4	4	16	**September 2016** **No change** August 2016 Interim Business Case drafted for TMC on 24 Aug. Estates input still finalising some details of the CPW design report. Finance still providing input into revenue capital split on costs and on whether VAT can be reclaimed. Meeting planned for 17 Aug to finalise procurement process. Risk rating remains the same	Business case presented to August meeting of TMC; minutes of TMC and IM & T Programme Board.	3	4	12	↔	The need for additional Access Points to improve wi-fi coverage is being assessed as an interim measure. Detailed work is underway with a contractor to develop the basis of an Output Based Specification for use in tendering for considerable improvements and replacements of parts of the existing infrastructure, including cabling, trunking, switches and cabinets. This will be subject to Full Business Case approval.	Q4 2016/17	2	3	6
1048	Operations	Garry Marsh	**NEW:** There is a risk that performance targets in respect of the 18 weeks RTT target may not be met as a result of poor administration practice and lack of understanding of current national guidance, a Patient Tracking List that is not fit for purpose and data quality issues with the patient pathway information.	Safe and efficient processes that are patient-centred	Data Quality Committee/Divisional Management Board	4	4	16	**September 2016** **Division 1 and 3 are working with informatics to provide a more robust means to track patients while a new Patient Tracking List is in development. The position is reviewed at a weekly performance review meeting chaired by the DGM for Division 3. Weekly local PTL meetings keep track of patients on their pathway and monitoring against 18 weeks RTT guidance.**	RSM audit into 18 weeks; notes form divisional performance meetings	4	4	16	NEW	Development of a more robust Patient Tracking mechanism; Reaudit by RSM to identify areas of improvement and provide assurance that the process is being managed appropriately. Delivery of the RSM audit action plan.	Q4 2016/17	3	3	9

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	28 September 2016
Guests	Stacey Keegan – Matron Michael Grant – Ward Manager for Ward 3 Sally Xerri-Brooks – Head of Communications Lisa Kealey – Public & Patient Services Manager
Presentations received	Pressure ulcer prevention
Major agenda items discussed	• Theatres closure: Root Cause Analysis • Upward report from Clinical Quality Committee • Children's Committee terms of reference & minutes • Quality & Patient Safety report • Never Event (wrong side block): Root Cause Analysis • Friends & Family Test update • Annual complaints report • Pain management update • Progress with Quality Impact Assessments • Corporate Risk Register • Divisional governance update
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Board	• The Root Cause Analysis (RCA) associated with the theatres closure in June was discussed, which highlighted that the decision to suspend operating had been triggered by a rise in Surgical Site Infections, which prompted a review of the cleanliness of the theatre environment & the integrity of the filters used in some operating theatres. It was found that none of the filters were beyond their useful life and the cleanliness issues were not a cause for concern. The action plan associated with the RCA was reviewed which was extensive and suggested a number of areas for improvement in terms of compliance with the dress code policy and the better enforcement of restricted access. • As part of the upward report from the Clinical Quality Committee, there were two specific concerns highlighted: the need for a risk assessment around ligature points in the Trust and a second concerning the lack of replacement parts for some equipment which may be needed as part of routine maintenance programme. It was agreed that a separate report into medical devices should be presented

	at the next meeting. • The risk around the blood fridges and management of blood was discussed specificially and agreed that further assurance was needed that the policies and practice around this were appropriate • The Committee noted the risk around cover in the governance team, given that there had been some gaps due to sickness absence and maternity leave recently. • The Quality & Patient Safety report highlighted an increase in the number of incidents that had been reported. It was noted that this reflected the work undertaken to simplify the reporting process and the recent incident roadshow that had generated a greater number of lower level incidents that had been reported. • The RCA for the wrong side block Never Event was reviewed, an incident which was noted to be associated with human error. The patient had not suffered any long term harm, howevet the Committee was advised that the practice of undertaking a final check by an independent individual in theatres prior to administering the block had not been followed. There had been good medical engagement with the investigation and a comprehenive action plan had been developed to prevent a reoccurrence of the incident. • The Corporate Risk Register was discussed. It was noted that despite the current financial challenges, care needed to be taken to ensure that quality and safety standards were maintained. It was noted that the Medical Director had reinforced this message with consultant colleagues when he had met with them at a recent clinical engagement event. • As part of the divisional governance update it was noted that that there were concerns over some recent infection control audit results. Recovery work was to be a joint effort between the Head of Nursing and the Head of Infection Control.
Positive assurances and highlights of note for the Board	• The quality of the Root Cause Analyses that the Committee considered was agreed to be very high. • The Committee received the terms of reference for the new Children's Committee, which was to be the forum where the Royal College of Paediatric and Child Health action planwould be monitored. The Committee was pleased to note that there was good medical engagement with the group. • The Committee received a comprehensive presentation on the measures taken to improve pressure ulcer prevention and management. It was reported that much effort had been directed into improving documentation,

	accountability, training and harnessing lessons learned from the Root Cause Analyses of pressure events that occurred. The Committee was pleased to receive this level of assurance but encouraged the position to be kept under review to ensure that the improvements were sustained. • The Committee received a report which highlighted the measures taken to improve compliance with the Friends and Family Test requirements; improved data collection was now in place and the statutory returns were being made robustly. Work was underway to generate an improvement in the response rates in Outpatients. • Good assurance was provided by the annual complaints report, which highlighted that there was improved patient satisfaction at the way complaints had been investigated and responded to. It was reported that the Trust was ranked highly nationally in terms of patients understanding the process by which a complaint could be made. • The Committee received an update on the plan to improve the pain management service, which included extended training for staff and further investment into the critical care outreach team. The plans formed a CQUIN for 2016/17.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Mortality report to be presented in October (deferred from September) • Further detail on the plans to shared lessons learned is to be presented at the next meeting • The Infection Control report on the theatre closures is to be discussed at the next meeting • An update on the plans to mitigate the risks around blood fridges and blood management is to be presented at the next meeting. • The development of a First Aid policy is to be followed by at the next meeting of the Clinical Quality Group.
Decisions made	• None specifically

Kathryn Sallah
NON EXECUTIVE DIRECTOR AND CHAIR OF QUALITY & SAFETY COMMITTEE

For the meeting of the Trust Board scheduled for 5 October 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	19 September 2016
Guests	None
Presentations received and discussed	None
Major agenda items discussed	• Finance & Performance Overview – Month 05 • 2016/17 delivery programme report • NHS Improvement informal review
Matters presented for information or noting	• Risk register
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The Committee was advised that the financial deficit to date was £2.7m, a position which was behind the expectations set out in the annual plan • Agency costs were noted to have been higher than planned in August, which were associated with the need to cover annual leave over the summer period; it also appeared that the annual leave scheduling rules had not been robustly applied during this time, a matter which would be helped in future by the introduction of e-rostering software. An update on this and the preparations for the October half term period were requested for the next meeting. • There was reported to be some slippage with the delivery of cost savings schemes, particularly those in Division 1 • It was agreed that work should be undertaken to prioritise Day Case work to help offset the shortfall in inpatient procedures • The Committee was advised that theatre utilisation had been poor at times over the summer period, a position the Committee agreed was critical to address as part of the recovery plan • The Committee noted that there was further room for improving the cancellation rate and to avoid admission prior to the day of surgery. The discharge processes also needed to be improved to provide additional capacity for those being treated as inpatients. This was to be led by the Head of Nursing, supported by Operations. • Length of stay for patients being treated for primary hip and knee replacement was noted to be unacceptable and

	work was needed to address this. • A number of patients were reported to be being consented on the day of surgery, a practice which was not in line with the consent policy. • High vacancy rates in some areas was noted to be a key risk to the recovery plan • An informal meeting had been held with NHS Improvement to review the Trust's recovery plan. It was anticipated that further assurance would be requested shortly.
Positive assurances and highlights of note for the Board	• Revised job plans were due to be launched in December/January, although the Committee urged greater expediency with this where possible • The governance arrangements for discussing and monitoring the recovery plan were seen as robust by NHS Improvement
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	It was agreed that the following updates would be presented at the next meeting: • Update on implant rationalisation to be presented at the October meeting (AP) • Update on HR framework/annual leave rules to facilitate prospective planning (AC) • Sickness absence update (AC) • Forward plan of spend (following cost centre by cost centre analysis) to be presented at the next meeting (PA) • Outcome of clinical engagement event on 27 September to be presented (AP) • Update on prioritisation of job planning to be presented at the next meeting (AC) • Update on discussions and review by NHSI (PA)
Decisions made	• None specifically

Mr Tim Pile

VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 5 October 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Minutes of the Charitable Funds Meeting held on 27th May 2016
Charitable Funds Committee, 1:00 PM in the Board Room

Present
Mrs Frances Kirkham (Chair)
Mr Paul Athey, Director of Finance
Mrs Jo Chambers, Chief Executive Officer
Ms Stella Noon, Patient Representative
Mr Rod Anthony, Non-Executive Director
Mr Mohammed Qasim, Assistant Financial Accountant and minute taker
Mr Garry Marsh, Director of Nursing and Governance
Ms Yvonne Scott, Patient Representative
Mr Tim Pile, Non-Executive Director

Apologies
Ms Lin Russell, Oncology Service
Mr Andrew Pearson, Medical Director
Mr Jonathan Lofthouse, Director of Operations
Dame Yve Buckland, Chairman
Professor Taunton Southwood, Non-Executive Director
Mrs Kathryn Sallah, Non-Executive Director

Minute no.	Detail	Actions
270516-01	**Minutes from March 2016** The minutes of the previous meeting were accepted by the committee as an accurate record of the meeting.	
270516-02	**Actions from previous meeting** 170316-07 PA mentioned that advice has been received from Mills and Reeves in regards to Dubrowsky Legacy; this is further discussed further in agenda item 8. 170316-08 FK advised that the joining of the NHS Association should be delayed until a fundraiser is in post. It would be deemed more sensible to progress with this in order that the Trusts reaps maximum benefit from joining	

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	the Association. 170316-09e FK advised that a meeting should be set up in the future to review the feedback in regards to the L&D bids that have been approved. 170316-09g SN queried what actions have been taken in regards to the ANP nurse qualification? PA advised that as the Trustees had previously requested to see if the funding would be available via the Spinal Fund, it was not deemed essential. He also advised that if the Trustees would like the item to be included on the agenda then it can be arranged.	
270516-03	**Bids for funding** The Committee heard the bid Enclosure 3	
	Pump Priming Research **Presented by Ed Davis** The bid entails the need to continue research in identifying novel inflammatory molecules (called lincRNAs) that regulate joint inflammation in patients with Osteoarthritis. The current research collaboration with University of Birmingham and the ROH has delivered world-leading research in regards to the above mentioned and in order to continue to be able to cover the funding gap that is faced due to the novelty of this area which has meant the large Research Councils have been slow to catch on. PA asked if the Charitable Funds was the only bid for funds they are putting forward. ED there will be other bids that are put forward and it is required to keep current work ongoing. SN asked whether council would provide funding. ED advised the Arthritis Research UK have put forward a bid but this has not been successful. Also, they have changed their funding priorities and it would be unlikely that they would help but they will continue to try.	PA to liaise with fund holders of the Hip Research Fund to see if they are willing to allow funding to be used.

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	JC queried whether this research strategy would be suitable and in line with the current strategy. ED responded that it is and one of the strengths of the ROH is the research into Osteoarthritis. He also advised that the research of Osteoarthritis is already a large pillar of the research the ROH currently do and in order to remain as a world leader in this research field, continuation of the research would be required. TP queried if it is fully costed. ED mentioned it is the just the costing of the research. TP then asked how they are planning to leverage the work that would be carried against the benefit it would provide the Trust. ED advised the benefits of being a leading researcher would be reputational benefits along with potential revenue streams that would sit as the largest profit from pharmaceutical trials when it gets to that stage. Phase 3 and 4 require large numbers of patients and is fully funded by industry and if the pharmaceutical companies feel as though we have the reputation and they will come to us. RA asked if there would be intellectual property generated from this that the ROH could potentially have rights over. ED advised that if the charity were to provide the funding then they can draw up a contract with the university that if any pharmaceutical/financial gains were generated then the charity receives an element. YS queried whether cost would outweigh the need for hip replacement and if the requirement of medicine would be long-term? ED advised that the inflammation is caused by signals; when the signals turn off, this is what causes the degradation. Ultimately the pharmaceutical companies have the choice of whether they produce the drug or not. JC supports the bid on the basis that it is built up over time and seems as though it is going in the right direction. She also advised that we should make sure we are satisfied with any governance issues before	

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	commencing, such as around the idea of Intellectual Property. PA advised Hip Research does fit into the purpose of the bid but needs to ensure we have support of fund holders for this before we can make a decision. He also mentioned that only £84K of General Funds only remaining and that this could be something that we could fundraise for. RA investing charitable funds into this will help improve lives and help enhance the reputation of the ROH. This should be acknowledged and from a commercial aspect if any progress is made, we should receive a suitable return and knowledge of our contribution should be recognised. TP mentioned that if there is a reputational and financial benefit to the ROH, then RA above point is valid; the charity is making an investment and it should see a return. He also felt it is the correct use of charitable funds and when the fundraiser joins they will be aiming to improve the environment and research so it fits well with future plans and targets. GM advised that he feels as though the research would life and the impact would be something good to be linked to the ROH. FK advised costs could be coming from Hip Research Fund and then it would be ideal. She also advised that we should iron out any governance issues such as investment return and intellectual property. Also, if the Hip Research fund can't fund this project then we should look at ways of seeking funding. **The Trustees approved of the funding subject to discussion with the fund holders of the Hip Research fund. If the funding cannot be provided from the above then alternative methods will be looked at.**	

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270516-04	**<u>Review of financial position to 31st March 2016</u>** **Presented by P Athey** PA Advised of income of £21k and expenditure of £49k. PA also advised that most funds are now being used and he identified that future plans are better than previous years. FK queried the £5k expenditure against the Mr Dubrowsky fund. PA advised that it relates to administration charges and audit fee for the financial year.	
270516-05	**<u>Cazenove market update and review of investments</u>** The report was noted by the committee.	
270516-06	**<u>Charitable Funds Annual Report and Accounts March 2016</u>** PA advised that due to the changes in SORP and transition to the new FRS 102, the Income Recognition accounting policy would have recognised the Dubrowksy Legacy in the 2014/15 period even though the legacy was received into the Charity bank in 2015/16. PA also advised of a post year-end event where a further £170k was received in regards to the Dubrowksy Legacy and after discussions with the external auditors, this had to be recognised in 2015/16 rather than 2016/17. GM advised that on page 3, the dates of office were incorrect and they only included the interim dates and should be updated to include the substantive dates. FK advised that in the Future Plans section on page 6, the plans for the Research Lab should state that these plans are only a possibility at this moment until further review and discussions have taken place. PA suggested that Trustees should review and advised if any further changes are required.	MQ to action any changes

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270516-07	**<u>Mr Dubrowsky Legacy</u>** PA advised that advice had been received from our solicitors Mills & Reeves that the Trust would be allowed to use funds for wider reason ie. Research lab use for sarcoma and then other purposes. Mills & Reeves suggested that it is only a request to utilise the funds but they should be expended as closely as possible to the fund purpose. FK asked for the advice from Mills & Reeves to be circulated to all the Trustees and to include the instruction that was sent out to the solicitors for them to provide the advice received. PA mentioned that he will aim to find an appropriate time for a meeting outside of the Charitable Funds Committee as the meetings clash with the Consultants clinical priorities. FK agreed but ensuring enough time to discuss due to the size of the bid.	PA to circulate advice from Mills and Reeves PA to set up meeting
270516-08	**<u>Fundraising</u>** TP feels that the charity should go ahead with the recruitment of a Fundraiser and it would be the first step towards going in the right direction of fundraising. RA also supports and feels that it is a good idea. YS asked should the funding for the fundraiser only be provided for a year? TP advised that the fundraising post should be able to recoup the funding for the post. PA queried for ATR purposes, if the position was fixed term or a permanent post. FK queried target of £1m. JC advised that this isn't the first year target but it is a target that will help get the ball running. GM advised that there should be communication in regards to the post; the benefits of the post and the fact that it is funded by the Charity as there have been difficulties around not replacing posts in the Trust.	

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	JC agreed as the current hold on recruitment could potentially raise questions and this way the post of the Fundraiser will be promoted and introduced to the Trust in the right way.	
170316-14	**<u>Physiotherapy Fund- purpose amendment</u>** PA advised that Option 1 is very similar to setting up new fund and that setting up of new funds has been restricted due to the amount of funds that the charity currently has. PA mentioned that Option 2 would be the most ideal. The general view of the Trustees is that they accepted this and were happy for this to be actioned.	
	<u>Any other business</u> FK Would like prioritisation of requests for expenditure. Look at way of filtering requests and see of criteria to apply for requests that come through. TP advised of potential tests that and advised	MQ to look at ideas.
	<u>Date of future meetings</u> TBC	MQ to confirm by email new date.

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The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 2 November 2016

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 2 November 2016 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 November 2016: 1100h – 1300h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair & Non Executive Director	(TP)
HH Frances Kirkham	Non Executive Director	(FK)
Prof Tauny Southwood	Non Executive Director	(TS)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Rod Anthony	Non Executive Director	(RA)
Mrs Jo Chambers	Chief Executive	(JC)
Mr Andrew Pearson	Medical Director	(AP)
Mr Paul Athey	Director of Finance & Performance	(PA)
Mr Garry Marsh	Director of Operations, Nursing & Clinical Governance	(GM)
Prof Phil Begg	Director of Strategy & Transformation	(PB)

In attendance

Ms Anne Cholmondeley	Director of Workforce & OD	(AC)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies – Richard Phillips	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	Patient story	Presentation	GM
1125h	4	Minutes of Public Board Meeting held on the 5 October 2016: *for approval*	ROHTB (10/16) 017	Chair
1130h	5	Trust Board action points: *for assurance*	ROHTB (10/16) 017 (a)	SGL
1135h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (11/16) 002 ROHTB (11/16) 002 (a)	YB/JC
		QUALITY & PATIENT SAFETY		
1150h	7	Patient Safety & Quality report: *for assurance*	ROHTB (11/16) 003 ROHTB (11/16) 003 (a)	GM
1205h	8	Safe Staffing Report: *for assurance*	ROHTB (11/16) 005 ROHTB (11/16) 005 (a)	GM
1215h	9	CQC action plan:	ROHTB (11/16) 006	GM

		for assurance	ROHTB (11/16) 006 (a)	
FINANCE AND PERFORMANCE				
1225h	10	Finance & Performance overview: *for assurance*	ROHTB (11/16) 007 ROHTB (11/16) 007 (a)	PA
ASSURANCE UPDATES FROM THE BOARD COMMITTEES				
1240h	11	Quality & Safety Committee & annual report	ROHTB (11/16) 008 ROHTB (11/16) 009	KS
1245h	12	Audit Committee & annual report	ROHTB (11/16) 010 ROHTB (11/16) 011	RA
1250h	13	Finance & Performance Committee	ROHTB (11/16) 012	TP
1255h	14	Transformation Committee	ROHTB (11/16) 013	TP
MATTERS FOR INFORMATION				
	15	Birmingham & Solihull Sustainability & Transformation Plan	ROHTB (11/16) 014	
1300h	16	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 7th December 2016 at 1600h, 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.

MINUTES

Trust Board (Public Session) - DRAFT v0.3

Venue Boardroom, Trust Headquarters **Date** 5 October 2016: 1100h – 1300h

Members present

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair	(TP)
Mr Rod Anthony	Non Executive Director	(RA)
Mrs Kathryn Sallah	Non Executive Director	(KS)
HH Frances Kirkham	Non Executive Director	(FK)
Prof Tauny Southwood	Non Executive Director	(TS)
Mrs Jo Chambers	Chief Executive	(JC)
Mr Paul Athey	Director of Finance	(PA)
Mr Andrew Pearson	Medical Director	(AP)
Mr Garry Marsh	Director of Operations, Nursing & Clinical Governance	(GM)
Prof Phil Begg	Director of Strategy & Transformation	(PB)

In attendance

Mr Richard Phillips	Associate Non Executive Director	(RP)	
Ms Anne Cholmondeley	Director of Workforce & OD	(ACh)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

	Paper Reference
1 Apologies	**Verbal**
There were no apologies for absence. Alex Gilder joined the meeting as staff governor.	
2 Declarations of Interest	**Verbal**
No Declarations of Interest had been received since the last meeting and no declarations were made in connection with any item.	
3 Patient Story	**Presentation**
The Board welcomed Jackie Hayes, Katie Richards and Nikki Mason who presented an overview of Occupational Therapy (OT) patient experiences. The presentation focussed on case studies of a patient that was seen by OTs pre-operatively and another that was not seen pre-operatively and the audit results for both. The presentation highlighted the benefits of OT input to the pre-operative process,	

in terms of patient's length of stay, arranging a package of care in advance ready for discharge and ensuring that the patient had the correct equipment for their post operative recuperation in a timely way. The Chief Executive asked where the additional patients that had not been seen in the Pre Operative Assessment Centre were now within their patient pathway. She was advised that some would have had not had their surgery but the majority would have been treated since the audit. The team were thanked for their presentation and the importance of clinical audits such as this work was noted, particularly the impact on the organisation and its finances. It was suggested that with this benefit in mind, more clinical audits should be conducted in future. The team was asked how it had been decided to undertake the work in the first place. Mrs Mason advised that a business case had been made to the Trust Management Committee which had been clear about the benefits of the investment for the work. It was noted that there was not much evidence of the benefits of this pre-operative therapy intervention outside of the organisation and therefore it was suggested that this could become a 'gold standard' that could be published. The Medical Director praised the work, however he noted that the Knee Workshops had ceased to be held. He was advised that these would be reinstated as part of the rapid recovery work. The Director of Finance asked whether the additional workshop was likely to deliver better value for money through reductions in length of stay for instance. He was advised that this was not always the case as the impact varied on a case by case basis. It was noted that the Finance & Performance report showed that length of stay for primary hips and knee patients had increased, which needed to be addressed. The Director of Operations, Nursing & Clinical Governance agreed that the workshops should be reinstated from a patient safety perspective, highlighting that there had been an increase in VTEs and additional scrutiny on pressure sores, discussions on which could be included in these workshops. The equipment delivery service was noted to be unreliable but was not within the remit of the team to influence. As much work as possible was being done in advance with the equipment team however. Prof Begg agreed with earlier comments that the work should be published and asked whether there was any linkage into the current Pre-Operative Assessment Centre development. It was reported that this was the case, as part of the revised workforce model. A number of patients were under the care of the Trust at present which did not have Occupational Therapy input, however work was planned to address this through the business case discussed earlier. The team were thanked for their work and attendance at the meeting.	
4 Minutes of the Public Board 7 September 2016	**ROHTB (7/16) 020**
The minutes of the public meeting were accepted as a true and accurate record of discussions held, subject to some minor comments.	

AGREEMENT: The minutes of the previous meeting were approved	
5 Trust Board action points	**ROHTB (9/16) 015 (a)**
The Associate Director of Governance & Company Secretary reported that: • A further update on delivery of a Paperless Board solution would be provide at the end of the year. • Dementia was to be discussed by Quality & Safety Committee in October • The Board Assurance Framework was to be discussed as part of the agenda of the meeting All further actions were noted to be on track to be delivered as planned or had been completed.	
6 Chairman's and Chief Executive's update	**ROHTB (10/16) 002** **ROHTB (10/16) 002 (a)**
The Chairman advised that The Nominations Committee for Executive Directors had met after the last Board meeting, the outcome of which resulted in the Director of Strategy & Transformation post being designated as a voting member of the Board. The Associate Director of Governance & Company Secretary outlined the process by which this decision had been reached. He reminded the Board that the Nominations Committee was a Committee of the Board with delegated powers to review the balance and skills required of the Executive Directors and to approve appointments into these posts where appropriate. The Committee, through a paper presented by the Chief Executive agreed that the Board would benefit from the addition of the Director of Strategy & Transformation post to the voting cadre of Executive Directors, this being occupied by Professor Begg. This decision was noted to have the benefit of retaining a balance between Executive and Non Executive colleagues, given that the Director of Operations post was being carried as a vacancy at present since Jonathan Lofthouse had left the organisation in September. It was agreed that the decision reached would be visited later in the year, when the Nominations Committee would meet again. Professor Begg was congratulated on the elevation of his role to being a voting member of the Board. The Chairman continued with a number of key highlights from the last month, as follows: • The Annual Members Meeting was held on 14 September in the Max Harrison Lecture theatre. The meeting was reasonably well attended, however work was already underway to see how the meeting could be improved for next year including how the Trust's bicentenary celebrations	

might be built into discussions.

- In terms of Non Executive recruitment, the clinical NED recruitment round had been held since the last meeting (19 September) and an appointment had been made, subject to usual pre-engagement checks and formal approval by the Council of Governors at their meeting in January 2017
- The Chairman had attended:
    - a NHS Providers Chairs & CEOs event on 21 September in London
    - the Patient & Carers' Council meeting on 27 September
    - a range of STP-related meetings during the month as the deadline for submission of the plan approaches (21 October)

In terms of forthcoming plans:

- Dame Gill Morgan chair of NHS Providers was visiting the Trust on the afternoon of 12 October. Dame Gill was interested in learning about the Trust and would like to discuss the NHS Providers role in areas of particular interest.
- Ed Smith, Chair of NHS Improvement was visiting the Trust on the morning of Monday 14 November. Ed Smith had been invited to the Trust following the last Chief Executive and Chair's NHS Provider meeting as he had offered to keep listening to those at the front line and was keen to meet Chairs and see organisations first hand.
- Dame Professor Donna Kinnair who was the Deputy Director of Nursing at the Royal College of Nursing had accepted an invitation to spend a day with the Trust on 16 March. Planning a day of events around her visit in our bi-centenary year had started, to include a Harrison lecture and celebrations surrounding nursing in the Trust.
- The next Harrison Lecture was being held on 17 November when Prof Sir Keith Porter would talk on from 'Bastion to Birmingham'. Much work had been undertaken to build links with some local schools to encourage those who were interested in a medical career to attend these lectures and consideration was being given to running an earlier slot from 6.00pm – 7.00pm for these students to help them to better understand what was involved.

The Chief Executive presented an update on the national context. She advised that there had been a detailed discussion around the STP submission planned for 21 October, which she advised was not to be shared with the Board in public at present.

The key points of discussion from the Trust Management Committee were highlighted.

The Chief Executive was asked for further detail on the new 'Top Ten Tips' for saving costs issued by NHS Improvement. It was noted that these opportunities were harnessed from experience of a number of NHS organisations and the

response to these would be considered as part of the Trust's recovery plan being considered by the Finance & Performance Committee. On a separate matter, the Company Secretary was asked to check whether Non Executives were included on the circulation list for all staff communications e-mails.	
ACTION: SGL to check whether Non Executives are included on the circulation list for all staff communications e-mails	
7 Nominations Committee (Executive Directors) terms of reference	**ROHTB (10/16) 003** **ROHTB (10/16) 003 (a)**
The Associate Director of Governance & Company Secretary presented the revised terms of reference for the Nominations Committee (Executive Directors), which he advised had been discussed and accepted by the Nominations Committee (Executive Directors) at the meeting held on 7 September 2016. The changes were noted to be largely cosmetic, these being to bring the format in line with the terms of reference of the Board's other committees. The Trust Board approved the revised terms of reference.	
8 Patient Safety & Quality report	**ROHTB (10/16) 004** **ROHTB (10/16) 004 (a)**
The Director of Operations, Nursing & Clinical Governance presented the key highlights from the Patient Safety & Quality report. It was reported that one Serious Incident had been reported, this being a Grade 3 pressure ulcer. The Board was asked to note that there was now additional information concerning incidents relating to Paediatric patients; there had been 22 of these incidents during August. An in depth Root Cause Analysis had been produced around the wrong side block Never Event, which had concluded that there were four different SOPs in theatres describing the process and checks prior to administering an anaesthetic block. While these were noted to be visually different, they were consistent in content. It was reported that the Safety Thermometer information was being separated into adult and paediatrics data. There was highlighted to have been a rise in the number of incidents reported, although not in the level of harm incurred; this was to be regarded as positive and likely to be a consequence of the work done to promote the incident reporting process. Pressure ulcer prevention was reported to be a key area of focus at present. There had been no Grade 4 pressure ulcers reported within the month. The Board was advised that the matron and ward manager had attended the Quality & Safety Committee and had delivered a presentation to show how the processes to	

prevent tissue damage had been strengthened. The review of falls within the organisation had transferred to the Head of Nursing. The Board was pleased to hear that the new Head of Nursing had been positively received and was delivering positive challenge to practices at the ROH. Structural changes would be made to give the Head of Nursing more control over the work of the nursing teams. The new Deputy Director of Nursing & Clinical Governance would start in the new year. The recruitment of a Head of Nursing in theatres was noted to be underway. The Chief Executive noted that pressure ulcers and environmental cleanliness were an issue and challenge was needed with the professional leads for these portfolios, with these to be held to account through the operational structure. The Trust was reported to be currently breaching contractual obligations in respect of cleanliness. It was suggested that the impact of the revised nursing levels on the performance against quality indicators should be clarified where possible. Poor documentation needed to be addressed as a priority. It was suggested that inclusion of the previous year's performance within the report would be useful by way of a benchmark would also be good; incidents as a percentage of inpatients would also be useful.	
ACTION: **GM to consider how the impact of the revised nursing levels on the performance against quality indicators could be identified**	
9 Safe Staffing Report	**ROHTB (10/16) 005** **ROHTB (10/16) 005 (a)**
The Director of Operations, Nursing & Clinical Governance reported that e-rostering roll out had started, which would focus on Ward 11 and HDU to gain some financial oversight and create efficiency. There were reported to be 15 registered nurse vacancies at present and 5 Healthcare Care Assistants. The biggest challenge was reported be around Paediatric nursing, with a number of candidates being invited for interview, not arriving on the day. Those candidates remaining were not appointable based on the results against the mathematics test. It was noted that this provided some financial pressure given that agency staff needed to be used, sometimes this being off framework. Earlier in the year, joint appointment discussions had been held with Birmingham Children's Hospital NHS FT however these were not likely to be a useful solution. The Board was advised that since the report had been produced, it had been determined that high annual leave was a contributor to the high agency staff usage in August and to ensure that this would not be repeated rotas would be reviewed for half term and Christmas particularly. It was noted that the policy framework for annual leave was being reviewed to understand whether this needed to be tightened to add in extra controls to avoid non-compliance. It was noted that this	

was a specific action to report back on to the Finance & Performance Committee. The Executive Team was looking at bed occupancy around the Christmas period. It was highlighted that by Sunday there was a dip in occupancy and therefore a forward look on discharges against staff levels was being developed.	
10 Infection Control annual report	**ROHTB (10/16) 006** **ROHTB (10/16) 006 (a)**
The Director of Operations, Nursing & Clinical Governance highlighted that the report had been scrutinised by the Infection Control Committee and the Quality & Safety Committee received a quarterly update on Infection Control as part of its routine cycle of business. The Director of Infection Prevention & Control responsibility had moved to Mr Marsh during the year. The Infection Control Committee was reported to sit bimonthly and included external stakeholders in the attendance. No MRSA bacteraemias had been reported during the year; 6 C. difficile infections had been reported, all of which were identified as being unavoidable. A Contract Performance Notice over practice around the management of central venous catheters had been received during the year, where the required level of observations had not met. An external review of the Trust's decontamination facility was undertaken during the year and it was highlighted that the facility should return to a 'dropped incident' facility rather than being used to decontaminate whole trays. Surgical Site Infections (SSIs) for hips and knees fell during the period and deep infections were static in numbers. The bone infection unit saw a rise in annual referrals and in 2015/16 there had been a particular rise in external referrals. The diagnostic of the deep wound infections leading to the closure of theatres in June was still to be concluded. A programme of quality assurance visits was in place, designed to pre-empt any infection control issues, this being supported by walkabouts by the Medical Director. Lost income through readmissions was discussed. In terms of benchmarking, the Trust was part of the 'Getting it Right First Time' initiative and the Trust was seen as positive compared to peer organisations. A unified quality report presenting the position against all specialist orthopaedic providers was planned. It was noted that there had been points of failure in terms of hand hygiene during the year which had been identified through CQC visits, however this was not reflected within the report. The actions to challenge 'bare below the elbow'	

practice were not clear and would be given focus over the next year. The operational model around bone infection was highlighted to be different to that depicted in the report. The Director of Operations, Nursing & Clinical Governance reported that the decision around bone infection had been taken to not physically cohort bone infection patients into the private patient area. A new model needed to be developed given the benefits known to be associated with this cohorted approach. For the second month, cleanliness audits had failed to meet contractual requirements and the Trust receiving a Contract Performance Notice was a possibility. The process had changed to ensure action was undertaken in future to address issued identified by the audit, rather than just reaudit, a matter being led by the Head of Nursing. The Board noted the report bearing in mind the points of clarity provided.	
11 Complaints annual report	**ROHTB (10/16) 007** **ROHTB (10/16) 007 (a)**
The Board noted the annual complaints report. The Director of Operations, Nursing & Clinical Governance was asked whether there was any benchmarking information available on complaints. It was noted that there had been a similar challenge by the Quality & Safety Committee. In terms of the national positon, the level of complaints received into the Trust was lower than the NHS average. It was suggested that benchmarking against the best organisations in the private sector would be useful. The Chair of the Quality & Safety Committee highlighted that the Trust had upheld 81% of some aspect of complaints. 90% of complaints were around communication issues. It was agreed that the learning points in the report were welcome.	
12 Finance & Performance overview	**ROHTB (10/16) 008**
It was noted that the Finance & Performance overview report had been considered by the Finance & Performance Committee at its meeting on 19 September. The deficit was reported to be £2.7m against a plan of £1.7m. The Trust was handling 22% lower activity than planned, partly explained through casemix. Underperformance was noted to not just reflect casemix but also theatre inefficiencies and a failure to structure theatre lists robustly. It was agreed that this would be discussed at Finance & Performance Committee at its next meeting. The significant increase in agency staff was highlighted to have been discussed in previous parts of the agenda. The cash position had largely stabilised but was still on a downward trajectory, with current extrapolations predicting that cash would run out in Quarter 2 - 3 of	

2017/18. There had been a disappointing increase in length of stay and in particular in primary hip and knee treatment. It was noted that detailed discussions had been held in private in terms of cost control, length of stay and pre-operative processes. The next Finance & Performance Committee would be reviewing the activity recovery plan ahead of the NHS Improvement meeting.	
13 Self assessment against the NHS England Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	**ROHTB (10/16) 009** **ROHTB (10/16) 009 (a)** **ROHTB (10/16) 009 (b)**
It was noted that the areas of non-compliance against the NHS England Core Standards for Emergency Preparedness, Resilience & Response (EPRR) were not the same areas as declared last year, with these non-compliances largely related to training internally. The Trust Board noted the action plan to address non-compliance.	
14 Quarter 2 2016/17 - Board Assurance Framework	**ROHTB (10/16) 010** **ROHTB (10/16) 010 (a)**
The Associate Director of Governance & Company Secretary presented the updated Board Assurance Framework for receipt and noting. It was agreed that the BAF was a useful tool and there had been good improvement over the year. The Board was advised that the Audit Committee would scrutinise this fully at its meeting on 7 October 2016.	
15 Quality & Safety Committee	**ROHTB (10/16) 011**
The Chair of the Quality & Safety Committee provided the highlights from the recent meeting of the Committee. It was reported that there was to be a focus on plaster casts as part of pressure injury prevention. The risks around blood management and fridges had been agreed as a matter needing to be addressed as a priority. It was reported that the Commissioners and the public governor who attended the meeting were pleased by the level of challenge and the healthy debate at the meeting.	
16 Finance & Performance Committee	**ROHTB (10/16) 012**
The Chair of Finance & Performance Committee noted that the key outcome of the last meeting was that a recovery plan was needed, detailing key responsibilities	

and outcomes that needed to be implemented as a matter of urgency.	
17 Charitable Funds Committee	**ROHTB (10/16) 012**
The minutes approved at the last meeting of the Charitable Funds Committee were received and noted. Discussions were reported to have centred on pump priming of the research work which had been discussed at the last Trust Board meeting. This assurance was now in place, however sources of funding needed to be identified. A further discussion would occur outside of the meeting. It was reported that the recruitment of a fundraising manager had been undertaken and an appointment made.	
18 Update from the Council of Governors	**Verbal**
The Chairman provided an overview of the points of discussions from the last meeting of the Council of Governors held on 14 September, these being: • The Council had welcomed new public governor, Brian Toner from the 'Rest of England & Wales' constituency who replaced Stella Noon; it also welcomed Lynda Hindley and Mel Grainger as new staff governors • The main item discussed were the appraisals of the Non Executive Directors and the Chairman • The Council had approved the proposal from the Nominations & Remuneration Committee of the Council of Governors to appoint Richard Phillips as a new Non Executive Director • The Council was given an update on the developments regarding the STP and some national context • The Director of Strategy & Transformation had joined the meeting to provide an overview of the plans to refresh the Trust's strategy • There was a significant discussions on the activity and performance recovery plan and the governors levied some heavy challenge around what was different this time, given that they were familiar with the key messages year upon year • The Chair of the Quality & Safety Committee had provided a briefing on some of the key discussions from Quality & Safety Committee	
19 Any Other Business	**Verbal**
There was none.	
Details of next meeting	**Verbal**
The next meeting would be held on 2nd November 2016 at 1100h, Board Room,	

Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 2 November 2016, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

5 October 2016, Boardroom @ Trust Headquarters

Members present: Yve Buckland (YB), Tim Pile (TP), Rod Anthony (RJA), Kathryn Sallah (KS), Tauny Southwood (TS), Frances Kirkham (FK), Jo Chambers (JC), Paul Athey (PA), Garry Marsh (GM), Andrew Pearson (AP), Phil Begg (PB)

In Attendance: Richard Phillips (RP), Anne Cholmondeley (AC)

Apologies: None

Secretariat: Simon Grainger-Lloyd (SGL)

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
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	~~03/02/2016~~ 6-July-16 Review again in Dec-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. Further development work currently underway. Names of individuals suggested to trial the system have been put forward, however delay due to resolution of Information Governance issues for those wishing to use non-Trust iPads.	
ROHTBACT. 020	Board Assurance Framework	ROHTB (5/16) 009 ROHTB (5/16) 009 (a)	04/05/2016	Update the BAF to include risks to the sustainability of the organisation agreed at the Board strategy day	SGL	~~06/07/2016~~ ~~1/10/2016~~ 11/01/2017	Updated BAF considered at the Trust Board and Audit Committee in October. Risks reflected the ongoing viability of the organisation but will more fully cover the risks discussed as part of the strategy refresh in the next iteration.	
ROHTBACT. 022	Patient Safety & Quality report	ROHTB (10/16) 004 ROHTB (10/16) 004 (a)	05/10/2016	Consider how the impact of the revised nursing levels on the performance against quality indicators could be identified	GM	05-Dec-16	Action also raised by Quality and safety Committee and will be reported back in December	

ROHTBACT. 014	Patient Case – an illustration of the work we do	Presentation	06/04/2016	Quality & Safety Committee to consider the future plans for screening dementia patients	SGL	~~25/05/2016~~ 28/09/2016	Discussed at the meeting of Quality & safety committee in October and reflected in the upwards report from the Committee on the agenda of the November Trust Board meeting	
ROHTBACT. 007	Safe Staffing report	ROHTB (9/16) 003 ROHTB (9/16) 003 (a)	07/09/2016	The detail of nurse staffing incidents to be presented to a future meeting of the Quality & Safety Committee	GM	26-Oct-16	Included on the agenda of the October meeting	
ROHTBACT. 021	Chairman's and Chief Executive's update	ROHTB (10/16) 002 ROHTB (10/16) 002 (a)	05/10/2016	Check whether Non Executives are included on the circulation list for all staff communications e-mails	SGL	02-Nov-16	NEDs are included on the all staff distribution lists	
KEY:								

	Verbal update at meeting
	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

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 November 2016**

EXECUTIVE SUMMARY:

This report provides an update to board members on the national context and key local activities not covered elsewhere on the agenda.

The report also provides a summary of key discussions and decisions taken by the Trust Management Committee since the Board last met.

REPORT RECOMMENDATION:

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

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:

The contents discuss a number of developments which have the potential to impact on the delivery of a number of the Trust's strategic ambitions

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 2 November 2016

1 EXECUTIVE SUMMARY

1.1 This paper provides an update on a number of key priorities for the Trust, as well as stakeholder and partnership engagement activities undertaken since the last Trust Board meeting on 5 October 2016.

2 NHS Improvement (NHSI) – SINGLE OVERSIGHT FRAMEWORK

2.1 NHSI has now issued the shadow segmentation decisions for all NHS providers against the new Single Oversight Framework which has previously been shared with the Board. The Trust has been identified in Segment 2, being the second of four segments. This signals one or more concern against the five domains, these being quality and finance. NHS Providers have developed an 'On the Day Briefing' which is attached for information.

The Trust is developing its financial recovery plan for discussion with NHSI colleagues during November, which Board members are considering in more detail in other meetings.

2.2 During the week beginning 24 October 2016, specialty meetings have taken place with consultants led by the Chief Executive, Medical Director and Director of Operations, Nursing and Clinical Governance. These meetings have given consultants the opportunity to confirm their understanding of the Trust's recovery positon, and to discuss what needs to happen or to be unblocked to allow for an increase in activity and efficiency in theatres. A number of actions have been agreed to allow for immediate remedial action to take place.

2.3 Additionally, there will be a follow up meeting with NHSI to review progress of our quality improvement action plans in relation to the CQC inspection and report issued in December 2015; this will take place later in November.

3 NHSI - REDUCING AGENCY SPEND

3.1 NHSI have written to Trusts with new reporting and assurance requirements around agency spend. This includes:

- Monthly breakdown of agency spend by cost centre/service line – *24 October*
- Twenty highest-earning agency staff (anonymous) – *31 October*

- Agency staff employed for six consecutive months or more – *31 October*
- Completion of Board level agency self-certification assessment – *30 November*
- Chief Executive sign off of all shifts higher than £120 per hour, and any agency requests above cap – *embed in Trust*
- NHSI sign off on any agency spend on contractors charging higher than £750 per day – *from 31 October*

3.2 The Trust's current agency spend is under significant internal scrutiny and additional control measures and there is professional input to ensure that staff levels are safe and appropriate.

4 STAKEHOLDER AND PARTNERSHIP ENGAGEMENT

4.1 In addition to routine business meetings with partners, other key stakeholder and partnership engagement activities over the period include:

- Birmingham and Solihull STP Board meeting
- Hosted visit from Dame Gill Morgan, Chair of NHS Providers
- Attended Leadership Transformation Theme Group
- West Midlands Provider CEO meeting
- Site visit and meeting with Alison Tonge, Director of Operations (NHSE - West Midlands)
- Site visit and meeting with executive officers from the Greater Birmingham and Solihull Local Enterprise Partnership and partners from the University of Birmingham, West Midlands Academic Health Sciences Network and our commercial partner.

5 UPDATE FROM TRUST MANAGEMENT COMMITTEE

6.1 Since the last meeting of the Board on 5 October 2016, the Trust Management Committee (TMC) was held on 26 October 2016.

6.2 TMC considered the following items to be of note to the Board:

- TMC reviewed the Trust's Contract Performance Scorecard. A number of KPIs have are not being met, and are likely to result in Contract Performance Notices (CPN), namely:
    - Mandatory training compliance – not meeting compliance of 95%. Directorates are required to submit trajectories to meet compliance by the end of October.
    - Safeguarding training compliance – revised trajectory has been met in September, however risk that this will not be met in October due to a cancelled mandatory training day
    - Cancellations not re-booked within 28 days
    - Single Sex Accommodation breaches - significant number of breaches in September is likely to trigger a CPN

- The 2017-18 Standard NHS Contract and local commissioning intentions were discussed, and it was noted that:
    - The new contract covers a two year period
    - 1.5% CQUIN funding is linked to mandated national CQUINs with no local variation
    - The remaining 1% CQUIN funding is dependent on achieving 2016-17 control total and participating in STP schemes
    - All specialties are required to be on the e-Referral system
    - The CCG are intending to develop Spinal Pathfinder, and review neck, shoulder, hip and knee pathways
    - There will be an increased use of Orthopaedic Triage services
- The Deputy Director of Finance confirmed that the Trust has received a rating of '2' for the new Use of Resources Rating which replaces the previous Financial Sustainability Rating. This is one below the top rating available.
- Additional expertise are being provided to support the investigation into the large number of open referrals within the Trust's Patient Administration System (PAS) to identify where there are processes within the system that either are not functioning correctly, or are not being adhered to.

6.3 The following policies were reviewed by TMC and recommended for approval:

- Professional Registration Policy
- Disciplinary Policy
- Grievance and Disputes Policy
- Accessible Information Standard Policy
- Patient Access Policy (a summary of this policy will be circulated to all consultants)

6.4 The Corporate Risk Register was reviewed and it was noted that an additional risk would be added to reflect the Trust's cash flow position.

7 RECOMMENDATION(S)

7.1 The Board is asked to discuss the contents of the report, and

7.2 Note the contents of the report.

Jo Chambers
Chief Executive
28 October 2016

NHS IMPROVEMENT SHADOW SEGMENTATION PUBLISHED

Today NHS Improvement (NHSI) published its shadow segmentation of all NHS trusts and foundation trusts, according to their support needs. This briefing offers our initial analysis into the segmentation and includes our press release in response to today's publication.

We have previously published an on the day briefing on the Single Oversight Framework which can be found on our website and offers more detail on how the segmentation process is undertaken.

INTRODUCTION

NHSI published its new Single Oversight Framework (SOF) last month, following a consultation period over the summer. The SOF introduced a new mechanism of categorising trusts according to their performance against a number of metrics across five themes (quality of care; finance and use of resources; operational performance; strategic change; leadership and improvement capability). This segmentation replaces the previously used risk ratings by Monitor through its Risk Assessment Framework, and categories used by the NHS Trust Development Authority through its Accountability Framework.

Since the publication of the SOF NHSI has undertaken a shadow segmentation process based on performance and other intelligence gathered over recent months. It is our understanding that NHSI have completed this process in dialogue with providers and that you have had the opportunity to discuss your indicative segment with your relationship manager. The results of this process have been published today and our initial analysis can be found below.

SHADOW SEGMENTATION ANALYSIS

The majority (60 per cent) of providers are in segments one and two, demonstrating that despite current challenges trusts are working hard to provide high quality patient care (see figure 1). However when broken down by trust type the figures lay bare that the ambulance and acute sector are facing the extreme pressure, with two thirds of acute trusts and half of ambulance trusts in segments three and four (see figure 2).

FIGURE 1

NHSI segmentation

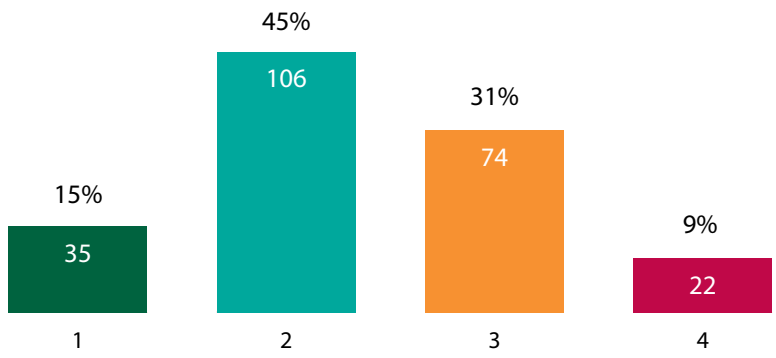
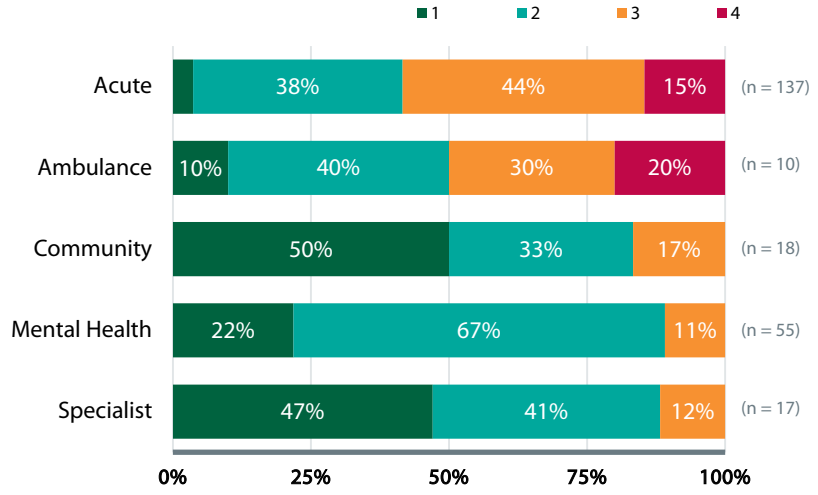


FIGURE 2

NHSI segmentation by trust type

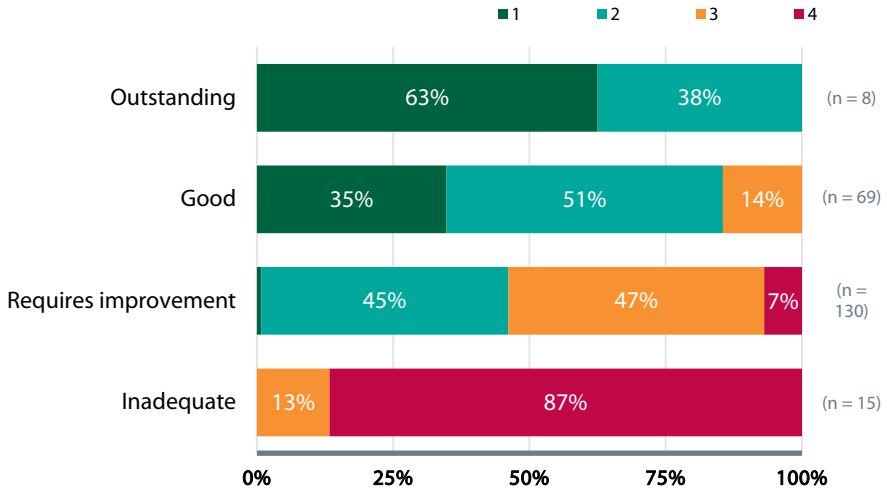


Alignment with CQC

We believe the SOF offers real potential for NHSI and CQC to align their regulatory approaches. In fact, NHSI states that the SOF is designed to increase the number of providers who achieve 'good' or 'outstanding' CQC ratings. When looking at the segmentation figures by CQC rating, there is clearly a correlation (see figure 3).

FIGURE 3

NHSI segmentation by CQC rating

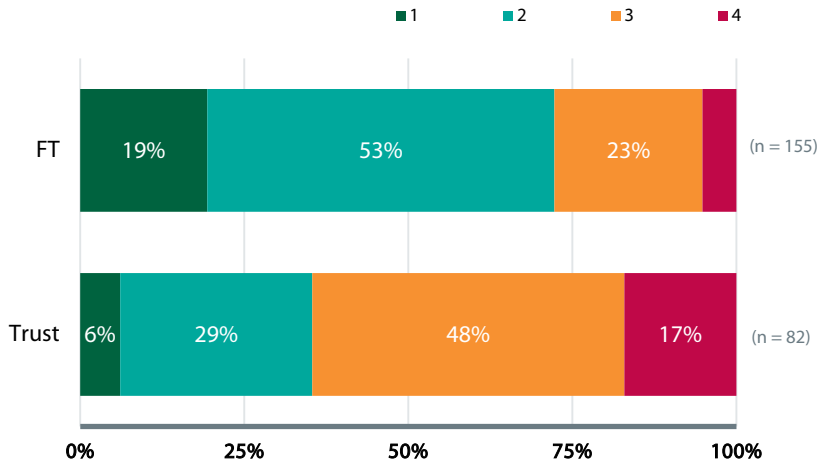


Segmentation by Foundation Trust status

Despite the change in approach and tighter 'grip' experienced by foundation trusts, the majority (72 per cent) of foundation trusts have been included in segments one and two (see figure 4) and should therefore enjoy higher levels of autonomy compared with providers in segments three and four.

FIGURE 4

NHSI segmentation by foundation trust and NHS trust



NEXT STEPS

NHSI will be working with providers to help identify the best support each trust requires. This support will include sector-led support, as well as direct support from NHSI in some cases. We expect that those trusts in segment one will be approached to explore how they can offer support to others across the sector. The first formal segmentation will then follow in November.

NHS Providers will continue to engage with colleagues at NHSI on the implementation of the new regulatory approach and focus on support. To inform this work we would welcome your feedback on the shadow segmentation process and the support your trust receives from NHSI. To share your views please contact Amber Davenport, head of policy, amber.davenport@nhsproviders.org.

NHS PROVIDERS PRESS RELEASE

Please find below our press statement in response to the shadow segmentation publication.

Responding to today's publication of NHS providers' shadow segmentation under NHS Improvement's new single oversight framework, NHS Providers head of policy Amber Davenport said:

"We welcomed publication of the new single oversight framework (SOF) last month as offering a more coordinated approach to measuring NHS providers' performance and targeting the improvement support they need.

"Today's shadow segmentation highlights how hard trust leadership teams are working to provide great patient care in a very difficult environment, with the majority of providers (60 per cent) placed in segments one and two. Despite the well-documented pressures they are facing, the public can be satisfied that over half of NHS trusts and foundation trusts continue to provide good levels of performance.

"What the figures do lay bare, however, is the enormous pressure the acute sector is facing, with almost two thirds of these trusts – 80 out of 137 – falling in segments 3 and 4. While the new SOF marks a significant shift from NHS Improvement as it places much greater emphasis on improvement and support, it is difficult to separate the segmentation from the difficult context in which providers are operating. This is one of increasingly challenged finances, a social care system that has now reached a tipping point and rapidly rising demand.

"We welcome the way NHSI engaged with the sector during the shadow segmentation process and look forward to working with them to monitor the impact for trusts in each of the four segments. In particular the extent to which those providers in segments 1 and 2 enjoy autonomy and how trusts can move between segments. We will also work with NHSI to help shape the remaining areas of the SOF that still need developing around strategic change and leadership."

-Ends-

APPENDIX ONE: OVERVIEW OF THE SINGLE OVERSIGHT FRAMEWORK AND SEGMENTATION DESCRIPTIONS

FIVE OVERSIGHT THEMES

In carrying out its role NHSI will oversee and assess providers' performance against five themes:

	Theme	Overview of oversight measures
1	Quality of Care	NHSI will use CQC's most recent assessments of whether a provider's care is safe, effective, caring and responsive In-year information where available Delivery of the four priority standards for 7-day hospital services
2	Finance and use of resources	Focus on a provider's financial efficiency and progress in meeting its control total Use of resources approach is being co-developed with CQC
3	Operational performance	NHS constitutional standards Other national standards
4	Strategic change	How well providers are delivering the strategic changes set out in the Five Year Forward View with a particular focus on STPs, new care models and devolution (where relevant)
5	Leadership and improvement capability (well-led)	Building on their well-led framework CQC and NHSI will develop a shared system view of what good governance and leadership looks like, including ability to learn and improve

SEGMENTATION

Depending on the extent of support needs identified through its oversight process and performance against the above measures, NHSI will segment providers into four. Segmentation will be based on:

- All available information on providers – both obtained directly and from third parties
- Identifying providers with a potential support need in one or more of the above themes
- Using NHSI's judgement, based on relationship knowledge and/or findings of formal or informal investigations, or analysis, consideration of the scale of the issues faced by a provider and whether it is in breach or suspected breach of licence conditions (or equivalent for NHS trusts).

Segment	Description	Levels of support	Segmentation frequency
1 – Maximum autonomy	No potential support needs identified across five themes – lowest level of oversight and expectation that providers in	Universal support	Providers in segment 1 will only reviewed on a quarterly basis (unless there is evidence that

	segment 1 will support providers in other segments		a provider is in breach of its licence, or equivalent for NHS trusts)
2 – targeted support	Potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action needed	Universal support Targeted support as agreed by provider: • To address issues • Help provider move to segment 1	Ongoing – Where in-year, annual or ad-hoc monitoring flags a potential support need, NHSI will review the provider's situation and consider whether it needs to change its allocated segment.
3 – mandated support	The provider is in actual/suspected breach of the licence (or equivalent for NHS trusts) and/or requires formal action	Universal support Targeted support Mandated support as determined by NHSI: • To address specific issues and help provider move to segment 2 or 1 • Compliance required	Ongoing – as above
4 – special measures	The provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that may mean that they are in special measures	Universal support Targeted support Mandated support as determined by NHSI: • To help minimise the time the provider is in segment 4 • Compliance required	Ongoing – as above

Contact: Amber Davenport, Head of Policy, amber.davenport@nhsproviders.org

ROHTB (11/16) 003

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Quality and Patient Safety Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Executive Director of Nursing and Governance**
AUTHOR:	**Ms Faye Rafferty, Governance Manager**
DATE OF MEETING:	**2nd November 2016**

EXECUTIVE SUMMARY:

The Quality and Patient Safety Report aims to increase accountability and drive quality across the Trust by triangulating a number of data sources including incidents, litigation and complaints. Through this report areas for improvement will be identified together with risks to the Trust.

Its purpose is to provide assurance to the Trust Board that action is being taken in response to recommendations identified.

REPORT RECOMMENDATION:

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

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:

Aligns to strategic intentions
BAF Risk 16

PREVIOUS CONSIDERATION:

Quality and Safety Committee on 26 October 2016

GOVERNANCE DEPARTMENT

QUALITY REPORT

October 2016

EXECUTIVE DIRECTOR: Garry Marsh *Director of Nursing and Governance*
AUTHOR: Faye Rafferty *Governance Manager*

CONTENTS

1. INTRODUCTION

This integrated Quality Report aims to provide a trust wide overview and assurance relating to patient safety, quality and patient experience activity at The Royal Orthopaedic Hospital NHS Trust (ROH). This report is also submitted to Birmingham Cross City Clinical Commissioning Group in order to satisfy contractual information requirements.

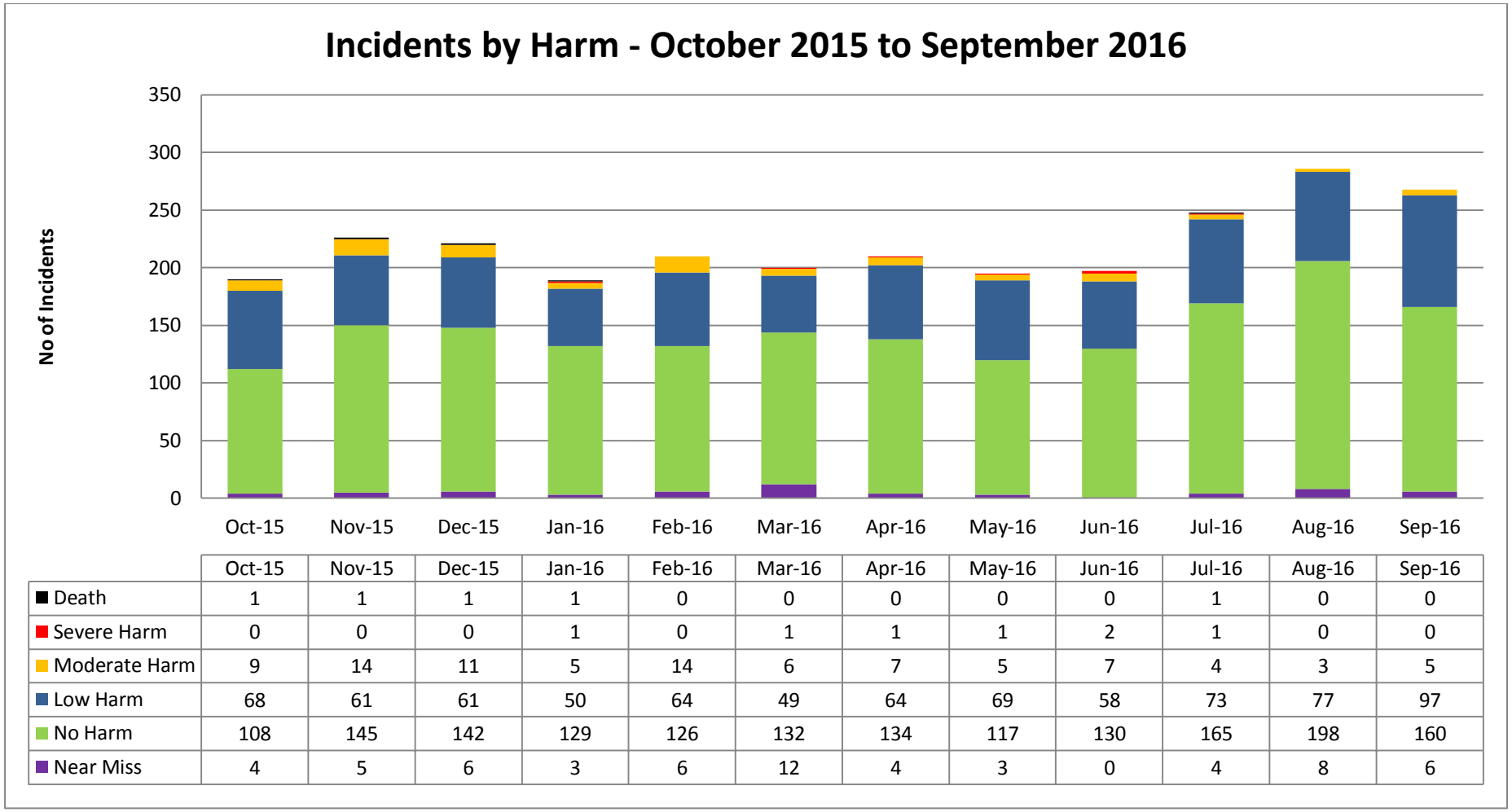
This Quality Report is a dynamic document, the data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this Quality Report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department;

Email: **roh-tr.governance@nhs.net**

Tel: 0121 685 4000 (ext. 55641)

2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.



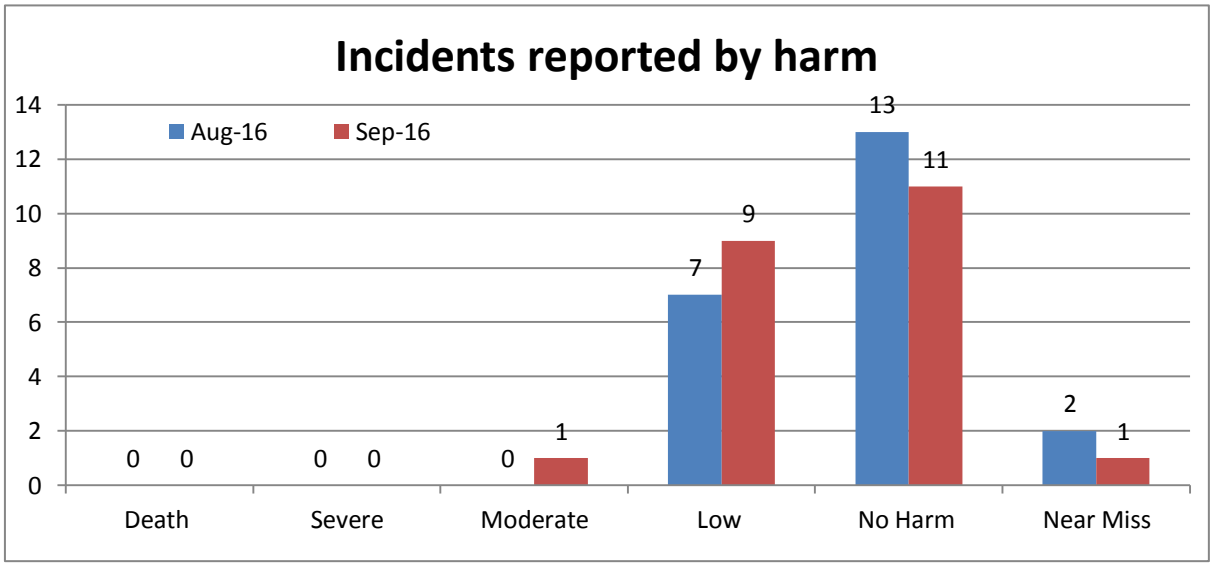
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Death	1	1	1	1	0	0	0	0	0	1	0	0
Severe Harm	0	0	0	1	0	1	1	1	2	1	0	0
Moderate Harm	9	14	11	5	14	6	7	5	7	4	3	5
Low Harm	68	61	61	50	64	49	64	69	58	73	77	97
No Harm	108	145	142	129	126	132	134	117	130	165	198	160
Near Miss	4	5	6	3	6	12	4	3	0	4	8	6

INFORMATION

There were 268 incidents reported during September 2016, including **5 Moderate Harms**

Paediatric Incidents

A total of 22 incidents were reported during September that involved a paediatric patient. An ongoing log of incidents reported that have caused harm is reviewed at the monthly Children's Board.



ACTIONS FOR IMPROVEMENTS / LEARNING

An update to Ulysses has now been made to ensure the Trust is able to identify and report on incidents that have been reported that relate to paediatric patients separately as recommended by the Royal College of Paediatrics and Child Health.

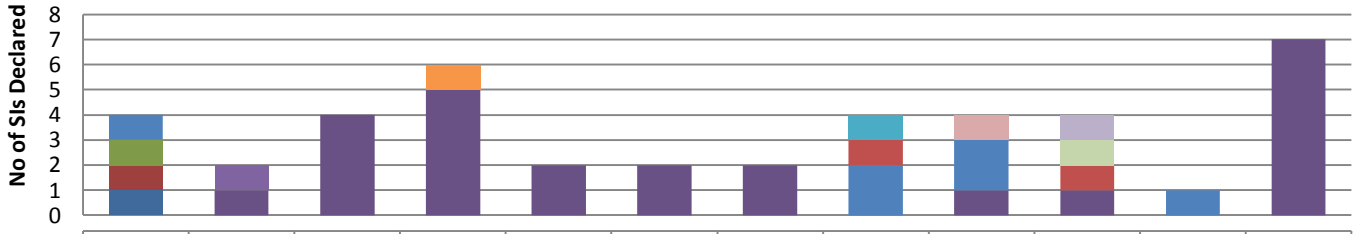
This information will be reported to the Children's committee monthly for review, trend analysis in relation to incident numbers and harm will be provided in this report. A log of ongoing incidents that are currently under investigation will be reported at the Children's board together with findings from investigations. This will also be shared at Divisional Management Boards.

RISKS / ISSUES

None Identified

3. Serious Incidents – are incidents that are declared on STEiS to the Commissioners by the Governance Department. The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage.

Serious Incidents - Declared October15 - September 16



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Wrong Site Incision										1		
Wrong Implant										1		
Suspension to services									1			
Delayed diagnosis				1								
Wrong side injection								1				
Unexpected deaths		1										
Staff conduct incidents												
Slips, trips & falls								1		1		
Pressure Ulcers	1							2	2		1	
Emergency transfer out of Trust												
VTE meeting SI criteria		1	4	5	2	2	2		1	1		7
Surgical incident meeting SI criteria	1											
Emergency transfer to HDU	1											
Failure to act on test results	1											

INFORMATION

There were 7 Serious Incidents (SI) declared during September 2016, which all related to VTE incidents.

All SIs are currently under investigation within contractual timescales.

ACTIONS FOR IMPROVEMENTS / LEARNING

6 Serious Incident reports were submitted for closure to Commissioners during September 2016.

2 reports were in response to VTEs that met the criteria for reporting to commissioners. Details of recommendations are provided in the VTE section below

1 report was in response to an inpatient fall that met the criteria for reporting to commissioners. Details of recommendations are provided in the falls section below

The final report in response to the Theatre closure was submitted to commissioners and has been approved for closure. The final report covered 21 points for investigation as identified in the terms of reference. A 77 point action plan has been developed and is currently being monitored through appropriate Trust committees. The full report was presented to the Quality and Safety committee at September's meeting for discussion.

The final report written following the investigation of the wrong sided prosthesis being implanted into a patient was submitted and has been approved for closure by the commissioners
Recommendations identified during the investigation of this incident include –

- WHO briefing part 2 (Time-out) to consider any implant as special equipment required, defining exact design, and anticipated estimate of size, and any side specific components
- All implants, where sterile wrapped, are stored in a clearly labelled manner
- A standard operating procedure is implemented setting down protocol for implant retrieval and confirmation of prosthesis by scrub team prior to opening sterile boxes. This should consider:
    - Pause in the surgical procedure to avoid distractions – a silent 'time-out'
    - Identification of single member of theatre team to open prosthesis

- Review in a standardised manner of implant type, size, side and expiry date by both Scrub Nurse and operating surgeon, with both visual check and spoken confirmation of the above read from the packing.
- Confirmation of implants used from stickers placed into theatre records

- Where surgeons note mismatch between trial and definitive implants, a review of the implants opened should be considered.
- WHO part 3 (Sign-out), when confirming compatibility of implants should confirm the prosthesis used stating type, size and side there by confirming the appropriate implants have been used as well as providing an accurate list of implants to be re-stocked. Where implants have been opened but not used, these should be confirmed as well, stating clearly what has been opened and not retained in the patient.

The final report written in response to an incision being made on the wrong side of a patient's leg was submitted and has been approved for closure by the commissioners

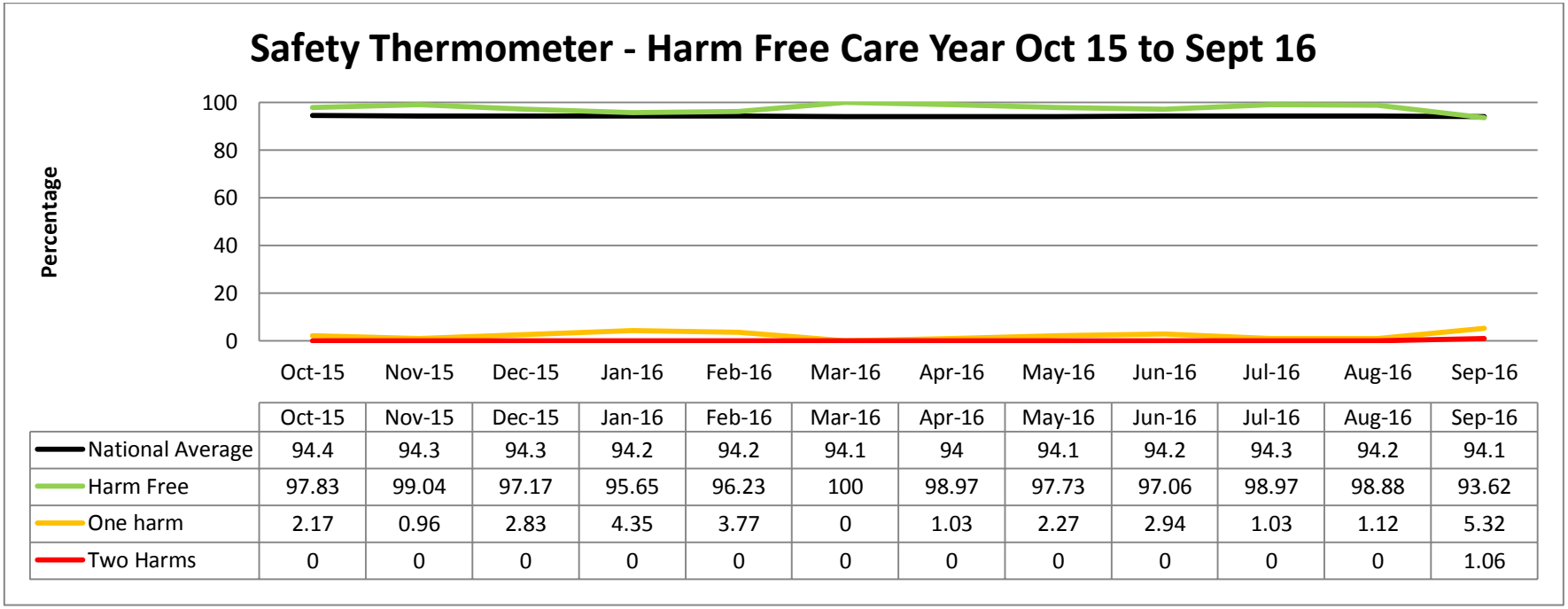
Recommendations identified during the investigation of this incident include –

- Multiple scars can cause confusion when patients return for metalwork removal. The risk of wrong site surgery should be minimised by marking the proposed scar pre operatively rather than just the limb. The safe surgery policy makes this clear already.
- Radiographs should always be on display at commencement of procedure and checked as part of the WHO. Both the presence of the films and the implant position should be confirmed preoperatively at team brief.
- Familiarity with the surgical procedure may be increased by ensuring that when patients are transferred from one consultant to another, the patient is reviewed in outpatients prior to surgery.
- This never event will be presented at hospital audit/morbidity meeting to highlight awareness for potential further incidents and disseminated to directorate leads.

RISKS / ISSUES

None identified.

4. **NHS Safety Thermometer - provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.**



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
National Average	94.4	94.3	94.3	94.2	94.2	94.1	94	94.1	94.2	94.3	94.2	94.1
Harm Free	97.83	99.04	97.17	95.65	96.23	100	98.97	97.73	97.06	98.97	98.88	93.62
One harm	2.17	0.96	2.83	4.35	3.77	0	1.03	2.27	2.94	1.03	1.12	5.32
Two Harms	0	0	0	0	0	0	0	0	0	0	0	1.06

There were a total of 7 harms reported during September which were 3 falls with harm all reported on ward 12 and 4 pressure ulcers. Two of the pressure ulcers were inherited and were not caused by care omissions at the ROH. The 2 pressure ulcers that were attributable to ROH were reported on Ward 3 and ward 12.
The patient who sustained 2 harms had a fall whilst on ward 12 and also had a pressure ulcer that was not ROH attributable.

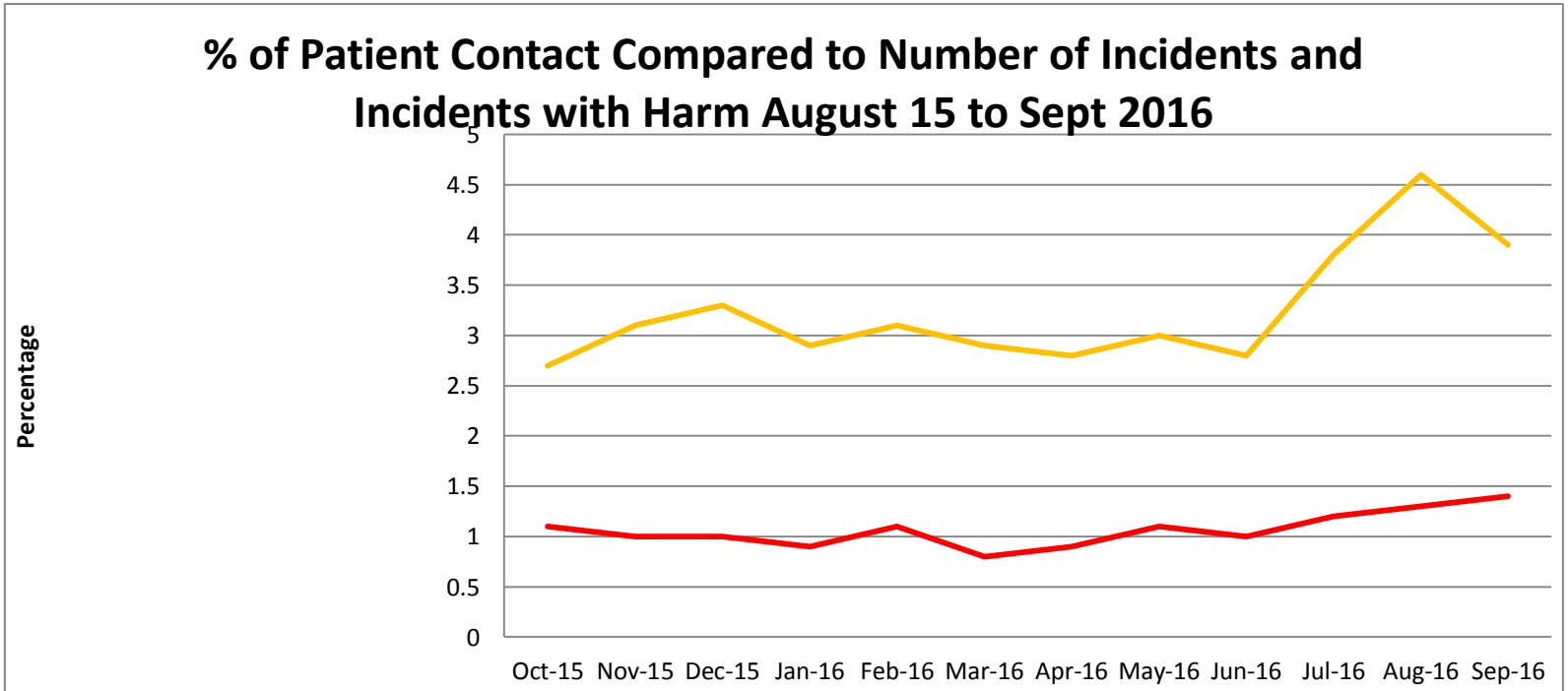
Children and Young Person's Safety Thermometer
The Trust has started to submit data to the Children and Young Person's Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. A meeting is to be arranged with informatics to discuss how the Trust can use this information in the meantime.

5. **All patient contact and harm – In contrast to the Safety Thermometer which measures the number of harm on one particular day of the month, the following data represents the total number of patient contacts in June 2016 compared to all incidents reported and incidents resulting in harm. Harm includes low harm, moderate harm, severe harm and deaths.**

	Low Harm	Moderate Harm	Severe Harm	Death	Total Incident with Harm	All Incidents Total	Total Patient Contacts
Oct-15	68	9	0	1	78	190	7082
Nov-15	61	14	0	1	76	226	7251
Dec-15	61	11	0	0	72	220	6714
Jan-16	50	5	1	1	57	189	6627
Feb-16	64	14	0	0	78	210	6768
Mar-16	49	6	1	0	56	200	6862
Apr-16	64	7	1	0	72	210	7636
May-16	69	5	1	0	75	195	6528
Jun-16	58	7	2	0	67	197	7037
Jul-16	73	4	1	1	79	248	6426
Aug -16	77	3	0	0	80	286	6274
Sep - 16	97	5	0	0	102	268	6823

* This report is written prior to the validation of the total patient contacts. This figure is therefore subject to change following publication.

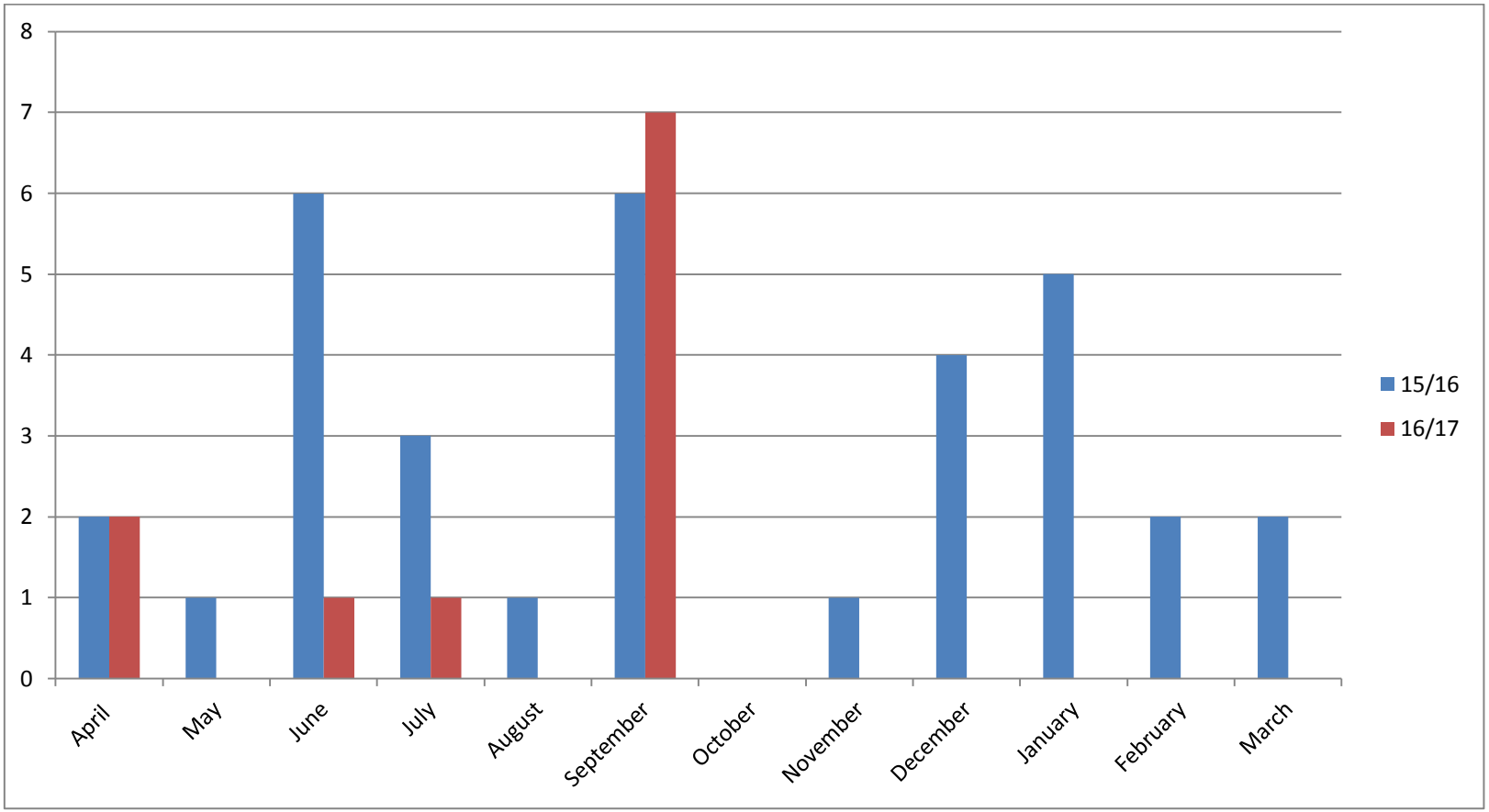
In September 2016, there were a total of 6823 patient contacts. There were 268 incidents reported which is 3.9 percent of the total patient contacts. Of those 268 reported incidents, 102 incidents resulted in harm which is 1.4% of the total patient contact for the month.



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
% of Patient Contacts with Incidents Causing Harm	1.1	1	1	0.9	1.1	0.8	0.9	1.1	1	1.2	1.3	1.4
% of Patient Contact With All Incidents Reported	2.7	3.1	3.3	2.9	3.1	2.9	2.8	3	2.8	3.8	4.6	3.9

There has been an upward trend in the number of incidents being reported monthly at the Trust; however no significant increase in the degree of harm caused has been observed. This demonstrates that staff are confident to report incidents and the Trust is able to demonstrate an open reporting culture.

6. **VTEs - A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (embolises) and flows towards the lungs, it can become a life-threatening pulmonary embolism (PE), a blood clot in the lungs. When a blood clot breaks loose and travels in the blood, this is called a venous thromboembolism (VTE). The abbreviation DVT/PE refers to a VTE where a deep vein thrombosis (DVT) has moved to the lungs (PE or pulmonary embolism).**



INFORMATION

There were 7 VTE incidents that met the requirements for reporting externally to Commissioners during September.

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 2 final investigation reports in response to VTEs that were due for submission to Commissioners during September 2016. Both investigations have found the VTE's to be unavoidable confirming that all appropriate preventative measures were taken.

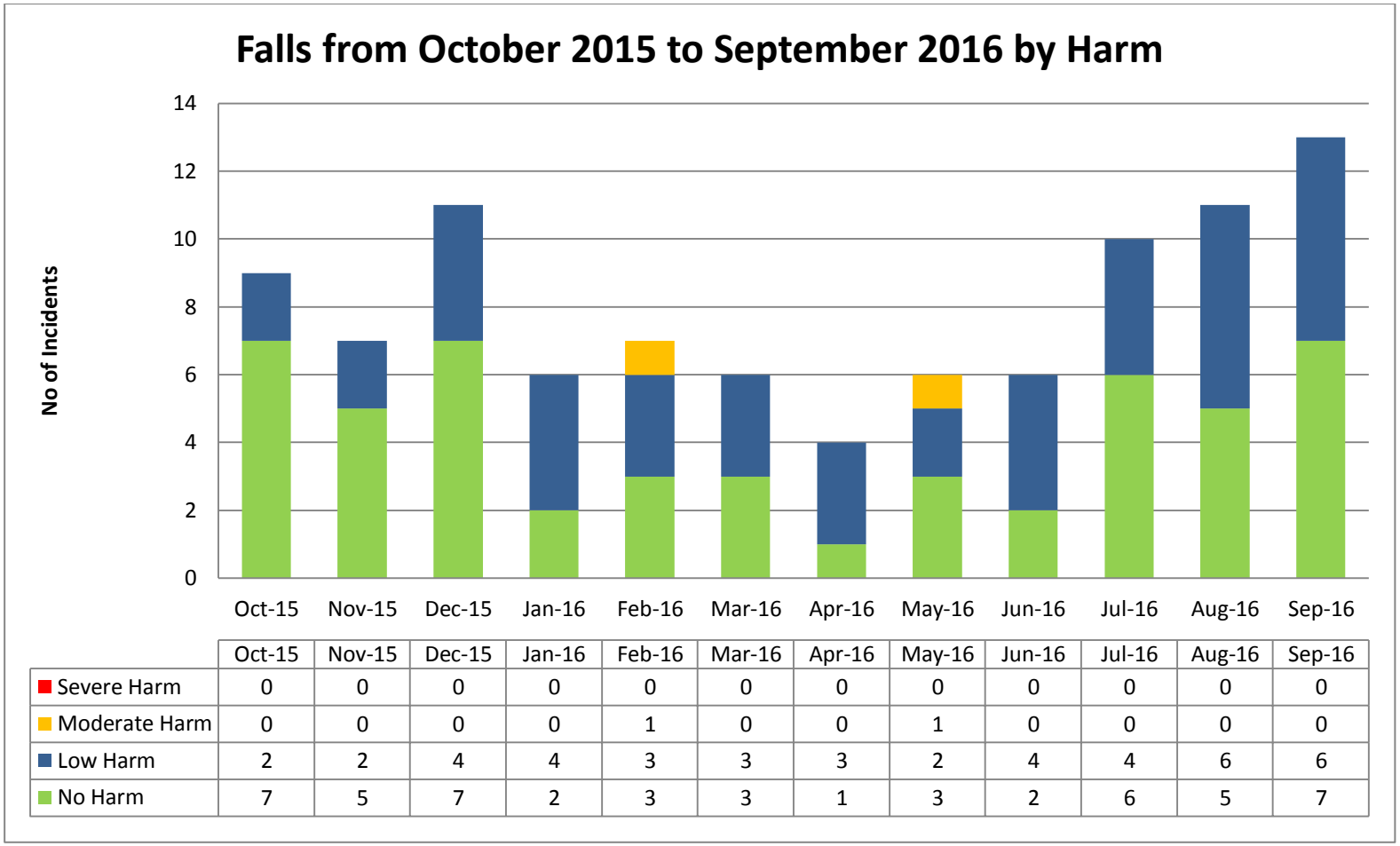
A questionnaire is now in use to collate patient feedback when completing post discharge VTE RCA's.
VTE reporting email and telephone lines are now in place and information is printed on discharge and patient information letters to enable reporting of diagnosed VTEs post discharge.
Both SCD and AED training continues to be provided Trust wide by company trainers.
Foot sleeves for patients for whom calf sequential compression devices are contra-indicated are being trialled.

ROH continues to exceed expected targets set in relation to VTE risk assessment on admission and compliance with Thromboprophylaxis for high risk patients.
Many of the requirements within the 2016/17 CQUIN are already (at least partially) in place at ROH. Through outpatients follow ups, Infection Control hotline and Surgical site 90 day questionnaires. The Trust is able to identify and review patients who have been diagnosed with a VTE post discharge. Work to fully meet the requirements of the CQUIN will enhance this further.

RISKS / ISSUES

None identified.

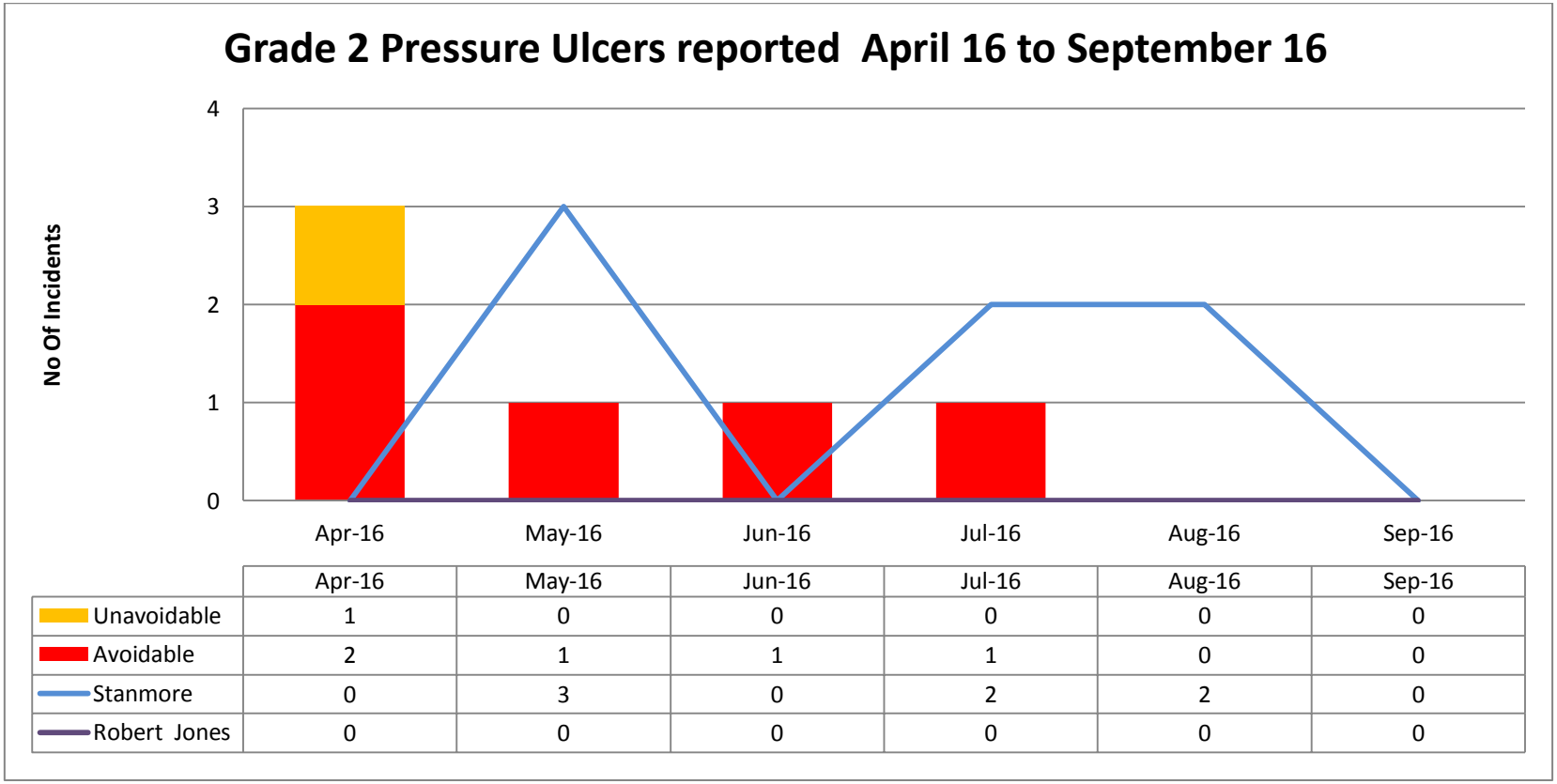
7. Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident



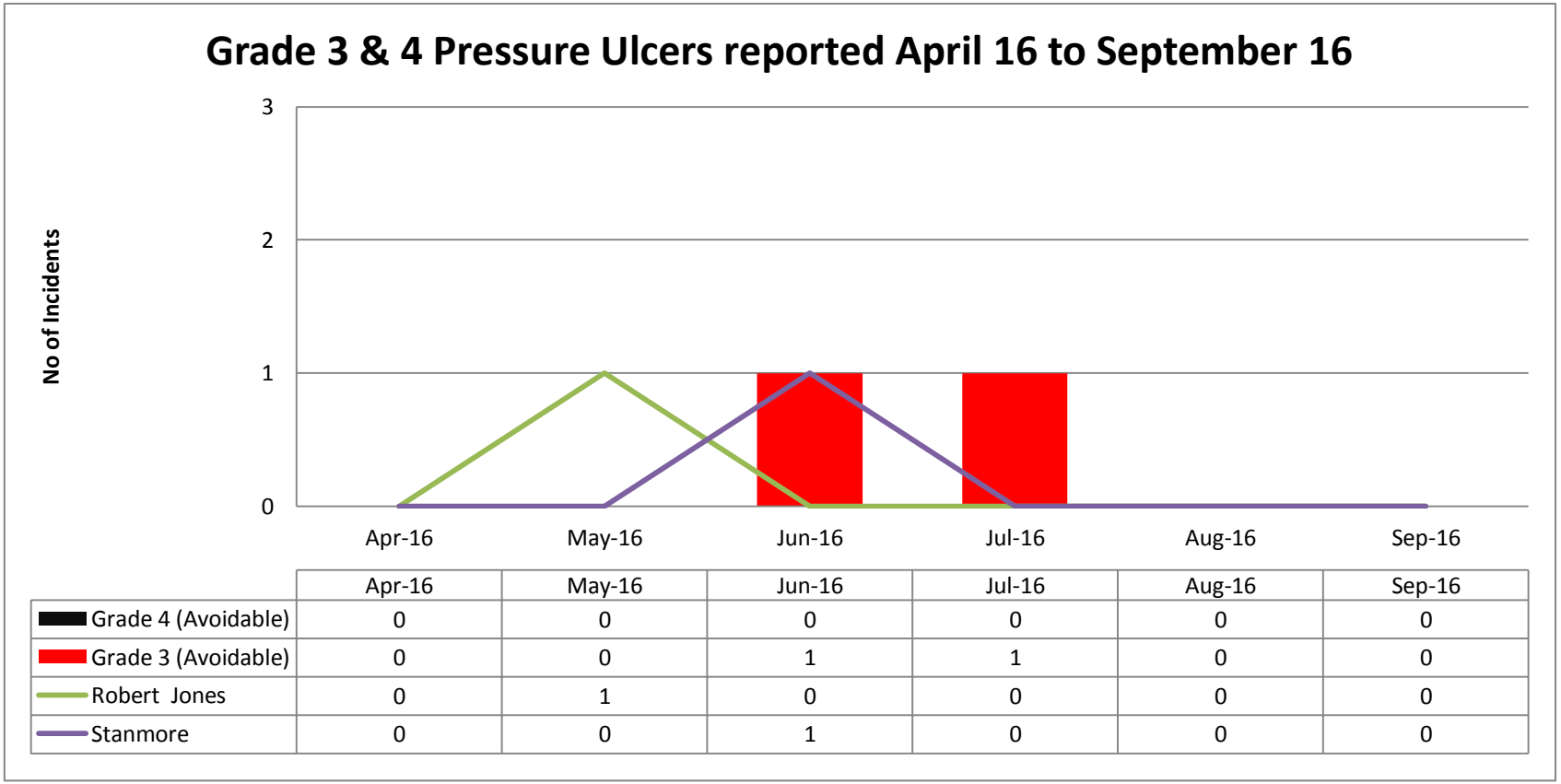
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	1	0	0	1	0	0	0	0
Low Harm	2	2	4	4	3	3	3	2	4	4	6	6
No Harm	7	5	7	2	3	3	1	3	2	6	5	7

INFORMATION
During September 2016, 13 inpatient falls have been reported.
ACTIONS FOR IMPROVEMENTS / LEARNING
The Head of Nursing will be responsible for reviewing falls within the Trust. Findings of this review will be included in the quality report once available. 1 report in response to a patient fall was submitted to commissioners and approved for closure during September.
RISKS / ISSUES
None identified.

8. **Pressure Ulcers - are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. This illustrates the number of ROH acquired pressure ulcers that patients have developed and they are identified by whether they were avoidable or unavoidable.**



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Unavoidable	1	0	0	0	0	0
Avoidable	2	1	1	1	0	0
Stanmore	0	3	0	2	2	0
Robert Jones	0	0	0	0	0	0



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Grade 4 (Avoidable)	0	0	0	0	0	0
Grade 3 (Avoidable)	0	0	1	1	0	0
Robert Jones	0	1	0	0	0	0
Stanmore	0	0	1	0	0	0

Stanmore have confirmed that the figures contained in the graphs above only relate to non-device related pressure damage. Device related damage is reported separately. Year to date Stanmore have reported 30 cases of pressure damage relating to devices.

INFORMATION

The Director of Operations, Nursing and Clinical Governance is having discussions with colleagues at both Stanmore and Robert Jones to better understand the reporting methodology and reporting for all three organisations.

There were two Grade 2 Pressure Ulcers reported this month which are currently awaiting investigation from ward managers, one involves a complex patient provisionally deemed to be unavoidable. The second involves a patient who declined care measures. This has provisionally been deemed as unavoidable. These incidents will be included in figures once investigations have been completed.

There have been 2 Grade 3/4 Pressure Ulcers reported during September.

ROH contractual limit for Pressure Ulcers in 2016/17
Grade 2 Avoidable Limit is 15 - at September 2016 = 5 avoidable
Grade 3 Avoidable Limit is 0 - at September 2016 = 2.
Grade 4 Avoidable Limit is 0 - at September 2016 = 0

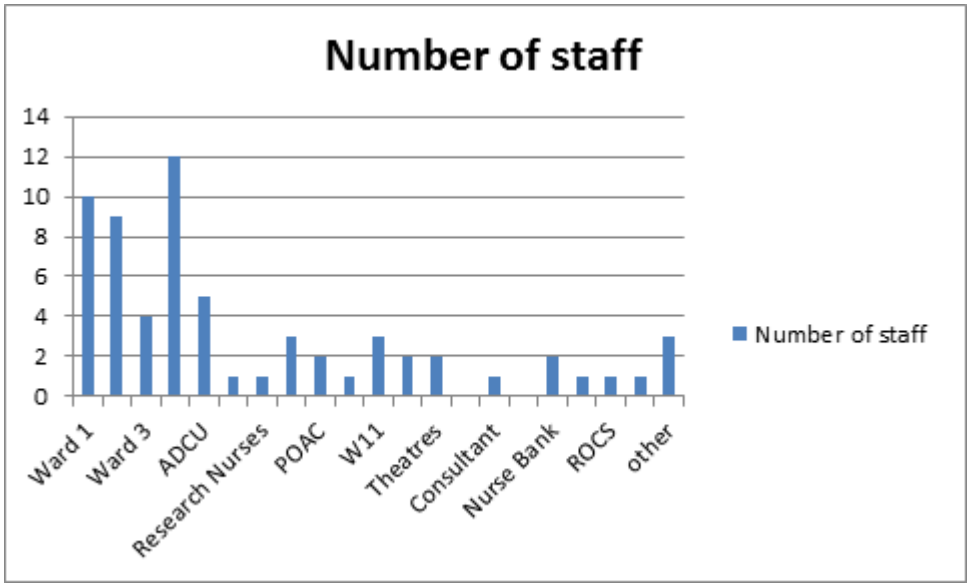
ACTIONS FOR IMPROVEMENTS / LEARNING

No final reports were due for submission to commissioners during September in response to Pressure ulcers that meet the SI criteria.

The tissue viability team manned a stall outside the canteen on 18th October and visited wards and departments to share information about:

- Pressure ulcers (documentation)
- Plaster Cast Care
- Wound Care plan / management

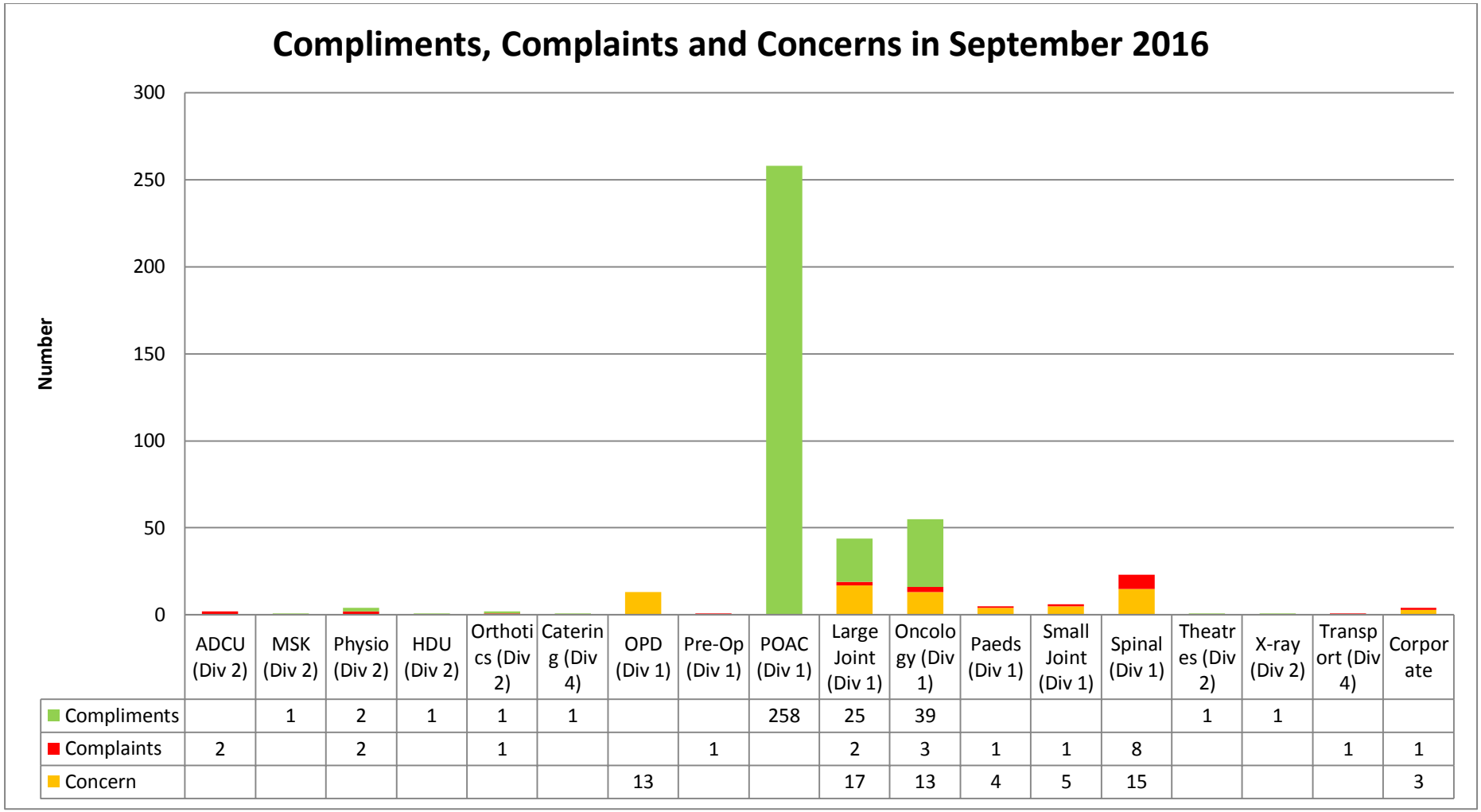
The graph below represents the contacts at the documentation event day and link nurses, which included promotion of the new plaster cast care plan and care, changes to the pressure ulcer prevention and management booklet and wound management care plan. The Tissue Viability Team plan to visit areas with low contacts during October.



RISKS / ISSUES

There is a risk of a financial penalty to the Trust by the Commissioners as ROH have exceeded the contractual threshold set relating to the number of avoidable grade 3/4 pressure ulcers reported during 2016/17. The fines associated with pressure ulcers within this year's contract are as follows
Grade 2 first 3 pressure ulcers reported above the 15 threshold = £1000
Grade 3 first 3 reported - £1000
Grade 4 first 2 reported - £1000

9. Patient Experience - this illustrates feedback from patients on what actually happened in the course of receiving care or treatment, both the objective facts and their subjective view of it.



	ADCU (Div 2)	MSK (Div 2)	Physio (Div 2)	HDU (Div 2)	Orthotics (Div 2)	Catering (Div 4)	OPD (Div 1)	Pre-Op (Div 1)	POAC (Div 1)	Large Joint (Div 1)	Oncology (Div 1)	Paeds (Div 1)	Small Joint (Div 1)	Spinal (Div 1)	Theatres (Div 2)	X-ray (Div 2)	Transport (Div 4)	Corporate
Compliments		1	2	1	1	1			258	25	39				1	1		
Complaints	2		2		1			1		2	3	1	1	8			1	1
Concern							13			17	13	4	5	15				3

INFORMATION

In September there were 23 complaints, 70 concerns and 330 compliments received.

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 14 complaints closed in September 2016, all of which were closed within the agreed timescales. This gives a 100% completion on time rate and meets the KPI. The average length of time to close complaints in September 2016 was 22 days which is within normal limits.

Learning/Actions from complaints

Of the 14 complaints closed in September 2016:

- 8 were upheld
- 1 were partially upheld
- 5 were not upheld

All upheld complaints had elements of poor communication that had caused misunderstanding or difficulty for the patients involved.
Learning identified and actions taken as a result of complaints closed in September 2016 include:

- The process for managing short notice cancellations of clinic appointments is not robust

  Action: A review of this is currently being undertaken by Patient Access

- An agency nurse completed incorrect information on an admission

  Action: Professional Conversation has been requested and this staff member will not work at the ROH until it has been completed.

- A member of staff did not follow the discharge process and did not check the queries that had been raised by the patient

  Action: Professional conversation undertaken

- Perception of nursing care generally appears to be more negative

  Action: Case discussion at Ward meetings and Senior Nurse meetings to identify any common traits

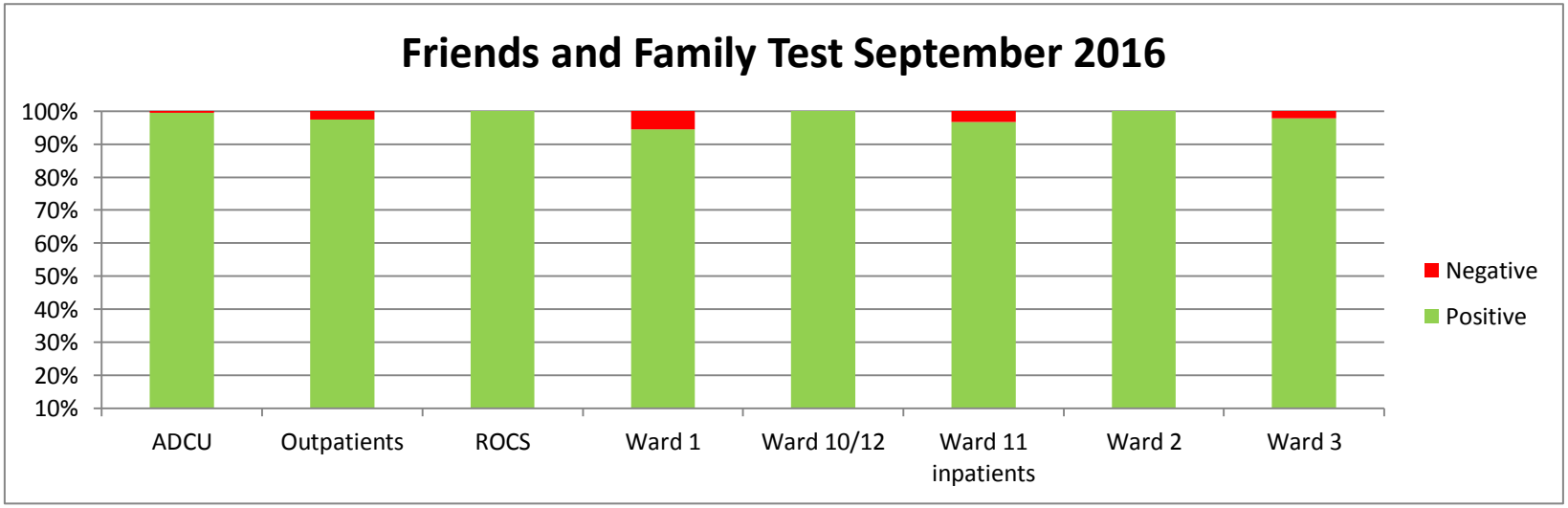
RISKS / ISSUES

None Identified

10. Friends and Family Test Results - The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

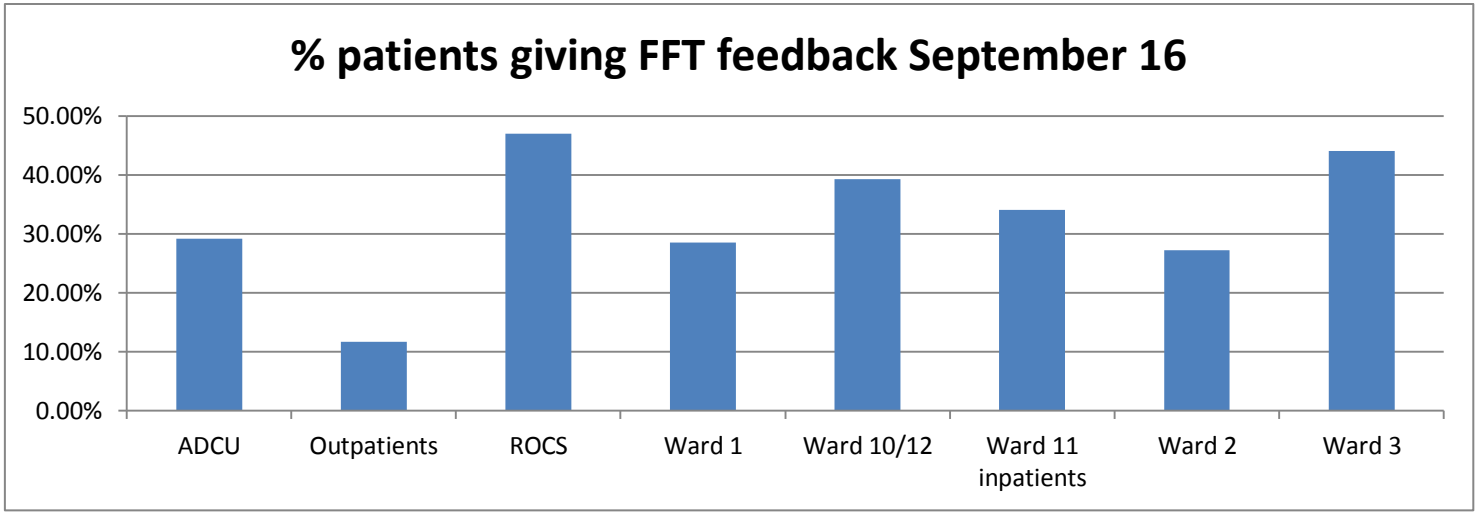
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting patient choice

This is a positive percentage score and it can be seen that almost all patients that we care for would recommend ROH to their family and friends.



The Scores for Friends and Family are calculated using a straightforward percentage response to the question 'How likely are you to recommend this area to friends or family if they require similar care or treatment?' Any patients answering the question as Extremely Likely / Likely are classified as Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely/Extremely Unlikely are classified as negative.

The percentages for all inpatient activity for August 2016 are 97.63% of those who responded would promote ROH.



Department	Positive	Negative	satisfaction rate	Eligible	Completion rate
ADCU	170	1	98.84%	590	29.15%
Outpatients	858	23	93.74%	7862	11.66%
ROCS	69	0	98.57%	149	46.98%
Ward 1	34	2	94.44%	126	28.57%
Ward 10/12	45	0	97.83%	117	39.32%
Ward 11 inpatients	30	1	96.77%	91	34.07%
Ward 2	33	0	100.00%	121	27.27%
Ward 3	47	1	97.92%	109	44.04%

All areas receive a detailed breakdown of the friends and family data received relating to their areas together with the free text comments that patients have completed. All areas also receive ward level displays including information about FFT scores, response rates, numbers of complaints and compliments received and individual examples of key feedback received during the previous month.

11. Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 20 to apologise to and inform patients where incidents have occurred resulting in moderate harm and above.

There are currently 27 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

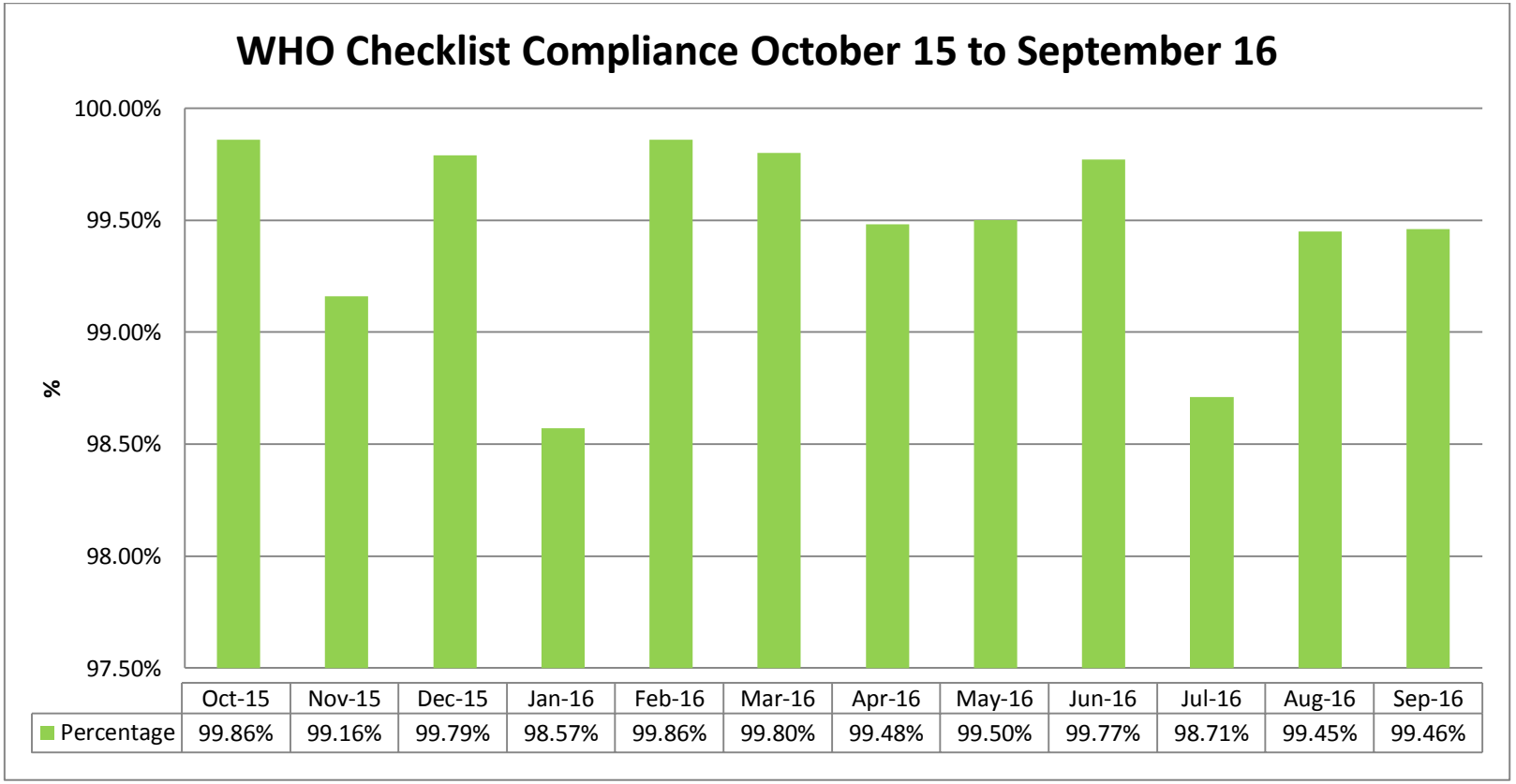
12. Litigation

The Trust has received 1 new claim during September.

Current Status
Letter of Claim received
Liability being assessed to inform drafting of formal Letter of Response

No cases have been closed during September 2016

13. WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases of perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Percentage	99.86%	99.16%	99.79%	98.57%	99.86%	99.80%	99.48%	99.50%	99.77%	98.71%	99.45%	99.46%

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INFORMATION

Total Cases in September = 553

Total Non-Compliance = 3

Total Compliance = **99.46% Total**

An external review of the Trust's safety processes within theatres has been commissioned for assurance and learning a draft report has been received by the Trust which is currently being reviewed for factual accuracy.

ACTIONS FOR IMPROVEMENTS / LEARNING

The following recommendations are made following the audit collation:

1. Quarterly report to be disseminated to the Medical director, Clinical Directors, Clinical Leads, Consultants and Team Leaders.
2. Directorates with consistent 100% compliance to share best practice.
3. Continue with weekly and monthly reporting to the Medical Director and Director of Nursing & Governance.
4. Monthly reporting to the Commissioners.
5. Non-compliance percentages and incomplete sections and areas of the WHO Patient Safety Checklist to continue to be emailed directly to the Consultant and the staff member involved.
6. Audit results are also discussed as a standing agenda item at the Theatre User Group meetings

RISKS / ISSUES

None identified.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Nurse Staffing Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Nursing and Clinical Governance**
AUTHOR:	**Mrs Sue Smith, Head of Nursing – Patient Services Division**
DATE OF MEETING:	**2 November 2016**

EXECUTIVE SUMMARY:

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. This paper provides the Trust Management Committee with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for August 2016.

REPORT RECOMMENDATION:

The Trust Board is asked to note:

- Fill rates across ward areas show that minimum safe staffing has been achieved.
- CHPPD is the principle measure of nurse deployment recommended by NHSI. It should therefore be a key measure in future nurse establishment reviews.
- Good progress has been made in appointing to adult nurse and health care support worker vacancies with 12 WTE registered staff with start dates, 2 in recruitment process and of the remaining 8.73 WTE Band 5 vacancies, 6.0 being Paediatric nursing vacancies.
- Children's Nurse recruitment remains challenging (vacancies as above), with an assessment centre planned for 31st October
- The Safer Nursing Care Tool (SNCT) was used across the Trust in late June/early July 2016. It is recommended that the SNCT should be repeated in November 2016 with much greater attention paid to quality assuring data collection.
- Agency use has risen this month compared to August, driven by an increase in agency use across the wards

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	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:

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. The provision of a monthly Safe Staffing report supports compliance CQC regulation.

PREVIOUS CONSIDERATION:

The report will be circulated to all matrons, general managers and ward sisters. It is an agenda item on the monthly Ward managers meeting and will be added to Divisional board Meetings from August 2016. Trust Board receives a monthly report on safe staffing.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Nurse Staffing Report

REPORT TO TRUST BOARD: September 2016 data

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 continued commitment to providing open, honest and transparent nurse staffing information through the publication of this data both on the Trust and NHS Choices Websites. This report provides details of Care hours Per Patient Day (CHPPD) which has become the principle measure of nurse deployment in line with NHSI (2016) requirements.

The paper provides the Trust Board with detailed information relating to the nursing workforce and highlights issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mix. It provides the planned and actual workforce information for September 2016 with additional information relating to vacancy and plans for recruitment to vacant posts.

2.0 Workforce Information: Trust Overview of Planned Versus Actual Nursing Hours

The overall nurse staffing fill rate for September 2016 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. The actual staffing levels for September 2016 were manually entered into the data collection spreadsheet by the nurse in charge of the shift and subsequently verified by the senior sister and matron. Planned staffing hours are based on funded establishment which provides a minimum ratio of 1 to 8 on day and night shifts for all adult in patient wards. The planned hours are adjusted each month to allow for the number of days in the month.

Table 1 below provides further detail regarding nurse staffing fill rates for September 2016. The Unify upload for September 2016 is provided in Appendix 1. In the absence of national guidance, ROH will RAG rates each ward against a locally agreed framework as follows: Green - where actual available hours are within 5% of planned; Amber -within 5 and 10% and Red where the difference is greater than 10.

Although it should be noted that nationally other parameters are used:

- Green – where actual hours are within 10% of planned
- Amber – where actual hours are within 10-20% of planned
- Red – where actual hours are below 80% of planned

Table 1: Detailed Ward Breakdown (using current ROH RAG rating) September 2016

	Day		Night	
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
1	88.9%	101.7%	96.7%	109.8%
2	93.1%	98.5%	98.8%	66.0%
3	96.8%	88.7%	98.7%	95.2%
12	99.4%	97.4%	99.1%	98.5%
11	101.6%	102.2%	100%	
HDU	101.9%	100.0%	100.6%	-

- The RN fill rate on Ward 1 is due to reduced fill rate for bank and agency. All shifts have had minimum safe staffing numbers of 3RN per shift
- Ward 2 RN fill rate is low due to a reduced fill rate for bank and agency. The shifts have always been staffed with a minimum of 3RNs. One of the staff nurses from ward 12 has been moved to ward 2 for 6 months to reduce our reliance on agency staff for ward 2.
- Ward 2 HCA fill rate on nights – staffing changed from 2 HCA per night shift to 1 HCA per night shift, template had not been changed therefore reflects a low fill rate. The template has now been changed. If the template was correct the fill rate for HCA on night shifts for September would have shown 102.5%
- Ward 3 – HCA day fill rate is low – Ward manager reports this is due to numbers being proactively reduced during periods of low acuity / activity against the template for the ward.

2.1 Care Hours per Patient Day (CHPPD)

Following the publication of the Carter Review (2016**)** NHS Improvement have issued new guidance which requires all Trusts to report Care Hours per Patient Day. From May 2016 CHPPD will become the principle measure of nursing and care support deployment. CHPPD provides a single consistent metric of nursing and healthcare support worker deployment on inpatient wards and units.

During September 2016, CHPPD were calculated by ward as detailed in Table 2 below, with the totals in brackets representing August results as a comparison.

WARD	Table 2: Care Hours Per Patient Day (CHPPD) SEPTEMBER 2016			
	Cumulative count over the month of patients at 23:59 each day	**Registered midwives/ nurses**	**Care Staff**	**Overall CHPPD**
1	601(441)	3.9 (5.5)	2.7 (3.5)	6.6 (9.0)
2	652 (507)	3.6 (4.3)	2.0 (3.1)	5.6 (7.3)
3	581 (515)	4.2 (4.5)	2.3 (3.0)	6.5 (7.4)
12	732 (640)	4.0 (4.8)	2.7 (3.3)	6.8 (8.2)
11	204 (193)	10.6 (10.8)	1.4 (1.7)	11.9 (12.5)
HDU	162 (147)	24.1 (22.1)	1.1 (2.0)	25.2 (24.1)

The data shows that with an increase in patient numbers in September 2016 recorded each day at 23.59 hrs, there is a relative decrease in the care hours per patient.

Benchmarking data is not currently available but it can be seen that there is variation in the number of CHPPD recorded over the past two months. The Carter review (February 2016) notes significant variation in CHPPD in the sample of 1000 wards used to gather the original data source with a range from 6.3 CHPPD to 16.8 CHPPD. On this basis ROH is at the lower end of the spectrum but Carter (2016) notes that we should be mindful of comparing different types of wards and departments and that CHPPD should be used against measures of harm and experience in order to establish ward baselines.

More work is therefore required to understand the optimum number of CHPPD required in a specialist orthopaedic hospital. CHPPD has already been included as a measure on the monthly Ward Healthcheck. CHPPD will be used as one of the measures in staffing establishment reviews and as the data matures it will be possible to compare wards of similar type and activity in order to enable greater understanding of the requirements of patients here at ROH.

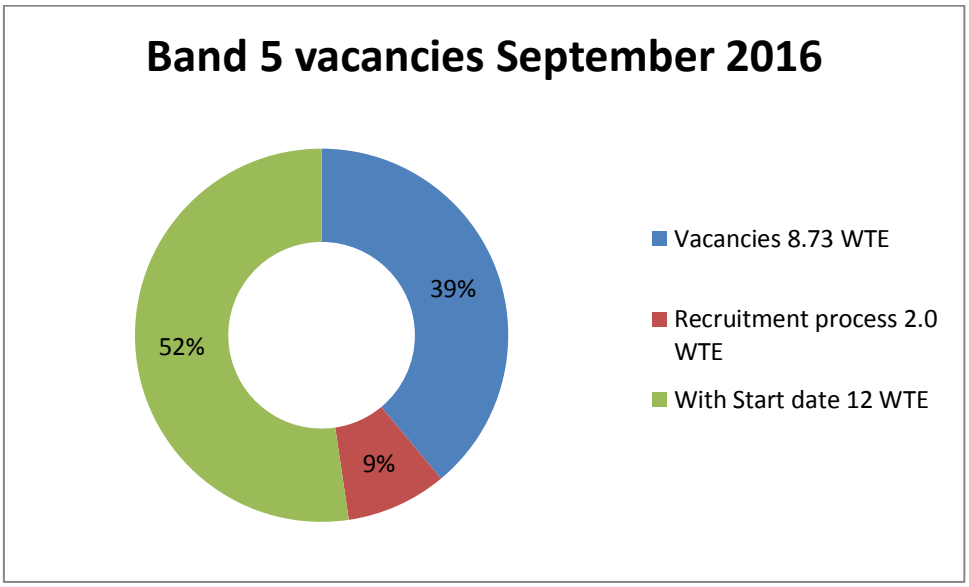
2.2 Vacancy Information

Table 3 below shows the ward budgets at Band 5 and 2 for each of the ward areas. Note that for HDU the baseline includes Band 6.

Table 3 Band 5 WTE Vacancy (Based on Revised Figures from Matrons and Ward Managers September 2016)

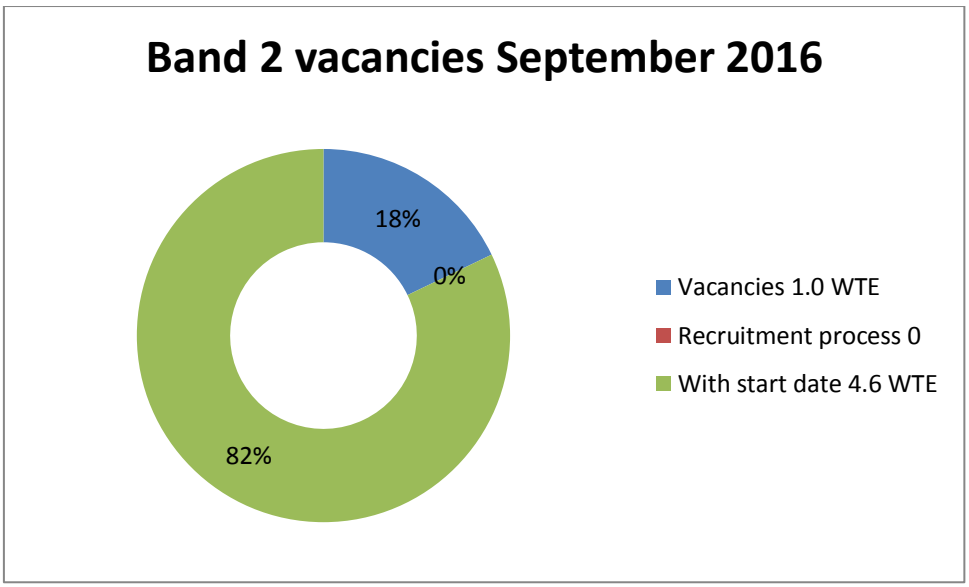
Ward/Department	Band 5 Funded Establishment (WTE)	Band 5 Vacancy (WTE)	Band 2 Funded Establishment (WTE)	Band 2 Vacancy (WTE)
OPD	4.43	2.0	8.48	1
POAC	5.6	Nil	3.15	Nil
Ward 1	13.57	1.0	10.32	Nil
Ward 2	13.80	5.73	9.05	Nil
Ward 3	14.16	1.0	7.65	Nil
Ward 12/10	18.61	2.2	13.91	4.59
Ward 11	15.96	2.0	1.8	1.2 (held)
HDU (Includes Band 6)	23.32	5.0	1.8	Nil
HDU Paeds	9.69	4.0	Nil	Nil
Totals	109.45	22.93	56.16	6.79

Table 4 Band 5 vacancies, recruited staff in recruitment process and recruited staff with start dates.



The Band 5 vacancies include 6.0 WTE paediatric registered nurse vacancies (2.0 WTE Ward 11, 4.0 WTE HDU)

Table 5 Band 2 vacancies, recruited staff in recruitment process and recruited staff with start dates.



A number of key actions are in place to address recruitment at the Trust and are listed below:

- The Nursing Workforce group is now meeting monthly. The group is responsible for the development of targeted recruitment campaigns and the introduction of accurate vacancy monitoring across the Trust. Good progress has been made against the establishment of a Trust wide recruitment plan with OPD/POAC and ADCU joining the generic assessment centres and conforming to the recruitment calendar for HCAs. Further work will be undertaken with the theatre team over the next three months to ensure that good practice is shared and where possible Trust wide recruitment events are planned.
- The template that was developed is completed monthly by Ward sisters/ Charge Nurses to ensure accuracy in vacancy reporting. The introduction of e-rostering will also ensure that vacancy data is accurately captured.
- The Paediatric Matron has a planned start date of 1 November 2016.

- Band 5 vacancies in OPD have been fully recruited to and are awaiting start dates (shown above in 9% in table 4)
- Band 5 vacancies on Ward 2 (6.73 WTE) have 5.0 WTE recruited to, commencing as follows:1x Oct, 1xNov, 1X Dec, 2x Jan
- Band 5 vacancies on Ward 10/12 (2.28 WTE) have 2.0 WTE recruited to commencing in Feb 2017
- Interviews are planned for registered nurses on 3rd November 2016 and Paediatric Nurse interviews are scheduled for 31st October 2016 (3 shortlisted, 2 with previous HDU experience)

2.3 Acuity data

TMC are asked to note that Division 1 team have supported the use of the PANDA tool and the source of funding has been agreed and approved by DGM. The next step is to identify the IT requirements and agree timescale for implementation. An update will be provided at the next Children's board in November and an implementation plan devised

There are a number of caveats to using this single data source to draw conclusions about safe staffing levels on in patient wards:

- The Safer Nursing Care Tool which forms the basis of the data collection was not intended to be used on a daily basis because it is recognised that patient acuity will vary over time
- The tool is not completed at the same time each day.
- Variation is normal and the Safer Nursing Care tool makes clear that this should be expected.

Nevertheless, whilst we continue to use this tool it is recommended that change in demand must be kept under review over the next three months. As we move towards the introduction of e-rostering in October 2016, we will also enable the use of a Safer Staffing tool connected to the software which will enable recording of staffing numbers against acuity in real time.

2.4 Safer Nursing Care Tool:

It is recommended that the next audit should be repeated in November 2016

2.6 Skill Mix

The minimum skill mix recommended by the RCN (2014) is a ratio of 65/35 registered nurses/clinical support workers. All in patient wards at ROH meet this requirement within a percentage point and the ratio on Ward 3 is 70:30 Registered Nurse:Health Care support worker. Under no circumstances should the skill mix reduce below the RCN recommended level.

2.7 Safe Staffing and Efficiency

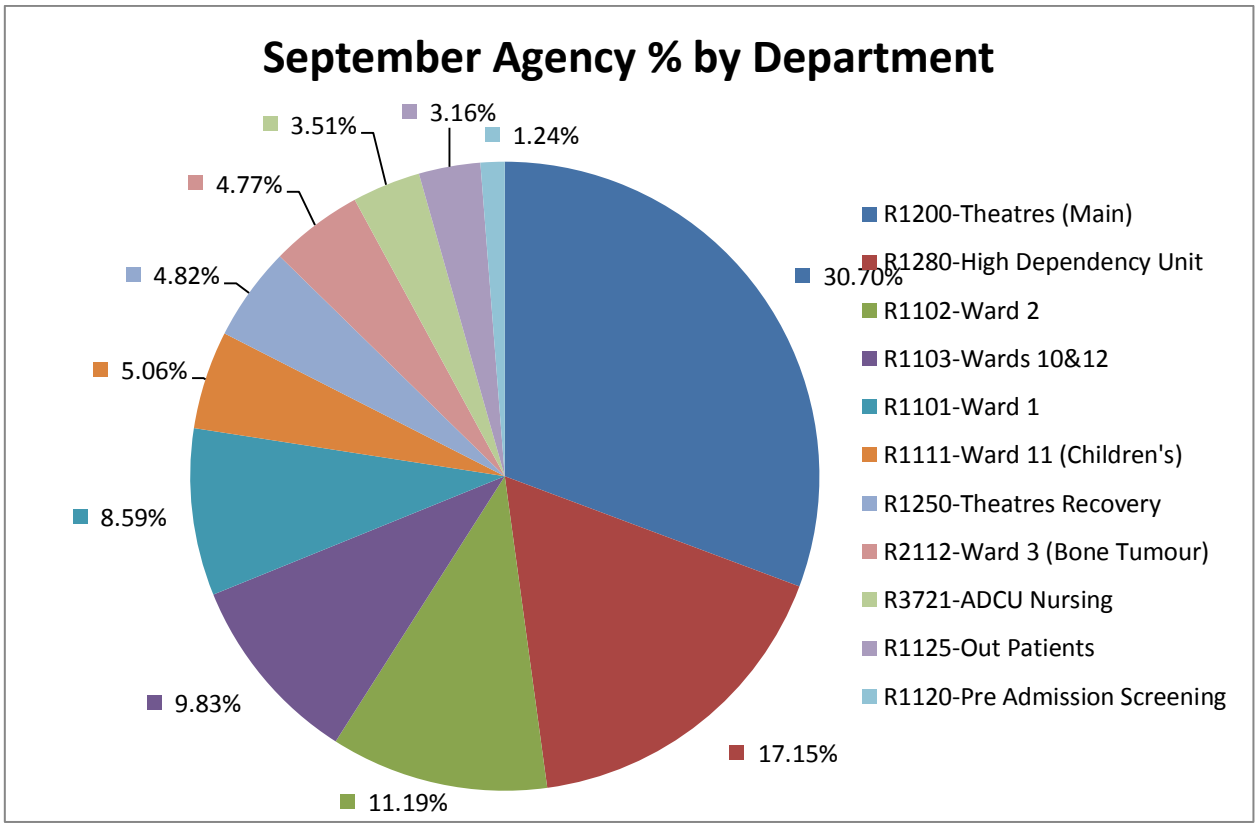
Caps on agency spend for Registered Nurses, mandated by NHS Improvement, have been in place at ROH since 1 October 2015. The ceiling for ROH has been set at 10% which is a reflection of the relatively high use of agency staff at the Trust. During September 2016 overall nurse agency use at ROH was 17.6% which is a significant increase of 4.6%. Table 8 shows total nurse agency use across the Trust since October 2015.

Table 6: Registered Agency use as a % of total cost (Whole Trust)

Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	April 16	May 16	June 16	Jul 16	Aug 16	Sept 16
20.9 %	13.5 %	15.9 %	13.7 %	14.2 %	10.7 %	11.2 %	10.9 %	8.6 %	12. 4%	17 %	17.6 %

Table 7 presents agency use by area as a total of agency spends across the Trust.

Table 7: Agency use (as a percentage of total spend)



- The use of agency staff in theatres/ recovery and HDU has decreased slightly from August data (decrease of 2.66% in theatres and 2.72% in HDU)
- Ward 11 use of agency has increased by 4.6% as the staffing template has been increased from 2RN to 3RN on night shift as per national guidance by RCN and as a result of RCHCH review
- All of the in- patient ward areas have agency use less than 10%, apart from Ward 2. An RN has been moved from Ward 10/12 for 6 months to cover Ward 2 to reduce the agency spend on Ward 2.
- An increase in agency spend has been seen across all the inpatient wards which is being investigated and discussed at the now weekly Bank & Agency Reference Group
- A slight decrease in agency spend has been seen in ADCU, Out patients, Pre-admission and discharge lounge

Staffing controls:

- Twice weekly meetings commenced to review staffing numbers against activity and acuity of patients.
- Weekend plans for reduction of staffing where safe, dependent on patient numbers and acuity
- Prospective planning for ADCU opening at weekends if not required
- 'Cohorting' of empty beds in one area to facilitate reducing staffing numbers
- Prospective audit of October half term week annual leave over the ward areas has taken place and actions taken to reduce any over booking

- Ward managers / Departmental managers communication regarding the annual leave ceiling of 15%

3.0 Progress against E–Rostering at ROH

- The roll out commenced on 17th October 2016
- Allocate representatives have been supporting the training and roll out

- The Project team and Project Board are established
- The e-rostering policy has been completed and will be circulated for comments and it is proposed to bring this policy to November TMC.
- The roll out plan for the whole Trust is as follows:
    - 10th Oct – Ward 3 (completed)
    - 17th Oct – HDU (in progress at time of writing report)
    - 31st Oct – Ward 1, Ward 2 & Ward 10/12
    - 7th Nov – ADCU
    - 21st Nov – Theatres and recovery
    - 28th Nov – Ward 11, Outpatients & Discharge lounge
    - 5th Dec – POAC, BIU & ROCS

4.0 Incident Reporting and Levels of Harm

Reported Staffing Incidents

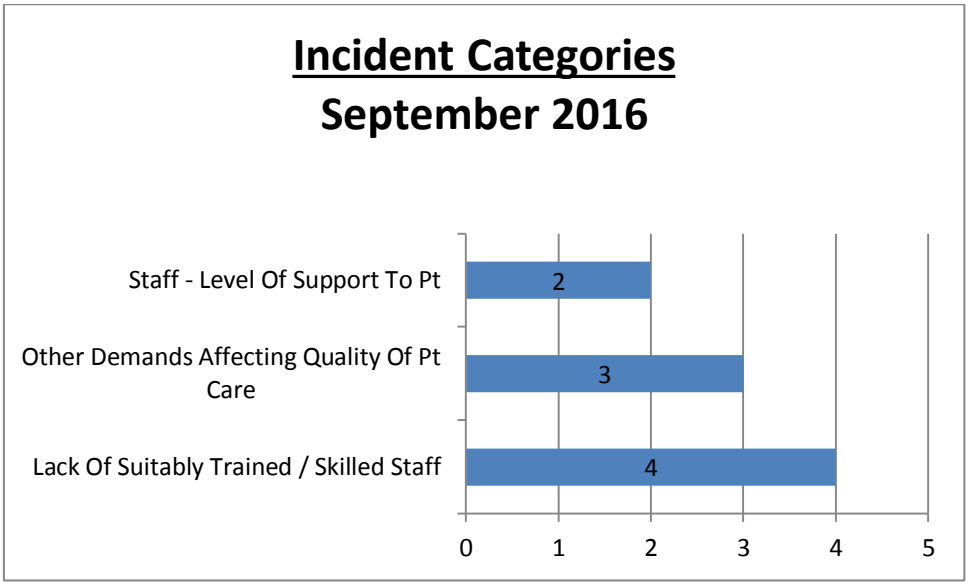
In addition to the Safer Nurse Staffing tool being used and interpreted, clinical areas are encouraged to report all Safe Staffing incidents.

An analysis and review of the 9 nursing related safe staffing incidents reported during the period of September 2016 has been undertaken and is represented in the graph below.

Incident Categories

Two incidents were categorised as 'level of support to patient' and four incidents were categorised as 'lack of suitably trained/skilled staff'.

There were 3 incidents with "Other Demands Affecting Quality of Pt Care"



Lack Of Suitably Trained / Skilled Staff

18709 – No Bleepholder to handover to

18785 – Agency Nurse DNA on HDU

18809 – Worsening working conditions in theatres due to increase in agency staff

18824 – No PLO in oncology

Other Demands Affecting Quality Of Pt Care

18748 – No Paed nurse on HDU

18801 – Low staffing in ROCS team. Unable to deliver TTOs to patient

18897- Low staffing on ward 1. 2 agency staff on shift

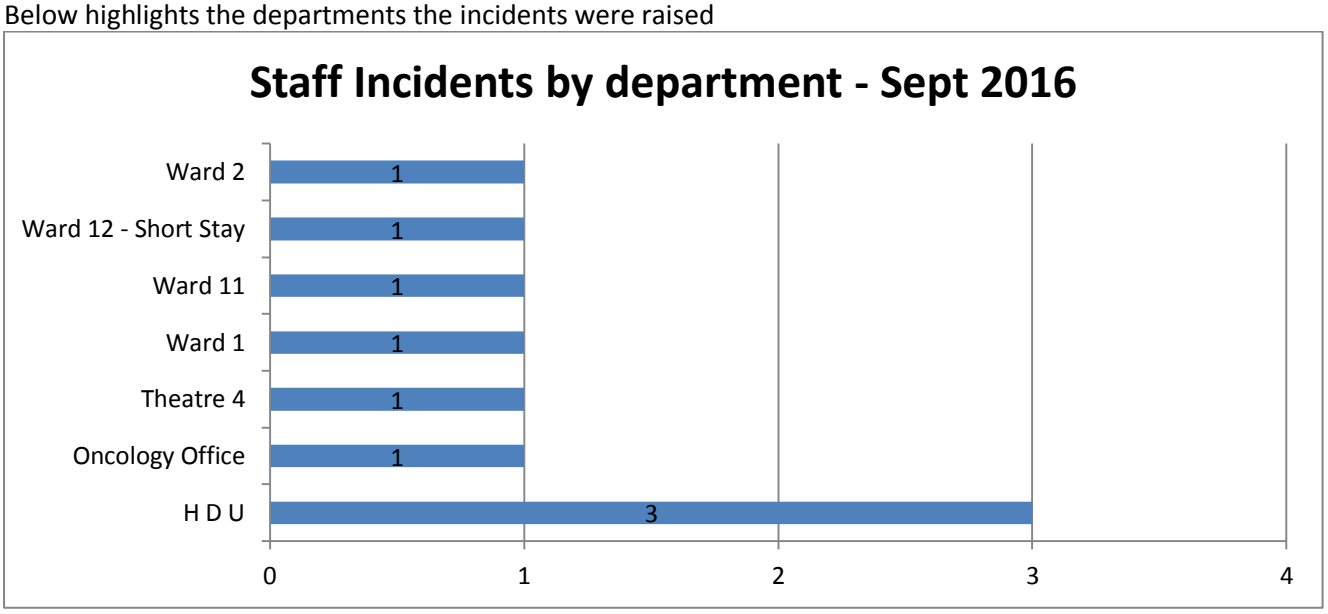
Staff - Level Of Support To Pt

18705 - Bleepholder was unable to be supernumerary

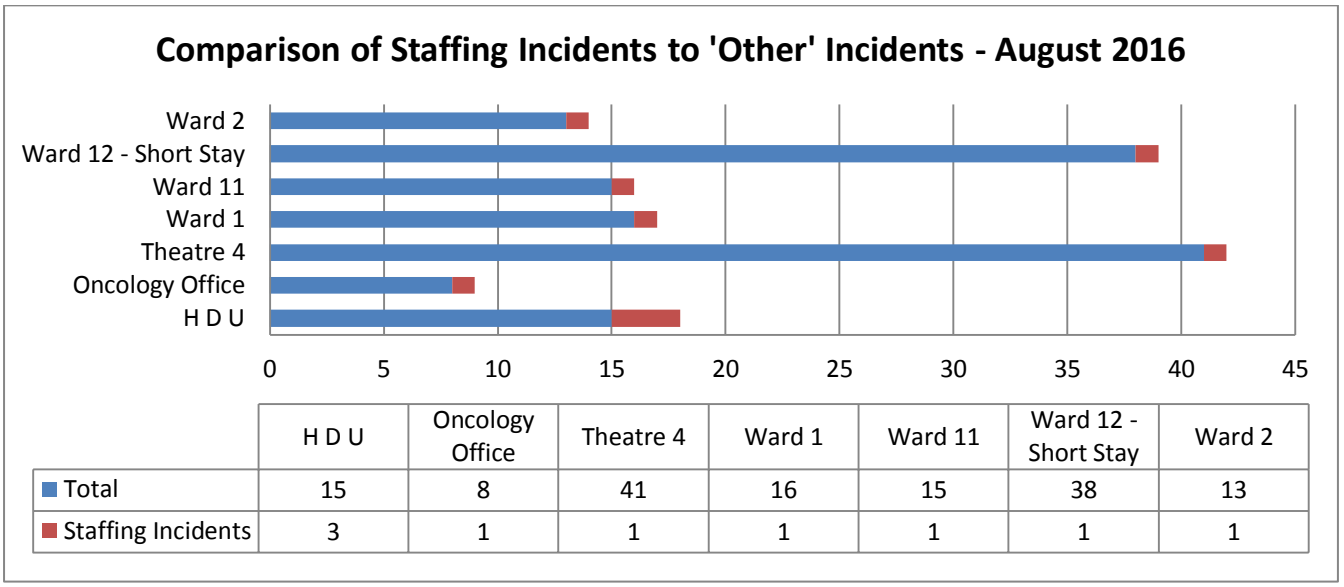
18812 – low staffing on ward 11

Incidents by area/ward:

Below highlights the departments the incidents were raised



Comparison of total incidents to staffing incidents to give a proportion



	H D U	Oncology Office	Theatre 4	Ward 1	Ward 11	Ward 12 - Short Stay	Ward 2
Total	15	8	41	16	15	38	13
Staffing Incidents	3	1	1	1	1	1	1

20% of HDU reported incidents were staffing incidents (3 incidents out of a total of 15)
13% of Oncology reported incidents were staffing incidents (1 incident out of a total of 8)
2% of theatres reported incidents were staffing incidents (1 incident out of a total of 41)
6% of Ward 1 reported incidents were staffing incidents (1 incident out of a total of 16)
7% of Ward 11 reported incidents were staffing incidents (1 incident out of a total of 15)
3% of Ward 12 reported incidents were staffing incidents (1 incident out of a total of 38)
8% of Ward 2 reported incidents were staffing incidents (1 incident out of a total of 13)

Level of harm

2 staffing incident was graded as 'low harm'. The remaining 7 staffing incidents were graded as 'no harm'

Red Flag Shifts Questionnaire

Two Incidents triggered red flags

18705
Incident reported on HDU.
HDU Co-ordinator had the hospital bleep and reported that therefore there was no supernumary co-ordinator on the early & late shift. In the report it states that all patients remained safe and all patient care was given. No patient safety incidents were reported during this shift.

18812 – Red Flag due to delay more than 30 mins of pain relief
Incident reported on ward 11.
Unable to get agency/ bank cover for a paediatric nurse therefore only 2 trained paediatric registered nurses on duty.
Action taken: Agency nurse block booked (covering Mat leave/sickness /vacancies) and HDU temporarily frozen until staffing numbers allow for rotation to recommence safely.

5.0 Conclusion and Recommendations.

The Trust Board is asked to note:

- Fill rates across ward areas show that minimum safe staffing has been achieved.
- CHPPD is the principle measure of nurse deployment recommended by NHSI. It should therefore be a key measure in future nurse establishment reviews.
- Good progress has been made in appointing to adult nurse and health care support worker vacancies with 12 WTE registered staff with start dates, 2 in recruitment process and of the remaining 8.93 WTE Band 5 vacancies, 6.0 being Paediatric nursing vacancies.
- Children's Nurse recruitment remains challenging (vacancies as above), with an assessment centre planned for 31st October
- The Safer Nursing Care Tool (SNCT) was used across the Trust in late June/early July 2016. It is recommended that the SNCT should be repeated in November 2016 with much greater attention paid to quality assuring data collection.
- Agency use has risen this month compared to August, driven by an increase in agency use across the wards

Garry Marsh
Director of Operations, Nursing & Clinical Governance

28 October 2016

Appendix 1

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		1569	1395.5	1243	1264	990	957	330	362.5	88.9 %	101.7 %	96.7 %	109.8 %
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1488	1385	934.5	920.5	946	935	583	385	93.1 %	98.5 %	98.8 %	66.0 %
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1740	1684.5	1065	945	780	770	420	400	96.8 %	88.7 %	98.7 %	95.2 %
Ward 10 & 12	110 - TRAUMA & ORTHOPAEDICS		1750	1739.5	1303	1269	1232	1221	748	737	99.4 %	97.4 %	99.1 %	98.5 %
Ward 11	110 - TRAUMA & ORTHOPAEDICS		1145	1163.5	276	282	990	990	0	0	101.6 %	102.2 %	100.0 %	-
HDU	110 - TRAUMA & ORTHOPAEDICS		2016	2054	172.5	172.5	1837	1848	0	0	101.9 %	100.0 %	100.6 %	-

Appendix 2
Incident Details

Department	Incident Date	Incident Number	Actual Impact	Incident Type	Details Of Incident	Outcome Description
Ward 12 - Short Stay	04/09/2016	18709	1 - No Harm	Staff Incident	At end of bleep shift, went to ward 12 expecting to hand over all bleep information to the next bleep holder. However, at this time 0800hrs, he had still not turned up, I therefore decided to wait a further few more minutes thinking that he must just be late. After ten minutes I asked the ward staff to contact him as my shift had ended at 0730. He eventually text the nurse in charge stating that he was ill, there was no evidence of this in the ward off duty and there was no other band 6 or 7 on this ward to handover to. HDU did have a band 6 working, but she had not fully completed her bleep training, I did not feel that this was a safe situation to leave the bleep in. There were no other options available as there was no other band 6 or 7 in the trust. Executive on call was contacted.	Bleep holder and incident reporter were offered an personal apology for the situation she was left in and reassured her that had I have known the named nurse was not planning to attend his for his bleep shift I would have organised cover on Friday for Sunday also. Upon return to work the individual involved will be reminded they need to keep in touch when off sick and inform ward if they do not intend to come in for the next shift this is especially important when you are holding the hospital bleep and cover needs to be arranged LN
Ward 2	15/09/2016	18801	1 - No Harm	Patient Incident	Requested by ward 2 to take out some TTOs which were left on ward to a patient Discharged to a nursing home today (op date 20/6/16).TTO's had not been made ready for discharge by ward even though the patient had been an IP for so long. The TTOs included CDs. Advised Manager that we are unable to fulfil this request due to poor staffing on ROCS at the present time. Only 4 staff on duty tomorrow. The team has x 2 vacant positions, x2 fulltime members of staff off sick, 5 patient visits have had to be cancelled/moved to another day , had to request a BIU patients relative to collect medication tomorrow rather than ROCS team taking them out. Bank staff needed to be rostered to work.	Short staffing in ROCS department, Following discussion with staff on duty it would appear medication was delivered to patient despite ROCS being unable to facilitate

Oncology Office	20/09/2016	18824	1 - No Harm	Patient Incident	Usually 2x PLOs in office. 1x on annual leave, 1x has rang in stating she will be unable to attend work. She left halfway through the day yesterday due to personal reasons. We have 1x PLO on bank who has come in, however has a personal appointment to attend at QE, therefore we currently have no PLOs in the department. PLOs are responsible for receipting our Oncology referrals, on PAS and Onkos. This starts the patient pathway. Without a PLO, we cannot action referrals. They also book our imaging and outpatient appointments, meaning further delays to existing patient pathways. Staff turnover and sick leave seem to have become a vicious circle, causing delays to the patient journey within Oncology. From Risk Assessment Guide: 'Late delivery of key objective / service due to lack of staff. Minor error due to ineffective training. On-going problems with level of staffing Some disruption in service with unacceptable impact on patient care Non-permanent loss of ability to provide service.'	1x bank staff asked to concentrate on patient referrals when she returns from personal appointment. 1x Data Manager was previously a PLO, therefore he is assisting where he can, however has his own commitments to prioritise amongst this.
Ward 11	16/09/2016	18812	1 - No Harm	Staff Incident	There are 13 patients on the ward today with one going to HDU after surgery. Staffing was looked at prior today and was put out to bank and agency due to there being only two qualified members of staff on the ward on the late shift. The dependency of some of the patients is 1a. The ward could not get anyone from the bank or agency to cover the shift. This left the two members of staff short staffed.	Staffing has been an issue over the last few weeks and has been escalated as required. Agency nurse has now been block booked and HDU rotation frozen. 2 vacancies outstanding that are currently advertised. Ward also trying to support clinic, backfill maternity leave as well as any sickness and full capacity AL. Incident closed 21/09/16
Ward 1	23/09/2016	18897	1 - No Harm	Staff Incident	I arrived at work for a night shift to find that i was on duty with 2 agency RGN's one which had not worked on the ward before, an agency HCA and a bank nurse that does not work on the ward very often.	To make sure that there are 2 RNs on the ward from the ROH. , so as to provide support for each other. To continue to actively recruit staff to be permanent members of staff on the ward. To plan to off duty in advance to give the bank time to fill the shifts with ROH staff where possible. E-rostering will be coming on line soon and this will mean that the off duty has to be completed 4-6 weeks in advance.
H D U	03/09/2016	18705	1 - No Harm	Staff Incident	Holding the hospital bleep on the late shift unable to be supernumerary as had patients no supernumerary co-ordinator on the early exec on call contacted. Unable to carry out ward rounds no breaks taken on the late shift by staff on HDU	All patients remained safe and full care given. No patient safety incident

H D U	08/09/2016	18748	2 - Low Harm	Other - I.E. Non-Patient Relat	Patient planned admission for complex THR. HDU ward manager informed 1 week before admission that a HDU bed will be required and also informed of the amount of paediatric patients going through HDU this week. Seen in POAC and deemed HDU bed needed post op. Post op patient spent several hours in recovery and then deemed to need a HDU bed. HDU did not have enough paediatric nurses and so could only accept patient if they took agency nurse off the ward. Exec on call agreed this which left ward 11 short with only 2 trained nurses and a heavy ward.	Agency nurse sent to HDU for night shift so patient could be cared for in appropriate environment.
H D U	14/09/2016	18785	1 - No Harm	Staff Incident	Agency staff has not turned up for the long day on HDU. No Supernumerary coordinator available on the unit as i am looking after a patient. Nurse bank coordinator informed.	Nurse bank coordinator informed and DOM of the day

Theatre 4	14/09/2016	18809	2 - Low Harm	Staff Incident	Worsening working conditions in theatres noticed in the recent weeks due to increasing agency staff with inadequate knowledge and experience. The lists are slowed and moreover add to the frustration and loss of morale of senior staff and consultants. This is carrying potential risk of patient harm and poor outcomes. This is partly due to lack of induction and orientation of agency staff before they start. Being a specialist hospital, it is essential to have highly trained personnel to run the lists smoothly. This is only possible with dedicated permanent or agency member having good experience of working in this set up as earlier identified from Ford team. As well noticed, permanent recruitment is challenging but not impossible to train the new member supporting. If this is better than employing an agency member with no knowledge of the working atmosphere - is not observed. Certainly there is a probationary period for the recruit during which it can be demonstrated if he or she would be a right person for the job. Similar challenge is identified across the HDU and outreach recruitment as well. I am very sure huge sum of money is spent on hiring agency staff. Question is that is it cost-effective to run the service with the agency staff. Providing acceptable wages to the regular staff for overtime or extra days of working is well proven across various organisations. This certainly should match the payments of the agency member's pay but less the agency commission. It has the advantage of the experienced and well oriented staff who can go hand in hand with all the rest of the staff. All these are provisions until permanent recruits are successfully inducted. I am happy to discuss this with relevant responsible member of staff.	

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**CQC Action Plan Update Report**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh, Director of Operations, Nursing and Clinical Governance**
AUTHOR:	**Mustafa Ahmed, Governance Improvement Manager**
DATE OF MEETING:	**2 November 2016**

EXECUTIVE SUMMARY:

The attached report presents a detailed summary of achievement against all of the milestones and actions identified in the CQC action plan developed following receipt of the CQC report in December 2015.

Trust Board has previously considered action plan updates in summary form and is therefore sighted on the risks and off- track issues identified within the detailed report. The version attached has been amended as follows:

1. The RAG rating has been amended to reflect that used in other key documents used within the Trust.
2. Each of the milestones has been RAG rated as in previous versions, and in this version the expected outcome and KPIs have also been RAG rated in order to provide an easily accessible overview of progress.
3. The action plan has been separated into the two key areas that were the subject of the CQC inspection in July 2015, OPD and HDU, for ease of reference
4. Executive leads have been updated as required

Risks for the attention for the Board;

- The delay in reviewing and updating the clinic templates for use across all services due to an interdependency on job planning
- Difficulties in the recruitment of registered paediatric nurses.

REPORT RECOMMENDATION:

Trust Board is asked to note the progress that has been made against delivery of the CQC action plan and to note that where actions are off track a plan is in place to ensure delivery within a revised timescale.

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

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

KEY AREAS OF IMPACT *(Indicate with 'x' all those that apply):*					
Financial	x	Environmental	x	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:
The report has direct alignment to all the Trusts Objectives

PREVIOUS CONSIDERATION:
Quality & Safety Committee on 26 October 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROH ACTION PLAN - HDU

18 October 2016 | v2

NO	QUALITY IMPROVEMENT PROJECT	EXPECTED OUTCOME	KPI / MEASURE	EXECUTIVE LEAD	CLINICAL / PROJECT LEAD	ROH ACTION NO	ACTION	FINAL DEADLINE	UPDATES (Unsatisfactory Progress / Slow Progress / Satisfactory Progress / Completed)	ONGOING ASSURANCE
REQUIREMENT NOTICES										
3	Improved facilities for the care of paediatric patients on HDU	There will be a distinct paediatric facility on HDU which meets national and best practice standards	100% of children will be cared for in a distinct paediatric facility	Phil Begg	**Stuart Lovack**	**1**	Appoint architect by Jan 2016. Design development to be completed by the end of March 2016	31 March 2016	Plans have been developed to enable tender to be completed.	
						2	Tender and evaluation to be completed	~~31 April 2016~~ 31 July 2016	This action was not completed by end April however a tender document has been completed by July 2016.	
						3	Construction begins ~~June 2016~~ August 2016 and completes ~~October 2016~~ January 2017. New paediatric premises will be available for use by end ~~November 2016~~ January 2017.	31 January 2017	Construction begins June 2016 August 2016 and completes (October 2016) in January 2017.	
4	Improved facilities for all adult patients on HDU ensuring compliance with DH MSSA requirements and compliance with NHS Contract	Separate Toilet and bathroom facilities will be available for male and female patients on HDU	Full compliance with MSSA Guidance and requirements of the NHS Contract	Phil Begg	**Stuart Lovack**	**4**	Identify additional facility Develop business plan and secure funding Draw up plans for new facility	28 February 2016	Action complete.	
						5	Undertake building work to create additional facility Confirm compliance with DSSA requirements and NHS Contract requirements	31 May 2016	October 2016: Works completed for the additional toilet facility in HDU. This is now operational.	
5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	y Marsh	**a Carding**	**7**	Approve the SOPs for admission of elective and emergency patients to HDU (action complete- approved December 2015)	28 February 2016	SOPS have been developed and ratified	

				Garr	Talith	8	Develop implementation plan for SOPS and demonstrate completion to TMC	31 May 2016	SOPS are in place.	TMC agenda and minutes.
5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	Garry Marsh	Talitha Carding	9	Undertake recruitment of registered children's nurses	28 February 2016	Recruitment has continued since December 2015. The Paediatric establishment on HDU has been increased to 7.6 WTE.	
						10	An increase to a minimum of 2 Registered Paediatric nurses at all times to achieve RCN standards.	~~31/05/2016~~ 31 January 2017	October 2016 Current position is 5.6 WTE. 3 of the 4 nurses recruited have dropped out of the process. Another advert has been placed and interviews are due to take place 31 October 2016. Another advert will have to placed as only 3 candidates have been shortlisted for a total of 5 posts.	
						11	The Trust will be complaint with the requirement to staff each shift on HDU with 2 paediatric nurses by end Jan 2017	31 January 2017	October 2016 Current position is 5.6 WTE. 3 of the 4 nurses recruited have dropped out of the process. Another advert has been placed and interviews are due to take place 31 October 2016. Another advert will have to placed as only 3 candidates have been shortlisted for a total of 5 posts.	
5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	Garry Marsh	Talitha Carding	12	All Children's Nurses to complete 'Children's Critical care Passport' arrangements at BCH by end January 2016 Assess adult nurses against the passport competencies in line with trajectory agreed at TMC in December 2015	28 February 2016	A plan has been developed to ensure delivery of this action. All Children's nurses in HDU completed rotation by end January 2016	
						13	All eligible adult nurses on HDU will have completed the paediatric competency document	~~31 March 2016~~ 31 May 2016	October 2016: This is complete apart from one new adult nurse as there are enough Band 5 and 6 nurses with paediatric competencies.	
5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	Garry Marsh	Talitha Carding	14	Implement rotation programme between paediatric HDU and in-patient ward.	28 February 2016	Implementation programme has been developed	
						15	Rotational programme between Ward 11 and HDU fully implemented.	31 May 2016	October 2016 This has been suspended due to the risk of staffing levels on Ward 11. HDU paediatric care provision not affected / impacted on as RGN from Ward 11 supernumary.	
						16	All nursing staff on ward 11 will have completed rotation to HDU by end December 2016 May 2017	31 May 2016	October 2016 This has been suspended due to the risk of staffing levels on Ward 11. HDU paediatric care provision not affected / impacted on as RGN from Ward 11 supernumary.	

5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	Garry Marsh	**Talitha Carding**	**17**	Develop a programme of collaboration with BCH to access competency based training for all HDU nursing staff and present to TMC by end January 2016.	28 February 2016	October 2016 The SLA is being finalised for this.	
						18	Implement a revised preceptorship programme for all new starters to HDU	31 May 2016	Good progress has been made against delivery of this action. As detailed below: 4 staff have attended a deteriorating child course at BCH in April 2016 2 staff attended an airway management course at BCH in June 2016 A RAPT Course is planned for August 2016 with 8 members of the HDU team attending.	
							Develop roll out programme for competency based training with BCH	31 May 2016	An SLA has been developed with BCH which formalises access to their training programme.	
						19	All relevant nursing staff on HDU will have completed competency based training programmes at BCH by end October 2016 to include: -RAPT courses A TNA will be developed to evidence achievement by end October 2016.	31 October 2016	October 2016: As below. SLA in the process of being finalised. August 2016: The TNA is in progress following agreement with BCH about access to their in house courses. The education component of the SLA has been identified and work is underway to agree costs and numbers. Expected completion by September 2016	
5	Improved access to paediatric nurse cover	All Children will be cared for a Registered Children's Nurse	100% of children in HDU will be cared for a Registered Children's Nurse	Garry Marsh	**Talitha Carding**	**20**	Review and approve Transitional Care Policy by end March 2016	28 February 2016	The Transitional Care Policy was ratified at TMC in June 2016.	
						21	Complete implementation of Transitional Care Policy by end May 2016	31 May 2016	October 2016 Updated implementation plan presented at Clinical Quality Group on 26.09.2016 and Childrens Board 05.09.2016.	
						22	Audit implementation of revised Transitional Care Policy	30 November 2016	October 2016 Updated implementation plan presented at Clinical Quality Group on 26.09.2016 and Childrens Board 05.09.2016.	
	Improved access to paediatric medical cover	review by RCPCH to include: Review of current arrangements for medical	Completion of RCPCH review			**23**	Agree TORs for review Establish timeframe for review	28 February 2016	Terms of reference agreed In December 2015 Review planned for March 2016	

6		advice, nursing support and management Review of the processes for risk assessing children prior to admission Review of processes for management of the deteriorating child and the safety of arrangements for transfer through the Critical Care Network		Andrew Pearson	**Dr Da Silva**	**24**	Completion of review Development of an action plan to respond to review recommendations	31 May 2016	Review completed March 2016 Final report received 17th June 2016 Medical Director has written to the Division 2 GM detailing the requirement that all children in the Trust must have review by visiting paediatrician with the inclusion of HDU.	
						25	Monitoring arrangements for implementation of action plan in place Audit of compliance with this requirement is required by end August 2016	31 August 2016	20.10.2016 This has been incorporated into the job description of the Associate Medical Director at BCH who has now been appointed. Action plan developed. Quality Meeting Chaired by NHSI planned 26 July 2016	
MUST DO										
7	Locked storage is available for intravenous fluids on HDU	IV Fluids will be stored in a locked cupboard.	IV Fluids are secured in locked cupboard 100% of the time	Garry Marsh	**Talitha Carding**	**26**	Lock away all intravenous fluids. Completed December 2015 Undertake audit of compliance by end Feb 2016	28 February 2016	Action completed immediately	Matron walkabout and review confirms that cupboard has remained closed and locked.
8	Consistency in recording and reporting Safety Thermometer Data	Accurate completion and recording of Safety Thermometer data	Data accurately recorded and presented 100% of the time from end February 2016	Garry Marsh	**Talitha Carding**	**27**	Review process of Safety Thermometer data collection by end Jan 2016 Make recommendations for implementation of revised process Implement revised process	28 February 2016	A revised Safety thermometer SOP has been developed The SOP was shared at Ward managers meetings for roll out. The SOP includes collection of paediatric safety thermometer data	The upload of Paediatric Safety Thermometer data commenced in April 2016. ST reports to UNIFY include paediatric data.
9	Enable benchmarking against other Critical care Units	Upload of monthly data to ICNARC website	100% benchmarking uploaded to ICNARC monthly from March 2016	Garry Marsh	**Talitha Carding**	**28**	plete September 2015 Roll out Training programme- complete November 2015 Complete recruitment for admin assistant to enable data input Enrol with ICNARC	28 February 2016	The software has been secured and the Trust is enrolled with ICNARC	
						29	Begin Upload to ICNARC by end April 2016 Monthly benchmarking reports to Divisional Governance Board by end May 2016	30 April 2016	The ICNARC upload takes place on a quarterly basis. The first upload will take place in July 2016. However data collection has begun in Q1 2016/17 in preparation for upload.	First data upload complete

14	Access in an emergency situation enabled	All side rooms will have adequate space to allow access to emergency equipment	N/A	Garry Marsh	**Talitha Carding**	**30**	Patient & Carer beds removed from side rooms November 2015 Source and procure recliner for parent use completed by December 2015	28 February 2016	Action complete. Beds removed and recliners purchased for parent use	
15	Adequate storage facilities for HDU equipment when not in use	All staff will have access to improved storage facilities	There will be no equipment stored in bays on HDU	Phil Begg	**Stuart Lovack**	**31**	Scoping of additional storage creation within estates plan to be completed. Identification of additional storage facilities	28 February 2016	This action is within scope of the refurbishment plan	
						32	This action will be completed as part of the refurbishment of HDU detailed in action 3 above	31 May 2016	This action was not completed by end April however a tender document has been completed by July 2016	
						33	No further action once refurbishment complete. Expected completion January 2017.	31 August 2016	October 2016: Theatres have released 30.G15 equipment store for use by HDU. Through the HDU project Board further areas will be reviewed. There is currently adequate space for equipment but only just.	
16	All ward rounds will have MDT input	All patients will have a MDT ward round daily	100% of ward rounds will have MDT input	Andrew Pearson	**Matt Payne**	**34**	Reviews ward round process to include NHS England seven day services standard around MDT working.	28 February 2016	Progress has been made against introduction of MDT ward rounds with physiotherapist and pharmacist joining the team	
						35	Implementation of revised ward round to ensure compliance with NHS England seven day services standard around MDT working	31 May 2016	Progress has been made against introduction of MDT ward rounds with physiotherapist and pharmacist joining the team	Audit of compliance undertaken and presented to Divisional Governance Board by December 2016

ROH ACTION PLAN - OPD

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NO	QUALITY IMPROVEMENT PROJECT	EXPECTED OUTCOME	KPI / MEASURE	UTIVE LEAD	AL / PROJECT LEAD	ROH ACTION NO	ACTION	FINAL DEADLINE	UPDATES	ONGOING ASSURANCE
									Unsatisfactory Progress	

				EXEC	CLINICAL	NO			Slow Progress Satisfactory Progress Completed	
REQUIREMENT NOTICES										
1	Improvement in waiting times in OPD. Improvement in access to imaging services for patients Improved Patient Experience	Improved access and flow to OPD Improved access to diagnostic tests Implementation of single clinic template.	Waiting times for clinic less than 60 minutes by April 2016 Waiting times for clinic less than 30 minutes by October 2016 Block booking of clinics to stop in line with timescale below: End March 2016: no more than 40% of clinics using block booking End June 2016 No more than 20% of clinics using block booking End August 2016: no clinics will use block booking as a clinic template. All staff trained in use of' In Touch' software system by end March 2016.	Garry Marsh	**Janet Davies**	**36**	New reports developed to track bookings, cancellations and waiting times.	28 February 2016	New report has been developed to track waiting times. Bookings, DNA's and cancellation data available from PAS.	
						37	Implementation of "In touch" system in OPD by April 2016. Monthly reports on clinic bookings, waiting time, DNA's and cancellations to Divisional Governance Board by end April 2016	31 May 2016	The In touch system is operational. Delays occurred in implementation in radiology due to technical difficulties but the system became live in this area on 13th June 2016. The first report set to go to Division 1 Board in July 2016 (June data).	Reports are regularly presented at Divisional governance boards
						38	Roll out of training programme for all staff in use of IN TOUCH system.	28 February 2016	Training was completed in line with this timescale	
						39	Training was completed in line with this timescale	28 February 2016	A waiting times SOP has been developed and is in place across all PODS.	An audit report was presented to Divisional Board in September 2016 which demonstrated compliance with the SOP.
	Improvement in waiting times in OPD. Improvement in access to imaging services for patients	Improved access and flow to OPD Improved access to diagnostic	Waiting times for clinic less than 60 minutes by April 2016 Waiting times for clinic less			**40**	Development of a SOP for booking diagnostic tests prior to OPD appointment	28 February 2016	A SOP for booking diagnostic tests has been developed (completed March 2016)	

1	Imaging services for patients Improved Patient Experience	Improved access to diagnostic tests Implementation of single clinic template.	Waiting times for clinic less than 30 minutes by October 2016 Block booking of clinics to stop in line with timescale below: End March 2016: no more than 40% of clinics using block booking End June 2016 No more than 20% of clinics using block booking End August 2016: no clinics will use block booking as a clinic template. All staff trained in use of' In Touch' software system by end March 2016.	Garry Marsh	**Jo Phillips**	**41**	Implementation of SOP for booking diagnostic tests prior to clinic appointment Develop roll out plan for implementation of revised clinic template	31 May 2016	Incidents are raised when there is non-compliance with notifications received by the Division 3 and Imaging General Managers.	Regular reports of compliance presented to Divisional Board from September 2016 onwards
1	Improvement in waiting times in OPD. Improvement in access to imaging services for patients Improved Patient Experience	Improved access and flow to OPD Improved access to diagnostic tests Implementation of single clinic template.	Waiting times for clinic less than 60 minutes by April 2016 Waiting times for clinic less than 30 minutes by October 2016 Block booking of clinics to stop in line with timescale below: End March 2016: no more than 40% of clinics using block booking End June 2016 No more than 20% of clinics using block booking End August 2016: no clinics will use block booking as a clinic template. All staff trained in use of' In Touch' software system by end March 2016.	Garry Marsh	**Janet Davies**	**42**	Commence Review of all consultant clinic templates in order to develop a standardised clinic template for use across all services	28 February 2016	Commence Review of all consultant clinic templates in order to develop a standardised clinic template for use across all services	
						43	Continue the review of all consultant clinics in order to develop a standardised clinic template for use across all services	~~31/05/2016~~ 75% by 30 November 2016 Remaining 25% by 31 December 2016	A comprehensive review of clinic templates by sub-specialty and individual clinician basis is underway with work started within Large Joints and Oncology. Issue with 'block booking' further understood and is in part related to the way the PAS system presents a clinic with more one clinician seeing patients at the same time. In addition to this further work is being undertaken to suitably reduce the size of clinics whenever a staff member is on leave and that agreed booking rules are followed whenever overbooked clinics are required (i.e. due to clinical need and agreed with the consultant. There is a reliance on job planning for this action which is causing a delay in delivery. A comprehensive project plan has been developed by the Clinical Service Manager which is overseen by the Divisional Board. No risks to delivery of the November timescale have been identified.	

1	Improvement in waiting times in OPD. Improvement in access to imaging services for patients Improved Patient Experience	Improved access and flow to OPD Improved access to diagnostic tests Implementation of single clinic template.	Waiting times for clinic less than 60 minutes by April 2016 Waiting times for clinic less than 30 minutes by October 2016 Block booking of clinics to stop in line with timescale below: End March 2016: no more than 40% of clinics using block booking End June 2016 No more than 20% of clinics using block booking End August 2016: no clinics will use block booking as a clinic template. All staff trained in use of' In Touch' software system by end March 2016.	Garry Marsh	**Jo Phillips**	**44**	Develop a local SOP to be followed in the event of a planned clinic cancellation	28 February 2016	Local SOPs are in place	
						45	Evidence that Local SOPs are effective presented to Divisional Board	31 May 2016	SOP being revised to bring control to CSM (Clinical Service Manager) level. CSMs will be notified of any requests of delays or cancellations. This will be audited.	
						46	SOPs reviewed in line with agreed timescale (end July 2016)	31 August 2016	An audit of compliance was completed in July 2016 with submission of findings to Divisional Governance Board in August 2016	
2	Staff access to appropriate level of Safeguarding Training	All staff will have received the appropriate level of safeguarding training.	100 % of nursing staff will have achieved: Level 2 Children's Safeguarding Training Level 1 Adult Safeguarding Training. 100% of A&C staff will have achieved:	Garry Marsh	**Rebecca Hemming (Sister OPD)**	**47**	Level 2 Children Safeguarding: 9/12: staff to have completed Level 2 Adult Safeguarding 12/12 staff to have completed	28 February 2016	All Staff have completed Level 2 Adult safeguarding training	
						48	Level 2 Children Safeguarding: 12/12 staff to have completed by end March 2016	31 May 2016	All staff have completed Level 2 Training as planned	
						49	Evidence of monitoring of mandatory requirement that all staff are compliant with KPI to be reported monthly to Divisional Governance Board.	31 August 2016	This action is completed.	Compliance with mandatory training is reviewed at all Division 1 Board Meetings
MUST DO										
	Compliance with Regulation 20-Statutory Duty of Candour	100% of all staff will comply with Duty of Candour	100% of staff will comply with CQC DoC Regulation 20			**50**	Relaunch of policy and process within the Trust by end January 2016 Review of mandatory training by end February 2016	28 February 2016	DoC policy approved on 1st April 2016.	

10				Garry Marsh	**Faye Rafferty**	**51**	Implement revised mandatory training programme by end March 2016 Audit of compliance with DoC presented to QSC by end April 2016	31 May 2016	The mandatory training programme has been revised to include the revised DoC process	The first audit of compliance was completed By CCG in April 2016. Internal audit will complete audit of DoC in Q3 2016/17 with upward reporting to QSC
11	Improved staff attendance	All staff will be managed in line with Trust sickness/ absence policy.	100% of all staff sickness will be managed in line with Trust Sickness/ absence Policy	Garry Marsh	**Janet Davies**	**52**	Provide evidence that Trust sickness management policy being fully adhered to within the Department to the Divisional Governance Board by end January 2016	28 February 2016	The Divisional Board regular review sickness / absence as part of their monitoring of performance.	The review of all sickness/ absence and compliance with policy will form part of Divisional Board agenda
12	Training and Development of staff	All staff will be up to date with mandatory training	95% of staff In OPD will be up to date with Mandatory Training	Garry Marsh	**Janet Davies**	**53**	Ensure schedule of training to ensure staff are meeting mandatory training. 4 staff January 2016 4 Staff February 2016	28 February 2016	Review of mandatory training compliance is a regular agenda item at Divisional Board with reports presenting evidence of compliance	The review of all mandatory training and compliance with policy will form part of Divisional Board agenda and evidence that actions identified have been followed up will be added to the agenda in September 2016
13	Sharing learning and implementing actions from SIs	All staff will be aware of the process by which learning from incidents is disseminated and implemented	95% of all staff will be able to describe how learning from incidents and implementation of actions is shared across the Trust	Garry Marsh	**Faye Rafferty**	**54**	Relaunch of SI policy and process within the Trust . Introduction to revised policy included as part of mandatory training programme	28 February 2016	This action was not completed by end Feb due to need to ensure that feedback received from a range of stakeholders. However a revised policy and process was agreed in April and June 2016 respectively.	Bi-annual audit has been added to CQG work plan with next audit due Dec 2016
SHOULD DO										
17	All Patients will a Learning disability will have full access to Trust services	All Patients with a learning disability will be supported to have full access to Trust Services	100% of patients with a Learning Disability will be supported to have full access to all Trust Services.	Garry Marsh	**Evelyn O'Kane**	**55**	Relaunch of Learning Disability services available to our patients	28 February 2016	The LD passport is in use	
						56	Develop and launch a LD strategy	31 May 2016	The Director of Operations, Nursing and Governance had drafted a job description for a Learning Disabilities Nurse in September 2016. This is currently with 'Agenda for Change' for appropriate banding and to secure funding. The current champion and lead has been absent for a period of time. This has been added to the Safeguarding Committee risk register.	

						57	Undertake audit of compliance with principles of strategy and present to Safeguarding Committee	31 August 2016	This action will be delayed due to delay of LD strategy

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Finance & Performance Overview**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Director of Finance & Performance**
AUTHOR:	**Various**
DATE OF MEETING:	**2nd November 2016**

EXECUTIVE SUMMARY:

The report covers the main performance metrics related to finance, activity, operational efficiency and operational workforce.

The Trust has delivered a cumulative deficit of £2,963,000 as at the end of September against a planned deficit of £1,691,000. In month, the Trust delivered a deficit of £222,000 against a planned surplus of £7,000.

The Trust is therefore £1,272,000 behind plan at the end of M6. During the month of June all operating theatres were closed for a week due to problems with the air filtration canopy system. It is estimated that this closure resulted in a loss of £954,000. Excluding the impact of this closure, the Trust would be behind plan by £318,000. £480,000 of CIP savings were released in September against a plan of £360,000. This increases the overall achievement for the year to date to £1,507,000, £72,000 behind plan.

Activity levels have been at their highest levels this year, both in terms of Day Case and Inpatient activity. However, this activity is still below the levels seen at the high points of last year, and falls short of the activity plans set.

Whilst August had an exceptionally high agency spend, September has seen an additional increase (£460,000 up from £443,000). This spend is against a plan of £343,000.

A cash levels are £1.35m million lower than planned levels at the end of September 2016. The Trust is forecasting an end of year cash balance of circa £5m, which relies upon the delivery of our deficit plan and the control of capital spend within the budget that has been set.

The Trust failed the 92% incomplete pathways < 18 weeks target in August (91.3%) and it is unlikely we will achieve the target in September.

September has seen a slight improvement in the vacancy position. Sickness absence and turnover headline figures remained almost identical to last month's reported figure, but mandatory training and PDR/appraisals have both decreased versus the August outturn figures.

REPORT RECOMMENDATION:
Trust Board is asked to note this report and discuss actions to be taken with regards to the issues outlined in the 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	X	Environmental	X	Communications & Media	
Business and market share	X	Legal & Policy	X	Patient Experience	
Clinical	X	Equality and Diversity		Workforce	X
Comments:					

ALIGNMENT TO TRUST OBJECTIVES, RISK REGISTERS, BAF, STANDARDS AND PERFORMANCE METRICS:
The Finance & Performance Report, alongside the Quality Report, demonstrates performance against a number of key metrics linked to the delivery of the Trust objectives.
PREVIOUS CONSIDERATION:
This report was considered by Finance & Performance committee and TMC in October 2016.

FINANCE & PERFORMANCE REPORT

OCTOBER 2016

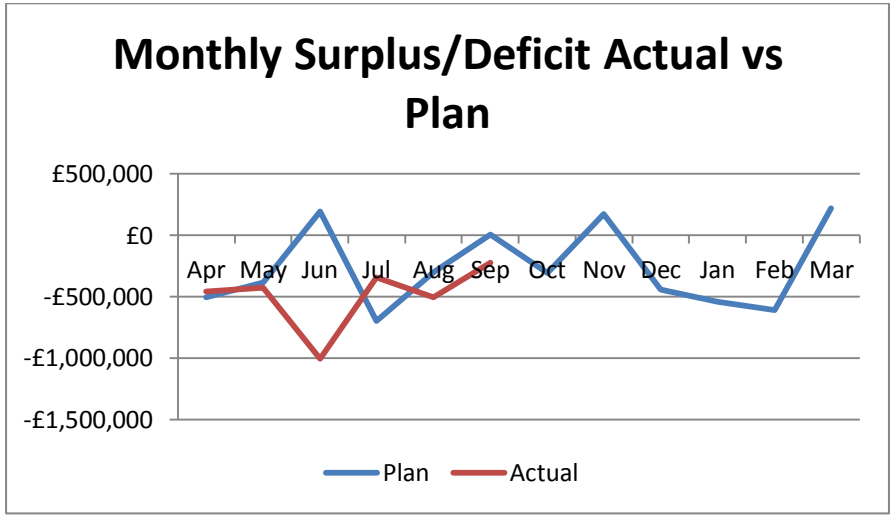
CONTENTS

INTRODUCTION

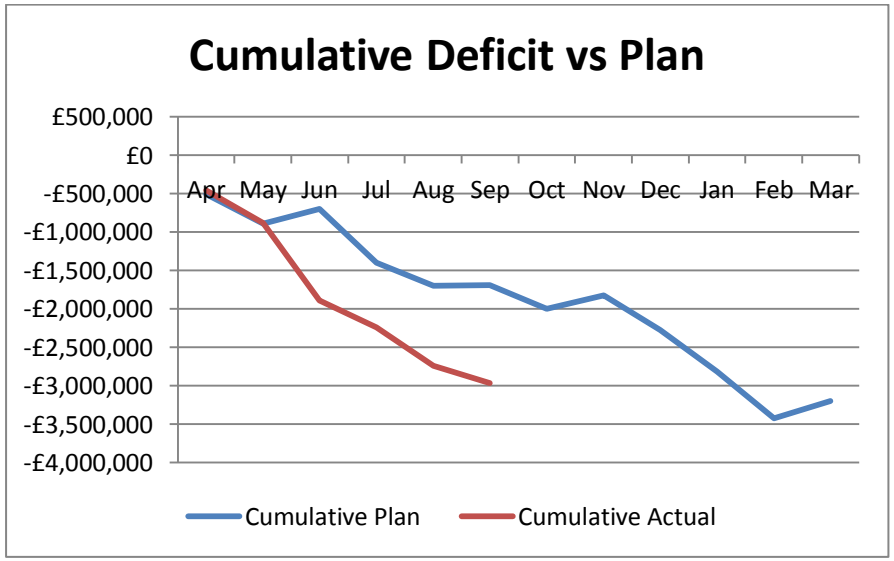
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

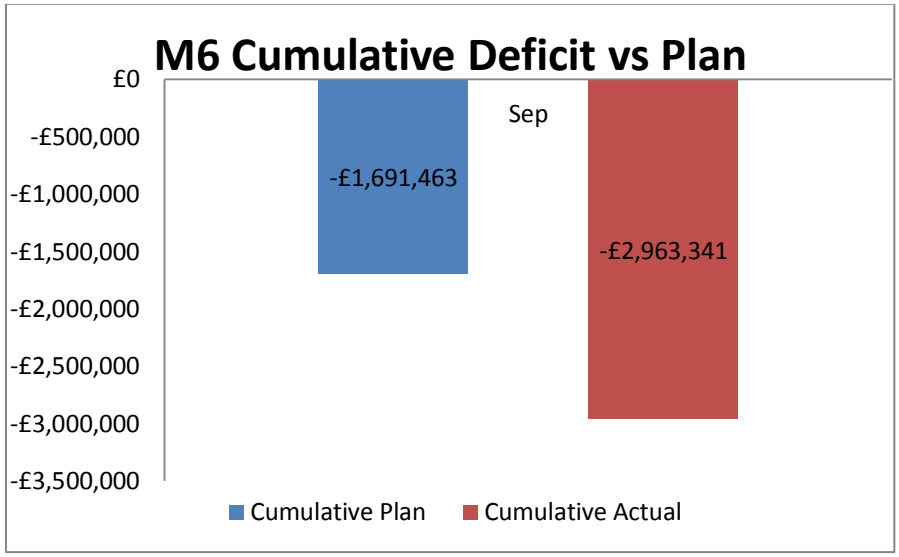
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)



NHSI Use of Resources Rating (UOR)		
	Plan	**Actual**
Capital Service Cover	4	4
Liquidity	1	2
I&E Margin	4	4
I&E Margin – Variance against plan	N/A	4
Agency metric	1	2
Overall UOR	N/A	3





INFORMATION

The Trust has delivered a cumulative deficit of £2,963,000 as at the end of September against a planned deficit of £1,691,000. In month, the Trust delivered a deficit of £222,000 against a planned surplus of £7,000.

The Trust is therefore £1,272,000 behind plan at the end of M6. During the month of June all operating theatres were closed for a week due to problems with the air filtration canopy system. It is estimated that this closure resulted in a loss of £954,000. Excluding the impact of this closure, the Trust would be behind plan by £318,000. Further detail on the key drivers of the financial position is provided in the income and expenditure sections below.

£480,000 of CIP savings were released in September against a plan of £360,000. This increases the overall achievement for the year to date to £1,507,000, £72,000 behind plan.

In month NHSI have altered how the overall financial risk of an organisation is calculated, moving from the previous Financial Sustainability Risk Rating (FSRR) to a Use of Resources Risk Rating (UOR). The previous indicators of financial sustainability are still measured under UOR (i.e. capital service cover, liquidity, I&E margin and I&E margin variance) but there is now an additional measurement to show the Trust's performance against the agency ceiling. In addition, each metric has reversed scoring (i.e. they are still measured on a range between 1 and 4, but 1 is now the highest score instead of 4). Each element has an equal 20% weighting against the Trust's overall score. However, if any individual rating is a 4, then the overall score is capped to a 3 at best.

The deficit position results in the Trust achieving ratings of 4 for our Capital Service Cover, I&E Margin metrics and I&E Margin Metrics against plan. In addition, the Trust's liquidity position has decreased for the first time, and now is rated as a 2 instead of the previous 1. This will be discussed further in the liquidity section. As the Trust is breaching the agency spend cap, it is also scoring a 2 in this new metric instead of a 1. Due to the capping mentioned above where a Trust has any score of 4, the overall Trust score has been capped to a 3.

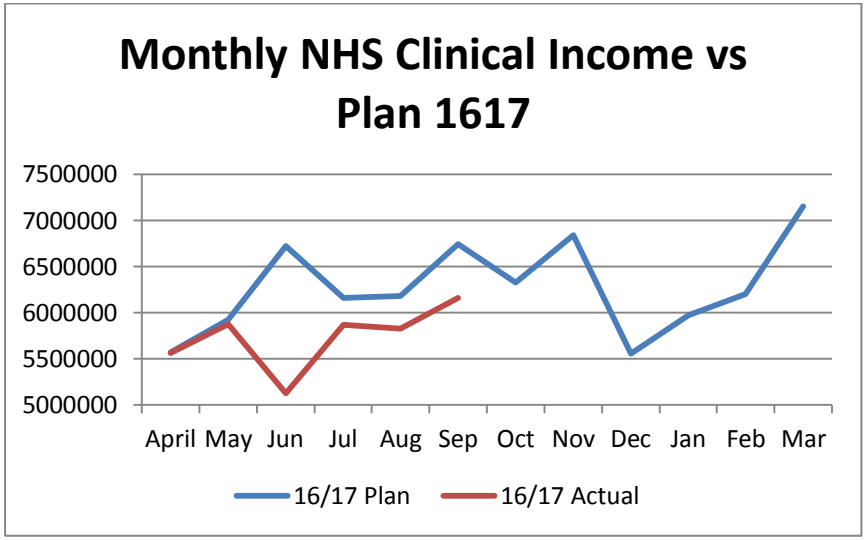
ACTIONS FOR IMPROVEMENTS / LEARNING

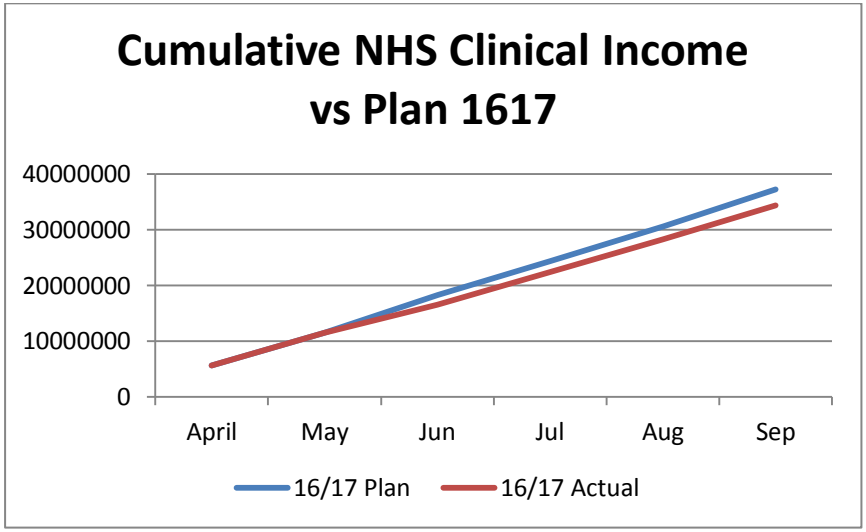
The Trust is currently finalising a detailed financial recovery action plan, which has been considered by F&P committee in October. This recovery plan contains individual detailed actions with a named operational and executive lead and will form the basis of recovery tracking moving forwards. The plan covers both increasing activity and additional new measures to reduce cost.

RISKS / ISSUES

Activity improved in September, but not to the levels required. In order to clawback the shortfall, a significant growth in activity is required moving into the second half of the year. This will put pressure on theatres and wards to ensure that patient flow runs smoothly as there will be no excess capacity in the system. The Trust is not eligible for its £200,000 sustainability funding until our financial position is back in line with our planned trajectory.

2. Income – This illustrates the total income generated by the Trust in 2016/17, including the split of income by category





NHS Clinical Income – September 2016			
	Plan	**Actual**	**Variance**
Inpatients	3,221	2,985	(236)
Excess Bed Days	274	238	(36)
Day Cases	804	722	(82)
Outpatients	747	667	(80)
Critical Care	251	232	(19)
Therapies	253	243	(10)
Pass-through income	219	254	35
Other variable income	415	354	(61)
Block income	559	527	(32)
TOTAL	6,743	6,223	(520)

NHS Clinical Income – YTD 2016			
	Plan	**Actual**	**Variance**
Inpatients	17,756	15,786	(1,970)
Excess Bed Days	1,502	1,420	(82)
Day Cases	4,426	3,918	(508)
Outpatients	4,166	3,799	(367)
Critical Care	1,383	1,389	6
Therapies	1,406	1,492	86
Pass-through income	1,229	1,232	3
Other variable income	2,308	2,411	103
Block income	3,117	3,162	45
TOTAL	37,293	34,612	(2,681)

INFORMATION

Activity levels have been at their highest levels this year, both in terms of Day Case and Inpatient activity. However, this activity is still below the levels seen at the high points of last year, and falls short of the activity plans set.

The average tariff for elective inpatients discharged in September was £5,658 against a plan of £5,226, which although lower than previous month, is still higher than the start of the year. However, for non-electives, the average tariff was £5,747 against a plan of £6,082. This is roughly in line with where it has been for the early part of the year, although last month was a particular high value.

ACTIONS FOR IMPROVEMENTS / LEARNING

A full activity recovery plan has been developed to clawback activity shortfalls to date. Actions within this plan include:

- Improvement in utilisation linked to new recruits (Spinal, Oncology, Pain Management, Radiology)
- Targeted weekend work for those surgeons with 18 week backlogs
- Revisions to the theatre timetable to make more effectiveness and productive use of planned slots
- Targeted work with key firms to increase in-session utilisation
- Focus on pre-op and theatre booking processes to reduce theatre cancellations
- Development of support from clinical teams to support more effective recycling and sharing of lists.

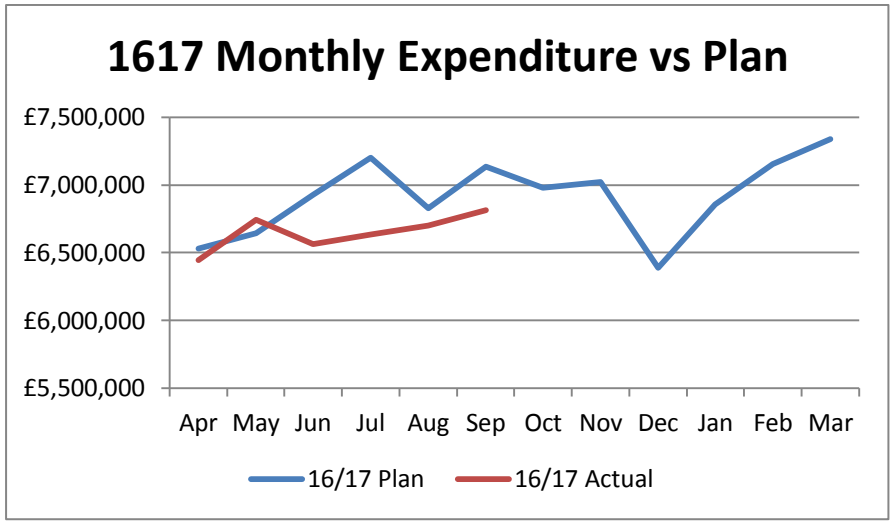
In addition to this a full list of other cost cutting activity is being developed to support the increase in income.

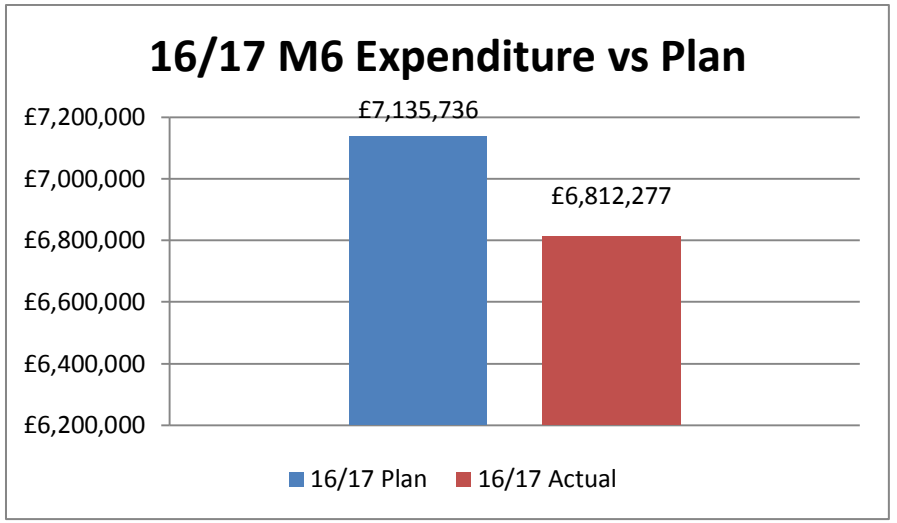
RISKS / ISSUES

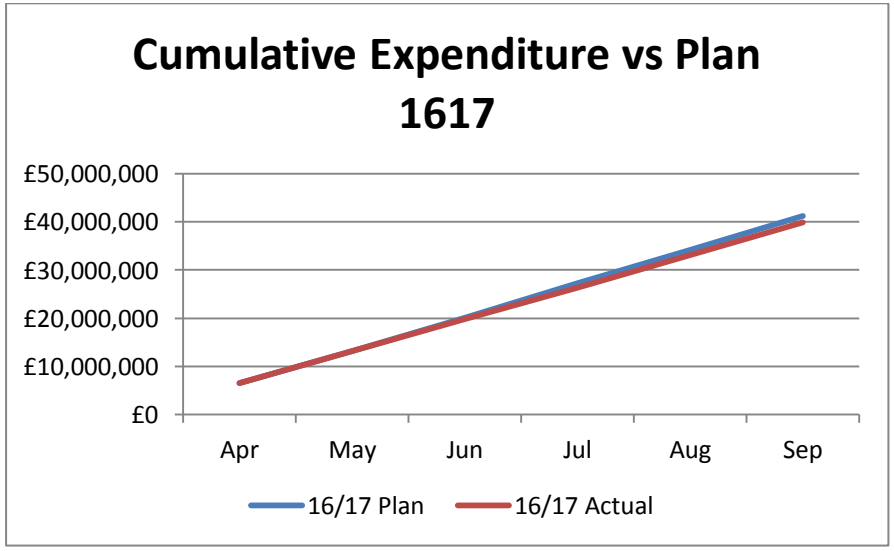
The level of activity required to deliver a full clawback is in excess of the ceiling levels delivered over the last 18 months. There is a major risk that, if enabling actions across other areas of the Trust are not successful, the hospital system will be unable to deliver the range of capacity required to meet planned activity levels.

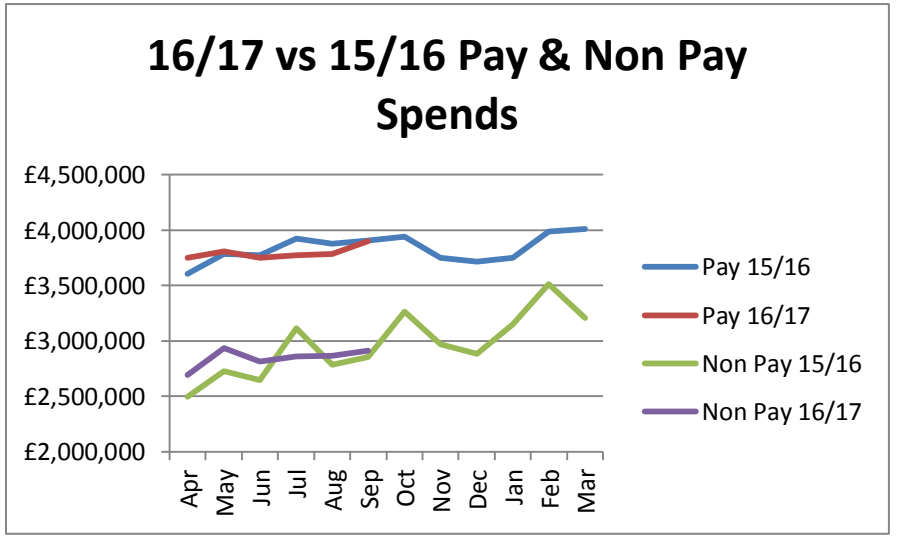
The governance processes around day-to-day challenge of key actions are now in place to attempt to mitigate this risk

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2016/17, compared to historic trends









INFORMATION

Expenditure levels remain reasonably consistent across 2016/17, and continue to deliver below the plan set as the start of the year. For the year to date, expenditure levels are over £1.3m below plan.

Pay increased in month, driven by an increase in substantive, bank and agency spend. The increase in agency spend is described in more detail in section 4.

Non pay remained stable, with only a slight increase. With an increase in activity in month this suggests some of the CIP schemes are reducing spend, although there are significant further actions which are being considered as part of the recovery plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Trust is currently finalising a detailed financial recovery action plan, which will be taken to F&P committee in October. This recovery plan contains individual detailed actions with a named operational and executive lead and will form the basis of recovery tracking moving forwards. The plan covers both increasing activity and additional new measures to reduce cost.

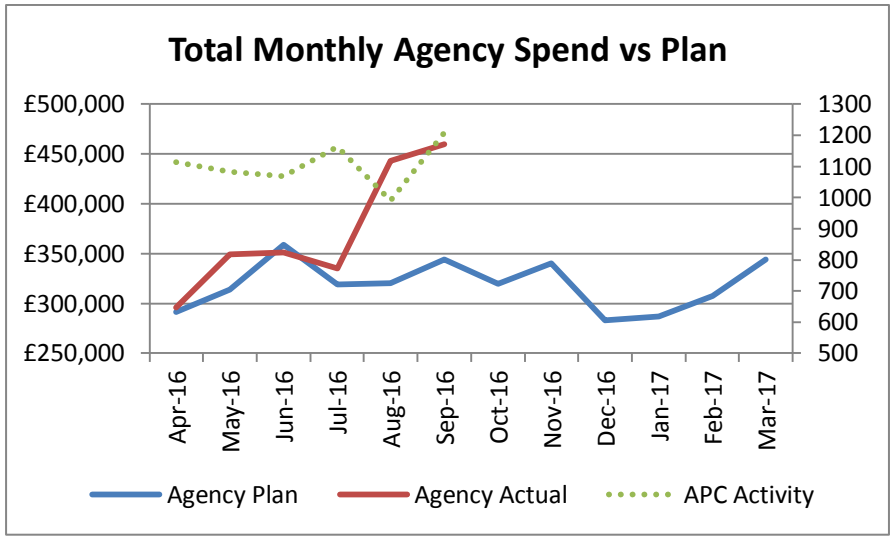
A detailed action plan is in place with regards to agency staffing and overall workforce controls. This is described in section 4.

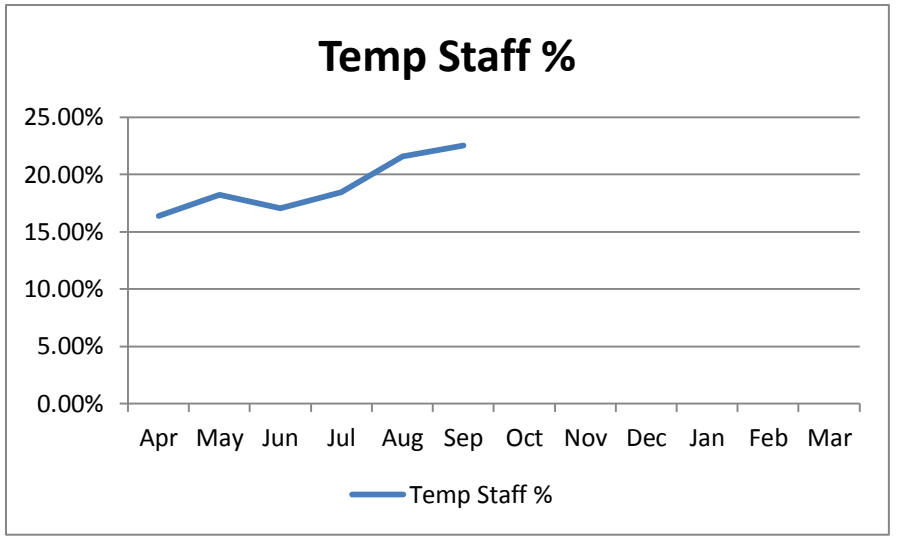
RISKS / ISSUES

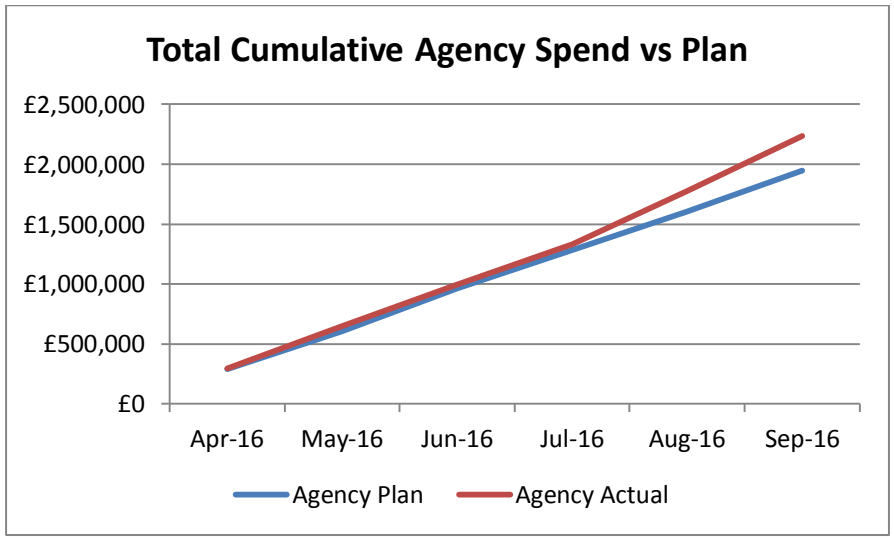
The implementation of recommendations relating to the review into theatre stock control and processes continues, however until full cyclical stock takes are completed, there remains a risk around the robustness of non pay spend within the ledger. The theatres team are moving all prosthesis stock into a new controlled location over the weekend of 15th October as part of the implementation of EDC gold, which will allow greater control over the removal and return of stock, in addition to more frequent cyclical counts.

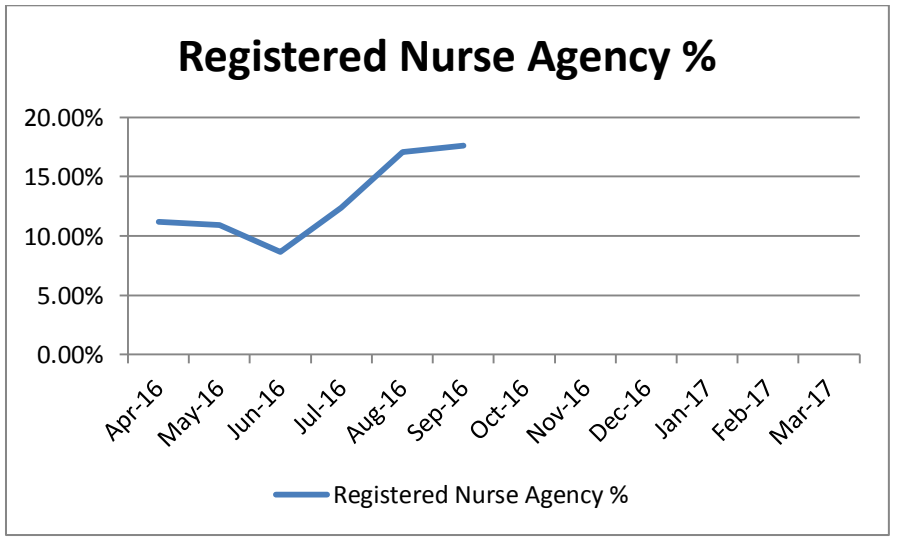
Unplanned pressures in the junior doctor rota are expected to result in a continuation of the overspend against agency trajectories into Q3.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2016/17, and performance against the NHSI agency requirements

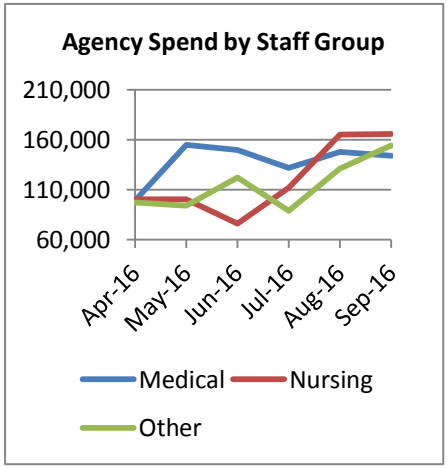






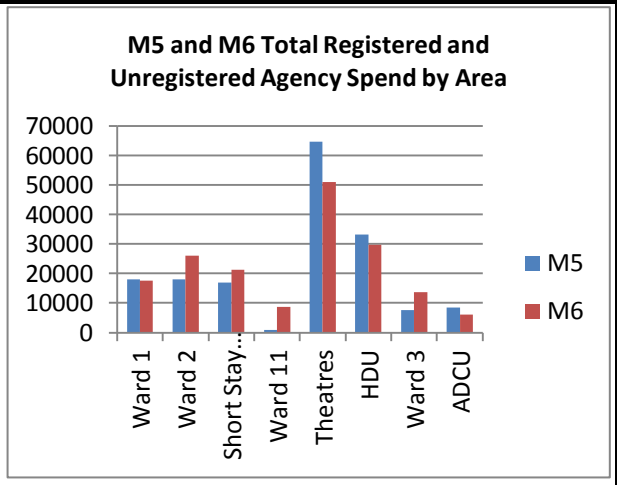


INFORMATION



Whilst August had an exceptionally high agency spend, September has seen an additional increase (£460,000 up from £443,000). This spend is against a plan of £343,000.

Locum spend has remained largely consistent throughout the year and has dropped in month. Other includes a range of staff groups and has increased due to an increase of £18,000 for ODPs and £11,000 for Admin and Clerical & Infrastructure. Nursing spend increased significantly from July despite not tracking a comparative increase in activity, and has increased again slightly in M6. Whilst some improvement has been made in theatres in particular spend has increased on Wards 2, 3 and the short stay ward as shown below.



ACTIONS FOR IMPROVEMENTS / LEARNING

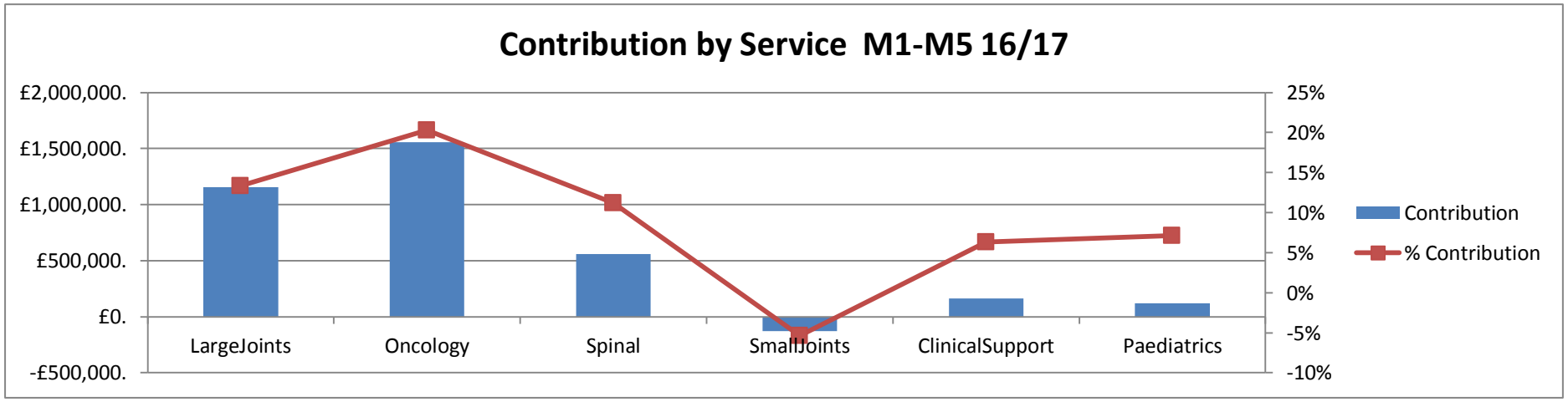
A detailed action plan is in place to address the ongoing trajectory of increased spend. The main actions include:

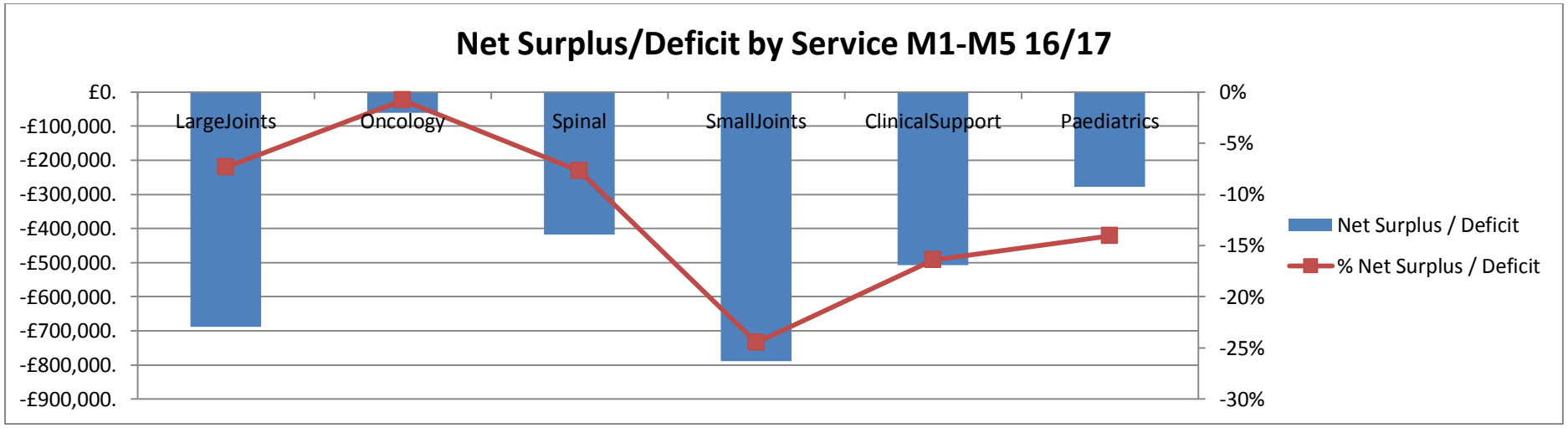
- A re-profiling of expenditure based on known factors
- Enhanced delivery of Healthroster to partially offset variance from plan
- Implementation of the new POAC workforce model from January 2015
- Further review of short term mitigations
- Increasing quantity of substantive clinical workforce
- Improved oversight and governance via the multi-professional agency group, reporting up to Finance and Performance Committee

RISKS / ISSUES

Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is now being built into the Single Oversight Framework from Q3. An overspend against the trajectory will therefore have a direct impact on our regulator ratings.

Service Line Reporting – This represents the profitability of service units, in terms of both consultant and HRG groupings





INFORMATION

The graphs above, and the associated narrative, relate to Months 1-5 of 2016-17.

The first graph is showing the contribution each service is generating, currently the Trust target is set at <20%. Oncology is the only service to have achieved this set target to the end of August 2016. Small Joints is the only service to have provided a negative contribution. This is mainly due to Tariff configuration and service provision.

It can be seen in the second graph that once the finance costs for overheads, depreciation and interest are applied; all service lines are then running at a net loss, this is reflected in the overall Trust position of a £2.74m deficit up to August 2016.

Large Joints is currently the second highest gross loss producing service, due to theatre utilisation, case mix and increased direct costs in relation to HRG tariff funding.

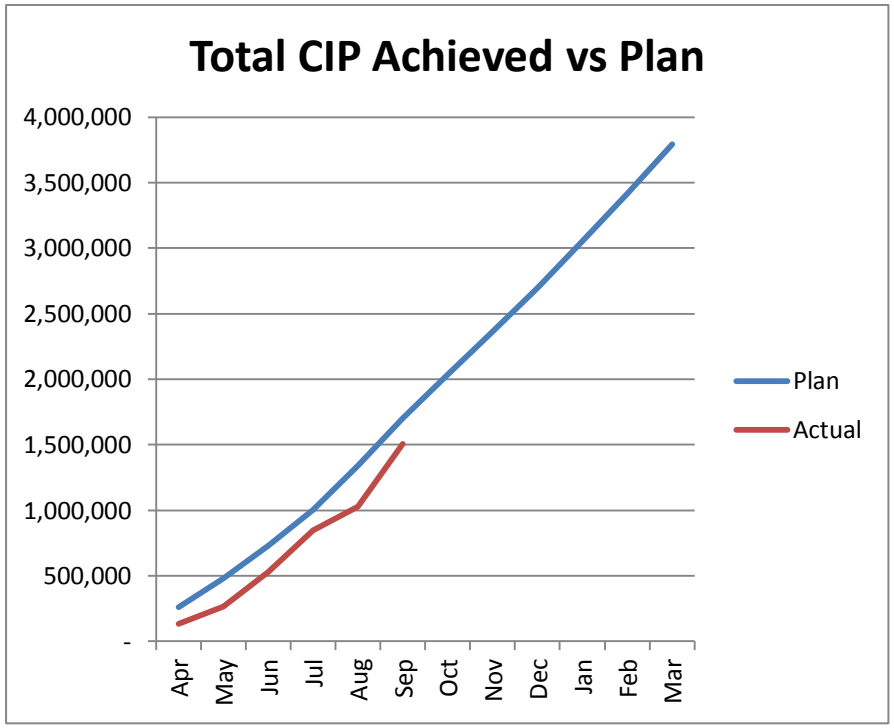
Currently services are being reviewed in terms of session planning for certain operation types to improve theatre utilisation and patient throughput.

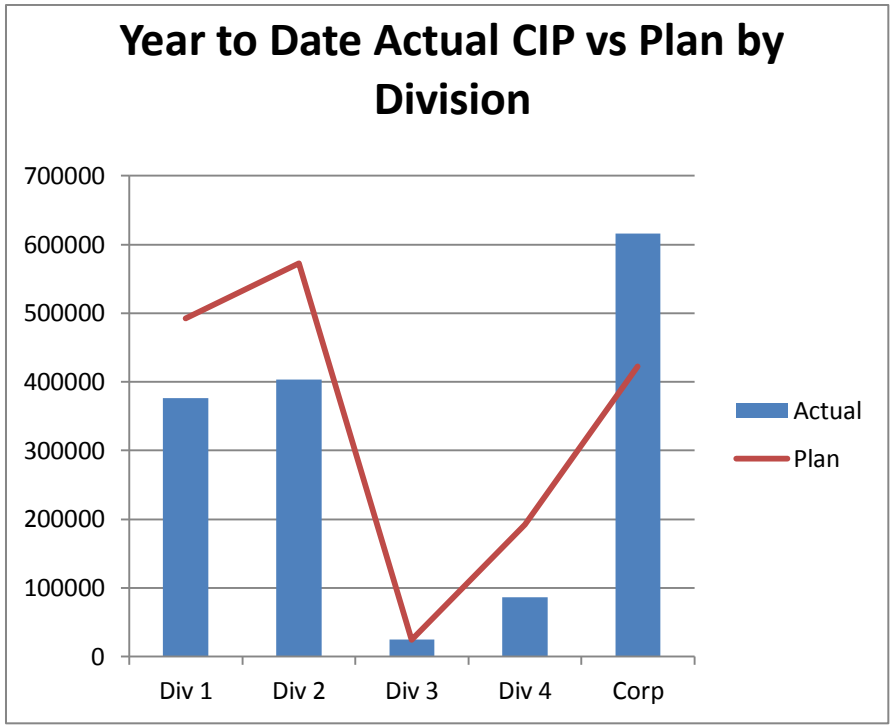
ACTIONS FOR IMPROVEMENTS / LEARNING

It is important that the use of SLR is embedded into the Trust, as this information provides the vehicle to challenge clinical and price variation at all levels. SLR reporting will form part of the divisional reporting moving forwards, and will be challenged at monthly performance meetings.

RISKS / ISSUES

5. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2016/17





INFORMATION

As at the end of Month 6, the Trust has recognised £1,507k of savings, against a plan of £1,578k. £503k (33%) of savings to date are non-recurrent. The in month savings recognised were £480k against a September target of £360k.

With regards to key schemes, the following actions have been taken or are in the process of being taken to deliver savings through the remainder of the financial year:

- The executive team in addition to key operational staff are considering as part of the development of the recovery plan a detailed list of options for further cost saving.
- A staffing model has been agreed by a multi-professional group, and job adverts are being placed, to deliver a revised pre-op workforce model for January 2017. This will enable locum doctors to be removed and support the medical staffing CIP.
- Meetings were held with key implant suppliers on 4th October to gain agreement to costing structure proposed by the Trust. A range of options have been developed following these meetings, which will be presented to the surgical body for agreement on 19th October.
- A revised offer has been received from NHS Supply Chain which also provides an opportunity for implant savings.
- The Trust is developing the scope for a piece of joint work with UHB and HEFT to review prices paid for a range of clinical products.
- Business cases have been approved and recruitment in ongoing to support the transfer of anaesthetic and theatre staffing costs from agency to substantive.

The majority of undelivered CIP schemes are still rated as medium or high risk in terms of likely delivery. Further work is required by CIP leads to ensure that these schemes are delivered, and that additional mitigation schemes are developed to cover any future slippage. Some of this information is described within the financial recovery plan.

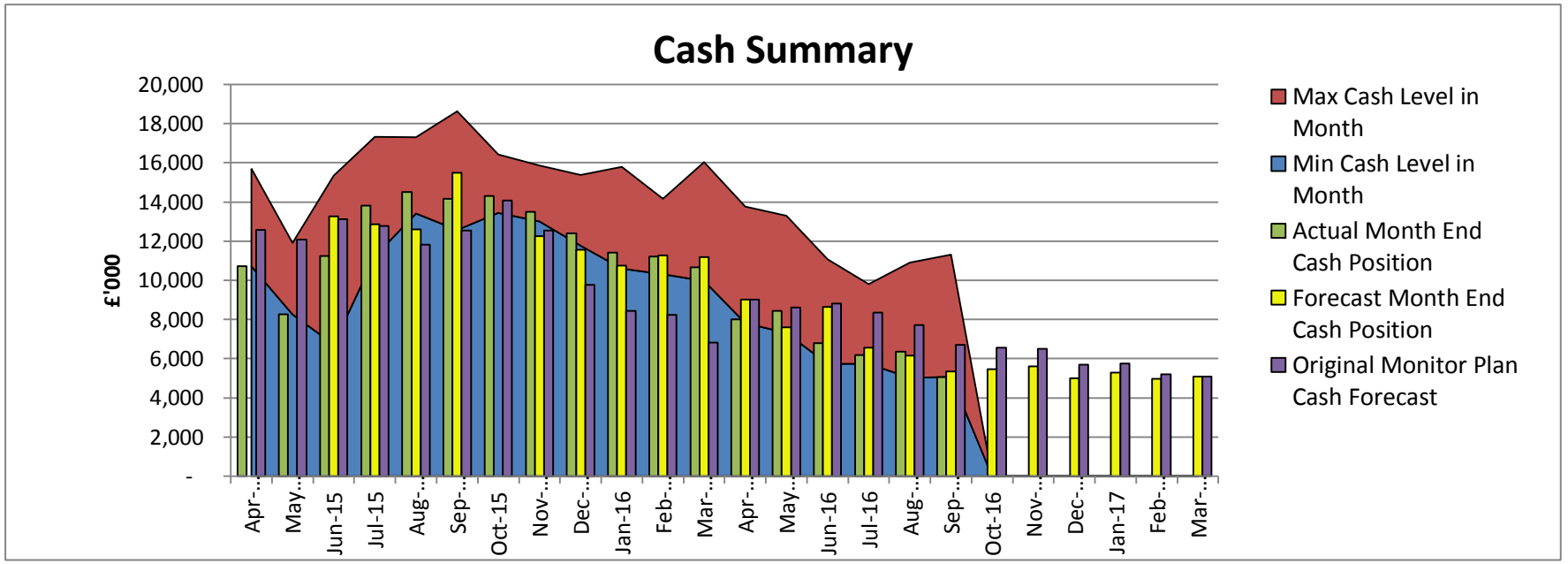
ACTIONS FOR IMPROVEMENTS / LEARNING

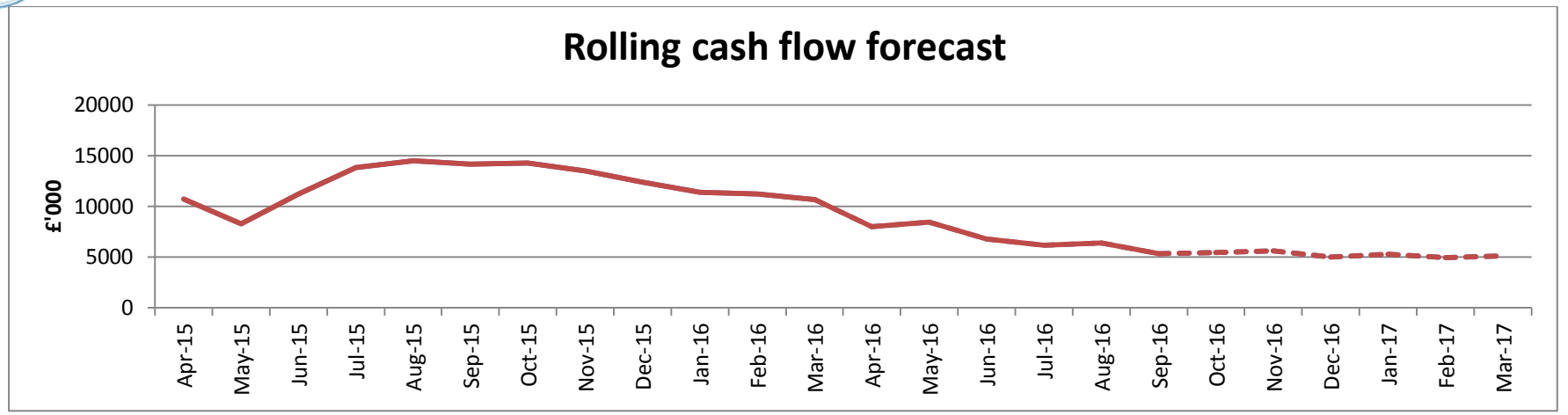
There are still gaps in some areas with regards to the required CIP documentation, largely relating to implementation plans and QIAs. The DDOF is currently working with the Divisional Heads to ensure that these are signed off with the Director of Operations, Nursing and Clinical Governance and the Medical Director as quickly as possible.

RISKS / ISSUES

The CIP target of £3.67m represents a significant challenge to the Trust. It is vital that we remain on target in the early months as it will not be possible to make significant clawbacks against this level of savings target later in the year.

6. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet





INFORMATION

A cash levels are £1.35m million lower than planned levels at the end of September 2016. The Trust is forecasting an end of year cash balance of circa £5m, which relies upon the delivery of our deficit plan and the control of capital spend within the budget that has been set.

The lower than planned cash position is mainly linked to the increased deficit, with some changes in overall working capital levels.

For the first time, liquidity levels within the Use of Resources Rating (previously the Financial Sustainability Risk Rating) have dropped from the highest rating from a 1 to a 2.

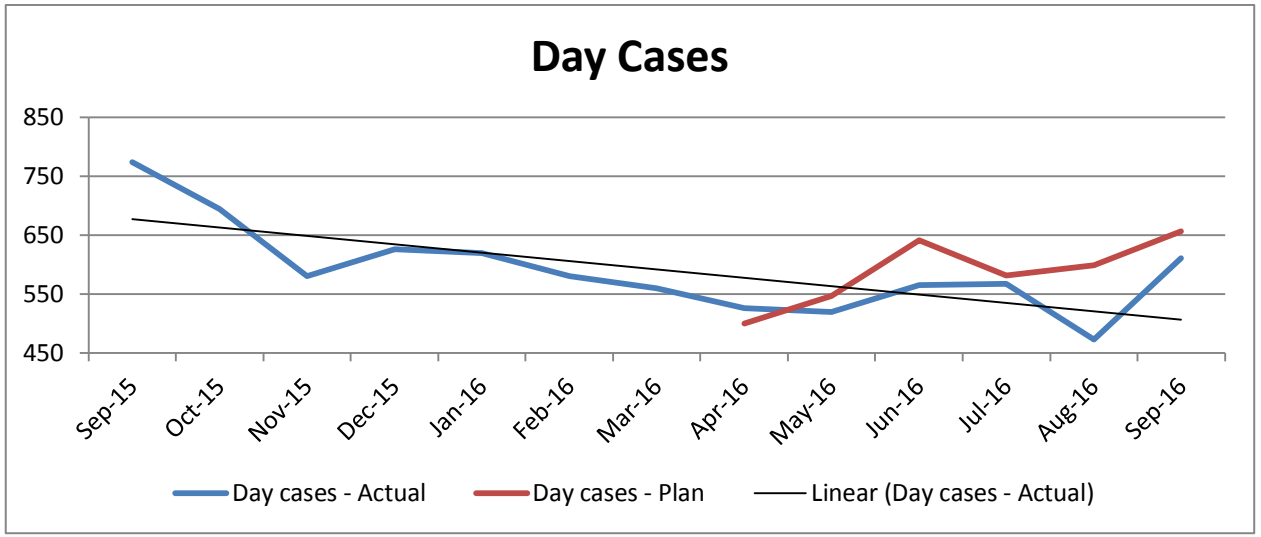
ACTIONS FOR IMPROVEMENTS / LEARNING

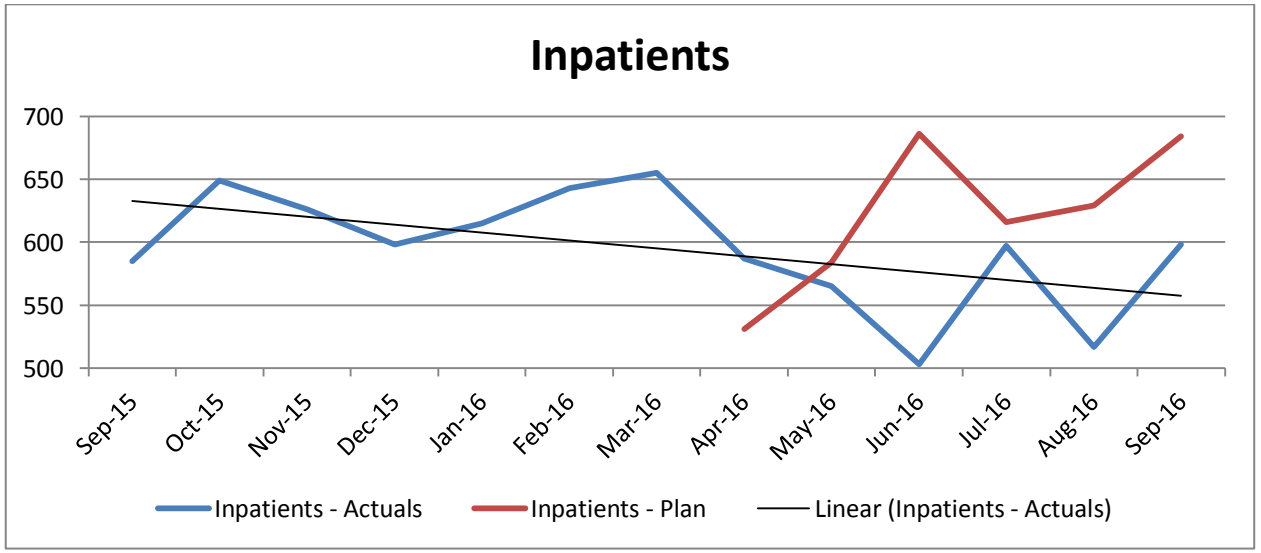
The Financial accounting team are continuing to review opportunities to improve the monitoring and projection of working capital movements, particularly in relation to early warnings around stock purchases and issuing.

RISKS / ISSUES

Given the in-month fluctuation of the cash position, which can potentially hit levels £1m-£2m below month end figures before mandate payments are received, it is vital that financial projections are met to ensure that cash can be comfortably managed within safe tolerances.

7. Activity: Admitted Patient Care – This illustrates the number of inpatient and day case discharges in the month, and year to date





INFORMATION

The activity levels for both day case and inpatient activity were significantly below the profiled plan for June due to the theatres being closed for one week in June.

Whilst there was some recovery during July, getting towards the profiled plan, there was again a dip in August related to surgeon annual leave (where the opportunity was taken to undertake further maintenance work in three of the theatres.) There are signs of recovery in September and in to October, with activity in some weeks at around 300 cases. However, this remains below the profiled plan, and does not recover any of the slippage from prior months.

ACTIONS FOR IMPROVEMENTS / LEARNING

Work continues as part of the "6,4,2" planning process to achieve optimal utilisation of lists, to backfill lists that would otherwise be unused due to surgeon leave, to understand the reasons when patients DNA or cancel, to improve pre-operative assessment processes and robust list order / lock down process. This is not incorporated in to the overall Activity Recovery Plan (ARP.)

Longer term, there is work as part of team service objectives linked to the 2016-17 job planning round to achieve improved list uptake, in order to deliver the planned level of activity as it is profiled through the year, and to recover the slippage.

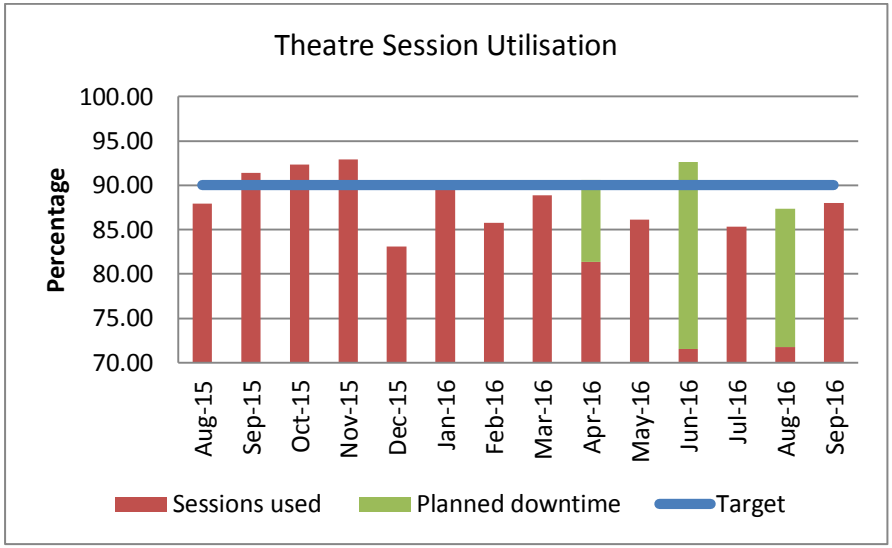
Significant engagement work is required across the clinical body and wider workforce to appreciate the scale of the challenge that is now facing the Trust to deliver the activity and associated income each week, in order to deliver the Trust's agreed financial control total.

RISKS / ISSUES

Key risks are the willingness of speciality teams to recycle lists, and to put more patients on lists. There are challenges as part of the Trust's decentralised model of administration to ensure the lists are populated sufficiently well in advance to maximise utilisation, and with getting sufficient volumes of patients through pre operative assessment in a timely manner. There may be a need for clinical engagement in list pooling for both operating and out patients, given that some consultants have very short waiting lists, and this could compound the issue of under utilisation of our clinic and theatre fixed resources.

Finally, assuming that activity does increase, there will be a significant pressure on beds, which will require renewed vigour and engagement in reducing length of stay.

8. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Local auditing data in Theatres has established that 90.5% of timetabled lists either go ahead with the planned surgeon or are recycled and used by another surgeon, meaning that 9.5% of lists are fallow (based on the period April – August 2016, excluding the week of 6th June.). It is therefore assumed that there are some glitches in the theatre session utilisation graph supplied. A new reporting suite will be available when the new Theatre Management System (Theatreman) is in place from December 2016.

ACTIONS FOR IMPROVEMENTS / LEARNING

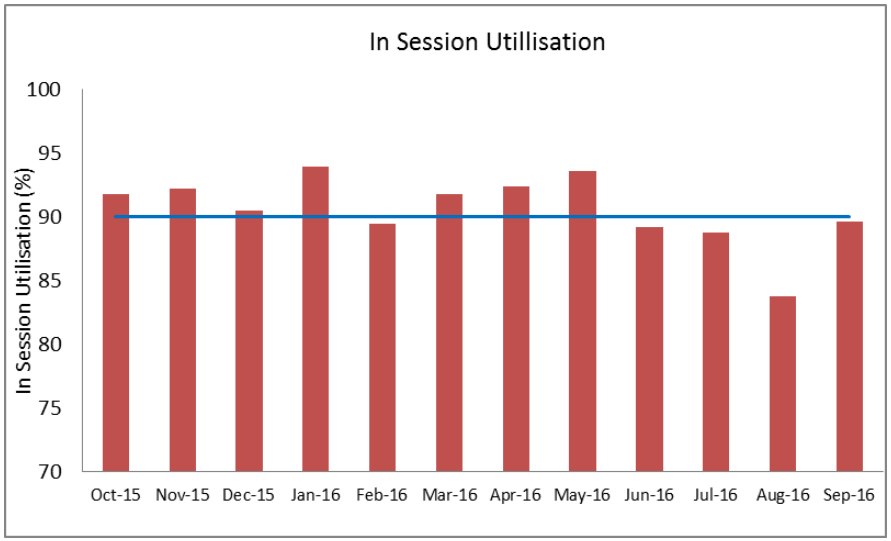
Due to annual leave / study leave, we should typically expect surgeons to cover a 42 week year. Timetables are currently based on a 52 week year. Discussions take place proactively as part of the "6,4,2" process to ensure that other surgeons pick up lists that would otherwise be fallow. A more robust approach to job planning to build in buddy arrangements and prospective cover, as well as recruitment to specialities where there are vacancies or that are under pressure from an activity / RTT / 52 week perspective, will improve this position.

In the meantime, there is a process to take down outpatient clinics to provide surgeons to recycle theatre lists, where it is practical to do so for the speciality concerned. We are now starting to see the benefits in Oncology and Spinal of the additional consultant recruitment.

RISKS / ISSUES

Engagement in the job planning process and delivery of timescales. Notice required to establish buddying timetable arrangements and co-ordination of leave evenly through the year. The job planning cycle is mearing completion as at beginning October, following some delays, and this is a new way of working for ROH which will require some adjustment.

9. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



Add graph showing theatre in-session usage by month – may need to wait for Theatreman for this

INFORMATION

Utilisation against this measure had remained consistently above the target 90% until May 2016. However, the previous measure was flawed in that it included the overrun minutes in the numerator, against the planned time available in the denominator. From June, this has been amended to follow national best practice (The Productive Operating Theatre) with overrun minutes not included, so as not to skew performance to look better than it is in reality.

A realistic target against this measure is 85%. After poor in session utilisation during August which appears to have been related to complex casemix, in session utilisation has returned to a good level during September. Late starts and early finishes continue to be monitored daily, and focus is now shifting to gaps between cases (though 20 minutes between cases is required for cleaning and air changes for all cases requiring ultraclean air, and the evidence is that turnaround rarely exceeds this.)

ACTIONS FOR IMPROVEMENTS / LEARNING

There are a range of actions being undertaken to ensure continual improvement in theatre in session utilisation, focussing on start time, turnaround, optimal list composition and the eradication of unplanned overruns.

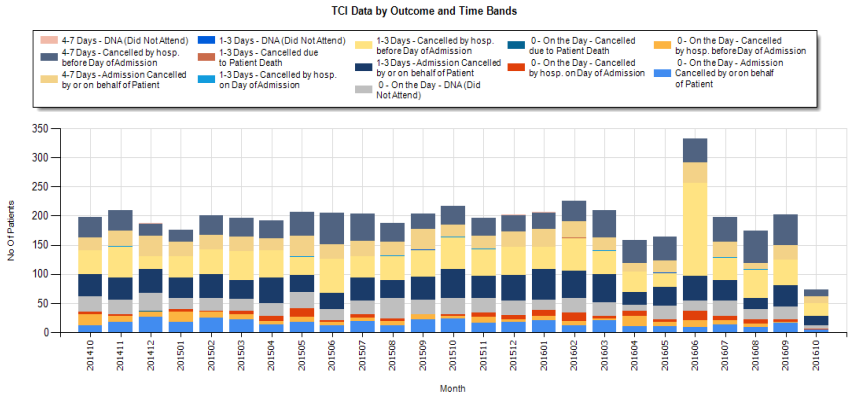
The implementation of the new Theatre Management System (Theatreman) planned for December 2016 will be a further vehicle to ensure that lists are optimally booked based on the available time.

RISKS / ISSUES

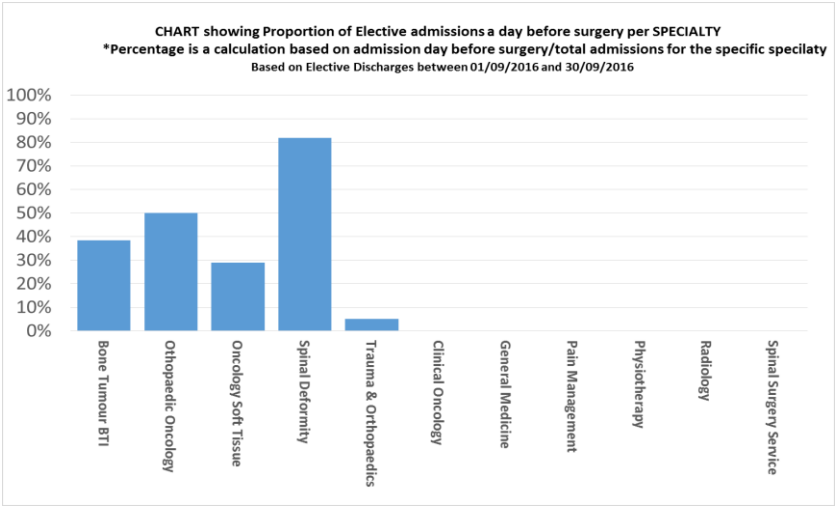
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (eg experience in spinal scrub) to ensure the best possible use of available operating time. Equipment issues (for example, limited microscopes) can impact on list efficiency. Ongoing issues with availability of sufficient radiographers to support theatre work (recruitment underway) and with the responsiveness of the offsite Sterile Services Department.

10. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

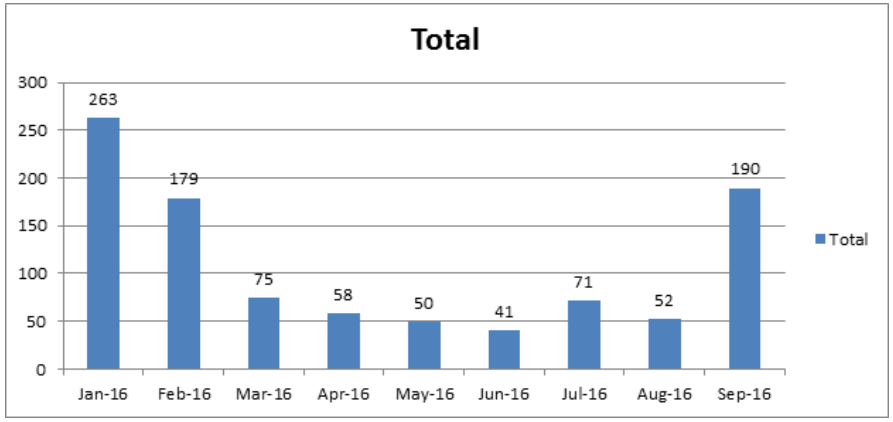
Cancellations by patient / hospital



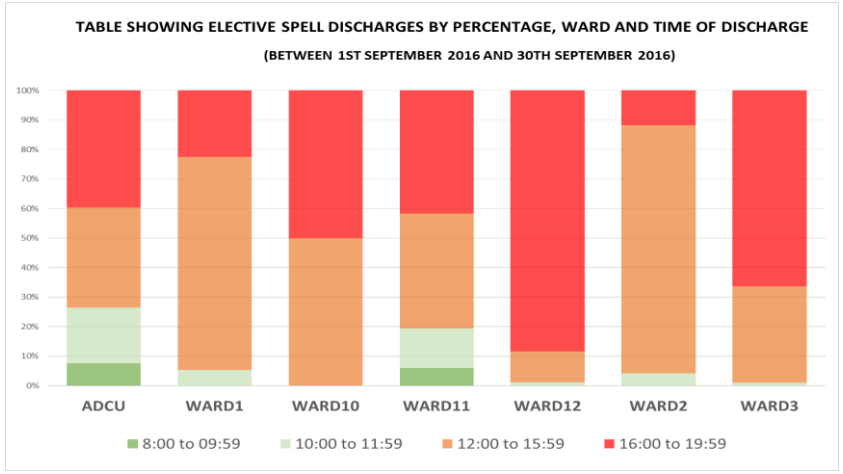
Admission the day before surgery



Delays out of recovery



Time of day patients discharged



INFORMATION

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. There is some root cause analysis work that is ongoing, linked to the daily operational huddles, about the effectiveness of the pre-operative assessment process, and adherence to the Trust Consent Policy. Both of these areas are likely to be leading to cancellations (both patient reason because patients do not feel adequately prepared for surgery, and hospital reason where co-morbidities have not been considered sufficiently well in advance to be able to safely proceed.) It is not clear whether the 72 hour reminder call is assisting in the reduction of patient cancellations, and it is recommended that further work is done on setting our expectations with patients at the time they are listed for surgery. Work is ongoing to understand whether there are any specific specialties/consultants where this occurs more frequently, to be able to focus action.

The Oncology team and spinal deformity team continue to admit large numbers of patients the day before surgery, and not make use of the pre-operative assessment service. It is disappointing that the Trust still has very few patients discharged before midday, which must be addressed as activity increases.

The delay in patients leaving Recovery after they are deemed suitable for transfer is an indication of pressures in ward bed availability and staffing allocation as the activity recovery plan (ARP) has been put in to place. The renewed focus on length of stay, pro-active management of estimated date of discharge (EDD), the "home before lunch" concept, admission on day of surgery, more rigour in the management of complex discharge and delayed transfers of care (DTOCs) and increased utilisation of the discharge lounge will all assist towards ensuring sufficient beds of the right gender on the right base ward to support timely transfer back from Recovery, even at a time when activity is planned to increase.

Whilst mixed sex accommodation "breaches" trigger at 4 hours for external monitoring, internally the Trust is working to a maximum 1 hour standard. This is to support the patient being cared for in the correct environment and to support their early mobilisation following surgery, and crucially to enable good flow through theatres by ensuring the a recovery bay is immediately available to support all 10 theatres in preventing list over runs and cancellations, and to maximise theatre utilisation as per the ARP.

In previous months, where Recovery staffing allowed, the team were delivering patients back to the wards when the ward teams were unable to support a patient's transfer in a timely way. This principle has been discussed, and it has been agreed that the Recovery staffing model does not support this, that ward staffing numbers should enable the teams to collect patients from Recovery, that from a clinical perspective handover is best performed in Recovery, and that from an infection control perspective the Recovery staff cannot leave the theatre suite in "blues" to deliver patients to the wards. This is likely to explain the dip in performance as compared to prior months, and a further issue cited has been availability of porters to support transfer, which is under investigation.

ACTIONS FOR IMPROVEMENTS / LEARNING

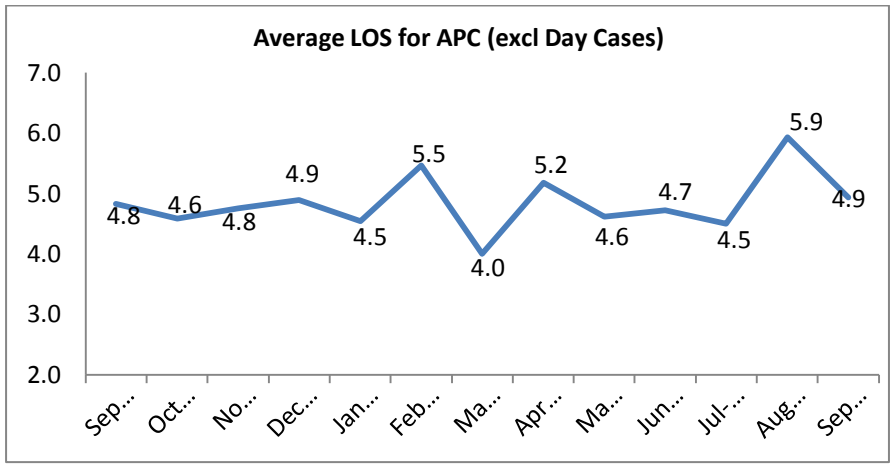
Continued work is required to ensure that all specialties have a pool of patients who are pre-op'd and available to be called in at short notice to fill cancellation slots. The concept of pooling of appropriate patients between consultants also needs to be undertaken to maximise efficiency.

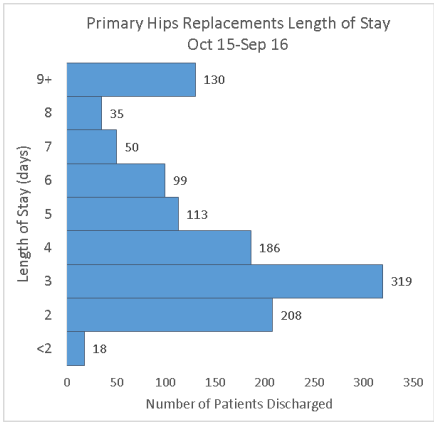
Work is required to agree with clinical teams to use pre-operative assessment in a consistent way, to list patients with sufficient notice, and to admit patients on the day of surgery as the norm. As activity increases in line with the commissioned profile, it is important that these issues are addressed so that bed availability does not become a constraint to delivery.

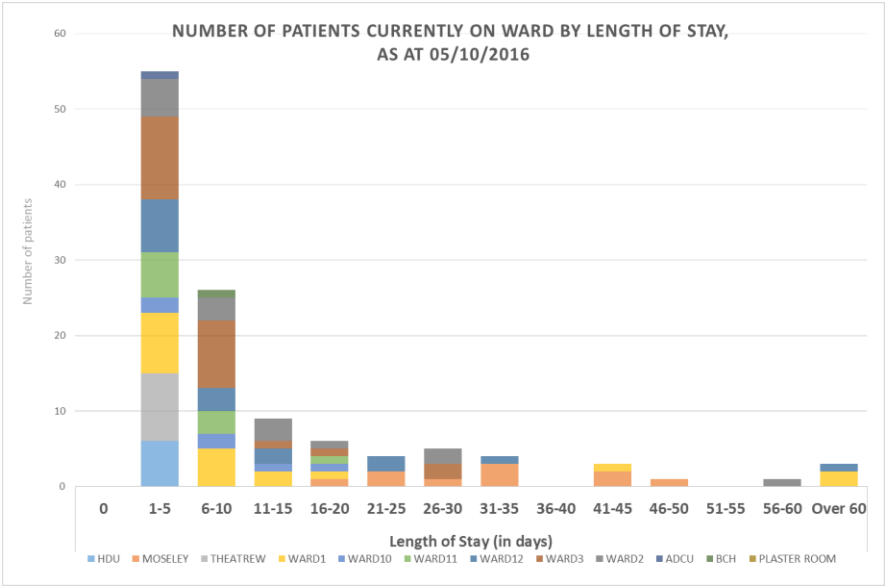
RISKS / ISSUES

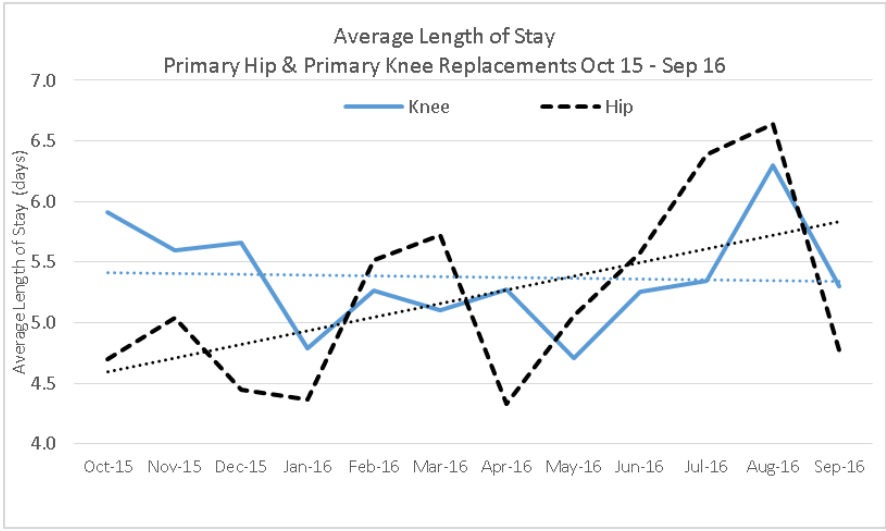
As activity increases in line with the profiled plan, and to deliver the catch-up work, it will become increasingly difficult to sustain admission before the day of surgery, and it is necessary to achieve a higher level of discharges before midday to ensure goof flow through the hospital and avoid increased numbers of cancelled patients.

11. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways









INFORMATION

Length of stay of spiked in August and has reduced slightly in September. It is understood that this was a combination of several long stay patients being discharged in month, together with limited availability of senior decision makers. Length of stay remains above where it needs to be to enable the increase in activity through Quarters 3 and 4.

ACTIONS FOR IMPROVEMENTS / LEARNING

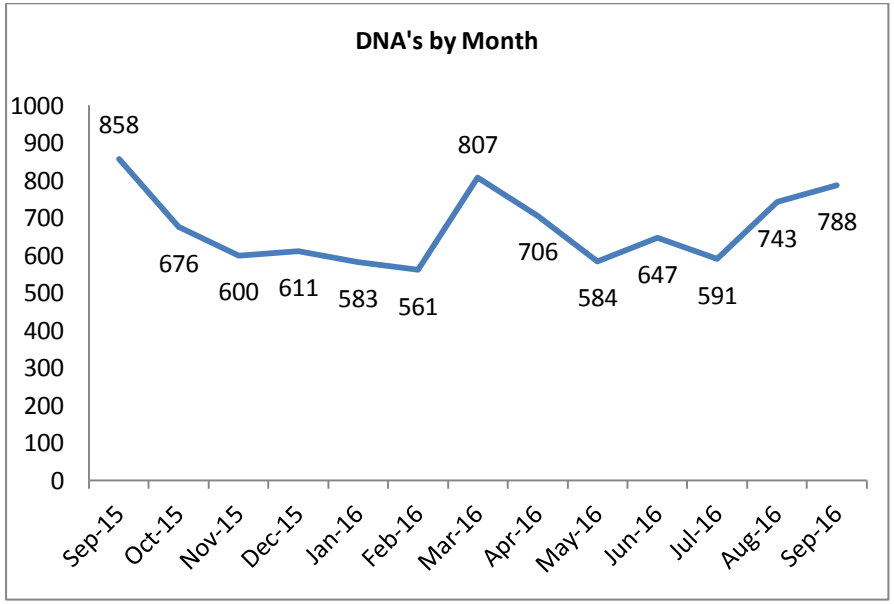
Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.

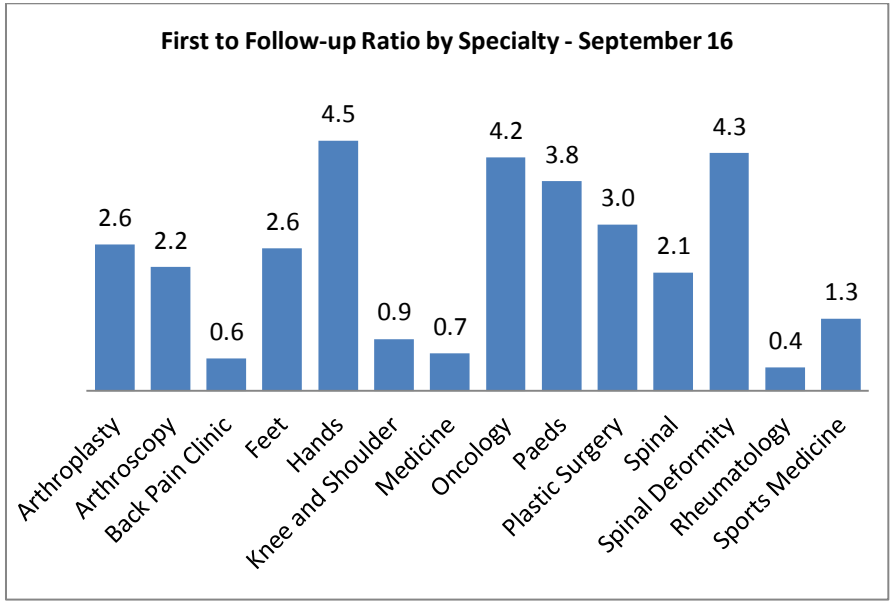
More formalised ward reviews should be part of consultant job planning discussions, which will be helpful in speeding up decision making and therefore shaving days off individual patient length of stay, or bringing discharge earlier in the day so that the bed can be recycled for incoming patients.

RISKS / ISSUES

With a defined bed stock, these changes need to happen at pace in order to deliver the Activity Recovery Plan.

12. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients





Graph showing average waiting time in outpatients by month under development

Graph showing under / overbooking of clinic by specialty under development

INFORMATION

Outpatient DNAs remain stubbornly high. The first to follow up ratios at consultant level remain variable, relating to individual clinical practice. Work on clinic templates is underway, but has been slowed by absence of key administrative staff. A new Trust Access Policy will be presented at October TMC.

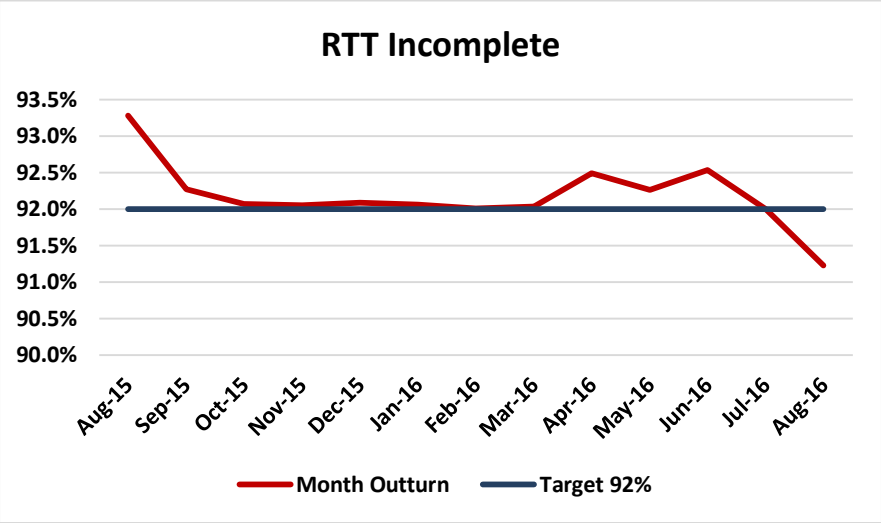
ACTIONS FOR IMPROVEMENTS / LEARNING

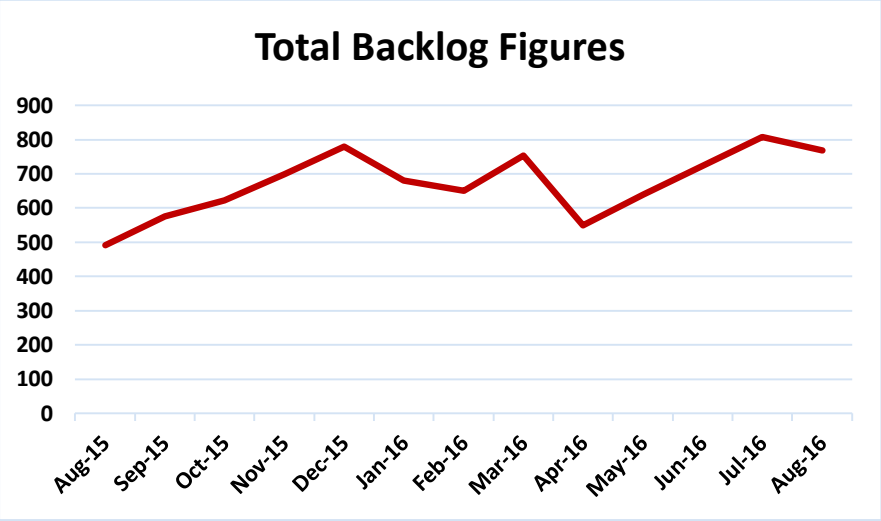
In Touch has started to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

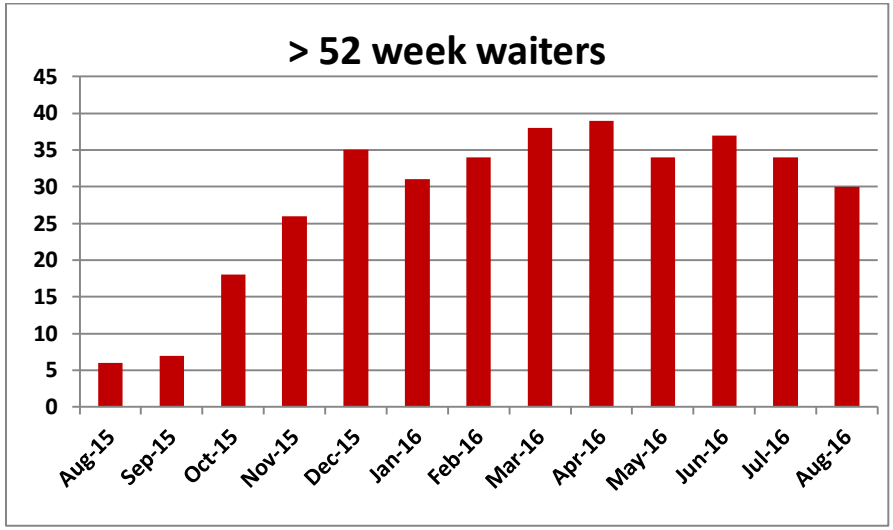
RISKS / ISSUES

Clinical engagement in the redesign of patient pathways.

13. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets	Target / Trajectory	Actual (September)	Actual (YTD)
52 week waiters	0	32	32
18 week RTT	92%	TBC	TBC
Cancer (2 week wait)	93%	100%	100%
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	97.87%
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	96.23%
Cancer (62 days)	85%	100%	N/A

INFORMATION

The 52 week wait position is steady but has not reduced.

The Trust failed the 92% incomplete pathways < 18 weeks target in August (91.3%) and it is unlikely we will achieve the target in September. Reasons for the Trust failing are:

1. Admitted backlog growth between April and September 2016 by 17.5%
2. Non admitted backlog growth between April and September 2016 by 7.7%

Admitted – key areas showing a rise in backlog are arthroscopy and paediatrics: impact of reduced clinic capacity during strike action specifically affected these services resulting in rescheduled appointments and delays in patient pathways and cancellation of procedures during week of 8th June.

Non admitted – Pain: consultant vacancies significantly reduced capacity over the last few months; this will resolve from November onwards as new appointment commence allowing for increases in capacity again. Feet: demand v capacity particularly in relation to new appointment capacity and Hands: demand v capacity in relation to new appointment capacity.

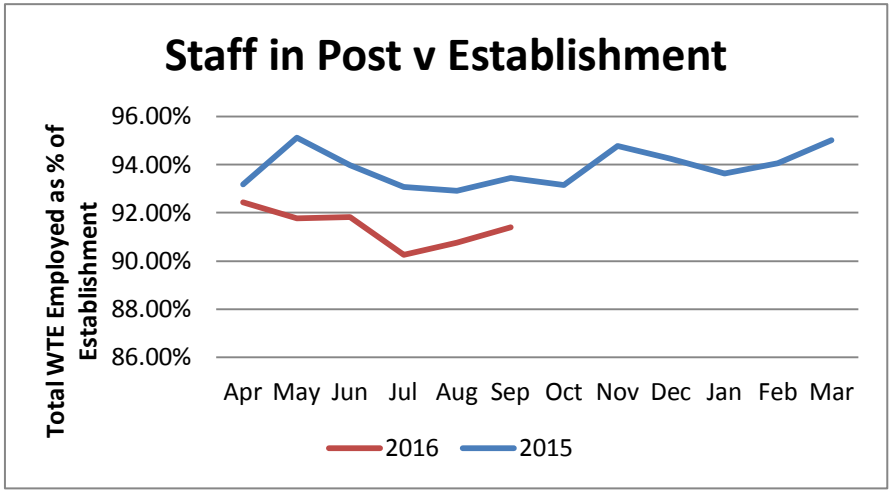
ACTIONS FOR IMPROVEMENTS / LEARNING

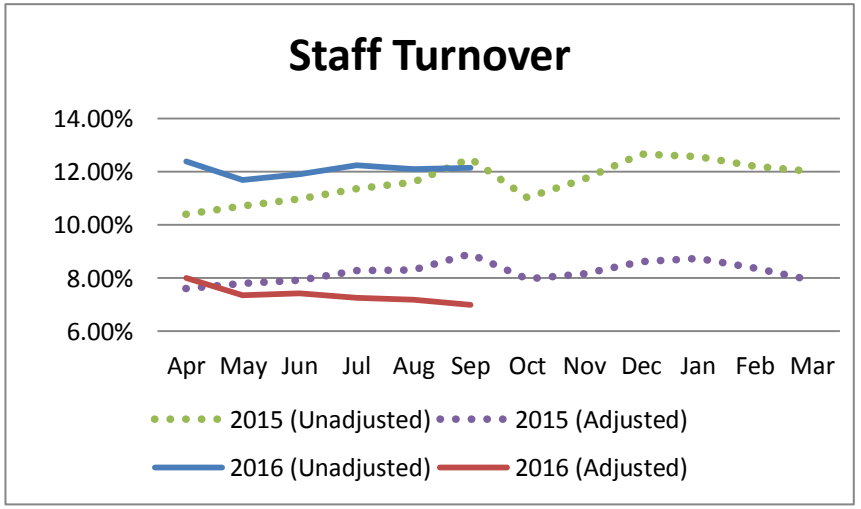
Effective use of additional operating lists at BCH, with potential requirement to treat further 52 weeks breaches in an alternative setting.

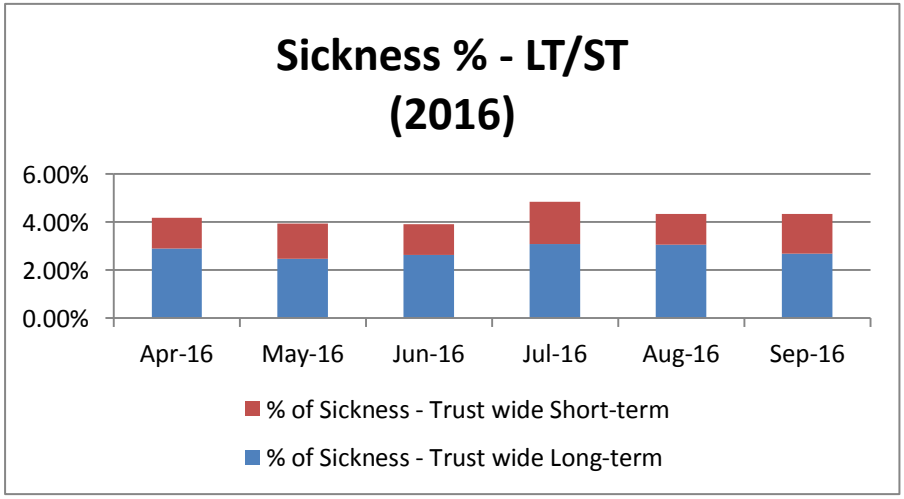
RISKS / ISSUES

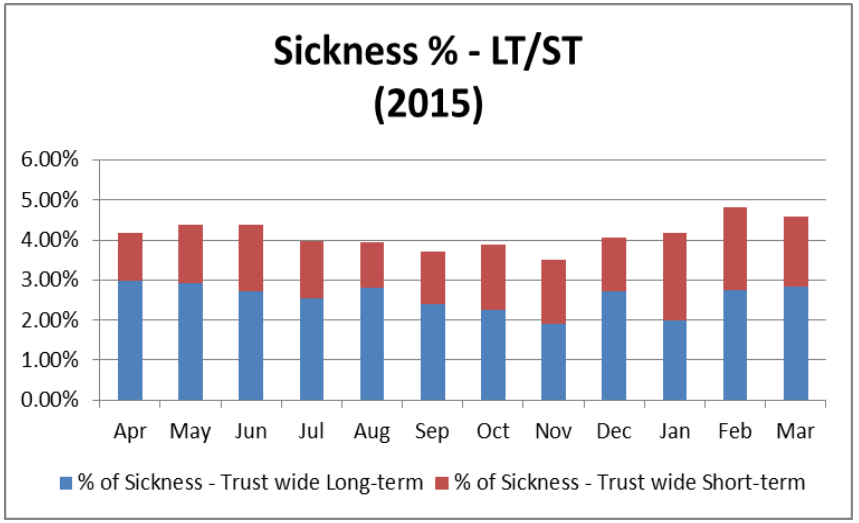
Spinal deformity remains a risk with regard to overall Trust performance, and discussions continue with BCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the 52 week wait position. There is a risk that the amnesty with regard to fines is only for the 2016-17 financial year, and that this regime could resume from April 2017.

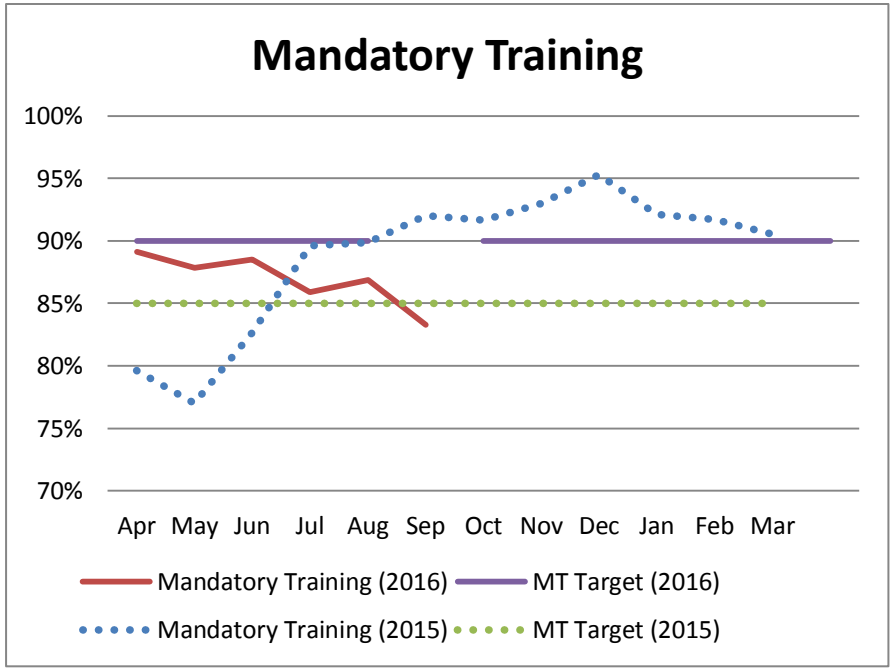
14. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training.

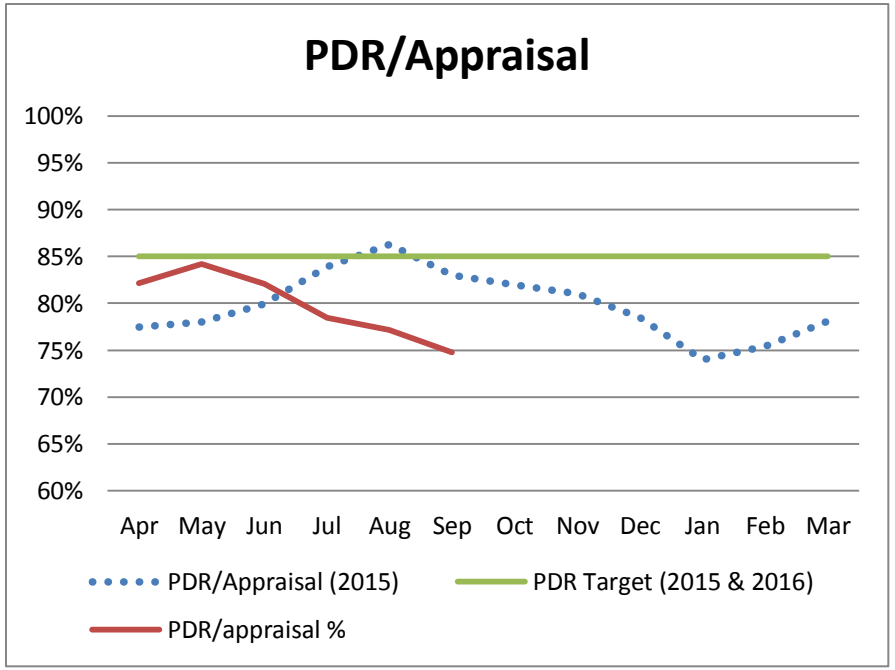









Mandatory Training
100%
95%
90%
85%
80%
75%
70%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
Mandatory Training (2016)
MT Target (2016)
Mandatory Training (2015)
MT Target (2015)


PDR/Appraisal
100%
95%
90%
85%
80%
75%
70%
65%
60%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
PDR/Appraisal (2015)
PDR Target (2015 & 2016)
PDR/appraisal %

INFORMATION
INFORMATION

September has seen a slight improvement in the vacancy position. Sickness absence and turnover headline figures remained almost identical to last month's reported figure, but mandatory training and PDR/appraisals have both decreased versus the August outturn figures.

Sickness absence is amber this month, with the (anticipated) decrease in long term absence being offset in month by a corresponding increase in short term related absence. The underlying 12 month figure is also amber, and is likely to remain amber during the winter months, even though the percentage itself may increase. This is because the winter months last year saw unusually low levels of sickness, and it is not clear whether this will manifest itself in 2016/17.

The vacancy position from the ledger has improved for the third consecutive month. This gap is expected to continue to close in the coming months as new clinical posts in particular are filled, although vacancy panels continue to meet to review all non-clinical posts which are proposed for recruitment.

The headline turnover figure (all leavers except doctors and retire/ returners) was almost identical to August's position, and the adjusted turnover figure ("true leavers") was lower than August.

The mandatory training position has decreased again this month by 4% but remains amber overall. Divisions have been asked for trajectories to improve performance; these have now been provided. Divisional Boards will track their performance against their trajectories, and divisional performance reviews will focus on these two areas in particular in October.

The appraisal position also decreased by a further 2% and remains red this month. Divisions will be invited to submit appraisal trajectories during the month of October to give assurance.

ACTIONS FOR IMPROVEMENTS / LEARNING

HR Managers will focus on appraisal and mandatory training performance with their respective Divisional Boards in October, and the HR section of divisional performance reviews will focus on these two areas in particular in October.

RISKS / ISSUES

There is now a high likelihood of a compliance notice from our commissioners in relation to statutory and mandatory training and appraisal.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	26 October 2016
Guests	Sarah Mimmack – Infection Control Lead Evelyn O'Kane – Safeguarding Lead Stacey Keegan – Matron Chris Warrilow – Senior Information Analyst
Presentations received	Dementia strategy
Major agenda items discussed	• Theatres closure: Infection control report • Upward report from the Infection Control Committee • Upward report from Clinical Quality Committee • Upward report from the Safeguarding Committee • Update on the Knowledge Hub • Dementia strategy update • Scrutiny of nurse staffing incidents • Progress with the delivery against the quality indicators • Quality & Patient Safety report • Never Events (wrong side implant and wrong side incision): Root Cause Analyses • Mortality update • Lessons learned update • Internal audit into compliance with Regulation 20: Duty of Candour • Corporate Risk Register • Divisional governance update
Matters presented for information or noting	• Royal College of Paediatrics & Child Health action plan progress report • CQC action plan progress report
Matters of concern, gaps in assurance or key risks to escalate to the Board	• It was highlighted that the Director of Research had stepped down from this position and a further update was requested at the next meeting on the plans for Research & Development • A detailed report was received in connection with the Surgical Site Infections that had caused the closure of theatres in June; two of the seven patients remained under the care of the Trust. The chance of reoccurrence was discussed, however it was highlighted that it was difficult to provide assurance that this would not be repeated given the pattern of infections over recent years. Nonetheless, the Committee was advised that cleaning practice in

	theatres was now more rigorous and there had been a significant reduction in any infections reported. The more rigorous application of the 'red line' policy was also noted. • The discussion widened into the Trust's obligations around cleanliness as per the contract with the CCG, where it was reported that the Trust was currently reporting on a more stringent set of indicators than most other trusts, however the move to the 'Credit for Cleaning' would be progressed shortly. Assurance was provided that the Head of Nursing and the Infection Control Lead were working together to ensure that the Trust performed well against cleanliness standards and the requirements of the hygiene code. • It was reported that complaints relating to Division 1 and particularly nursing care had increased • NICE guidance on diabetes was currently being reviewed, which may have wide implications and need to be referred upwards to the Board • The complexity of handling safeguarding alerts across local authority and other organisational boundaries was highlighted • A risk around non-compliance with learning disabilities national standards was highlighted; this would be discussed at the next meeting • As part of considering the Patient Safety & Quality report, the Committee was advised that there had been 268 incidents reported during the month, 5 of which had generated moderate harm; there had been a dip in the Safety Thermometer results during September and a single patient had experienced two harms under the care of the Trust. A rise in VTEs was noted to be concerning. There had been 13 inpatient falls during the month and two Grade 2 pressure ulcers reported. There had been 23 complaints during the month. • The Root Cause Analyses (RCAs) associated with the two Never Events (wrong side implant and wrong side incision): were reviewed, both of which concluded that these were due to human error. • The internal audit into Duty of candour compliance was noted to provide 'reasonable assurance'. Closure of actions would be considered at the December meeting. • The Committee was advised as part of the divisional governance update that the key concerns across the organisation were around high turnover of staff and vacancies in key posts in Division 1; challenges with the delivery of additional activity in Quarters 3 & 4; deterioration in the performance against the 18 weeks referral to treatment time target; inadequate medical records storage; and an inability to honour the 28 day

	guarantee to offer an alternative date for treatment in the event that the Trust cancelled an operation. • The balance of operations and nursing responsibilities under Mr Marsh would be discussed early in the New Year. • In terms of progress with the RCPCH action plan, the Committee was advised that the remained a challenge around the recruitment of Paediatric nurses; finalising the Service Level Agreement and amending the PEWS charts due to copyright restrictions.
Positive assurances and highlights of note for the Board	• The Committee noted that the Trust had acted in an appropriate and speedy manner once the results of the investigations into the Surgical Site Infections in theatres in June had been received, with there being good clinical engagement. • The Committee was advised that nearly 500 'flu vaccinations had been completed to date, which was a marked improvement on previous years. • There had been an improved in the rate of Safeguarding training, with this now being included within the mandatory training suite • The Committee was informed that there had been an improvement with the Trust's Patient Reported Outcome Measures (PROMs) scores, particularly the knee score. The position compared to other local and peer providers was good. The use of the Vanguard was cited as being useful to help the trust benchmark itself and set standards. • Good progress was noted in terms of the Trust's understanding of and accommodation of patients with dementia. The development of a dementia strategy would address a number of concerns expressed by the CQC, including the need for multi-disciplinary attention to dementia. Personal thanks were directed to Matron Keegan for her work overseeing this area. • Good progress was noted in relation to the commitments made in terms of mortality, including the production of a dedicated report and undertaking a benchmarking exercise. The challenges with identifying all deaths occurring within 30 days were discussed. It was noted that the Trust was not an outlier in terms of its mortality position. • The Committee was provided with a short video showing how lessons learned from incidents (in this case a pressure ulcer) could be cascaded to the organisation. It was suggested that the tool could be used interactively to stimulate learning. • The CCG representative advised that a recent unannounced visit to Ward 3 had evidenced that the measures being taken to prevent pressure damage that

	the Committee had been appraised of at the last meeting were in place and were working well.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• An update on the plans for R & D to be given at the next meeting • Triangulation exercise to link staffing levels to performance against quality indicators is to be undertaken • Safeguarding lead to think through what might constitute a 'near miss' in Safeguarding terms • An update on the plans to mitigate the risks around blood fridges and blood management is to be presented at the next meeting. • Drugs & Therapeutics Committee update to be deferred to the November meeting • Within the quality report, the following were requested for inclusion in the next iteration: o Analysis of which staff groups report incidents o Update on changes to bathroom facilities to prevent falls o Water starvation audit results • Report into progress with quality indicators to be provided for the next meeting • Update on closure of the actions arising from the Duty of candour audit to be considered at the December meeting • Discussion about the balance of Mr Marsh's operations and nursing portfolio to be included on the agenda of the January meeting • It was suggested that consideration of whether the treatment given to patients was in the interests of the patient should be undertaken
Decisions made	• The Committee approved its annual report and onward submission to the Trust Board on 2 November 2016

Kathryn Sallah
NON EXECUTIVE DIRECTOR AND CHAIR OF QUALITY & SAFETY COMMITTEE

For the meeting of the Trust Board scheduled for 2 November 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ANNUAL REPORT 2015/16

1.0 Introduction

1.1 The purpose of the report is to formally report to the Board of Directors on the work of the Quality & Safety Committee during 2015/16 and update the Board on its work to date in 2016/17.

1.2 The Quality & Safety Committee reviewed its Terms of Reference in November 2015, which were received and approved by the Board of Directors in December 2015. One of the key changes to the Terms of Reference was a change in name from Clinical Governance Committee to Quality & Safety Committee, to better reflect the remit of the Committee.

1.3 During the year, the Chair of the Quality & Safety Committee was Kathryn Sallah. Mrs Sallah is a member of the Trust's Audit Committee and routinely reports on the work of the Quality & Safety Committee at each meeting.

2.0 Meetings

2.1 During 2015/16 the Quality & Safety Committee met on eleven formal occasions and a workshop was also held in June 2015.

2.2 The attendance at these meetings is as below:

DIRECTOR	DATE											TOTAL
	15/4/15	13/5/15	10/6/15	8/7/15	11/9/15	14/10/15	13/11/15	9/12/15	27/1/16	24/2/16	30/3/16	
Kathryn Sallah (Ch) #2 #4	A	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	**9/11**
Frances Kirkham (Ch)#1	✓	✓	A	✓	✓	A	✓	✓	✓	A	✓	**8/11**
Tauny Southwood#3 #7	✓	A	✓	✓	A	A	A	✓	✓	✓	✓	**7/11**
Elizabeth Chignell#5	A											**1/11**
Jo Chambers	✓	A	✓	✓	A	✓	A	✓	A	✓	✓	**7/11**
Andy Pearson	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	**10/11**
Garry Marsh#6	A	✓	✓	✓	A	✓	✓	✓	A	✓	✓	**8/11**
Jonathan Lofthouse				A	A	A	A	✓	A	A	✓	**2/8**

Although not formal members the following Non-Executive Directors and Directors attended as follows:												
Yve Buckland	✓		✓	✓		✓		✓				
Rod Anthony		✓	✓	✓	✓				✓			
Tim Pile				✓		✓	✓					

KEY:

✓	Attended	#3	Meeting Chair June 2015
A	Apologies tendered	#4	Assumed Chair of Committee from July 2015
	Not in post or not required to attend	#5	Resigned 23/4/15
#1	Meeting Chair April 2015	#6	Interim Director of Nursing and Governance until 7/15
#2	Meeting Chair May 2015	#7	Meeting Chair March 2016

2.3 Meetings are also attended routinely by a representative from the Trust's lead Clinical Commissioning Group (CCG) and by a public governor.

2.4 The Secretariat to the Committee is the Associate Director of Governance & Company Secretary.

2.5 The Quality & Safety Committee's minutes are submitted to the Board of Directors for consideration as part of the private Board sessions, supported by a full assurance report in public, detailing the key points of discussions, risks noted & matters to escalate and decisions taken by the Committee.

3.0 Work undertaken 2015/16

The Committee dealt with the following key matters:

Routine Work

The Committee received upward reports from the Trust's Clinical Governance Committees, namely:

- Clinical Quality Committee
- Drugs & Therapeutics Committee
- Safeguarding Committee
- Infection Control Committee
- Safeguarding Committee
- Research & Development Committee

In year the process for systematising the upward reporting was strengthened, including a routine cycle for the Committee leads to attend the Quality & Safety Committee and the introduction of a standard template to ensure that reports upwards were consistent in content.

The following policies, guidelines & Patient Group Directions were approved by the Quality & safety Committee (in its mode of operation as Clinical Governance Committee):

- Clinical record keeping

- Transitional Care policy
- Treatment of severe local anaesthetic toxicity procedure
- Administration of tetracaine 4% gel PGD
- Viral haemorrhagic fever policy
- Bed rails policy

In year, the route for policy approval was simplified, such that all policies to be approved by the Chief Executive were considered by the Trust Management Committee (established from October 2015) who made a recommendation to the Chief Executive as to whether she should approve it using her delegated authority from the Board to do so.

The Committee during the year has received routine update reports on:

- Quality & Patient Safety report
- CQC action plan progress
- The evolving clinical governance structure
- Litigation (subsequently subsumed into the Quality & Patient safety report)
- Complaints (including Annual complaints) report
- Annual infection prevention & control report
- Annual safeguarding report
- Clinical audit development
- Policy governance
- Divisional governance development
- Never Events assurance action plan progress
- Corporate performance report
- Progress against Quality Improvement Priorities
- Patient Related Outcome Measures (PROMS), particularly focussing on the need to improve the scores that placed the Trust as an outlier compared to peer organisations
- Mortality
- Controlled Drugs Accountable Officer report
- Patient stories

Single issue or non-routine reports

During the year, the Committee received some specific reports providing assurance on particular key issues, these being:

- Quality Governance Framework position statement
- Serious Incident contract performance notice and action plan
- Pre-operative starvation, focussing on the improvement needed to improve the position to one more in line with national guidance
- Controlled Drugs (subsumed later into a routine update from Drugs & Therapeutics Committee)
- Medical equipment maintenance and training
- Compliance with Duty of Candour regulations
- National inpatient survey results

- Adherence to the consent policy
- Update on the launch of the Knowledge Hub
- Quality Account 2015/16 – process and suggested priorities
- Audit of compliance with Duty of Candour process

Workshop

The Committee held a workshop in June, which was primarily focussed on the following key topics and objectives:

- The role of the Committee, particularly in terms of its operational vs. assurance oversight
- Membership and attendance
- Bodies reporting up into the Committee
- Clinical engagement in governance, including learning & innovation through clinical governance
- Clinical Audit
- Clinical governance strategy & action plan
- Committee processes and administration

Some key actions arose from the workshop, which have been progressed during the year, these being most notably:

- Review alternative models for the role of the Committee, considering operation in organisations elsewhere
- Revising the terms of reference to clarify the membership which as to be three Non Executives, plus the Chief Executive, Medical Director, Director of Nursing & Clinical Governance and Director of Operations. Those in attendance would be the Deputy Director of Nursing & Clinical Governance, the Governance Manager and the Associate Director of Governance & Company Secretary who would administer the meeting. The terms of reference were approved at the meeting of the Trust Board in December 2015 and adopted by the Committee at its meeting in January 2016.
- Focus papers to the meeting on assurance rather than operational detail
- Realign the meetings of the Clinical Governance committees to those of the Committee to enable effective reporting
- Ensure that the Clinical Governance committees have an assigned chair and meet on a routine basis
- Refresh the workplan of the Committee
- Strengthen the administration regime to support the Committee
- Clarify responsibilities for implementing NICE guidance
- Arrange for the Clinical Audit plan to be presented to the Committee

4.0 2016/17 Work Plan

4.1 For 2016/17, the Quality & Safety Committee continues with its routine work as well dealing with ad hoc requirements that will emerge from time to time or remitted

from the Board and/or Audit Committee. Of particular emphasis for 2016/17 was the measures to be taken to prevent pressure ulcers and further development of the clinical audit function.

4.2 There will remain a focus on improving the effectiveness of the Committee during 2016/17, with particular focus on seeking appropriate assurance on matters within its remit, understanding how lessons learned from incidents, complaints, litigation and clinical audit are disseminated & acted upon and strengthening the upward reporting from the Trust's Clinical Governance committees.

5.0 Quality & Safety Committee Effectiveness

5.1 An item is included on the agenda of each meeting to review the effectiveness of the meeting and of the Committee in general. As a result of these discussions, a number of suggestions were made to the operation of the Committee:

- Given the breadth of the agenda the time slot for the meetings was extended
- Greater operational input to the meeting was needed and hence in the absence of the Director of Operations, a Divisional General Manager was required to attend
- If there were matters that required detailed debate, the agenda was constructed such that sufficient time was allowed for the item to be fully considered
- Meeting papers needed to be issued as far in advance of the meeting as possible

6.0 Conclusion

6.1 The Quality & Safety Committee has been fully overhauled during 2015/16 and is now operating effectively, providing adequate assurance upwards to the Trust Board across a comprehensive range of matters of a quality & patient safety nature.

Kathryn Sallah
Chair of Quality & Safety Committee

October 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	7 October 2016
Guests	Audit teams from RSM (Internal Audit) and Deloitte (External Audit) were in attendance at the meetings. A private pre meeting of Audit Committee members, including external and internal audit was held prior to the main meeting
Major agenda items discussed	• Internal Audit progress report • External Audit Planning Report 2016-17 • Counterfraud update • Recommendation trackers • Losses and compensation register • Breaches and waivers of SFIs • Review of Hospitality Register and Review of Declarations of Interest • Annual Audit Committee Report • Review of Effectiveness of Audit Services • Board Assurance Framework • Quality & Safety Committee feedback
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The Theatre Stock internal audit report had an opinion of 'No Assurance'. There would be a focus at the December Audit Committee meeting on following up on this report. Clear ownership by the Operations team would be required and staff would be invited to attend the meeting to provide assurance concerning implementation of the recommendations of the audit report. Deloitte would be looking for some form of interim testing and if they participated in the stocktake this year and there was a formal close down to carry out a proper stock count this would provide confidence. • Advisory Review of the End to End Patient Pathway 18 week Referral to Treatment (RTT). Following this review, Internal Audit had produced an action plan covering 53 management actions. Nine were 'high' priority and 34 'medium priority'. Delivery of 18 week RTT posed a significant risk to the Trust and it was important that the Trust did not mis-state RTT performance. The role of Audit Committee was to understand process and obtain assurance that the recommendations contained in the

	Action Plan were being implemented in the correct manner together with a clear timetable. The appropriate staff would be invited to attend the next Audit Committee to provide an update. • The Controlled Drugs review had provided 'Reasonable Assurance' that improvements had been made. This report would be considered by the Quality and Safety Committee. • The Pharmacy Stock review had provided a 'Reasonable Assurance' opinion and identified three 'medium priority and six low priority management actions which needed to be implemented to ensure pharmacy stock management processes were strengthened. • External Audit Planning report 2016/17. The Senior Partner in Deloitte cautioned that failure by the Trust to achieve planned CIPs would impact on the Trust's ability to reach its planned deficit position. The deterioration in financial performance was impacting on the Trust's cash position. This represented a major challenge for the Trust. When he had met with the Chair this had been highlighted as an area of particular concern. The Board would need to focus closely on this in terms of its 'Going Concern' declaration at year end. The Trust would need to work closely with the external auditors on controls and testing in particular in terms of RTT. Should there continue to be concerns surrounding the RTT process this could potentially be an area of qualification. • **On the basis that the professional fees that Deloitte expected to charge during the period from 1 April to 31 March were reasonable the schedule of fees would be recommended to the Board (see attached appendix).** • Recommendation Trackers would be an agenda item at the December Audit Committee. The Director of Finance would ensure a comprehensive update was provided at that meeting. Key areas would be prioritised and the appropriate staff invited to that meeting to discuss progress in addressing all outstanding Audit Committee recommendations. • Losses and compensation payments made since the Committee had last met were discussed • Breaches and waivers of SFIs were reviewed. During the period there had been slightly fewer single tenders. • Audit Committee questioned whether there should be more clarity on the BAF surrounding cash flow and its link to the capital programme to provide certainty that every pound of capital expenditure was linked to mitigating risks. • The Chairman of the Quality & Safety Committee provided feedback to the Audit Committee on the work of that

	committee. The importance of demonstrating the clear linkage between the two committees was reiterated.
Positive assurances and highlights of note for the Board	• Internal Audit's review of Duty of Candour provided the Trust with an opinion of 'Reasonable Assurance'. The Trust had demonstrated an open and transparent culture when things went wrong. There had been a large amount of focus on Duty of Candour and there was clear ownership by the Governance Manager. This report would be on the Agenda for the October meeting of the Quality & Safety Committee. • Good progress had been against the counter fraud work plan. Payslip messages had been arranged for September 2016 to highlight that key payroll and personal identifiers might be shared with auditing bodies for use in preventing or detecting fraud along with contact details of LCFS. • The LCFS Annual Report provided a summary against NHS Protect's antifraud standards. An operational fraud risk assessment had been undertaken which had resulted in the strengthening of controls across areas deemed to be at an exposed risk of fraud. The Self Review tool had been signed off by the Director of Finance with an amber rating. • The Committee reviewed the Hospitality Register and Declarations of Interest. It was pleasing to note there had been a major improvement in the recording of declarations of interest and hospitality. It was recognised that it was important to reaffirm to senior staff that this was a Trust requirement. The Director of Finance would discuss with the Director of Human Resources whether something needed to be included in the appraisal process to provide greater clarity surrounding what would and would not be viewed as a conflict. Key individuals should not make any declaration which was an anomaly. • The Audit Committee Annual Report was presented to the meeting • Each year Audit Committee needed to provide assurance surrounding the effectiveness of audit services. This year Internal Audit had carried out some really useful pieces of work by undertaking audits targeted at specific areas of concern. As these audits had been carried out early in the year good headway had been made against the annual audit plan which allowed time for improvements to be demonstrated ahead of preparing the Annual Governance Statement. Deloitte recognised the external audit process for the previous year had been particularly challenging. The Trust had a relatively lean financial team which at times particularly in terms of temporary staffing changes had challenged the resilience of the team. Looking ahead the Finance team would face more pinch points including

	the STP; 2 year contract negotiations and CIPs and the Trust would need to keep this under review. Internal and external audit were helping the ROH to navigate through difficult issues in what were challenging times. • In terms of effectiveness, the meeting had provided a clear focus on key issues.

Rod Anthony
NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Trust Board scheduled 2 November 2016

Appendix D- Independence and fees

As part of our obligations under International Standards on Auditing (UK and Ireland) , the Listing Rules and the Companies Act, we are required to report to you on the matters listed below:

Independence confirmation	We confirm we and, where applicable, all Deloitte network firms are independent of the Trust and will reconfirm our independence and objectivity to the Audit Committee for the year ending 31 March 2016 in our final report to the Audit Committee.
Fees	Details of audit and non-audit service fees proposed for the period are shown below.
Non-audit services	In our opinion there are no inconsistencies between APB Ethical Standards for Auditors and the company's policy for the supply of non-audit services or any apparent breach of that policy. We continue to review our independence and ensure that appropriate safeguards are in place including, but not limited to, the rotation of senior partners and professional staff and the involvement of additional partners and professional staff to carry out reviews of the work performed and to otherwise advise as necessary.

As part of our obligations under International Standards on Auditing (UK and Ireland) and the APB's Ethical Standards we are required to report to you on all relationships (including the provision of non-audit services) between us and the audited entity. We do not currently have any non-audit relationships with the Trust.

The professional fees expected to be charged by Deloitte in the period from 1 April 2016 to 31 March 2017 are as follows:

	2016/17 £	2015/16 £
Financial statement audit	39,000	39,000
Targeted audit work*	3,000 – 6,000	10,000
Estates specialist input	-	4,000
Audit/Independent Examination of Charitable fund	4,000	4,000
Procedures in respect of the Trust's quality accounts	15,000	15,000
Total audit fee	**61,000 – 64,000**	**72,000**
Other Non-audit services	-	-
Total non-audit fee	**-**	**-**
Total fees	**61,000 – 64,000**	**72,000**

* Targeted audit work in 2016/17 is expected to relate to our work on financial sustainability and going concern. Further details are set on pages 10 and 14.

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The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ANNUAL REPORT 2015/16

1.0 Introduction

1.1 The purpose of the report is to formally report to the Board of Directors on the work of the Audit Committee during 2015/16 and indicate its work plan for the financial year 2016/17.

1.2 The report ensures that that Trust conforms to best practice as recommended in the NHS Audit Committee Handbook (DH, 2005) and the Audit Committee Handbook (HM Treasury, 2007).

1.3 The Audit Committee reviewed its Terms of Reference in November 2015, which were then presented for final sign off at the meeting in February 2016. These were received and approved by the Board of Directors in April 2016.

1.4 During the year, the Chair of the Audit Committee was Rod Anthony.

2.0 Meetings

2.1 During 2015/16 the Audit Committee met on five formal occasions and a workshop was also held in October 2015.

2.2 The attendance at these meetings is as below:

DIRECTOR	TOTAL					TOTAL
	21/4/15	26/5/15	17/9/15	24/11/15	26/2/16	
Rod Anthony (Ch)	✓	✓	✓	✓	✓	**5/5**
Tim Pile	✓	✓	✓	✓	✓	**5/5**
Kathryn Sallah	A	✓	✓	✓	✓	**4/5**
Although not formal members the following Non-Executive Directors and Directors attended as follows:						
Yve Buckland		✓			✓	
Paul Athey	✓	✓	✓	✓	✓	
Jo Chambers		✓			✓	
Garry Marsh					✓	

KEY:

✓	Attended	A	Apologies tendered

2.3 Meetings are also attended routinely by representatives from the Trust's provider of External Audit and Internal Audit (to include Counterfraud) services. During the year the Director of Nursing & Clinical Governance and the Head of Facilities joined the meeting to provide updates to the Committee on progress with actions arising from some Internal Audit reviews that had provided limited or no assurance.

2.4 Prior to each meeting, the auditors meet in private with the members of the Audit Committee to discuss any matters or raise concerns where required, without any members of the Executive Team or guests present.

2.5 The Audit Committee's minutes are submitted to the Board of Directors for consideration as part of the private Board sessions, supported by a full assurance report in public, detailing the key points of discussions, matters to escalate and decisions taken by the Committee.

3.0 Work undertaken 2015/16

The Committee dealt with the following key matters:

Routine Work

The Committee

- Reviewed and approved the Annual Report and Accounts for 2014/15, together with the Quality Account, Commentary, Head of Internal Audits report and Annual Governance Statement (and other disclosures) contained within.
- Received the 2014/15 Audit report from the External Auditors.
- Approved the submission of the self-assessment and reference costing return to the DoH as compliant with the relevant guidance.
- Increased the focus on clearing outstanding audit recommendations, resulting in a review of all outstanding recommendations and an improvement in the performance of the Trust. This dipped towards the end on the year however, prompting renewed scrutiny
- Considered further and developed the relationship between Audit Committee and Quality & Safety Committee, strengthening in particular the upward assurance from the Quality & Safety Committee and the division in focus between the two committees
- Received the Deloitte audit planning report highlighting the key risks they had considered in planning their audit work.
- Received from Counter Fraud (Baker Tilly (in year renamed RSM)) updates on the counter fraud programme for 2015/16.
- Received regular update reports from Internal Audit (Baker Tilly) and reviewed all significant internal audit reports. The internal audit plan remained on schedule during the year.
- Received regular updates on the tracking of implementation of all internal and external audit recommendations.

- Reviewed the proposed internal audit plan for 2016/17. This plan had been aligned to the Board Assurance Framework (BAF) and other risk mechanisms within the organisation and was therefore fairly robust.
- Received regular updates on the BAF process. The Committee noted that significant progress has been made during the year and the Committee offered its continued support to the use of the BAF, particularly in embedding it deeper into the organisation.
- Received an annual risk report, detailing the processes in place for managing clinical governance in particular and progress with revising the risk management processes. The Committee agreed that this would be a continued area of focus for 2016/17.
- Received routine updates on payments made for loss or compensation and waivers & breaches of Standing Financial Instructions. The Committee challenged heavily the use of single tenders, given that the use of these had the potential to compromise best Value for Money
- Received updates on the statutory registers, concerning hospitality and declarations of interest
- The Committee adopted a set of revised terms of reference during the year

Briefings

- The Committee received regular reports and briefings from Deloitte and Baker Tilly regarding the risks facing the Trust, together with relevant issues and topics:
    - The outcome of the False and Misleading Information offence consultation
    - Freedom to Speak Up & the plans to introduce a 'Freedom to Speak Up' Guardian in NHS organisations in line with the Robert Francis QC recommendations
    - The consultation on the 2015/16 Annual Reporting Manual to further align it with the requirements of HM Treasury Financial Reporting Manual
- Deloitte notified the Committee that where senior managers were paid more than the Prime Minister (£142,000), the Trust needed to satisfy itself that the remuneration policy disclosures were clear within the Annual Report and that it was comfortable that these salaries were justified
- The Committee received a briefing on the proposed changes to the Risk Assessment Framework which would change the basis for its financial risk ratings from August 2015
- Monitor's planned tightening up on agency spend controls by setting a cap was discussed
- The Committee received a briefing from the Director of Finance concerning 'Payment & Tariff Assurance Framework 2014/15', which was a national audit commissioned by Monitor; the outcome for the Trust was very positive
- The Committee continued with its objective of receiving briefings from a wider range of management and executive staff. This has helped in obtained a broader and deeper level of assurance across the BAF and risk registers.
- Patient consent was a matter of interest for the Committee during the period and a briefing was provided by the Medical Director outlining the steps being taken to reduce the instances of consent on the day of surgery. The Quality & Safety Committee would maintain a watching brief on the matter.

Ad hoc matters

- The Committee received a report from the Director of Finance on contract risk, where it was highlighted that the Trust was underperforming against contract income plans and a rectification plan had been developed to address the position and improve performance against activity levels.
- The Committee received a detailed report on the Trust's status as a Going Concern and the Chairman and Chief Executive were invited to be present for the discussion. Taking all matters into account, it was agreed that as there were not material issues at present, the Trust could be declared as a Going Concern for 2016/17.

Workshop

The Committee held a workshop in October, which was primarily focussed on four key objectives:

- Raising the level of understanding and engagement in Board assurance processes and the Audit Committee's role in providing independent oversight and scrutiny on behalf of the Board
- Considering the existing Board assurance processes and providing a steer on where effort should be focussed to improve the wider systems of assurance
- Considering the oversight and scrutiny role of the Audit Committee and how this could be improved, both in terms of providing assurances to the Board and in supporting the Senior Management Team
- Capturing the issues that kept people 'awake at night' and considering how these could be managed through the Board assurance and Risk Management processes

Some key actions arose from the workshop, which strengthened the assurance process in year and have been built into the routine operation of the Committee and its interaction with other Board Committees and the Senior Management Team, these being most notably:

- Revision to the format and content of the Board Assurance Framework
- Revise and relaunch the Risk Management policy
- Alignment of the internal audit plan to the gaps in control and assurance within the Board Assurance Framework
- Better engagement of the Senior Management Team in the development of the internal audit plan
- Improved upwards reporting from the Quality & Safety Committee
- Realignment of the Audit Committee and Quality & Safety Committee meetings to create better information flow and improved assurance

4.0 2016/17 Work Plan

4.1 For 2016/17, the Audit Committee will continue with its routine work as well as to deal with ad hoc requirements that will emerge from time to time.

4.2 The three themes identified by the Committee during the previous year remain areas of focus and support the actions arising from the October 2015 workshop. These are:

- Continued improvement to the BAF process- and supporting the executive team during a period of personal changes
- Continuing to improve the link between the Audit Committee and the Quality & Safety Committee, and to support the QSC in improved clinical governance systems and processes.
- Continuing to support the executive team in broadening out and improving compliance with conflicts of interest declarations, together with the Trusts review of relevant policies.

4.3 Given the financial pressures on the organisation, close scrutiny on the Trust's Going Concern status will remain also an area of prime focus during the year.

5.0 Audit Committee Effectiveness

5.1 A full review of the effectiveness of the Audit Committee is planned for December 2016, which will be informed by a survey around the key areas of effectiveness as detailed in the Audit Committee Handbook.

6.0 Conclusion

6.1 The Audit Committee continues to play an important role in the ensuring that there was good governance and sound assurance processes in the organisation.

Rod Anthony
Chair of Audit Committee

September 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	18 October 2016
Guests	None
Presentations received and discussed	None
Major agenda items discussed	• Finance & Performance Overview – Month 06 • Implant rationalisation • HR framework and annual leave planning • 2016/17 delivery programme report and action plan: recovery trajectory and recovery plan
Matters presented for information or noting	• Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The Committee was advised that the financial deficit to date was £2.963m, a position which was behind the expectations set out in the annual plan, even taking into account the impact of the theatres closure in June • Agency costs were noted to remain high despite the review of the annual leave policy and HR framework which identified that these were robust. Reasons for the higher than expected use of agency staff were suggested to lie with poor planning, inability to secure bank staff and lack of cross cover for consultant lists. Ward-based nursing was the most significant contributor to the position. • Performance against the activity plan was noted to be poor, particularly in some specialities such as large joints. • Cash levels were reported to have dropped and impacted on the Trust's liquidity rating, this being the first time for several years. • Delays out of recovery had deteriorated and DNA rates remained high. • Performance against the 18 week Referral to Treatment time target was reported to be disappointing, this being driven by the increasing backlog of patients to be seen. Arthroscopy and Paediatric work was a particular concern. • There remained a concern over the Trust's compliance with mandatory training targets • It was reported that there was likely to be a slight shortfall against the planned CIP by year end

	• The Committee looked at the financial recovery trajectory based on a set of scenarios, these being 'most likely', 'current state' and 'full recovery'. It was agreed that the 'most likely' position was one that should be presented to NHSI as a revised position, given that to try to achieve a full recovery, may be potentially damaging to the future sustainability of the organisation. The risks to the achievement of the 'most likely' position were discussed, which included the need for robust processes to populate waiting lists and adequate flow through the system, including efficient discharge processes • The recovery plan was considered, which was a combination of responses to the NHSI 'Top Tips' and actions that were more local. A range of cost savings measures were also considered, a number of which were agreed to be unpalatable and impractical and therefore would not be progressed at present. As the action plan was still not fully populated with metrics and responsibilities, the Committee asked as a matter of urgency for the plan to be consolidated and additional information added
Positive assurances and highlights of note for the Board	• The Medical Director reported that good progress was underway to rationalise the number of implants used by surgeons in the organisation, which could potentially delivery a significant cost saving • Theatre utilisation had improved, although there remained further scope for this to be improved further • There was reported to have been good engagement with clinicians over recovery as part of the 'CEO Question Time' and specific engagement events recently • The Committee was advised that the Trust had been placed in Segment 2 of 4 (the second best category) as part of the introduction of the new Single Oversight Framework, although should there be a failure to deliver the recovery plan, then this position might worsen
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The main action arising from the meeting concerned the need to urgently progress the development of the single recovery action plan to include metrics and key responsibilities, as this being outstanding presented a continued severe risk to the Trust
Decisions made	• None specifically

Mr Tim Pile
VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 2 November 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRANSFORMATION COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	18 October 2016
Guests	None
Presentations received	None
Major agenda items discussed	• Workstreams 1 – 7 updates (by exception) • Rapid recovery • Arthroplasty small business unit model
Matters presented for information or noting	• Updates on Communications projects and the roll out of Amplitude
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• In the context of the development of the workforce model in POAC, the use of Physician Associates within the organisation was discussed where disappointment was expressed that the culture of the organisation and the professional limitations of the role meant that they had not been fully embraced as they had been elsewhere in the country. This created a risk to the delivery of the plan to remove locum doctor expenditure from the Trust. • There was a delay to making the workforce changes as a result of moving to a Voice Recognition system • There was reported to be a significant risk to the delivery of the ePMA system around the robustness of the Trust's infrastructure; an upgrade to the network was needed prior to going live with ePMA. The risk associated with this dependency concerned the need to extend the contracts of staff employed to support the work and thereby incur additional cost and possible financial penalties associated with the supplier contract if there was slippage on the plan • There was some delay reported on the GP engagement work, as there was further work to do to identify the services to promote to GPs in the light of the Trust's current waiting list position
Positive assurances and highlights of note for the Board	• Workstream 1: the Freedom to Speak Up Guardian had been appointed and a substantive Head of Organisational Development had also been appointed • Workstream 2: It was highlighted that this workstream needed to be re-evaluated to ensure its focus was different from the discussions that were being held at the Finance & Performance Committee. • Workstream 3: E-rostering roll out was reported to be

	progressing well • Workstream 4: It was reported that a new clinical briefing was now prepared and issued on alternate months. An appointment had been made to the post of Fundraising Manager. • Workstream 6: The new theatre stock management system would be implemented in December 2016 • Workstream 7: There were reported to be a number of changes in the Research & Development function in terms of key personnel. Undergraduate training continued to receive good feedback from the Deanery. Amplitude was being implemented to better monitor Outcomes. There had been a pleasing improvement in the Trust's Patient Reported Outcome Measures (PROMs); this would be considered by the Quality & Safety Committee at its next meeting • Good progress was reported with the implementation of the Rapid Recovery programme, the primary objective of this being to reduce length of stay. There was good clinical engagement with the work. • Progress was underway to develop the small business model in arthroplasty, which was anticipated to deliver benefits around patients flow and cross cover within the speciality.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A further update on the workforce model in POAC was requested at the next meeting, particularly highlighting the use of Advanced Nurse Practitioners and Physician Associates • The implementation plan for the People Strategy was to be presented at the next meeting • Options around ePMA and the network upgrade were to be developed and considered by the Executive prior to updating the Committee at its next meeting • A further update on GP engagement is to be presented at the next meeting • The IM & T strategy is to be considered at the next meeting • A further update on rapid recovery is to be presented 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 2 November 2016

Birmingham and Solihull Sustainability and Transformation Plan

21st October 2016 SUBMISSION

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

Foreword

The NHS in Birmingham and Solihull has a proud history of delivering high quality care to patients and families, and we have much to celebrate about our primary care, community and hospital based services.

We are also in the fortunate position of having already taken many of the bold decisions required to ensure sustainable services for the future over recent years. For example, we bought together the Queen Elizabeth and Selly Oak Hospitals into a brand new state- of –the- art centre in 2010. We have also consolidated many of our standalone specialist centres such as the Eye Hospital on to our main hospital sites to ensure their viability. We are a forward thinking system that does not shy away from doing the right thing for both patients and the taxpayer. As a result, we have some world-leading services right here in our city, serving people from all over the country.

We have worked hard to transform our social care services, focussing on supporting people to live independently for as long as is it is possible for them to do so. We are committed to ensuring our people have a high quality of life within their communities, accessing the care that is most appropriate for them, and if there comes a time when they need us more we want to make sure that the additional support is there.

However, demand for health and social care is growing. Our population is changing and facing many challenges– nearly half live in some of the poorest areas in the country. People in this group you are more likely to have a mental health problem or die from a condition that can be supported. We are also becoming more diverse as a population, with different expectations and requirements of health and care services.

We also know we have significant challenges around the future of community based services including both general practice and adult social care. Both are critical to the successful delivery of a high quality and sustainable future for health and care in Birmingham and Solihull. If we were to do nothing differently, within less than 5 years we would need to build a new 430-bed hospital to cope with the amount of patients needing our services. To do this will neither be affordable or right for our population who want to be kept well, independent and living in their own homes for as long as possible

As local leaders in Birmingham and Solihull, we are committed to working together to ensure that the services we provide meet the changing needs of local people now and in the future.

Within this draft Sustainability and Transformation Plan (STP), we feel that we have set out the first steps in how we might go about making the real transformational changes to the way we work and the services that we deliver. Despite the challenging backdrop to STPs, we feel we have a real opportunity to change things for the better. By developing our current system to be innovative and forward-thinking, making the most of new technology and supporting our people to live well for longer, we can ensure that everyone has a better experience of health and care and the opportunity to be independent for as long as possible for them.

Solihull Metropolitan Borough Council · Birmingham City Council · NHS

Contents

Executive summary

Overview

The Sustainability and Transformation Plan (STP) is about local leaders working together to deliver better health and care for local people. It's no secret that the NHS and in social care are addressing significant financial challenges and increased demand, so both need to work together to make resources go further whilst ensuring that we can still deliver the quality of care people need.

Across Birmingham and Solihull (BSol) , NHS and local government leaders have been working together to think about how we might start to tackle this issue. The STP is an iterative process, and this is the start of a longer transformation journey. It's not a short term plan - this is for long-term, sustainable change over 5 years and beyond

We have taken considerable steps to address previous feedback . A key aspect of this process was acknowledging that our organisations needed to work closer together and build stronger relationships between footprint partners. This has been a crucial step towards reaching an agreed baseline position and in further developing our delivery plans for how we address our future sustainability for health and social care.

Understanding the gap

To gain a better understanding of our system challenges, we have undertaken a detailed analysis of our system including the key gaps in our population's health and wellbeing, care and quality, and financial position. We recognise the scale of the challenge ahead and the level of transformation required to address this but if we get this right there will be considerable benefits for our populations.

Health and wellbeing	• **Deprivation** – 440,000 (46%) of the footprint population live in the "bottom 10%" most deprived areas in England. 1 in 3 children live in poverty • **Mental Health** – people in this percentage are three times more likely to be in contact with mental health services • **Obesity** – 39.2% of Birmingham and 29.9% of Solihull children aged 10-11 were classified overweight or obese in 2014/15 (the national average is 33.2%) • **Diabetes** – the prevalence of Diabetes for those registered with GP practices (aged 17+) in Birmingham is 8.3%, notably higher than the England average of 6.4% • **Infant mortality** – Birmingham is a national outlier for infant mortality (7.1 in Birmingham, 4.9 in Solihull – Deaths/1,000 live births). This is compared to the national average of 4 per 1,000 live births • **Cancer** – cancer mortality rates in all three CCGs are higher than the national average of 285 per 100,000 population (South Central CCG, Cross City CCG and Solihull CCG had cancer mortality rates of 291, 306 and 286 respectively)
Care and quality	• **A and E waiting times** – as reflected nationally, this is a key issue for BSol. Both UHB and HEFT have consistently failed to meet the A and E 4 hour waiting time target of 95% between January to June 2016 • **Delayed transfers of care** – those attributable to the NHS and Social Care across the STP footprint is 17.39 per 100,000 population (worst performing quartile nationally) • **Primary care** – The Birmingham and Solihull CCG's combined have the second lowest ratio of GPs and practice nurses per 100,000 population (0.53). The respective figures are Birmingham Cross City CCG 0.48, Birmingham South and Central CCG 0.65 and Solihull CCG 0.56 • **Reablement** – both Birmingham Local Authority (LA) and Solihull LA have lower rates than their peer averages for adults aged 65 and over receiving reablement services post hospitalisation. Solihull's rate was just over half that of Birmingham's (1.7% and 3%, respectively)
Finance and capacity	If nothing changes (the 'do nothing' scenario) in the way we deliver care, how we work with families and communities, and prevent early onset of disease, the system would need a further 430 hospital beds. This equates to almost a new hospital, in 5 years time, costing around £600m. When this is added to the social care funding shortfall our total system financial gap is around £721m i.e. additional funding requirement, which is not available to the NHS or social care. We must therefore change the way work together to improve care, quality and reduce the need for large scale funding increases. There are a number of reasons for this, including an increase in activity growth and inflation. Closing this financial gap is possible but it will mean changing the way we do things in the Birmingham and Solihull system.

Executive summary (cont'd)

Understanding the gap – Key drivers

In assessing our problems, we have used a framework to test a number of hypothesis which have helped us identify the underlying key drivers contributing to our position and system challenges as illustrated below (further detail on page 13):

3 Key drivers of our challenges:

1. Suboptimal system wide focus on use of resources

Due to non-clinical variation, lack of standardisation and inappropriate duplication of clinical and corporate support services. Also includes the use of estates and infrastructure.

2. Too much care that can be delivered elsewhere is provided in a hospital setting

Creating bottlenecks and queues with a knock on impact on quality and safety due to rising demand from the ageing population and historical over reliance on acute services

3. Variation in clinical services

Due to unjustified variation in quality and access

If we get this right, following further work, it will mean we can deliver what people say they want:

- A focus on promoting health and wellbeing,
- Helping people to stay independent for longer
- A reduction in health and social care crises,
- A more joined up approach to providing care,
- Greater access to community based services
- New sustainable models of general practice.

Our new models of care will:

- Promote a person centred approach and anticipate problems
- Promote self care and individual and community resilience
- Ensure consistency of care and better experience and outcomes for individuals

Our Strategic Objectives

We have identified and agreed the following three strategic objectives as an approach to address our system challenges and the key drivers which contribute to these:

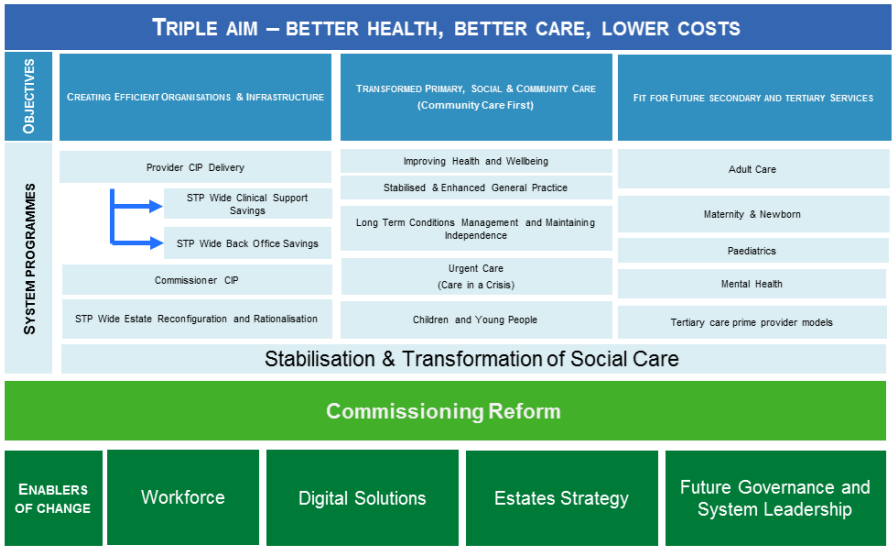
1.  **Creating Efficient Organisations and Infrastructure**	The initial step to building a sustainable health and care system for BSol through creating efficient and lean organisations by achieving successful delivery of CIPs/QIPPs supported by a robust programme of organisational recovery where required, to strengthen current performance. We also need to ensure effective use of our collective estate.
2.  **Transformed Primary, Social and Community Care *(Community Care First)***	Organisations will work collectively to address the growing demand for hospital care. This includes moving activity that is currently provided in a hospital setting into more local settings of care, ideally at home. This will be achieved through the prevention and self care agenda to improve health and wellbeing and through integrated and enhanced primary, social and community care, developing community resilience, and improved use of technology keeping people independent and reducing acute crises. This will include actions to stabilise general practice and social care. Into our work we will incorporate learning from the New Care Models Programme including Vanguards operating within the footprint.
3.  **Fit For Future Secondary and Tertiary Services**	The above two steps will enable us to better understand and manage demand which needs to be dealt with in secondary and tertiary care. We will deliver fit for future services by reducing variation and simplifying access to high quality secondary and tertiary services; including delivering prime provider and managed network models to transform acute services across multiple sites. Into our work we will incorporate learning from the New Care Models Programme including local Vanguards operating within the footprint.

Executive summary (cont'd)

STP Priority Programmes and key enablers

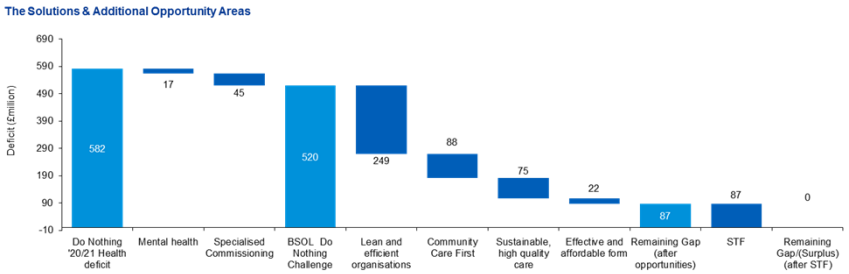
We have developed a number of priority STP programmes for each of our strategic objectives which form the basis of our delivery plan for the system . This will lead to the development and transformation of care and support received by patients and the public.

This is illustrated by our 5 year plan on a page:



Financial Impact Of 5 Year Plan

High level modelling has been conducted on our strategic objectives to quantify the impact and estimated financial savings for these schemes.



Next Steps – to end of March 2017

We recognise the scale and pace required by the system to accelerate the changes required, and the risks to delivery are set out in the plan. A key issue to be addressed as we move forward is that the process to date has focussed on addressing the projected financial gap for the NHS. Further work is now required to address the projected financial gap for social care

Our immediate next steps include:

DATA

- Agree approach to develop a more granular demand, capacity and cost model to generate a more detailed picture to support further planning over next 8 weeks
- Develop and refine analysis on all STP programmes to enable an options appraisal on preferred models
- Establish evaluation criteria
- Support prioritisation by identifying what will make a difference

Delivery & Programme Management

- Strengthen system PMO for the STP programme including additional capacity to support the future governance arrangements and further develop the STP, the delivery plan and implementation at a system level
- Identify and communicate working groups for STP programme and enabling workstreams
- Further develop the various STP priority initiatives into detailed project delivery plans to support programme solutions and operational planning requirements
- Develop a system level programme plan to monitor progress key milestones
- Include 90 Day Plan for immediate delivery

Finance

- Agree the social care financial gap and the impact on the delivery of social care services, and knock on impact on the rest of the system
- Identify opportunities to address remaining financial gap across health and social care
- Agree finance support for the further development of plans
- Develop business cases on priority STP programmes including return on investment

Engagement

- Further develop communications strategy for the STP and commence programme of activities to support wider engagement
- Obtain feedback on proposed solutions across STP programmes
- Agree key messages for STP programmes to support wider engagement including workforce, public, and political stakeholders

Governance

- System leaders and other key stakeholders to develop and formalise governance arrangements
- Define governance roles, responsibilities and terms of reference
- Agree and communicate governance arrangements
- Roll out of future governance arrangements

Understanding the gaps

Planning for health and social care in Birmingham and Solihull

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

Understanding the gap: BSol population

The BSol Footprint

- **1.3 million** people
- **2** local authorities
- **3** CCGs
- **182** GP practices
- **7** acute hospitals (**3** specialist facilities)
- **1** mental health trust
- **1** community health trust plus one vertically integrated community provider within an acute trust.

** Additional information provided following June submission*

- Birmingham is the youngest core city in Europe (46% of the population are under 30)
- Solihull has an ageing population (19% of the population are over 65, 13% in Birmingham)
- Birmingham is a diverse city (42% of residents come from an ethnic group other than white)
- Solihull has increasing diversity (11% of the population identify as Black, Asian or Mixed Ethnic Minority – BAME)
- Birmingham is a growing city linked in part to migration (9.9% increase since 2004, Solihull has increased by 3.6% since 2001)
- Solihull and Birmingham both have a prosperity gap reflected in the 10 year life expectancy gap between the least and most affluent wards
- Birmingham has a homelessness level more than three times the England average – 7.6 per 1,000 households against the England average of 2.3 per 1,000 households
- Birmingham has a long term unemployment rate around 2.5 times higher than the England average (19.8 per 1,000 population aged 16-64 against the England average of 7.1 per 1,000 population aged 16-64)

Other key facts

- Annual number of convictions for homicides (2011/13 average) in Birmingham and the Black Country is 2.20 per 100,000 population compared to Greater Manchester 1.18 per 100,000 population
- 90% of the Birmingham adult population owns a smart phone (the highest coverage in Europe), offering significant opportunities for use of new technology
- Solihull hosts significant economic hubs for the footprint – NEC, Land Rover, Birmingham Airport, and the future HS2 hub and associated development (UK Central) – currently drawing in 85,000 workers daily
- Birmingham hosts 5 universities

Understanding the gap: Health and Wellbeing

We recognise the need for improvement in our population's Health and Wellbeing as highlighted below and the Care and Quality Outcomes across Birmingham and Solihull (see following pages):

Vulnerable Groups and Communities

- 440,000 (~46% of the footprint population) live in the "bottom 10%" most deprived areas in England

Within this population

- In Birmingham life expectancy for men is 77.6 years (the national average is 79.4) and for women it is 82.2 years (national average 83.1 years). In Solihull life expectancy for men is 80.3 years and 84.8 years for women
- Birmingham has a gap in life expectancy between the most deprived and the least deprived areas of 7.4 and 4.9 years for males and females, respectively. Solihull has a gap in life expectancy of 10.3 and 10.5 years for males and females, respectively
- 1 in 3 children live in poverty
- People in this decile are 3x more likely to be in contact with mental health services, be admitted for ambulatory sensitive conditions, or die from conditions amenable to healthcare
- Birmingham and Solihull are in the bottom quartile for emergency admissions from falls, and have agreed targets for significant improvement.

Employment

- 59,000 people are on Employment Support Allowance
- This represents 4.5% of the BSol population, compared to 3.7% national average
- Of this population 49% experience a Mental Health condition
- 14% also have musculoskeletal issues
- Only 1% (Birmingham) and 3% (Solihull) of supported adults with Learning Disabilities are in paid employment (the national average is 7%)
- Only 6% of people with serious mental illness (on the Care Programme Approach) are recorded as employed

Health

- Birmingham Cross City CCG and Solihull CCG had 4.5% and 11% higher cancer incidence rates than the national average, respectively
- Mortality rate from cases considered preventable (in 2013/14) was 238 per 100,000 in Birmingham – 30% worse than the national average of 182.7
- Under 75 mortality rate from cardiovascular disease considered preventable in Birmingham is 67.7 compared to a national average of 49.2 (per 100,000)
- South Central CCG, Cross City CCG and Solihull CCG had cancer mortality rates of 291.3, 306 and 286.9 per 100,000 – all higher than the national average of 285.4
- Birmingham Cross City CCG had an incidence rate of lung cancer of 90.2 per 100,000 – 14% higher than the national average. Birmingham South Central CCG had an incidence rate of 97.8 per 100,000 – 23% higher than the national average

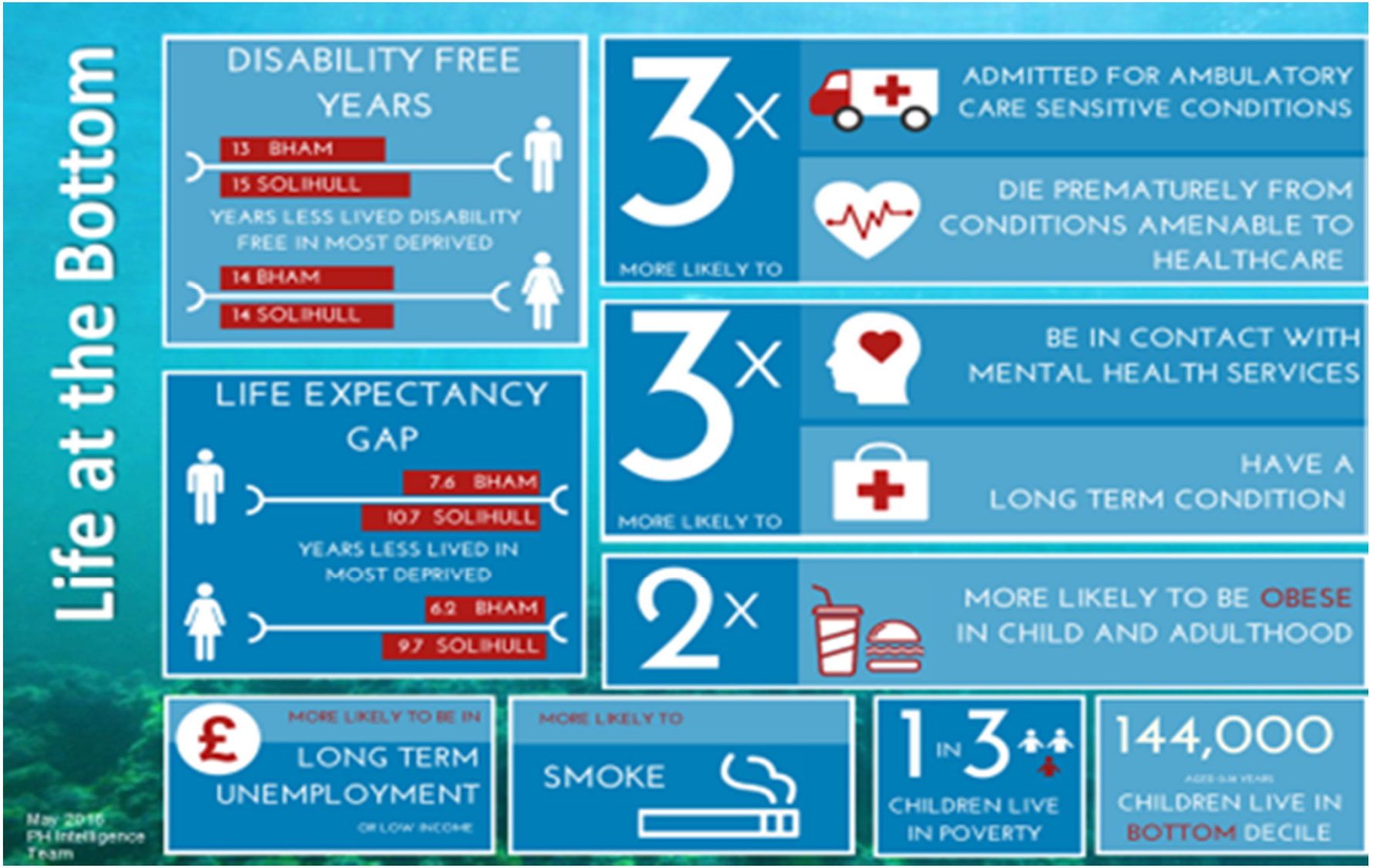
Projections

- Birmingham's population is projected to increase by 146,000 (13%) over the next 20 years
- The largest changes are for people aged 65-84 with a projected increase by 35%
- People aged 85+ are expected to increase by 75% by 2035
- (Children aged 5-14 are projected to increase by 10% over the next decade

Maternity and Early Years and Children and Young People

- Birmingham has high levels of A and E Attendances for 0-4 year olds – 585.9 per 1,000 compared to the national average of 540.5 per 1,000
- There is high infant mortality of 7.1 deaths per 1000 live births in Birmingham and 4.9 in Solihull .This is compared to the national average of 4 per 1,000 live births
- 39.2% of Birmingham and 29.9% of Solihull children aged 10-11 were classified overweight or obese in 2014/15 (the national average is 33.2%)

If you live in the most deprived areas you are:



Understanding the gap: Care and quality

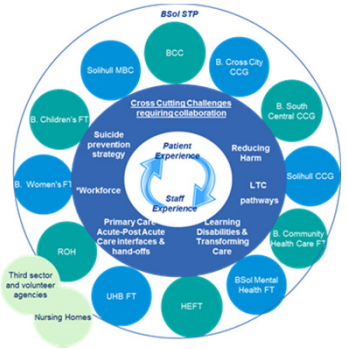
Overall, each individual organisation is responsible for addressing care and quality gaps at a local level through their own governance processes and structures. However, there are a number of challenges that need the engagement and collaboration of multiple organisations in a BSol-wide approach. Fundamental to improving care and quality is patient and staff satisfaction. Engaged/satisfied employees result in higher patient satisfaction and better outcomes.

PATIENT EXPERIENCE

- Whilst the Friends and Family Test (FFT) indicates the majority of people would recommend the service, the challenge is maintaining patient satisfaction whilst transformation programmes are underway.
- There is variation in the FFT scores across the organisations within the STP footprint with many organisations exceeding the national benchmarks *(please note these vary depending on the service):*
  - A and E
    81-85 % (national benchmark 86%)
  - Mental Health
    91-95% (national benchmark 93%)
  - Community services
    88-99% (national benchmark 95%)
  - Inpatient/day cases
    93-100% (national benchmark 96%)
  - Outpatients
    91-95% (national benchmark 93%)
  - Maternity
    91-94% (national benchmark 97%)

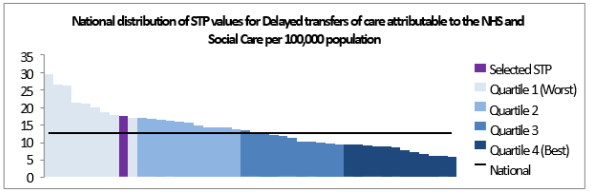
STAFF EXPERIENCE

- There is significant variation in the staff experience across the STP footprint:
  - Staff recommending their organisation as a place to work varies from 44 – 93% (national benchmark 64%)
  - Staff recommending their organisation as a place to care ranges from 56 – 93% depending on the organisation (national benchmark 80%)



PRIMARY CARE – ACUTE CARE – POST ACUTE CARE INTERFACES

This relates to key 'touchpoints' or hand-off's between the sectors e.g. primary care to the acute sector or from the acute sector to community or social care. Analysis on total spend shows that 8% of the over 65s account for 62% of total spend - which reflects the significance of these touch points.



A and E ADMISSIONS

- There is a growth in emergency admissions for conditions which would not usually need a hospital admission (currently 940.8 per 100,000 population).

DTOC

- Delayed transfers of care attributable to the NHS and Social Care across the STP is 17.39 per 100,000 population (worst performing quartile nationally)

A AND E ATTENDANCES

- In FY 2014/15 Birmingham Cross City and Birmingham South and Central CCG were identified for above average emergency admissions of both acute and emergency admissions that would not usually need a hospital admission.

CHC AND DOMICILIARY SERVICES

- There are significant challenges with available capacity as well as variability in quality of care in nursing homes and domiciliary care
- There is also a need to improve quality assurance in relation to personal budgets

PRIMARY CARE

- The Birmingham and Solihull CCG's combined have the second lowest ratio of GPs and Practice Nurses per 100,000 population (0.53). The respective figures are Birmingham Cross City CCG 0.48, Birmingham South and Central CCG 0.65 and Solihull CCG 0.56

Understanding the gap: Care and quality (cont'd)

LTC PATHWAYS

END OF LIFE CARE

- Across the STP 53.8% patients (Q1 2015/16) died in hospital. This was in the poorest performing quartile against the national figures

MANAGING OWN CONDITION

- 63.3% of people with a long term condition feel supported to manage their own condition (this is in the poorest performing quartile with national benchmark 66%)

RESPIRATORY

- Male under 75 mortality rates from respiratory disease in Birmingham South and Central CCG are 48 deaths compared to the national average of 31.2 (per 100,000)

DIABETES

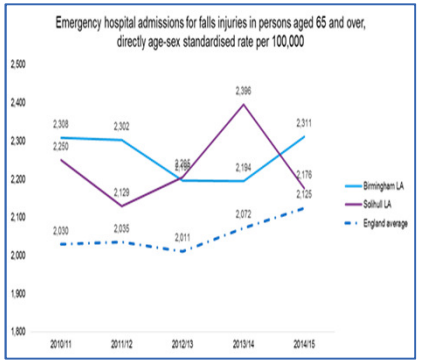
- Diabetes in the population registered with GP practices aged 17 and over in Birmingham is 8.3% – notably higher than the England average of 6.4%

LEARNING DISABILITIES AND TRANSFORMING CARE

- Across the STP the proportion of people with a learning disability on the GP register receiving an annual health check is the lowest across all STP's (28.6%). NHSE has set a target of 75% by 2020
- There are high rates for people with LD or autism receiving specialist inpatient care (across the STP – 65 per million population)

ELIMINATING HARM INCLUDING HCAI (HEALTHCARE-ASSOCIATED INFECTIONS)

- An estimated annual collective financial opportunity at BSol of between £3.5-4 million has been identified through reduction of falls with harm, pressure ulcers, c. difficile and MRSA (see right for falls injuries requiring hospital admission)
- There needs to be an alignment of efforts across public health, primary and secondary health care, and social care on key infections and events causing harm, that would benefit from a 'joined up' approach to prevention, recognition and management



SUICIDE PREVENTION STRATEGY

- Whilst Birmingham and Solihull are not outliers compared to national averages, there is clear room for improvement as the West Midlands Mental Health Commission has expressed a 'zero suicides ambition'
- In line with national priorities, BSol has agreed an STP-wide suicide prevention plan targeting high groups and locations and whilst led by the Mental Health Trust, there will need to be input from primary and secondary care as well as social care

WORKFORCE (ENABLER) ***SEE APPENDIX***

- In order to deliver this transformation in care and quality there will need to be changes within the workforce including:
  - Upskilling and retraining of staff to be able to manage higher acuity patients in community and primary care settings (the number of staff this will impact has yet to be quantified)
  - Addressing shortages in GPs and nursing staff in the community and reduce the reliance on temporary staff
  - introduction of a range of different skills and competencies in community based care, including care navigation and wide skilling approaches to existing roles

Understanding the gap: Key drivers

Our detailed analysis of BSol has enabled us to have a deeper understanding of the challenges within the footprint and the areas of improvement required across BSol's care, quality and financial performance. In assessing, we have used a framework to test three key hypothesis to help identify the underlying key drivers which may contribute to our problems and overall challenges.

1. **SUB-OPTIMAL SYSTEM WIDE FOCUS ON USE OF RESOURCES**

Due to non-clinical variation, lack of standardisation and inappropriate duplication of clinical and corporate support services. Also includes the use of estates and infrastructure

2. **TOO MUCH CARE THAT CAN BE DELIVERED ELSEWHERE IS PROVIDED IN A HOSPITAL SETTING**

Creating bottlenecks and queues with a knock on impact on quality and safety due to rising demand from the ageing population and historical over reliance on acute services

3. **VARIATION IN CLINICAL SERVICES**

Due to unjustified variation in quality and access

SUB-OPTIMAL USE OF RESOURCES

DELAYED TRANSFERS OF CARE (DTOC)

- There are a high number of delayed transfers , causing lost bed days and exacerbating operational difficulties in patient flow. Whilst there is a large amount of non-acute bed capacity, there are still significant issues around timely discharging of patients.
- Heart of England Foundation Trust (HEFT) has the highest number of days amongst its peer group, while University Hospital Birmingham Foundation Trust (UHB)is in line with its peer average. The primary reason for delays at both organisations being nursing home placement or availability. Similarly, Birmingham Community Healthcare NHS FT (BCHCFT) is third highest in its peer group for total delayed days amongst comparable community trusts, the primary reason being availability of nursing home placements.
- For Birmingham and Solihull NHS FT and the Royal Orthopaedic Hospital NHS FT (ROH) waiting for non-acute NHS care is the primary reason for delays

HIGH LENGTH OF STAY

- Recognising that DTOC are a key challenge for some patients, opportunities still exist to improve organisational efficiency to reduce length to stay.

ESTATES INFRASTRUCTURE

The BSol footprint currently comprises circa 650 buildings with 1000+ property interests. The quality and utilisation of the estate varies significantly across the footprint

There are areas of sizeable estate void. Across the footprint there are voids within LIFT buildings of circa £5m and £1m within the NHS Property Services portfolio

Providers use a considerable range of asset management options to secure tenure, including PFI, making rationalisation difficult to realise without considerable risk

There is unwarranted variation in the delivery facilities management (FM) support services across all providers exacerbated by disjointed procurement models

Providers complain of a lack of control over the provision and value for money at Local Improvement Finance Trust (LIFT)and NHS Property Services premises

Estates management is fragmented across 7 providers and 2 property company management teams

COMMUNITY BEDS

There is a high number of community beds supplied by all providers across Birmingham and Solihull when compared to peers

ACUTE BEDS (BETWEEN APRIL AND JUNE 2016)

HEFT had the second highest occupancy percentage amongst its peer group at 90.5%

UHB had the highest occupancy percentage amongst the peer group (99.1 % occupancy compared with 91%)

ROH has the highest occupancy rate (85% - 90%) amongst three comparable specialist orthopaedic Trusts

COMMISSIONING

The move to three CCGs across BSol has been perceived by providers and other key partners as a lack of unity in our approach to commissioning. National STP guidance clearly indicates that future CCG allocations will be contingent on robust system planning and working

** Please note that there are additional drivers but these have been identified as the key drivers of the STP (as a whole)*

Understanding the gap: Key drivers (cont'd)

1 SUB-OPTIMAL SYSTEM WIDE FOCUS ON USE OF RESOURCES

Due to non-clinical variation, lack of standardisation and inappropriate duplication of clinical and corporate support services. Also includes the use of estates and infrastructure

2. TOO MUCH CARE THAT CAN BE DELIVERED ELSEWHERE IS PROVIDED IN A HOSPITAL SETTING

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3. VARIATION IN CLINICAL SERVICES

Due to unjustified variation in quality and access

TOO MUCH CARE THAT CAN BE DELIVERED ELSEWHERE IS PROVIDED IN A HOSPITAL SETTING

POOR ACCESS TO PRIMARY CARE AND COMMUNITY SERVICES

- Birmingham Cross City CCG has the second lowest number of GPs per 100,000 population amongst its peer group, and almost half that of South Central CCG. Solihull CCG has the third lowest number of GPs per 100,000 population amongst its peer group. Birmingham Cross City CCG also has the third lowest number of practice nurses per 100,000 population against its peer group
- Both Birmingham LA and Solihull LA had lower rates than their peer averages for adults aged 65 and over receiving re-ablement services post hospitalisation. Solihull's rate is just over half that of Birmingham's (1.7% and 3%, respectively)

LOW NUMBER OF CARE HOME BEDS

- Solihull has the second lowest number of care home beds per 10,000 population (older than 65 years) amongst its peer group, while Birmingham is in line with its peer average.

MENTAL HEALTH

- There is a marked higher prevalence in Birmingham of patients requiring complex inpatient care with Birmingham second highest in its peer group for incidence of psychosis per 100,000 population
- In regards to psychosis two week wait times Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) reports 25% of patients starting treatment within two weeks of referral – which demonstrates recent steady improvement.

EMERGENCY ADMISSIONS THAT SHOULD NOT REQUIRE HOSPITAL ADMISSION

- Birmingham Cross City, South Central and Solihull CCGs had over 4,300 emergency admissions per 100,000 patients due to lack of community based alternatives/ fragmented services in 2014/15

VARIATION IN CLINICAL SERVICES

INAPPROPRIATE DUPLICATION OF SERVICES

The STP is working with Services to identify where any inappropriate duplication and variation is occurring which does not have a patient benefit.

VARIATION IN CLINICALSERVICES

MATERNITY

- Fragmented service provision with variations in outcomes across the system

CANCER

- All three CCGs (Birmingham Cross City, Birmingham South Central, and Solihull) ranked either first or second best for the proportion of cancers diagnosed early (stage 1 and 2) relative to their peers
- However, Birmingham Cross City CCG was the third worst performer against its peers and South Central CCG was the second worst performer against its peers for the 62 day cancer waiting standards from urgent GP referral in 2015/16
- The mortality rate for men from causes considered preventable is 311.7 per 100,000 population compared to the national average of 230.1. A 35% higher rate in Birmingham.

MENTAL HEALTH

- In 2016/17 across age ranges and provision BSol has a number of out of area admissions
- Birmingham Cross City CCG had the highest number of Improved Access to Psychological Therapies (IAPT) referrals waiting over 90 days for first assessment at the end of May 2016 within its peer group – this is the same service for al l CCGs

ORTHOPAEDICS

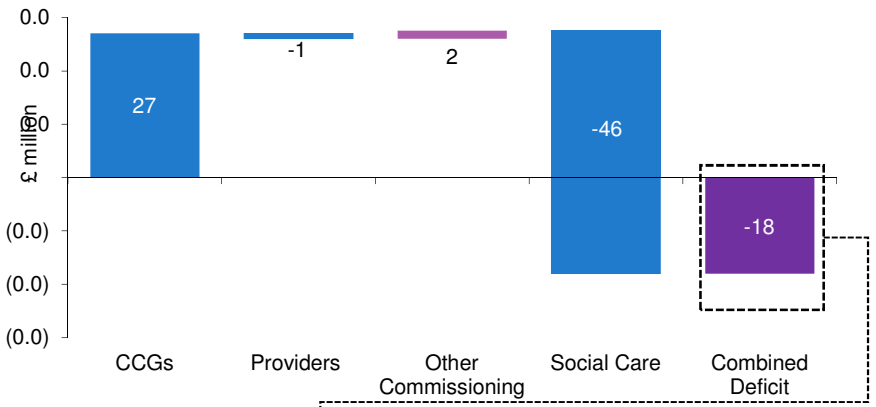
- Fragmented service provision with variations in outcomes across the system

Understanding the gap - Finance - 15/16 through to 20/21

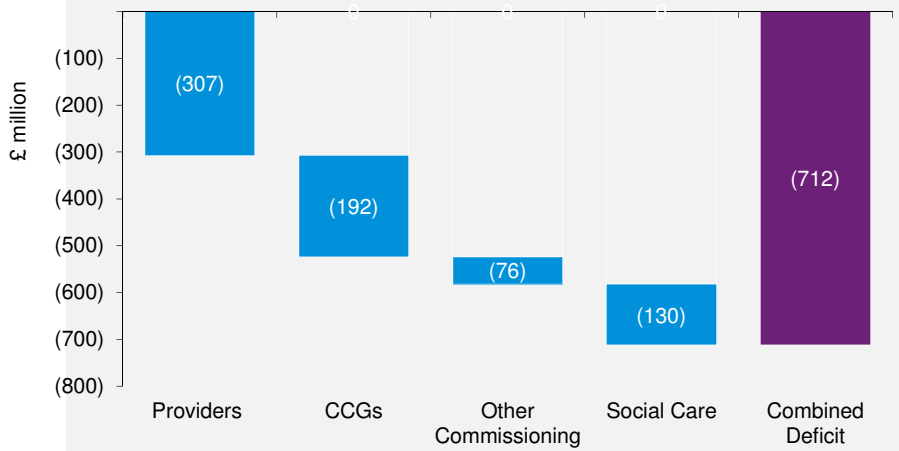
- The combined 16/17 forecast position for the health and care economy is an overall deficit of £18m. This is driven primarily by the £46m deficit in social care, with the health sector showing a forecast surplus for 16/17 of £24.5m
- As the chart opposite shows, by 2020/21 the overall combined health and care sector deficit for the Birmingham and Solihull STP grows to a £712m in-year deficit position
- The composition of the 20/21 combined deficit can be seen in the chart below, with the single biggest driver in the growth of the deficit being providers, which grow from a £1m to £307m deficit position.

NB Control Totals have not been agreed by NHS Organisations

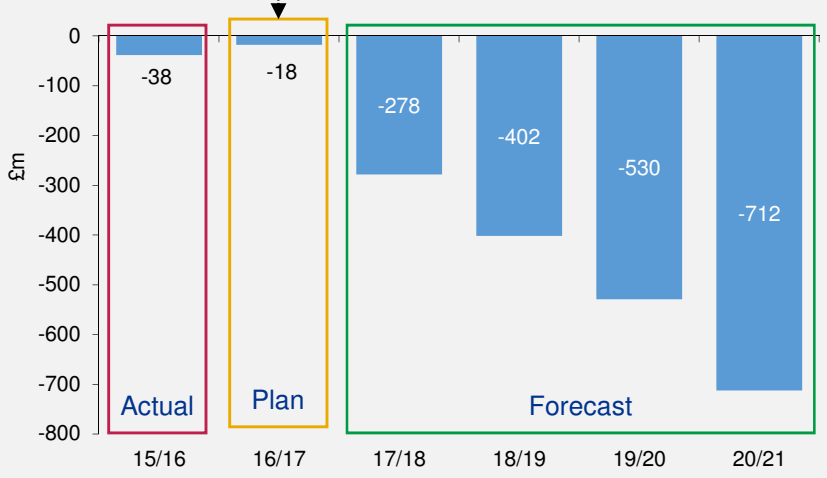
16/17 Forecast deficit by organisation type



20/21 Do Nothing Deficit by organisation type



20/21 Do Nothing financial Gap

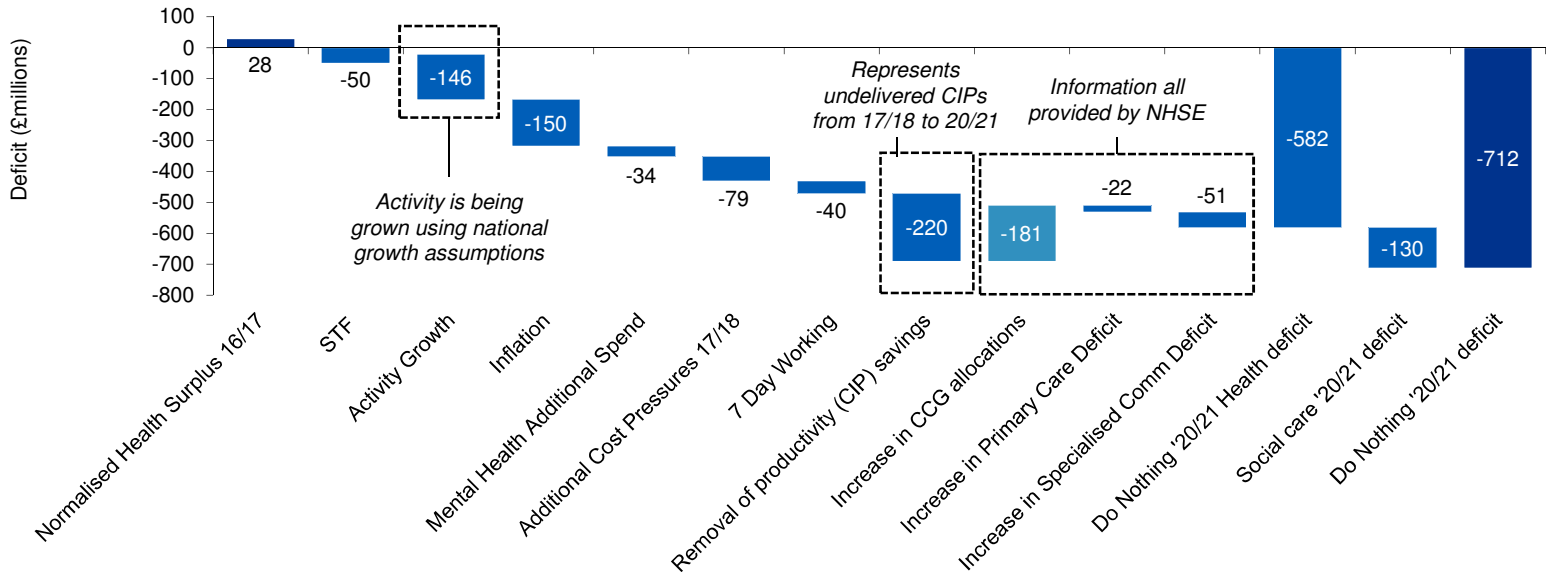


Understanding the gap: Finance (cont'd)

FINANCIAL GAP ANALYSIS – 'DO NOTHING'

The below chart shows the breakdown of the increased financial gap between the planned 2016/17 position and the forecast 20/21 position

Drivers of the Forecasted Health and Care Gap



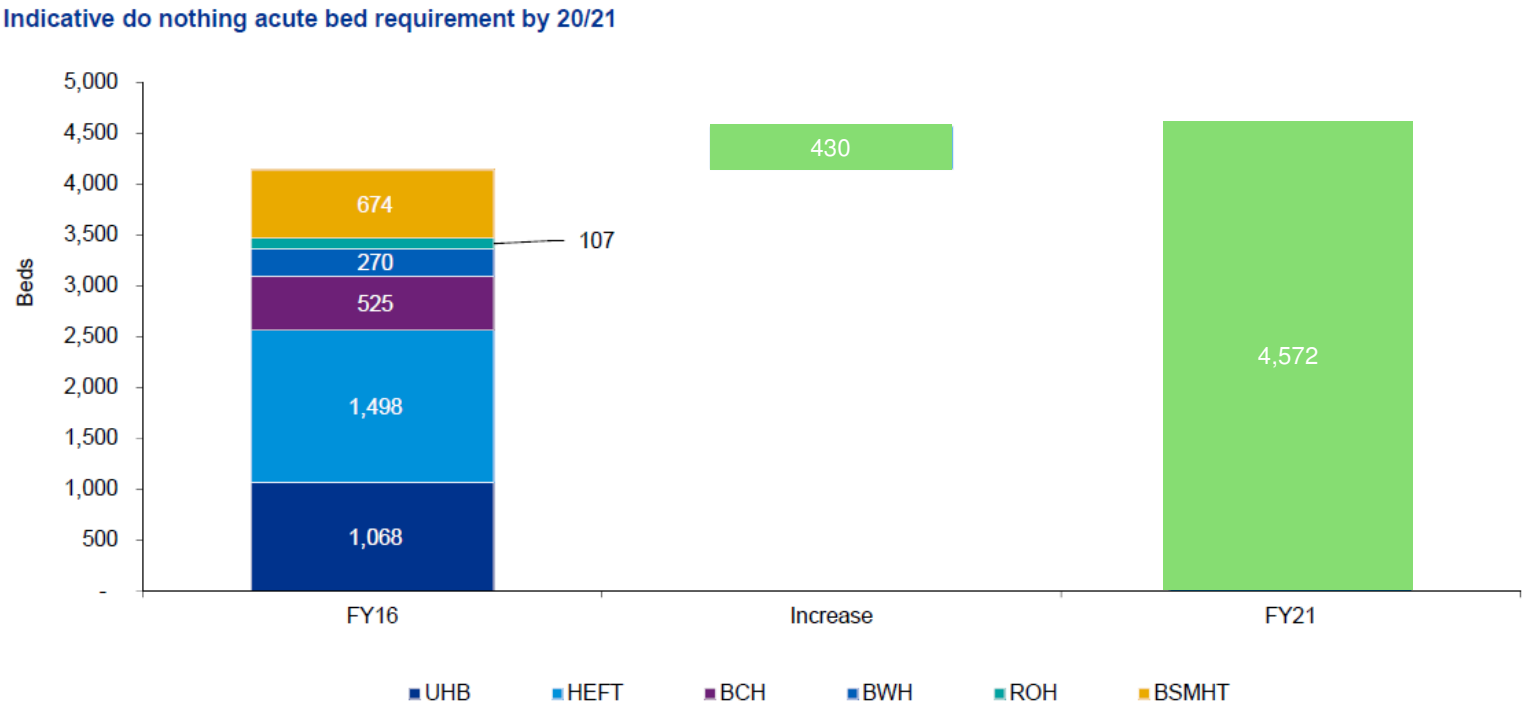
Footnote: this does not include the impact of the move to 17/18 tariff, other than the impact of the average tariff deflator. HRG4+ and top up changes are not taken into account

Understanding the gap: Capacity

We have not yet performed detailed demand, activity and capacity modelling which would provide a much more accurate and granular understanding of future capacity requirements across the system. However, the below chart shows the illustrative increase in acute beds required by 2020/21 in the 'do nothing' scenario, assuming the national activity growth assumptions, constant length of stay and utilisation during the forecast.
The FY16 bed numbers have been taken from the most recent NHSE publication of bed availability and occupancy
This suggests that if nothing were to change an additional 430 inpatient beds would be required in the system to manage the increasing demand – this is the size of a typical general hospital and there are not empty beds available to cover this demand. In addition the required workforce is also not available.

Therefore our plans are designed to:

- Avoid the need to open an additional 430 inpatient beds over the current baseline which would otherwise be required as outlined below



Addressing the gap

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

Strategic objectives

Understanding the three drivers to our collective challenges has enabled us to develop our approach on how to address these challenges and informed the solutions required to build a sustainable health and social care economy for BSol and to address the substantial health and wellbeing challenges on our patch. Our approach is based on three strategic objectives as outlined below, each of which have a number of priority programmes identified to achieve sustainable high quality health and social care.

1.  **CREATING EFFICIENT ORGANISATIONS AND INFRASTRUCTURE**	The initial step to building a sustainable health and care system for BSol is through creating efficient and lean organisations. This will be done by achieving successful delivery of CIPs/QIPPs supported by a robust programme of organisational recovery where required, to strengthen current performance. In addition there are opportunities to make better use of our resources by ensuring effective use of our collective estate.
2.  **TRANSFORMED PRIMARY, SOCIAL AND COMMUNITY CARE** *(COMMUNITY CARE FIRST)*	The organisations will work to address the growing demand for hospital care. This includes moving activity that is currently provided in a hospital setting into more local settings of care, ideally at home. This will be achieved through the prevention and self care agenda to improve health and wellbeing and through integrated and enhanced primary, social and community care, developing community resilience, and improved use of technology keeping people independent and reducing acute crises. This will include actions to stabilise general practice and social care. Into our work we will incorporate learning from the New Care Models Programme including Vanguards operating within the footprint.
3.  **FIT FOR FUTURE SECONDARY AND TERTIARY SERVICES**	The above two steps will enable us to better understand and manage demand which needs to be dealt with in secondary and tertiary care. We will deliver fit for future services by reducing variation and simplifying access to high quality secondary and tertiary services; including delivering prime provider and managed network models to transform acute services across multiple sites. Into our work we will incorporate learning from the New Care Models Programme including local Vanguards operating within the footprint.

If we get this right, following further work, it will mean we can deliver what people say they want:

- A focus on promoting health and wellbeing
- Helping people to stay independent for longer
- A reduction in health and social care crises
- A more joined up approach to providing care, greater access to community based services and new sustainable models of general practice.

Our new models of care will:

- Promote a person centred approach and anticipate problems
- Promote self care and individual and community resilience
- Ensure consistency of care and better experience and outcomes for individuals

5 Year plan on a page

TRIPLE AIM – BETTER HEALTH, BETTER CARE, LOWER COSTS

OBJECTIVES	CREATING EFFICIENT ORGANISATIONS AND INFRASTRUCTURE	TRANSFORMED PRIMARY, SOCIAL AND COMMUNITY CARE (Community Care First)	FIT FOR FUTURE SECONDARY AND TERTIARY SERVICES
SYSTEM PROGRAMMES	Provider CIP Delivery	Improving Health and Wellbeing	Adult Care
	STP Wide Clinical Support Savings	Stabilised and Enhanced General Practice	Maternity and Newborn
	STP Wide Back Office Savings	Long Term Conditions Management and Maintaining Independence	Paediatrics
	Commissioner CIP	Urgent Care (Care in a Crisis)	Mental Health
	STP Wide Estate Reconfiguration and Rationalisation	Children and Young People	Tertiary care prime provider models
	Stabilisation and Transformation of Social Care		

Commissioning Reform

ENABLERS OF CHANGE	Workforce	Digital Solutions	Estates Strategy	Future Governance and System Leadership

Critical decisions

Strategic objective	Immediate critical decision(s)	Decision enablers
Creating Efficient Organisations and Infrastructure	• Agree 'recovery plan' (for those organisations requiring one) to accelerate the pace and delivery of productivity and efficiency improvements across all organisations • Agreement between health and local authorities for a shared approach to estates and BSol-wide Estates strategy • Consensus on closure of unused/surplus estate and other quick win opportunities delivered	• Identification of further opportunities for system savings and including quick wins to improve efficiency and financial position e.g. collective staff bank • Options appraisal on BSol estates and future requirements aligned with proposed STP programmes including a System Estates inventory with current utilisation and status report
Transformed primary, social and community care (***Community care first***)	• Universal agreement of the modelling of the impact of the new model • Agree support required for stabilisation and extended access to general practice • Universal agreement on the role and purpose of Multidisciplinary Teams – the geography, professional make up and operational leadership, patient cohort, provider incentives and the performance measures used to review their impact • Agree alignment and interdependencies with Secondary and Tertiary Programme including Estates and operation of MDT model	• Defined operating model to identify requirements such as future workforce and estates • Detailed modelling to quantify and assess impact of new model • Detailed options appraisal including future benefits, forecast savings and investment requirements • Engagement including Local Medical Committees ('LMC') and other groups, workforce and public engagement • Primary care ownership of plans
Fit for future secondary and tertiary services	• Adult acute care opportunities will be identified following capacity and demand modelling • Agree how capacity and resource are best aligned to support the MH recovery focus and eliminate out of area placements • Agree on Organisational commitment to delivering the maternity programme at pace through a lead provider contracting model • Agree on Organisational commitment to delivering the paediatric programme at pace through a network model which includes all stakeholders • Agreement with regional specialised team on prime provider pathways of care that will be supported for tertiary services	• Demand and capacity modelling exercise to identify current baseline and assess future requirements aligned to new operating models • Development of more detailed future Operating models including using inputs from modelling exercise – to consider activity, beds, workforce, costs • Workforce and public engagement
Overarching system decisions	• Agreement upon preferred enabling BSol governance model	• Identify best practice and options for BSol governance model and guiding principles supported timeline for implementation

Solutions

CREATING EFFICIENT ORGANISATIONS and INFRASTRUCTURE

1a. Clinical Support Savings
1b. Back Office Savings
2. Commissioner CIP
3. STP Wide Estate Reconfiguration and Rationalisation

TRANSFORMED PRIMARY, SOCIAL and COMMUNITY CARE

(Community Care First)
4. Community Care First Programme Summary
5. Solihull Together
6. Improving Health and Wellbeing
7. Stabilised and Enhanced General Medical Practice
8. MyHealthCare – GP Access Fund
9. Long Term Conditions Management and Maintaining Independence
10. Urgent Care – Care in a Crisis
11. Children and Young People

FIT FOR FUTURE SECONDARY AND TERTIARY SERVICES

12. Adult Care
13. Maternity and Newborn
14. Paediatrics
15. Mental Health
16. Tertiary care prime provider models

OVERARCHING

17. Stabilisation and Transformation of Social Care
18. Commissioning Reform

Solihull Metropolitan Borough Council
Birmingham City Council
NHS

Creating Efficient Organisations and Infrastructure

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

1a. Creating Efficient Organisations and Infrastructure: Clinical Support Savings

SRO: Dame Julie Moore | **Relevant leads: Andrew McKirgan**

Organisations involved*: UHBFT, ROH, BCH, BWH, BSMHFT HoEFT, CCGs, Primary Care, NHSE*

Strategic objective:

We will develop a single integrated laboratory model across Birmingham and Solihull that will deliver a high quality pathology service by ensuring there is standardised and consistent care, equity of access thereby enabling the most cost effective model of laboratory provision. This will include developing high volume centralised laboratory provision for routine work whilst maintaining the specialist expertise required across BSol. Our service will be underpinned by a highly skilled and effective workforce supported by an IT structure that is interoperable so patients and clinicians on all sites can easily access data.

Outcomes:

Outcome:	Metric inc. baseline	Timeframe
Standardised care, consistent across BSol	Performance against service standards.	2019
Improved patient outcomes	KPI metrics	2019
Improved utilisation of resources	Unit Cost	2019
Improved recruitment and retention	WTE vacancies/turnover rates	2019
Improved specialist cover	Turnaround times	2019

Stakeholder Engagement and consultation: NHSE, provider organisations, GPs, neighbouring STPs and patient groups.

Top 5 Milestones	2017/18	2017/18-2020/21
Cross provider project group established	X	
Development of 5 year phased plan for BSol	X	
Establish appropriate contractual models	X	
Phased Implementation		X

Context/Description:
It is estimated that 70%-80% of all healthcare decisions affecting diagnosis or treatment involve a pathology investigation. Pathology services exist on all provider sites across Birmingham and Solihull yet there is considerable variability in:

- Laboratory Technology
- Standard Operating Procedures
- Integration with EPR/clinical systems
- Turnaround times
- IT interfaces
- Extent of 3rd party test delivery
- Recruitment and retention
- Research

Demand for pathology is expected to grow as a result of:

- Increasing numbers of patients with chronic diseases
- Development of more personalised medicine and preventative medicine; rising patient and clinical expectations
- A shift to increasingly supporting frail patients in the community.

To improve quality and efficiency the Lord Carter Reviews argued for:

- Pathology networks with single management structures
- Laboratory collaboration/consolidation

Within the BSol footprint a combined Women's and Children's Foundation Trust and closer collaboration between University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust provides a real opportunity to develop a place based laboratory model that delivers best outcomes at best value. This will build on the system collaboration achieved on Genomics.

Investment required:
The level of investment required will need to be identified once model has been agreed

Estimated financial benefits:

- Improved productivity
- Reduced clinical variation
- Improved clinical outcomes

Risk	RAG	Mitigation
Lack of cross organisational commitment to transformation		STP governance structure Proposed reduction in provider organisations and improved relationships.
Availability of capital for IT, equipment, estate, transport and logistics		STP financial modelling and early discussions with NHSE regarding capital to support system integration.
Inability to realign existing MES contracts delays phased implementation		Effective relationships with suppliers and early engagement regarding the transformational strategy.

1b. Creating Efficient Organisations and Infrastructure: Back Office Savings

SRO: TBC | **Relevant leads: BSol CFOs**

Context: Partnership arrangements already exist between a number of the healthcare organisations in the city however there remains scope to go further in sharing back office functions and reducing costs within the city.

There are three key partnerships:

BSol CCGs	Working in collaboration with CCGs in the Black Country the BSol CCGs have recently re-procured CSU services resulting in savings in back office delivery. The three CCGs are now setting out a path to merging organisations which will further reduce duplication of roles and function, and allow more effective decision making at a footprint level. This will facilitate the move to commissioning of new models of care and reduce costs by over £5m.
Acute Providers	Significant enabler to change will be the proposed case for change by HEFT and UHB and also BCH and BWH plans. BCH / BWH have stated a clear willingness for UHB / HEFT to provide back office functions to them in future resulting in a shared service across the 4 main acute providers in the STP footprint. This will include Finance, HR, IT, Procurement and Payroll. ROH has expressed an interest in participating.
Mental Health/	BSMHFT are in discussion with partners within its region wide MERIT vanguard around sharing BCHC and reducing costs of back office functions. CHCFT, given its extended footprint across multiple STPs, is working with its partners in 'Transforming Care Together' around back office provision targeting savings of £1m.

Vision / Aims:
Working in partnership to delver effective back office functions

Minimising costs of delivery to allow retention of resources for front line delivery of healthcare.

Reshaping commissioning to work at BSol level and to move towards commissioning of new care models.

Workstream Summary and Key Milestones:

BSol CCG merger (subject to consultation) proposed for April 2018. Timescale to be confirmed around interim steps in agreement with NHSE with realisation of earlier benefit dependent on approval to progress to single management team and commissioning function.

Acute Providers – the proposed case for change by HEFT and UHB, and BCH and BWH plans. The transactions will immediately start to consolidate the 4 current back office functions into 2. For example, payroll by Nov 2016. A common clinical IT solution across BSol providers will be supported by UHB's 'NHS Global Digital Exemplar Funds' award.

Key Assumptions:

Wider governance changes within CCG and acute providers (BWH & BCH and UHB & HEFT) are supported through formal processes with regulatory bodies (including commissioners, NHS Improvement and the Competition & Markets Authority). Academic evidence indicates the management and corporate savings can be achieved within 6-12 months of a merger , providing detailed project plans are in place.

Key Challenges:

There a clear willingness for UHB / HEFT to provide back office functions to BCH/BWH in future resulting in a shared service across the 4 main acute providers in the STP footprint. Key challenges relate to timescale for delivery, the need to migrate to common IT systems/platforms and resource requirements (human and capital).

CCG merger arrangements have similar governance changes that require formal processes with regulatory bodies and challenges.

Key Interdependencies:

- Commissioning reform
- Provision of Facilities Management services is being led within the estates workstream and savings will be captured there.
- Fit for Future Secondary and Tertiary Services

Resource Requirements:

Resource requirements will be confirmed in individual business cases but will include capital investment to achieve common IT platforms/systems.

2. Commissioner CIP

SRO: Diane Reeves	Relevant leads: Mark Das Gupta / Alima Batchelor / Kate Arnold – Prescribing Sue Nicholls – CHC, Diane Reeves - Disinvestment

Context:

A number of commissioner derived savings remain outside of the core STP workstreams where these relate to specific functional areas related to more effective and cost efficient provision. The most significant of these are:

1) Prescribing

2) Continuing Healthcare

3) Disinvestment in less effective services

Vision / Aims: The aims of all three programmes of work are similar and noted below:

To ensure all patients receive the appropriate therapeutic intervention at the best value

To ensure that all patients eligible for CHC receive an effective service in a timely manner provided in the most economic way.

To maximise allocative efficiency into programmes of spend and services that are achieving required results.

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Workstream Summary and Key Milestones:

Prescribing has four key workstreams with a further (Carehome medication) within CCF
The remaining four workstreams are:

Waste Management
Polypharmacy Medication Reviews
Nutrition Reviews
Prescribing Efficiency (ensuring best price)

The CCG CHC strategy consists of a number of areas including

CHC Procurement
Utilisation of high cost packages
Personal Health Budgets

The CCGs are currently developing a prioritisation policy that will support the review and possible divestment from services which are not delivering outcomes envisage (conversely where localised services are having a greater impact these will be scaled up)

Key Assumptions:

Key Challenges:

Pharmacy workforce

Clarity of pharmacy requirements within GPFV

Market response to CHC pricing and procurement

Opposition to disinvestment of services

Key Interdependencies:

CCF - pharmacy schemes and enhanced medical practice

CCF – enhanced support to care homes

IT – remote working and access to patient records

Resource Requirements:

Resource requirements will be confirmed in individual business cases

3. STP Wide Estate Reconfiguration and Rationalisation

SRO: Paul Sheriff

Relevant leads: Guy Carson (Programme Manager), John Guggenheim (Finance Lead), Graham Seager (Acute), Mike Lyden (Primary Care) and Phil Andrews (Local Authority)

Organisations involved: All organisations within the BSol STP footprint

Strategic objective:

To create an estate footprint that is fit-for-future purpose and flexible enough to adapt to and support changes in clinical service models, without the need for additional significant capital investment. This will be achieved by:

- Initial disposal of unused, poor condition, and/or surplus estate to fund estate change programme
- Reduce the known areas of estate void (e.g. in LIFT buildings) and implementation of other innovative opportunities to repurpose existing buildings enabling the delivery of high quality place based clinical services within the natural communities
- Ongoing oversight of estate utilisation across Birmingham and Solihull and planned use on a footprint-wide basis to realise additional benefits and optimised estates utilization.

Outcomes:

Outcome	Potential Metric	Timeframe for delivery
Reduced estates running costs	£m^2	12-18 months
Reduced variation in quality of estates across the footprint	Building condition	18-24 months
Optimised use of estates facilities which meet the future needs of the population for health and social care	Utilisation	18-24 months

Key milestones:

- *In 3 months* we will complete the mapping exercise to provide a baseline for Estates
- *In 6-9 months* we will have identified of surplus estate, proposals to reduce LIFT voids, and identification of other quick win estates initiatives, including options appraisal for identified opportunities
- In *9-12 months we will* have achieved consensus between health and local authorities for a shared approach to estates (One Public Estate and West Midlands Combined Authority) and BSol-wide Estates strategy agreed
- *In 18-24 months we will* have closed unused/surplus estate and delivered other quick win opportunities

Critical decisions to support next steps

- Clarification on potential sources of capital funding to support immediate changes to Estates e.g. Estates Technology Transformation Fund (ETTF) and other sources for investment
- Identify and agree which, if any, Head Leases and/or Freeholds should be obtained from NHS Property Services and CHP to provide the ability and flexibility to make changes to the existing estate and service charge provision

Stakeholder engagement and consultation:

- Repurpose the Local Estates Forum (LEF) to encompass all organisations within the footprint. Principles to be agreed to secure buy-in to the estates vision and quick-win opportunities
- Further engagement with STP programmes and enabling workstreams to develop quick win opportunities

Context/Description:

- The BSol footprint currently comprises circa 650 buildings with 1000+ property interests. The quality of estates is variable across the footprint, a large number of poor quality buildings in Birmingham, and overstretched buildings in Solihull. There is a clear need and opportunity to address poor quality and sub-optimal estate through a planned programme of rationalisation and investment, that will transform care across primary, community, and acute settings and provide an equitable estates footprint for the population of BSol
- An initial baseline for Estates has been completed, and work continues to establish a full asset baseline and condition report for all buildings. Some progress has been made towards identifying initial quick win opportunities that will increase utilisation of modern LIFT buildings providing the potential to enhance primary care and integrated services, and enabling disposal of unused, poor condition, or surplus estate. Further opportunities to make the Estate more efficient and cost effective will be achieved in response to the Carter recommendations.

Investment requirements:

Investment requirements for Estates is still being developed to align with the emerging future models of care, however the underlying assumption is that there will be a need for investment to upgrade and improve the Estate, and optimise the use of under-capacity buildings. This will be self-funded wherever possible by the programme e.g. through benefits realised by quick win disposal of buildings, assuming that capital receipts can be retained, and/or re-profiling of ETTF resources, but centrally provided and other sourced finance will be required for larger strategic schemes

Estimated financial benefits:

Ongoing work by the Estates programme suggests that there are potential benefits of £26m to be realised through quick win estates opportunities, however only £13m has been included currently as a risk-adjusted and prudent savings figure, agreed with FDs, whilst detailed work continues to qualify the additional financial benefits. Quick win opportunities include: reducing LIFT buildings void, disposal of unused or surplus estate, compliance with Carter benchmarks and other hard/soft FM opportunities.

Key underlying assumptions have been identified and are being worked through in further detail to validate the estimated benefits. Additional savings opportunities will also be identified as the Estates Strategy is further developed to support new models of care.

Risk	RAG	Mitigation
Not all stakeholders (internal or external) agree to estates plans		LEF Terms of Reference, Stakeholder engagement and Consultation, Escalation through STP PMO
The STP is unable to obtain the Head Leases or Freeholds to dispose of, or make necessary changes to Estates		Workshop in October with LIFT and Community Health Partnership (CHP); STP to apply for capital receipts
Quick win opportunities do not realise the full estimated benefits		Robust baseline developed, Key assumptions identified, tested and updated
The STP cannot retain capital receipts to fund future estate plans and developments		System to refine and clarify rules and procedures, and remove barriers to single year funding

Transformed primary, social and community care

Community Care First

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

4. Community Care First – Summary (page 1/2)

SRO: Tracy Taylor

Relevant leads: Les Williams (Programme Director) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, BSMHT, Local Authorities

Strategic objective:

Delivery of a new planned and deliberate care model which moves activity from secondary care into primary and community care settings through:

1. Urgent Care

- Development of 4/5 urgent care centres/integrated service hubs across the footprint, providing immediate access to urgent primary care, diagnostics, pharmacy, treatment of minor ailments (receiving WMAS conveyances), minor procedures
- A single accessible model for step up and step down urgent care services which prevent emergency admissions and enable speedy and effective discharge (recovery model)
- Expansion of 111 as a single point of access for joined up urgent care offer

2. Long term Conditions

- Development of community based multi-disciplinary teams (MDTs)
- Delivery of proactive care management pathways
- Development of a targeted preventative offer for self management and community resilience
- Definition of targeted population for MDT/Integrated Care Network support based on place

3. Enhanced General Medical Practice

- Improve sustainability and resilience of GP through new support team
- Support delivery of the GP Forward View
- Offer an enhanced 8 till 8 service to support patients and improve accessibility
- Development of universal offer and Practice of the Future
- Model based on 29 'natural communities'

4. Children and Young People (CYP)

- Service offer based on the Complete Care For Children model
- Delivery of paediatric integrated community teams on an MDT/ICN basis
- Implementation of a 24/7 rapid response team to meet complex care requirements
- Broadened early intervention offer to reduce crisis and avoid admissions

5. Health and Wellbeing

- Build community resilience through information, advice and guidance
- Use of population based digital interventions
- 3rd sector lead interventions – growing current capacity

Key milestones:

In Year 1 we will:

- Have fully tested financial modelling and obtained system wide sign off to savings targets
- Clarify investment totals and where the funding is to be obtained (critically the pump priming)
- Create further detailed project plans setting out the how we plan to rollout these workstream deliverables
- Clarify ongoing resource to deliver the workstreams
- Put in formal request to draw down initial funding to utilise from 2017/18

In Year 2 we will:

- Design and start phased roll out of the schemes
- Establish the provider incentives and contractual frameworks

Context:

Locally we are applying the NHS Five Year Forward View (5YFV) policy drivers to design this programme to address specific local problem. Birmingham is in the worst quartile on a number of key metrics which these workstreams will address:

- 1 in 3 children live in poverty
- People are 3x more likely to have a mental health condition, be admitted for ambulatory sensitive conditions and die from conditions amenable to healthcare
- There is a 10 year life expectancy gap of 7 years between richest and most deprived areas
- National outlier for infant mortality
- 13% (Sept 16) of primary medical services require improvement
- GPs and nurses in primary care per 1000 pop 2nd worst nationally (also see outcomes targets)

Vanguards and GP Access Fund (wave 2): There are 2 relevant programmes in BSol and we will use these to build in best practice: Solihull Together and MyHealthCare (South Birmingham)

Out of Scope: STP Plus programmes, Secondary and Tertiary care, acute Mental Health services, Maternity and Newborn, core GMS contract, investment in estate and digital

Outcome	Metric inc. Baseline	Timeframe
Reduce number of emergency admissions for ambulatory case sensitive conditions	Target: 632.1 per 100,000 Decrease of 308.7, 32.81% (WQ)	2020/21
Reduction in A and E attendances	Target: 17% reduction (adults), 22% children Baseline: 403,225 p.a (deloitte review)	2020/21
Reduce hospital admissions for falls injuries	Target: 1600 per 100,000 Reduction of 763, 23.63%	2020/21
Reduce delayed transfers of care	Target: 5 per 100,000 Reduction of 12.6 per 100,000, 72% (WQ)	2020/21
Improve quality of general practice	All GP practices rated Good or better by CQC. Baseline: 13% Require improvement or inadequate Sept16 (was 27% Apr 2016)	2019/20
Reduce number of emergency admissions of Geriatric and General Medical Take to be treated in AEC	Target: 25% reduction	2020/21
Reduce A and E attendances through the Enhanced General Medical Practice Universal Offer and UCC's	Target: 30% reduction	2020/21

In Years 3-5 we will:

- Full implementation of deliverables as set out in each workstream
- Move towards Business as Usual with these workstreams
- Embed deliver and review whether outcomes are being delivered
- Review whether savings targets were met

4. Community Care First – Summary (page 2/2)

SRO: Tracy Taylor | **Relevant leads:** Les Williams (Programme Director) and Angela Szabo (Finance Lead)

Critical Decisions to support next steps:

The Programme has been ambitious and bold in setting out the possible extent of change, but there remains more work to be done including further development of the Milestones. More engagement with the Secondary and Tertiary Programme is needed as the CCF Programme represents a change to the level of activity undertaken in traditional acute settings.

The approach in the Programme's 'bottom up' activity and financial modelling is based on the use of national and local modelling assumptions. These were circulated to the Finance Directors' Group after our presentation to their meeting on 18th August, but have not been discussed in any more detail as yet.

In the absence of system-wide agreement, the approach on funding of the reinvestment identified is based on a combination of resources released in commissioner spend from secondary settings and use of the STF and this is highlighted on the relevant sub-programme plans. It is acknowledged that this remains for discussion and agreement, as does the potential level of investment in the Enabler programmes of IT (LDR) and Estates, including the ETTF.

The arrangements for staffing the Programme and workstreams beyond the October submission date are not agreed as yet and this remains a critical decision to be made at STP level.

Stakeholder engagement and consultation:

Regular meetings with BSol GP providers and BSol GP Alliance, LMCs, Patients and Public, Urgent Care teams, Pharmacy, Acute and Community Providers, Mental Health Services, Public Health, 3rd Sector, Local Authority Social Care Teams, Nursing and Residential Homes and West Birmingham STP Partners

Modelling

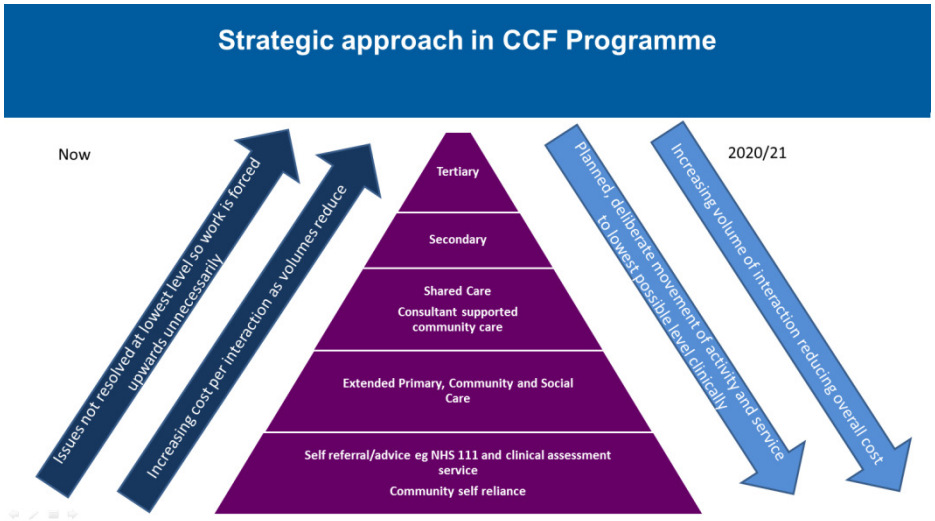
The CCF Programme has undertaken detailed modelling of the opportunities for moving the location of care to community and primary care settings, based on a combination of national and international best practice and achievement of radical ambitious change in the delivery of care. This has indicated on overall opportunity in the range of £30m-£88m net saving for the STP footprint.
This identifies a range of changes and issues which now need to be discussed with providers in greater detail, particularly through the Secondary and Tertiary Programme.

Impact on capacity:

Impact on bed base by 2020/21:

- The modelling has identified sufficient opportunities to avoid the need to open the additional 430 beds over the current baseline which would otherwise be required as outlined in the 'do nothing' option.
- Early modelling suggests the initiatives identified will enable a proportion of existing acute capacity at tertiary hospitals to be freed up to accommodate the expected increase in tertiary work as a result of the National Specialist Commissioning Strategy
- The opportunity to reduce enhanced Assessment/ Discharge to Assess beds by a range of 80- 180 also exists

Our new model



Risk	RAG	Mitigation
More engagement and contractual incentives required for secondary care to fully support and engage in programme design		STP governance lead appointed. Clarity on wider STP programme governance post submission
Unforeseen reduction in social care impacting on community offer		Shared understanding of LA savings and impact on services
Definition of required workforce and pressures on recruitment and retention of key roles		Involvement of Health Education England and local workforce planning for MDTs/ICNs
Failure to engage and persuade patients and professionals on a new care model		STP agreed communications and engagement strategy needed – including consultation
Level of investment required		Managing demand for secondary care services to release funds for CCF

5. Community Care First: Solihull Together (Page 1/2)

SRO: Patrick Brooke/ Nick Page	Relevant leads: Helen Kelly – Programme Director, Stephen Munday DPH, Dr Mike Baker Solihull CCG GB member, Viv Tsesmelis UHB/HEFT, Sue Hartley BSMHfT

Organisations involved*: HEFT/UHB, SMBC, Solihull CCG, BSMHfT, Solihealth (Primary Care)*

Strategic objective:

The future ambition of Solihull Together is to build upon our strong partnership approach to deliver a community-based model of integrated care. This will transform a system now focused on higher cost acute care to one focusing on earlier interventions, prevention, and wellness that are lower cost, within the context of a sustainable whole system.

This objective will now incorporate the wider ambitions of the STP where it makes sense for a 'place based' approach.
The change programme has already been progressing the four Vanguard service changes as follows:

1. Community Wellbeing Service - improving wellbeing, preventing ill health and escalation of LTCs through provision of advice and support, active management, and coaching that facilitate individual behaviour supported by tools such as wellbeing measures and Patient Activation Measure.
2. Integrated Primary and Community Care Service- transformation and integration of our primary and community teams in to one service that 'wraps around' the needs of the patient, using an MDT approach for at risk cohorts such as complex health and frailty.
3. An improved urgent care service - A joined up approach to urgent care through co location and integrated system working, e.g. Urgent Care Centre and Local Clinical Decision Hub.
4. Digital Population Health and Care Information System – learning from international models a commitment within the Global Digital Exemplar to align population health and care information system to benefit clinical and patient's requirements for access to records, information and analysis which will support flow, decision making and real time information for performance and outcome monitoring.

Outcomes	Draft Metric	Delivery timeframe
Reduction in DTOCs to 2 per 100,000	2	20/21
Percentage of deaths which take place in hospital	42%	20/21
Increase the proportion people with long term conditions feeling supported to manage their condition	BSol ambition to be in quartile 2 of the national data	20/21
Trialling National UEC System Data pack	TBC	20/21

Context/Description:

Solihull Together is a partnership of Solihull CCG, Solihull MBC, Birmingham and Solihull Mental Health NHS FT, Heart of England NHS FT and Solihealth (GP partnership), voluntary and third sector.

- Solihull Together was awarded UEC Vanguard status in August 2015.
- Value Proposition developed and awarded transformation funding in 2016/17 of £1.3m
- The Value Proposition is based on agreement of the Leaders within Solihull Together for a whole system total population approach based on local financial and service challenges which will deliver a sustainable and transformed system, delivering better clinical outcomes and patient, public and staff experience.
- Financial Modelling within our Value Proposition has been the basis of the work and is now included within the STP CCF programme..
- Approach is to accelerate delivery and proof of concept, in Solihull, of a place based model of care which can be replicated and scaled up across the BSol STP.
- Solihull has a relatively high proportion of older people, predicted to continue to rise with a largely acute based system. A priority area is the development and implementation of frailty pathways in Solihull as a centre of excellence, which can be rolled out across BSol footprint.
- To achieve a reduction in DTOCs to 2 per 100,000 to reflect our whole system partnership.
- Firm commitment to continue to evolve the place based model to meet the changing needs of people and improve care quality, access and affordability.
- Main interdependencies - IT, workforce, bed base (particularly community beds), care homes, domiciliary care providers and general market management.

Key milestones:

*In year 1 we will***:**

- Local Area Co-ordinators ('LAC') effectively working with communities, addressing isolation and prevention of escalating needs of people who do not meet current eligibility criteria for formal services.
- Care Navigators working as part of Integrated Community Teams, to impact on admission avoidance; readmissions and to divert/reduce activity in GP.
- Local clinical hub implemented to optimise the use of the Mobile DoS;
- Rapid community response and replicable frailty pathways;
- Scaled up Patient Activation Measure licences used to support people with LTC;
- Scope digital health and care system required for operating model.
- Developed a shared set of system measures

In year 2 we will:

- Define future place based model including firmly understood costs and value.
- Agree appetite for risk within the system.
- Implement an appropriate governance model for implementing a proactive place based system;
- Patient Activation Measure (PAM) Licences fully implemented across Solihull
- Increased digital technology;
- Increased coproduction and engagement of citizens in health and wellbeing

In year 3 we will:

- Align incentives and appropriate governance to drive and sustain place based model
- Collaborate with wider stakeholders to maximise transformation and ambition.

5. Community Care First: Solihull Together (Page 2/2)

SRO: Patrick Brooke/ Nick Page	Helen Kelly – Programme Director, Stephen Munday DPH, Dr Mike Baker Solihull CCG GB member, Viv Tsesmelis UHB/HEFT, Sue Hartley BSMHfT

Organisations involved*: HEFT/UHB, SMBC, Solihull CCG, BSMHfT, Solihealth (Primary Care)*

Current Financial Position*:

- Vanguard Financial Modelling has been the basis of and included within the CCF programme.
- 5-Year Return on Investment (total revenue funding) calculated within our Vanguard as 27%.

£M unless stated		2016/17	2017/18	2018/19	2019/20	2020/21
	Gross savings	0.00	0.32	2.19	4.71	5.05
Revenue costs	From Vanguard	1.30				
	From Local Contribution	0.00	2.01	2.01	2.01	2.01
	Total Revenue Costs	1.30	2.01	2.01	2.01	2.01
	Net savings	-1.30	-1.69	0.18	2.70	3.04

Critical Decisions to support next steps:

- Vanguard Programme funding for 2016/17 is £1.3m used to deliver Vanguard projects - Local Area Coordination, Care Navigators, Integrated Urgent Care and Digital Population Health and Care Information System.
- Confirmation of allocation of 2017/18 transformation funding to continue projects to realise return on investment
- Development of Place Based approach to deliver wider STP ambitions

Investment requirements:

2017/18 - £1.3m to maximise RoI of Vanguard projects

Impact on capacity:

Impact on workforce by 2020/21:

Workforce model *ensuring that staff work to the 'top of their licence' with less skilled tasks being delivered by generic staff i.e. care navigators;*

Enhanced roles within primary and community care, with specialist input as required, to meet the care needs of people with LTC and complex needs

Stakeholder engagement and consultation:

Solihull Together is sponsored by Solihull Health and Wellbeing Board (H&WBB)
Development of the programme has been with stakeholders and experts by experience.
We will continue to utilise these mechanisms as new projects are established.

Key risks:

Risk	RAG	Mitigation
Transformation funding for 17/18 not available which is critical to achieve the Return on Investment		Ensure Vanguard is sited within STP to access STF
Operational and clinical leads focused on short term business as usual		Senior leadership support for delivery of transformation and new model of care and a development model that engages at all levels.
Sustainable workforce to deliver new care model		Develop workforce plan which includes Voluntary and 3rd sector
Impact of organisational decisions which have unidentified consequences for delivering Vanguard		Leadership meetings in place to align strategic direction and support transparent communication

6. Community Care First: Improving Health and Wellbeing (page 1/2)

SRO: Dr Adrian Phillips / Dr Stephen Munday

Relevant leads: Jacquie Ashdown (Public Health Consultant); Lynn Gibbons (Specialty Registrar in Public Health) and Carol Herity (Programme Manager)

Organisations involved: All Public Sector including councils, acute, community, maternity, mental health and primary care providers

Strategic objective:

To enable people to achieve 'active, meaningful and independent lives', through addressing the following priorities:

- Tackling Primary Care Variation
- Employment and Health
- Vulnerable Groups
- Early Years
- Increasing Physical Activity across the population
- Radical upgrade in prevention

Outcome	Metric Inc. Baseline	Timeframe
Increase in proportion of vulnerable groups in meaningful work	• Baseline 5% of those on Care Programme Approach in meaningful employment. • Increase to 9%	2020/21
All public sector organisations to implement PHE Workplace Charter	• Delivery of the Health and Wellbeing CQUIN by 2017 • All Public Sector (PS) organisations to implement Workplace Charter (JA) • Reduction in sickness rates	2020/21 2020/21
Reduction in number of those who receive incapacity benefit	• 59,000 across Birmingham and Solihull, 5% reduction to 56,000	5% reduction by 2020/21
A radical upgrade in Prevention including effective use of new technology, social media and supported behavioural change	• 8% prevalence rate of smoking in pregnancy • 13% prevalence rate of smoking in all adults • Reduction of 10% smoking and alcohol attributable hospital admissions. A decrease in physical inactivity – 36.2% to 35% Birmingham. 27.1% to 26% Solihull	2020/21 2020/21 2020/21
Increase people with LTC feeling supported to manage their conditions – linked to LTC workstream	• Target 66% by 18/19 (increase of 3%), 72.5% by 2020/21 (increase of 8.9% (within LTC workstream)	2020/21
Increase in readiness for school – Public Health Outcomes Framework	As measured via the 2/2.5 yrs. development check. Baseline for school readiness, current baseline for school readiness 61.9% Bham, 75.5% Solihull. Target to be agreed.	2020/21

Critical Decisions to support next steps:

- Sign up to workplace charter and brief intervention skills across the system and all providers
- Employment critical part of mental health workstream

Stakeholder engagement and consultation:

All public sector including councils, acute, community, maternity and mental health providers, primary care through public health leads for each STP work stream, and patients and the public

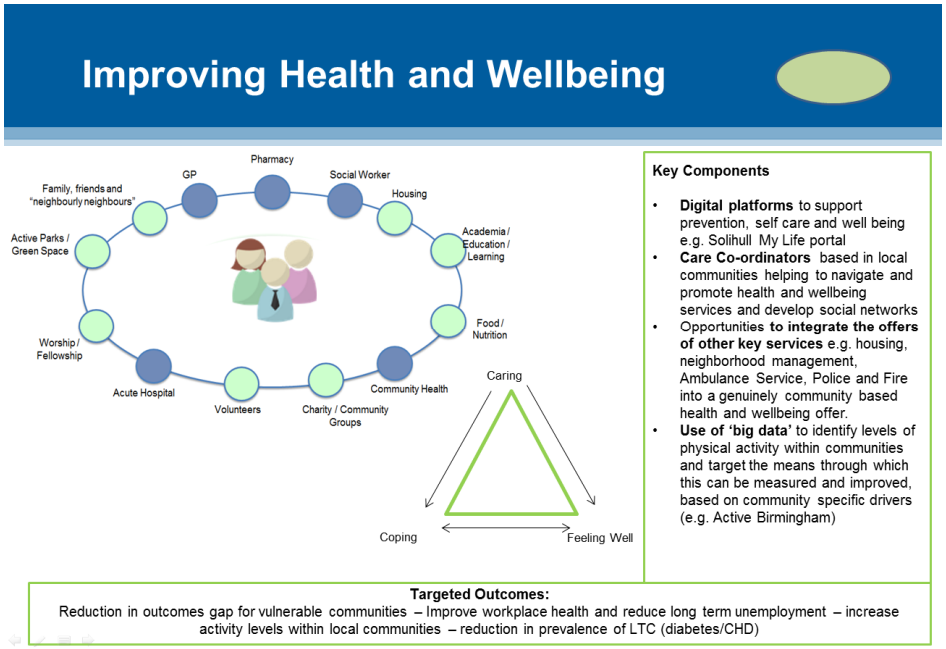
Context:

The aim of the Improving Health and Wellbeing (IHWB) workstream is to address the gap in life expectancy, quality of life and life chances across the life course. Through analysis of the characteristics of the bottom 10% of our population and vulnerable groups we have identified 6 HWB priorities (above in Strategic Objective). It is recognised that these need to be addressed and are an inherent part of the all the STP work programmes and not just Improving Health and Wellbeing workstream.

The focus of interventions will be on:

Those that are in the lower 10% are 3 times more likely to be admitted for ambulatory care sensitive conditions, die prematurely from conditions amenable to healthcare, 2 times more likely to be in contact with Mental Health Services, have a Long Term Condition, and more likely to be obese in child and adulthood. Key issues include:

- Our High Infant Mortality (7.1 in Birmingham, 4.7 in Solihull deaths/1000 live births)
- A significant health inequality gap exists particularly in north Solihull and east/central Birmingham
- Life expectancy and healthy life expectancy are lower for both men and women in Birmingham compared to England
- Cancer and CHD are the leading causes of the life expectancy gap



6. Community Care First: Improving Health and Wellbeing (page 2/2)

SRO: Dr Adrian Phillips / Dr Stephen Munday

Relevant leads: Jacquie Ashdown (Public Health Consultant); Lynn Gibbons (Specialty Registrar in Public Health) and Carol Herity (Programme Manager)

Top 5 Milestones	Actions for Year 1	Actions for Year 2	Years 3 to 5
Radical upgrade in prevention and promotion of wellbeing across the system with a focus on vulnerable groups, physical activity and across the life course	First 6 months: scope discussions and development Agreement achieved through commissioning round with each of the providers. Ensuring Making Every Contact Count (MECC) and in line with Combined Authority develop BSol Physical Activity Action Plan. Scope technological support required.	All Public Sector Organisations (PSO) have signed up to MECC in workforce development. Front line staff are being training in the delivery of Brief Intervention, with a focus on priority areas and vulnerable groups. Action Plan developed for Physical Activity. Implement technological change required to modify public behaviour in seeking help and promoting activity.	Priority area trained (Yr3) 70% of all PSO staff are skilled in MECC+ (Yr4) All PSO staff are skilled in MECC+ (Yr5)
All public sector organisations implement PHE Workplace Charter (WC)	First 6 months: scope discussions and development 6 – 12 months: development of a HBW CQUIN through the commissioning round. Identifying the role of PSO as a major employer and identify how each organisation can improve the HWB of their staff. The HWB CQUIN for each organisation delivered according to their Action Plan and being monitored as part of the contract agreements Agreement to the delivery and initial action plan for the PHE workplace charter by all PSO	Action plan for the implementation of the PHE workplace charter completed and delivery commenced by all PSO	Implementations starts (Yr3) 75% implementation (Yr4) Full Implementation of WC in system (Yr5)
Integrated Early Help Teams and parenting to identify potential and real ACE (Adverse Childhood Experience)	First 6 months: Public Health working with Children and Young People's workstream will identify and develop evidence based models of early intervention and parenting 6-12 months : Programme roll out	Will work with Children's and Young People's workstream on the implementation of the roll out programme across Birmingham and Solihull	Long term reduction in cost across the system (Yr5)
Increased proportion of vulnerable groups in meaningful work	First 6 months: discussions and development with workstreams 6-12 months: work with Mental Health and Wrap Around services to incorporate meaningful work, through influencing the Mental Health workstream	Continue to work with Mental Health workstream to ensure roll out of this intervention	Incremental increases Increasing to 9% (Yr5)
Universal place (including those with LTC) based health and wellbeing services to support independence through information and advice (including use if technology and social media), early support, rehabilitation, behavioural change connecting with community assets and local opportunities, including technological solutions	First 6 months: plan a scoping exercise to understand what is currently available and its format to enable development of a universal offer for Health and Wellbeing 6-12 months: implement scoping exercise	Using the intelligence from the scoping exercise to Identify gaps across the system. Develop a clear plan of interventions and development of a clear plan for delivery, including use of technology and social media.	Implement planned roll out of community wellbeing offer (Yr4) Increase those undertaking self care (Yr5)

Financial Benefits: n/a

IHandWB is an enabling workstream generating savings allocated to other CCF workstreams, stranded costs in acute not included, savings/investments to be approved.

Impact on capacity:

Impact on workforce by 2020/21: development of implementation of MECC+ and 5 Ways. Seamless referral to HWB services and opportunities

Impact on bed base by 2020/21: Detailed in other CCF plans

Risk	RAG	Mitigation
Prevention agenda is not integrated within pathways and across STP workstreams		Prevention integrated in all STP and workforce plans
Workforce Charter not implemented across the system		Incremental implementation through Commissioning Intentions
Infrastructure not funded to implement place based and technological approach to HWB		Clear plan across the systems and natural communities

7. Community Care First: Stabilised and Enhanced General Medical Practice (EGMP) Workstream (page 1/2)

SRO: Dr R Mendelsohn / Dr P Thebridge / Dr A Waddell

Relevant leads: Simon Doble (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, BSMHT, Local Authorities

Strategic objective:

The overarching objective is to co-ordinate, oversee, guide and monitor the implementation of the Enhanced General Medical Services strategy to deliver the Community Care First and out of hospital vision and objectives across the STP. The workstream supports the delivery of the 5YFV and GP Forward View (GPFV). The key focus is to develop an enhanced general medical practice offer which is aligned to long term conditions (LTC) priorities and preventative interventions (initially focussing on Frailty, Respiratory, Diabetes, End of Life and Dementia pathways) to deliver the place based integrated community model through a multi –disciplinary team approach (MDT)

- This will include work stream delivery against the following objectives:
- Sustainability and resilience of General Medical Practice (all practices rated good or better)
- A Universal Offer for Enhanced General Medical Practice to reduce health inequalities and improve health and wellbeing of population (to include the review and redesign of current LIS Schemes)
- Extended Access to General Medical Practice 8am to 8pm
- Practice of the Future 2020 – to be worked up with GPs

We will build on existing examples of good practice where enhanced general medical practice and community care are supporting these objectives such as the GP Access Fund 'MyHealthcare' model and the Solihull Together Partnership. We will use the LDR/City4Age and estate review/rationalisation to deliver a radically different approach to delivery of patient care.

Outcomes:

Outcome	Potential metric	Timeframe
Increase in number of patients reporting satisfactory patient experience of general practice	Target: 79%, increase of 10.1% on current baseline	2019
Increase in patients able to access general practice in and out of hours –% of patients able to get an appointment to see or speak to someone	Target: 75%, increase of 8.12% on current baseline	2019
Reduce number of General Practice DNAs	Target: 3.75%, decrease of 3.95% on current baseline	2020/21
Sustainable General Practice – 100% of practices rated as Good or Outstanding by CQC	100% of practices	2018

Context/description:

BSol CCGs have made strong progress in supporting member practices to achieve improved quality outcomes as at September 2016. 13% Primary Medical Services are deemed by CQC as 'Requires Improvement or Inadequate' as at Sept 2016 – compared to STP data pack position of 27% as at April 2016 (illustrating a14% improvement).

NHS FYFV and the GPFV focus on the changing role of general practice and the expectation for GPs to play a key role in the wider co-ordination of care in the community. This work stream delivers against these national drivers.

Issues:

- 2nd lowest in country for GPs and Nurses per thousand of the population
- Nearly 1 in 4 of current GPs are aged over 55 years
- Delivering coherent service plans for populations at scale.
- Definition of natural communities

In Scope:

- Enhanced General Medical Services/Medicines Optimisation (GP and Community)
- Reducing unwarranted variation in primary care/GP Access/Sustainable **U**niversal offer for patients

Out of Scope:

- Core General Medical Services/Out of Hours/People working but not registered with a GP within BSol
- Boundaries/Pharmacy (Dispensing) Optometry and Dental Services

Work Stream Dependencies:

Other CCF work streams/Workforce capacity/capability/IMandT and Estates/Communications and Engagement/Contractual Models

Servic**e Dependencies**:

Urgent Care/Community Pharmacy/Community Nursing Services/Community Mental Services/Social Workers/Third sector/Acute providers/Public health

Critical Decisions to support next steps:

Support for further MCP vanguards/Model for extended vs. enhanced core access/operational leadership at natural communities level/role of CCG locality commissioning networks – decisions will be supported through further dialogue with the GP Alliance and STP Board and further supported by ongoing NHSE guidance on new models.

Impact on capacity by 2020/21:

- Improve ratio of GPs and nurses per 1,000 population – deliver GPFV, BSol share of 5000 additional Doctors over 5 years = 114 increase FTE
- Deliver the GPFV BSol share of 3000 practice based Mental Health therapists = additional 68.4 FTE
- Deliver the GPFV BSol share of 1500 co-funded practice clinical pharmacists = additional 34.2 FTE
- Reductions in bed base are included in other workstreams and overall CCF position

7. Community Care First: Stabilised and Enhanced General Medical Practice (EGMP) Workstream (page 2/2)

SRO: Dr R Mendelsohn / Dr P Thebridge / Dr A Waddell

Relevant leads: Simon Doble (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, BSMHT, Local Authorities

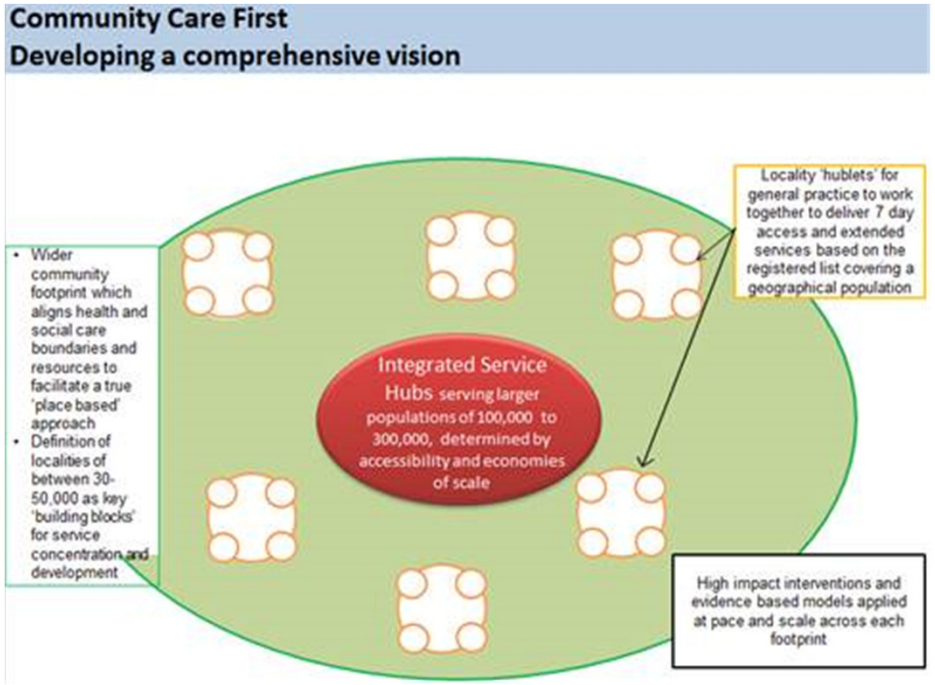
Key Milestones

In Year 1 we will:

- Establish a governance structure including steering group and four supporting workstream groups, by Jan 17 – as follows:
  - Sustainability and Resilience of General Medical Practice
  - Universal Offer for EGMP
  - Extended access to General Medical Practice
  - The Practice of the Future
- Scope and develop a response to the GP Forward View Planning Requirements (January 17)
- Continue stakeholder engagement alongside the wider STP (January 17)
- Develop draft working model of Practice of the Future (May 17)
- Agree the road map for primary care at scale/New Models of Care (May 17)
- Scope the requirements of the universal offer (May 17)
- Scope a framework to support practice sustainability and resilience (May 17)
- Agree the plan for extended access to meet the requirements of the GPFV (May 17)
- Understand and have a costed plan for tackling workforce and workload issues (May 17)
- Commence sustainability programme for General Medical Practice (October 17)
- Implement the ten high impact changes across 10% of practices (October 17)
- Roll out the universal offer to support enhanced general medical practice (October 17)
- Have at least one new model of care progressing through the road map towards an ACO (October 17)

In Years 2/3 we will have:

- Made progress to all practices being CQC rated as good or better
- Have extended and improved access in line with the requirements of the GP Forward View (March 19)
- Deliver sustainable at scale general medical practice, fully engaged and supporting the STP LTC Pathways and objectives



Stakeholder engagement and consultation:

Regular meetings with BSol GP providers and BSol GP Alliance, LMCs, Patients and Public, Urgent Care teams, Pharmacy, Acute and Community Providers, Mental Health Services, Public Health, 3rd Sector, Local Authority Social Care Teams, Nursing and Residential Homes and West Birmingham STP Partners.

Risk	RAG	Mitigation
Failure of Secondary and Tertiary providers to support CCF model and LTC pathways – failure to get funding released from STF to support CCF programme		City Council are STP lead. STP includes Secondary and Tertiary programme. Supported by financial plan and STP Governance Structure.
Universal sustainability and resilience of General Medical Practice is not realised		Resilience workstream, GPFV support programme and Workforce Development programme
New models of care are not clinically or cost effective in isolation		Initial evaluation of GP Access Fund model – taking forward findings
Offer is not equitable across GP providers and natural communities and is over medicalised		Explore methodology for health inequality impact assessment. Include and engage with LA and public. Contractual delivery of universal offer
Primary care feels alienated by change process		Include GP Alliance/LMC on steering/workstream groups, member consultation

8. Community Care First: MyHealthcare -GP Access Fund

SRO: Dr R Mendelsohn

Relevant leads: Simon Doble (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: MyHealthcare (Southdoc Services), MyHealthcare Practices , Digital and 3rd sector partners- Birmingham Community Healthcare Foundation Trust, Birmingham City Council, CCGs

Strategic objective:

The MyHealthcare model is a successful provider bid for Wave 2 of the NHS England - GP Access Fund. 23 of BSC CCG's practices came together under the umbrella of South Doc Services (a GP co-operative) to deliver an innovative programme working across three geographic hubs to provide place based care.

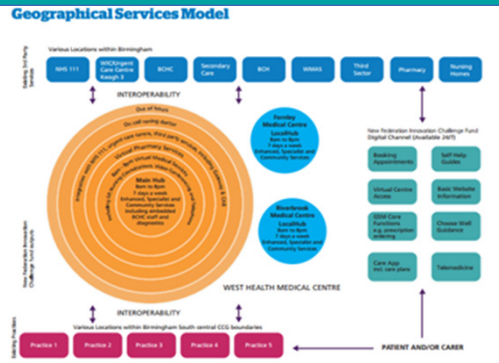
- The intention was to extend GP opening hours and redesign the interface between primary care, community based services and urgent care providers so that patients are able to access a range of services via a single point of contact. The model includes integrated working with the Urgent Care System (NHS 111, South Birmingham Walk In Centre and A and E)
- Service provision has been enhanced so that patients have access to a full range of General Medical Services and enhanced clinical services complimented by pharmacy and nursing support, health, wellbeing and lifestyle services. Creation of the infrastructure and capacity to shift services to a community setting.
- Services are delivered using both physical and virtual platforms via a 'Hub and Spoke model'.
- Patients access services using traditional methods and digital technologies giving a wider range of options to meet their varying needs. Patient Facing Digital services as per 2020 Personalised Health and Care (NIB)
- The model commenced in July 2015 and was successfully scaled up to support last year's winter pressures.

Context:

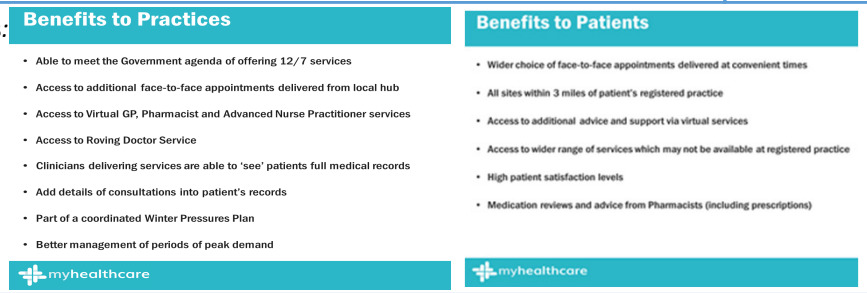
- Developing a new model of care – partnership approach between GPs, MyHealthcare, BCHC, Birmingham City Council
- The model fits well with the STP CCF and Enhanced General Medical Practice Vision and aligns to the GPFV
- The model supports the Local Digital Roadmap and vision for the STP
- The model creates efficiencies and resilience through primary care at scale that benefit whole system.

Service Scope:

- The service currently operates between 8:00am-8:00pm, 6 days a week (with Sunday opening responding to local demand). Delivering on the 7 day care agenda.
- Each element of the service reduces the waste of clinical time and inappropriate demands on urgent care services.
- This creates a systematic approach to alleviate access issues and service pressures by introducing extended hours and increasing the range of services available, with the aim being to convince patients that there is a viable OOHs alternative to A and E.



Outcomes:



Model based on population of 334,000 patients, supported by 1 Main/Virtual Hub, 3 Local Hubs, 2 Mini Hub

* Main hub includes - ICT/Operational Management/Comms

Service	Cost per patient	
Main Hub/Virtual Hub*	£	4.71
Local Hubs	£	2.15
Mini Hubs	£	0.81
Total	£	7.67

Top 3 milestones:

Milestone	Y1	Y2	Y3	Y4	Y5
Rollout across MyHealthcare Federation	Implementation of sustainable model across federation	Move from pilot phase to business as usual	Review cycle	Review cycle	Review cycle
Rollout of Digital Platform	Ongoing development with phased implementation	Ongoing development with phased implementation	Review cycle	Review cycle	Review cycle
Development of MCP	Develop model(s)	Phased implementation	Phased implementation	Phased implementation	Full implementation

Critical Decisions to support next steps

STP support for MCP vanguard application/Model for extended v enhanced core access/operational leadership at natural communities level/relationship to other new models of care/ most appropriate contractual framework

Stakeholder engagement and consultation: Regular meetings with MyHealthcare Practices, BCHC, BSol GP providers and BSol GP Alliance, LMCs, Patients and Public , Urgent Care teams, Pharmacy, Acute and Community Providers, Mental Health Services, Public Health, 3rd Sector , Local Authority Social Care Teams, Nursing and Residential Homes

Impact on capacity:

The GMS Contract specifies that GP surgeries must provide services for a minimum of 52.5 hours per week (minus contracted half days). Patients registered with My Healthcare are able to access services for 84 hours per week giving a total of 31.5 additional hours of access per general practice each week. Between December 15 and May 16 there have been at least an additional 32,527 completed appointments as a result of MyHealthcare (the total number will be far higher given the service commenced in a phased manner from July 15.

Top 3 risks:

Risk	RAG	Mitigation
Failure of Secondary and Tertiary providers to support CCF model and LTC pathways – failure to get funding released from STF to support CCF programme and new models of care		STP includes Fit for Future Secondary and Tertiary programme. Supported by financial plan. STP Governance Structure.
Failure to attract enough additional clinical workforce hours to support new model		Workforce Development programme, creation of attractive TandCs for clinical staff. MyHealthcare CPEN programme.
New models of care are not clinically or cost effective in isolation		Initial evaluation of GP Access Fund model- taking forward findings. Supported by workstream programme.

9. Community Care First – Long Term Conditions Management and Maintaining Independence (page 1/2)

SRO: Helen Kelly / Karen Heliwell (Co-Chairs)

Relevant leads: Nilima Rahman-Lais (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, BCHC, HEFT Community, BSol Acute Trusts, BSMHT, Local Authorities

Strategic objective:
A partnership approach to empower people with Long Term Conditions and Frailty to be able to self-care supported by a proactive, responsive integrated health and care system via:

- Access – a universal at scale offer for Primary Care to support management of LTCs
- Consistency – standardisation and coproduction of patient pathways and MDTs
- Holistic approach – co-produced and personalised around people
- E-health – digital solutions

Outcomes:

Outcome	Metric inc. baseline	Timeframe for delivery
Reduce in number of emergency admissions for Ambulatory Care Sensitive conditions	Baseline: 940.8 per 100,000 Target: 632.1 per 100,000 Reduction of 32.81%	2020/21
Reduction in health inequalities (life expectancy)	2.5% reduction in preventable years of life lost	2020/21
People with a long term condition feel supported to manage their own condition	Baseline 63.3% – Worse quartile; National Benchmark 66%; By 18/19 – 66% (whilst a 3% increase there is a significant shift across the quartile); BSol ambition to be in quartile 2 of the national data	2020/21
Increase the number of patients able to manage their own condition	Target: 94%, (Aspirational 95%)	2020/21
Reduce percentage of deaths in hospital	Baseline 53.8% National benchmark 47% Target: 42%	2020/21

In year 1 we will:

- Agree geography/footprint of integrated teams (March 17)
- Develop of Operating model including risk stratification and MDT model (June 17)
- Develop a coproduced model of self care to empower people with LTC (May 17)

In years 2 and 3 we will:

- Roll out Multi Disciplined Teams (MDTs) (April 18)
- Have a shared patient record across MDTs (April 19)

Impact on capacity:
Impact on workforce by 2020/21: increase in the number of staff working in Primary, Community and third sector – more detail to follow.
Impact on bed base by 2020/21:

- The modelling has identified sufficient opportunities to avoid the need to open the additional 430 beds over the current baseline which would otherwise be required as outlined in the 'do nothing' option.
- Early modelling suggests the initiatives identified will enable a proportion of existing acute capacity at tertiary hospitals to be freed up to accommodate the expected increase in tertiary work as a result of the National Specialist Commissioning Strategy
- The opportunity to reduce enhanced Assessment/ Discharge to Assess beds by a range of 80- 180 also exists

Context/description:

A high proportion of people with LTC across BSol do not feel supported to manage their condition. BSol also has a high proportion of the population dying in hospital compared to the national benchmark. This picture can be improved by:

- Early identification via risk stratification
- Proactive management of high dependency patients within the community setting
- Wide scale adoption of self care
- Optimisation of Multi-Disciplinary Teams
- Specialists working with primary care and community teams and patients/carers in a solution focussed approach
- The use of the 3rd sector to support care navigation and target patients that would benefit from social prescribing and other community based support

There is an interdependency across the CCF programme: enhanced general medical practice, urgent care planning, Health and Wellbeing, LTC including mental health. We need to align with mental health across areas such as Improving Access to Psychological Therapies. We anticipate a shift in activity from secondary to primary and community settings away from secondary and tertiary care.

In scope:

The scope of this programme will include: all adults over 18 with a Long Term Condition or at risk of developing a LTC; Frailty/MDT approach- Integrated Community Teams; Support to families and carers; People living in Care Homes; Dementia Community and Mental Health.

Out of scope:

Learning disabilities and autism are out of scope.

Critical Decisions to support next steps:

Universal agreement on the role and purpose of MDT – the geography, professional make up, patient cohort, provider incentives and the performance measures used to review their impact. Patient cohort to be defined based on risk stratification.

Integration of Mental Health and physical health within MDT approach – engagement of voluntary sector on targeted service provision models that can sit in front of complex MDT cases as an effective form of demand management based in the community promoting self management.

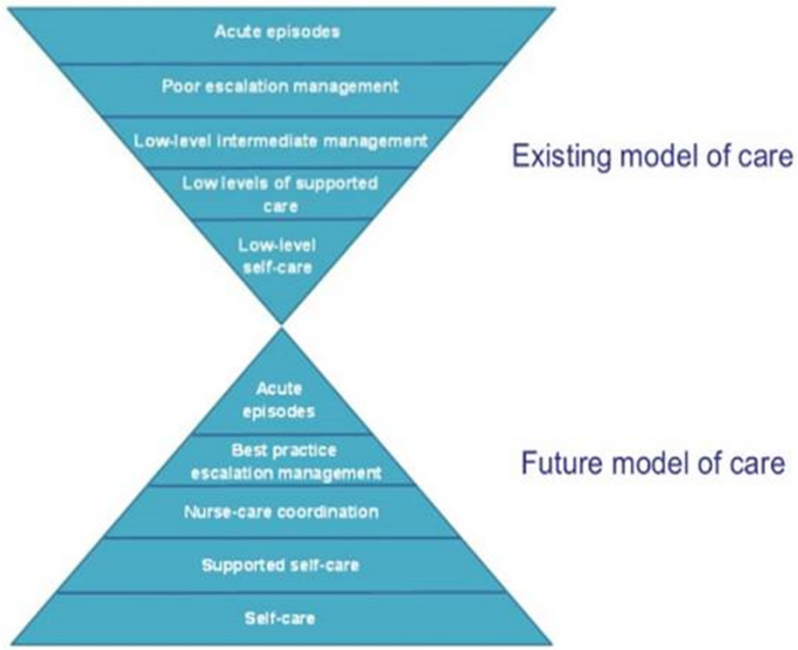
Engagement with secondary care on shift of workforce and skills from secondary to community settings, Social Care Engagement. Experts by Experience, Third Sector, Healthwatch, BVSC.

Stakeholder engagement and consultation:

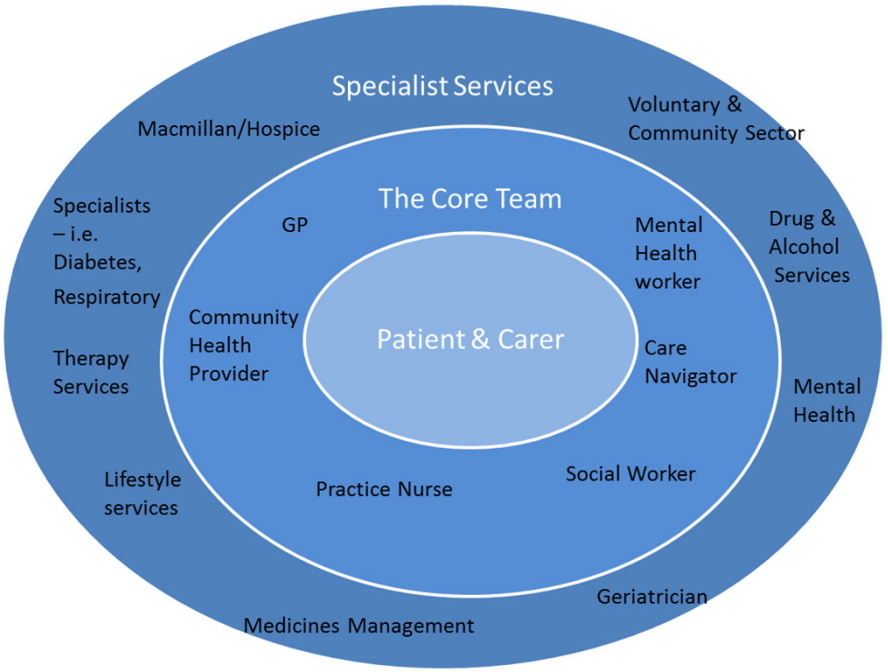
Primary Care, Community Services, Secondary Care, Mental Health, Workforce, Public Health

9. Community Care First: Long Term Conditions Management and Maintaining Independence (page 2/2)	
SRO: Helen Kelly / Karen Heliwell	**Relevant leads:** Nilima Rahman-Lais (Workstream Lead) and Angela Szabo (Finance Lead)
Organisations involved: BSol CCGs, BSol GP Alliance, BCHC, HEFT Community, BSol Acute Trusts, BSMHT, Local Authorities	

Model of Care



The MDT Approach



Risk	RAG	Mitigation
Vision and operating model not agreed across system		MDT workshop to develop shared vision and model for wider consultation with all stakeholders
Availability, capacity and capability of workforce to deliver hinders ability to deliver programme goals		Implementation of HEWM integrated workforce tool
Behavioural change for people with LTC and staff to become solution focused not achieved		Coproduced new model of care and supportive self care packages
Anticipated financial benefits may not be realised		Financial modelling to be completed and timescales for cost realisation to be mapped and monitored

10. Community Care First: Urgent Care - Care in a Crisis (page 1/2)

SRO: Dr B King / Andrew McKirgan | **Relevant lead:** Karen Richards (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, BSMHT, Local Authorities

Strategic objective:
We will have a fully integrated health and social care system that provides a simplified, safe and sustainable 24x7 urgent and emergency care service. We will ensure our population receives high quality and seamless care from easily accessible, appropriate, integrated and responsive services. This will be delivered by:

- One point of access – NHS 111 including clinical assessment, advice and appropriate designation, with robust DOS and directly bookable appointments
- Increased use of paramedic triage and assessment
- Development and implementation of standardised urgent care centres to provide a comprehensive alternative to A and E and ambulance conveyance
- Review and streamlining of front door assessment, creating a single assessment route within the acute hospital, proactively supported by radiology, pathology and specialist support
- Improved hospital flow – implementation of Clinical Utilisation Review and SAFER
- A single model for step up/down care including access management, bed capacity and integrated community teams. Streamlined discharge pathways to reduce the number of hand offs and ensure timely and appropriate discharge.

Outcomes	Metric inc. baseline	Timeframe
Reduction in DTOCs to target of 5 per 100,000	BSC 21.4/BXC 14/SCCG 14	2020/2021
A and E wait time of 95% in 4 hours	Baseline 86.5%/HEFT 89.5%/UHB 92.9%	As per STF Trajectories
%FFT in AE (data released July 2016)	All sites minimum 88% All sites minimum 95%	2018/2019 2020/2021
Reduction in emergency admissions	15% reduction in overall unplanned admissions	2020/2021
Reduction in emergency A and E attendances	17% reduction for adults, 22% for children	By 2020/2021
Trial national outcome metrics – Solihull UEC Vanguard	Baseline due November 16	Trial Nov 16 – Feb 17

Key Milestones:

In Year 1 (by Mar 2017) we will:

- Implement a single point of access including OOH with enhanced clinical assessment prior to A and E/ambulance dispatch. Directly bookable appointments into existing out of hospital provision
- Evaluate GP front door streaming model to inform the service specification of Urgent Care Centres (IUCC's). Agree the model, including patient and public consultation for IUCC's, before commencing the procurement of IUCC's.
- Complete rollout of Clinical Utilisation Review (CUR) within acute and community hospitals (subject to positive evaluation of the pilot)
- Agree terms of reference and approach to review of acute hospital front door assessment
- Agree a system wide A and E plan focused on the 5 mandated areas set out within the NHSE Rapid Implementation guidance
- Review and agree a single approach to discharge pathways including trusted assessor
- Agree the model for community recovery teams including procurement approach
- Agree interim approach to step up/down capacity to facilitate resilience to enable procurement of longer term model

Context:

In common with national trends, the Birmingham and Solihull health and social care economy continues to see growing levels of demand for urgent and emergency care services. This is evidenced through additional pressure on hospital based services, with UHB and HEFT experiencing growth in A and E attendances of 4.1% and 4.9% respectively, and increased admissions of 5.6% and 0.4% during 2015/16. Both HEFT and UHB are experiencing significant challenge in delivering their A and E 4 hour wait STF trajectories for the 2016/17 contractual year. There has also been an increase in delayed transfers of care at both HEFT and UHB. Stakeholders within Birmingham and Solihull have worked effectively together over the past two years through a number of forums including, System Resilience Groups, Urgent Care Programme Board, Better Care Fund and the Urgent, Emergency Care Network to gain a comprehensive view of the issues within the BSol urgent care system.

By way of support and to provide a firm evidence base to the collaborative working, a substantial design process was undertaken during 2014/15. This comprehensive process involved bringing all partners within the urgent and emergency care system together through a series of clinical workshops. Stakeholders worked together to review existing service provision, identifying key areas for focus and redesign. The work culminated in a detailed case for change and a current state summary as follows:

- Services are fragmented, creating confusion for patients on what and how to access services
- Inefficient services are creating incoherent patient pathways
- Continual increases in urgent care demand – as evidenced through additional pressure on hospital based services, with UHB and HEFT experiencing growth in A and E attendances and admissions as highlighted above
- The current system is not financially sustainable – additional £11m invested above contracted amounts to support resilience and improve performance against key indicators
- Failure to achieve the 95% for 4hr waiting time standard at both UHB and HEFT during 2014/15 and 2015/16. STF trajectories are not being met for UHB.

More recently, further analysis work and patient engagement has been undertaken to validate the picture. This work has been aligned to the Solihull Vanguard programme. The BSol urgent care strategy is based on recommendations within the Keogh Review and complies with the interventions set out within the associated UEC roadmap.

In Year 2 (by Dec 2018) we will:

- Develop a comprehensive directory of services to support appropriate designation through NHS 111
- Commence mobilisation of new IUCC's
- Operationalise local clinical hub within IUCC's, providing 24/7 access to advice and treatment, this will compliment the regional NHS 111 hub
- Pilot the agreed assessment unit approach at front door of acute hospitals
- Implement agreed step up/down model
- Evaluate comprehensiveness of agreed discharge pathways including trusted assessor
- Regularly monitor and refresh delivery against A and E plan, demonstrating impact of 5 mandated areas

In Year 3 (by Mar 2019) we will:

- Negotiate relevant service changes into contracts to enable comprehensive evaluation

10. Community Care First: Urgent Care - Care in a Crisis (page 2/2)

SRO: Dr B King / Andrew McKirgan

Relevant lead: Karen Richards (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, BSol GP Alliance, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, BSMHT, Local Authorities

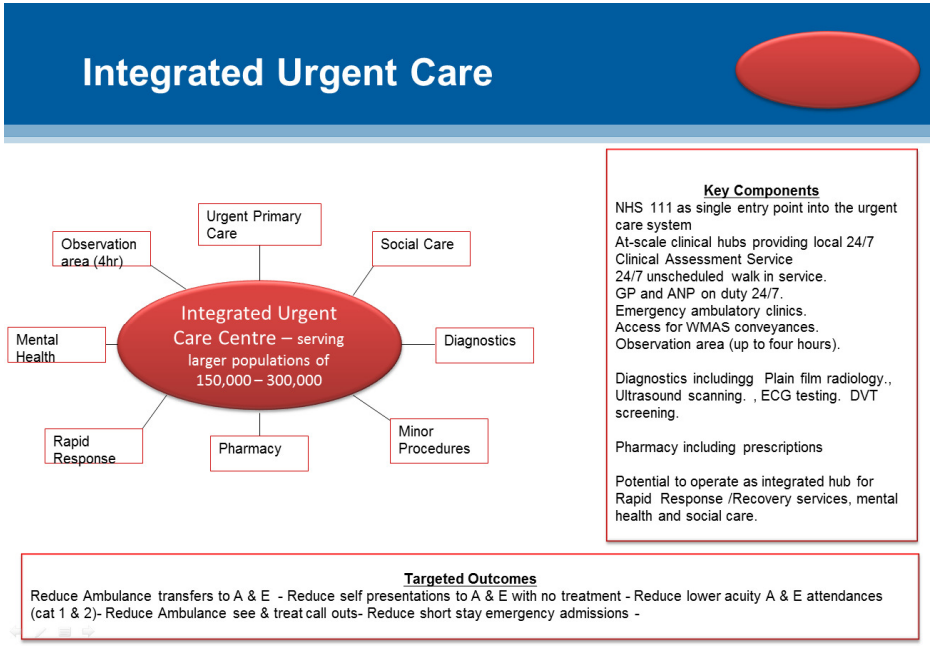
Critical Decisions to support next steps:

- Alignment with secondary and tertiary care programme
- Focused, collaborative approach to develop and agree new models of care, enhanced primary care provision, approach to estates (utilise existing or development of new or a mixture of both) and approach to IT to enable interoperability within the urgent care system

Stakeholder engagement and consultation:

Regular meetings with OSC, Patients and Public, Urgent Care teams, Pharmacy, Acute and Community Providers, Mental Health Services, Public Health, 3rd Sector, Local Authority Social Care Teams, Nursing and Residential Homes, West Birmingham STP Partners, BSol GP providers, BSol GP Alliance and UECN.

Top 5 Risks	RAG	Mitigation
Lack of engagement from secondary and tertiary programme		Align UCIC, secondary and tertiary work streams, BSol and A and E Delivery Board
Achieving successful public engagement and consultation outcomes on the role and function of UCCs and the impact on acute services configuration		• On-going clinical workshops between secondary and primary care colleagues to ensure alignment and agreement on UCC model. • Robust on-going engagement with OSC to ensure support when moving to public consultation
Unforeseen increases in demand and reduction in capacity of care services from local authority financial pressures		Development of detailed understanding in relation to proposed disinvestment. Joined up working on the development of MDT's.
Workforce not available to support the UCC model – transfer from acute sector, primary care strategy development and training for new roles		• Development of joint roles across secondary and community • Increase capacity from pharmacists and paramedics
Patient and public gaining confidence in new model.		Development of Communications and Engagement strategy including approach on consultation



Impact on bed base by 2020/2021:

Impact on bed base by 2020/21:

- The modelling has identified sufficient opportunities to avoid the need to open the additional 430 beds over the current baseline which would otherwise be required as outlined in the 'do nothing' option.
- Early modelling suggests the initiatives identified will enable a proportion of existing acute capacity at tertiary hospitals to be freed up to accommodate the expected increase in tertiary work as a result of the National Specialist Commissioning Strategy
- The opportunity to reduce enhanced Assessment/ Discharge to Assess beds by a range of 80- 180 also exists

11. Community Care First: Children and Young People (page 1/2)

SRO: Dr Doug Simkiss / John Lees / Dr Mary Montgomery

Relevant leads: David Coles (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, Forward Thinking Birmingham, Local Authorities

Strategic objective:

To provide care for children and young people (CYP) in the community across the Birmingham and Solihull footprint, delivering integrated support to them and their families around social, education and health care that proactively targets local early intervention and prevention

To interface with acute and higher levels of care across all sectors

Strategic Ambition to develop:

- Localism/place based integration: delivered through natural communities allowing practitioner relationships to develop across CYP specialisms – including skilled rapid response teams
- Community Engagement: preventative services through building social capital, enhance community and individual family and child resilience, promoting self help and development
- Biopsychosocial teams: integrated service provision for coordinated interventions for CYP
- Complete Care for Children: joined up MDT teams utilising: Team Around The Child (TAC) and care coordination approaches; Common Assessment Framework (CAF); Team Around the Family (TAF); Education Health and Care Plans (EHCP)
- Learning and development – a shared function across health and care, learning and development function delivered in a joined up fashion by professionals at a locality level.

The programme will pull paediatric expertise and community support into primary care to achieve better outcomes for children, delivered through a natural communities footprint and delivered through an integrated approach utilising developing GP practice hubs. The programme will build upon existing research and best practice through the 'Big 6' programme, focusing on six segmented groupings: Healthy children; Vulnerable children with social needs; Children with complex health needs; Child with a single long term condition, acute mild/moderately unwell children; acute severely unwell children.

Outcomes	Metric inc. baseline	Timeframe
Care and Quality: 1. Effective triage of cases in MDTs in localities resulting in both signposting to community services and more appropriate referrals to secondary care. 2. Learning and development function resulting in improved management of acute mild/moderate childhood illnesses in primary care. 3. Learning and Development function resulting in shared knowledge of the service provision in a locality.	• 38% reduction in acute paediatric admissions • 39% reduction in OPDs, • 22% reduction in A and E attendances • (review and refresh of assumptions on going and to be tested through staged rollout of model) • Rapid response cohort target based on 950 CYP	2020/21
Health and Wellbeing: 1. Community engagement resulting in coproduction of health promoting initiatives. 2. Assets mapping identifying community health and wellbeing resources 3. Readiness for school	• Community engagement delivered across localities through agreed engagement plan metrics • Metric, measurement at 2/2.5 development check	2018/19

Context:

BSol have one of the youngest and some of the most deprived population of children in the country. Additional statistics include:

- younger than national population: 19.8% of population are aged 0-14 years compared with 17.3% nationally (CYP pop of 330,000)
- 46% of population live in most deprived areas,
- considerable financial challenges across NHS and LA commissioning and provision,
- wide variation in services offered and delivered for CYP across BSol
- percentage of the population that are children varies across the STP: 17.4% Solihull, 20.3% BXC, 20.6% BSC.

Estimates nationally suggest that 40-50% of GPs have limited formal paediatric training. This and other factors leads to GPs having limited confidence to assess and treat children, with referral to secondary care for many CYP who could be managed in primary care. There is evidence to that focusing on care in the community can impact on the current increase in numbers of CYP presenting at Emergency Departments, and increasing admissions of CYP to Hospital.

In Scope:

0-18 services, Multi agency integrated approach inc. MDT; Rapid Response provision CYP with complex needs; Long Term Conditions; Special Educational Needs and Disabilities; Enhanced Primary Care access/response for CYP; improved access to paediatrics/child health in a community/local setting, Palliative/EOL care; Big 6 approach.

Out of Scope:

- Over 18s; Specialised commissioned services, urgent care, optometry services, dental services, pharmacy services; Mental Health (FTB); Maternity and Newborn

Work Stream Dependencies:

- Other CCF work streams/Children's STP +/workforce capacity and capability/IMandT and Estates/Communications and Engagement/Contractual Models
- Mental Health (FTB); Maternity and Newborn (BUMPs)
- Fit for Future Secondary and Tertiary Services

Critical Decisions to support next steps:

Definition of transition protocols for children to adult services. Clarity of design of LTC developments across all ages. Challenge to deliver required programme capacity. MDT approach development across Community/Acute/Social Care/Education

Stakeholder engagement and consultation:

Requires regular meetings with BSol Stakeholders including acute/community/mental health providers and primary care, Patients and Public, 3rd Sector, Local Authority Commissioning teams, public health, early years provision/settings and education. Specific development of clinical reference and design group.

11. Community Care First: Children and Young People (page 2/2)

SRO: Dr Doug Simkiss / John Lees / Dr Mary Montgomery

Relevant leads: David Coles (Workstream Lead) and Angela Szabo (Finance Lead)

Organisations involved: BSol CCGs, Birmingham Community Healthcare Foundation Trust, BSol Acute Trusts, Forward Thinking Birmingham, Local Authorities

Key Milestones

In Year 1 we will:

- Develop a clinical reference group, and have reviewed clinical pathway and Paediatric community team options and CC4C approach and Big 6 model (Apr 17)
- Scope and design MDT offer in collaboration with wider CCF programme (Apr 17)
- Review of governance arrangements to support/deliver CYP programme (Apr 17)
- Conduct review of and further design Rapid Response service and develop implementation plan for Rapid Response 'go live' in 17/18 (Apr 17)

In Year 2 we will:

- Complete mapping exercise of children's community assets across health, local authority and third sector by locality natural communities (Aug 17)
- Review and pilot 'Ready Steady Go, Hello' approach (Aug 17)
- Design pilot for Paediatric Integrated Community Team in readiness for 17/18 (Aug 17)
- Finalise Rapid Response pilot and review options to scale up in year (Aug 17)
- Prepare and pilot and roll out patient/community information in collaboration with HandWB leads (Oct 17)
- Review options to develop and deliver 'patient champions' model (Oct 17)
- Roll out Big 6 approach (Oct 17)
- Pilot Paediatric Integrated Community Team in locality (Oct 17)
- Scale up Rapid Response service (Oct 17)

In Year 3 we will:

- Further scale up of Paediatric Integrated Teams in line with Hub development/roll out
- Rapid Response fully operational
- Ready Steady Go Hello, fully implemented across BSol
- Review findings from ongoing developments and implemented programmes

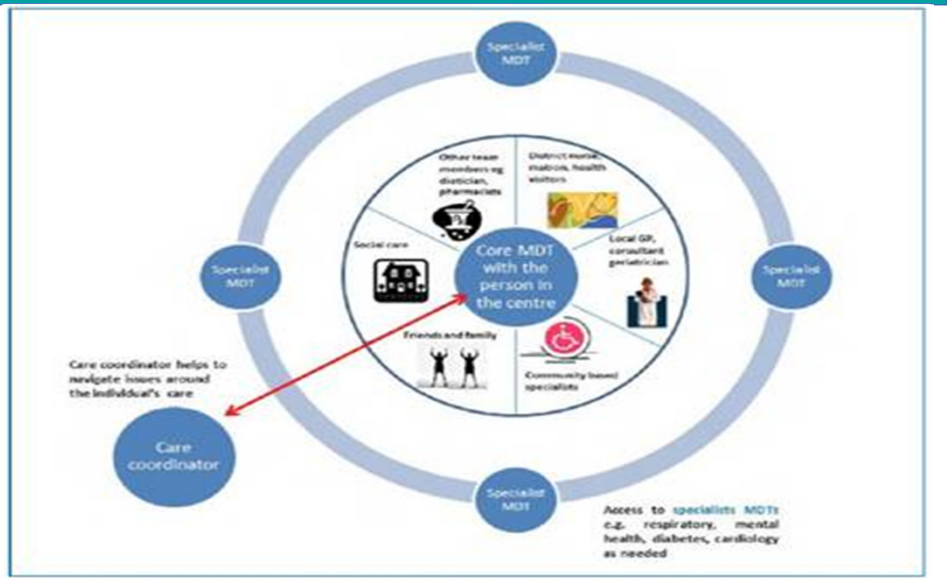
Impact on capacity:

Impact on bed base by 2020/21:

- Impact on bed base by 2020/21:
- The modelling has identified sufficient opportunities to avoid the need to open the additional 430 beds over the current baseline which would otherwise be required as outlined in the 'do nothing' option.
- Early modelling suggests the initiatives identified will enable a proportion of existing acute capacity at tertiary hospitals to be freed up to accommodate the expected increase in tertiary work as a result of the National Specialist Commissioning Strategy
- The opportunity to reduce enhanced Assessment/ Discharge to Assess beds by a range of 80- 180 also exists

Impact on workforce by 2020/21:

Potential new roles for secondary and primary care as part of MDT approach development. New roles inc. Community Paediatric Nurse Practitioners and opportunity to develop Practice Nurse + roles within primary care.



Top 5 Risks:	RAG	Mitigation
Failure of Secondary and Tertiary providers to support CCF CYP model and pathways		Overall STP includes Secondary and Tertiary Programme, supported by financial plan. Provider engagement continued through CCF CYP programme meetings/forums.
Specific CYP data may not be available/identifiable across data sets that will enable the programme to make informed decisions about activity and capacity flow and shift and pathway design		Initial data and assumptions to be tested though pilot roll out of Children's Hub and MDT developments. Finance and business intelligence support in programme to work through data requirements.
Impact of local authority commissioning intentions and redesign of local children's services and early years provision on proposed CYP CCF model		CYP CCF programme to link directly with BCC Commissioners through B'ham Early Help Strategic Programme commissioning workstream
Lack of/or limited paediatric expertise available amongst GPs and primary care to support shift in care		Learning and development approach, support and skilling up primary care to treat children's issues and through GP Forward View
Limited engagement of Service Users and wider stakeholders including neighbourhoods to support development of new models and pathways of care		Coordinated programme of engagement and consultation delivered across CCF programme and individual work streams

Fit for Future Secondary and Tertiary Services

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

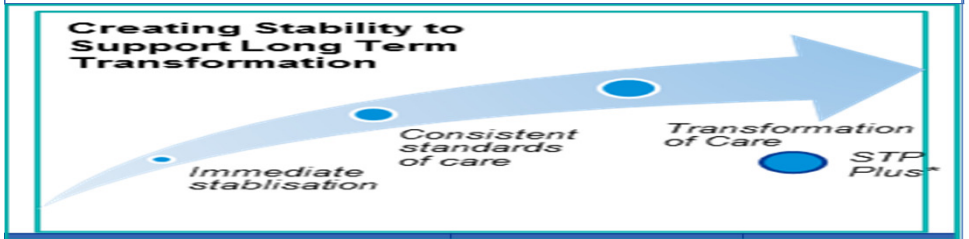
12. Fit for Future Secondary and Tertiary Services: Adult Care 1/2

SRO: Dame Julie Moore | **Relevant leads:** Andrew McKirgan, Jo Chambers/Philip Begg (for orthopaedics)

Organisations involved: UHB, HEFT, BCHC, ROH, Birmingham City Council, Solihull Metropolitan Borough Council Primary Care Services

Strategic objective:

- To provide stabilisation to Heart of England Foundation Trust in terms of clinical quality and financial controls.
- To deliver first class sustainable acute services across the STP footprint that are fit-for-purpose and provide high quality care to our local population, now and in the future:
- To create standardisation of clinical practice with the adoption of single care pathways and a shared set of clinical protocols and quality standards that optimise clinical outcome across Birmingham.
- Provide improved education, training and research opportunities to ensure the best individuals are attracted to come and work across the STP
- Build on the current research and development model with the creation of a single research and development hub creating greater access for the community to innovative new treatments.
- Create a more efficient, effective and integrated workforce
- To deliver better integration of acute care and adult social care for the benefit of patients.
- To manage in partnership with the Black Country STP the transition of services from City and Sandwell hospitals to the new Midland Metropolitan Hospital . Opening 2018.
- To continue to play a collaborative role across STPs with regard to all tertiary services.
- To work across STPs through West Midland Alliances.



Outcome	Metric inc. baseline	Delivery
Standardised of clinical practice / pathways	Performance standards	2018/19
Improved patient experience	Patient surveys	2018/19
Improved access to tertiary patients	Waiting times	2018/19
Improved recruitment and retention	Vacancy rates /Staff Surveys	2018/19
Reduction in acute DTOC rates	DTOC %	2018/19

Context:

Within the BSol STP footprint there are organisations at varying levels of maturity from those requiring stabilisation to those well-advanced on the transformation journey.

Our key challenges in this area:

Financial stability

The Birmingham and Solihull health economy faces significant financial challenges and the STP Leadership Board recognises that stabilisation and sustainable improvement of HEFT and adult social care services are fundamental to creating a solid foundation to the STP.

1. *Lack of clarity of long term governance arrangements for HEFT*
   - At the request of Monitor in November 2015, UHB has been providing support to HEFT and a decision has yet to made about the long term arrangements.
2. *Deficit in adult social care budget*
   - There is a forecast deficit of £30 million for 16/17 which is having a significant impact on acute providers .

There are 7 hospitals, 3 of which are specialist facilities. There is variation in the delivery of care and performance metrics

Workforce Shortages

There are limited resources available both within the primary, acute and community sectors and an ageing workforce. There are also shortages within particular specialty areas

Delayed Transfers of Care

Across the STP footprint there are, every day, hundreds of patients who experience a non-clinical delay in the acute sector which will require a collaborative transformational solution.

Opening of the Midland Metropolitan Hospital in 2018.

The closure of City Hospital has significant implications for the BSol STP in terms of patient flow from West Birmingham into the other Birmingham providers.

Orthopaedic Vanguard

The Royal Orthopaedic Hospital NHS Foundation Trust is part of the National Orthopaedic Alliance, a national vanguard which is developing evidence-based quality standards aimed at reducing clinical variation and improving outcomes for patients at all providers of orthopaedic care.

Critical Decisions to support next steps:

- Determine the long term arrangements for HEFT. This will be determined between the boards of UHB, HEFT and NHSI/NHSE.

12. Fit for Future Secondary and Tertiary Services: Adult Care (page 2/2)

SRO: Dame Julie Moore

Relevant leads: Andrew McKirgan, Jo Chambers/Philip Begg (for orthopaedics)

Organisations involved: UHB, HEFT, BCHC, ROH, Birmingham City Council, Solihull Metropolitan Borough Council, Primary Care Services

Estimated financial benefits:

Benefits will be realised through a variety of activities to be confirmed.

Interdependencies:

There are significant independencies with all other work streams, to be confirmed

Impact on capacity:

Impact on workforce by 2020/21:

- Reduction in utilisation of temporary workforce
- Workforce plan needs to address different models to ensure any change in capacity needs can be met

Impact on bed base by 2020/21:

- *There is currently no expectation that the current acute bed base in the system will reduce. The expectation is that through better collaboration, the work of the CCF work stream and a new model of integrated health and social care is that the system does not have to open in excess of 400 new inpatient beds to accommodate expected growth.*
- *Bed base needs to be created for additional capacity to meet the needs of the NHSE specialised commissioning strategy.*

Investment requirements:

Investment requirements to be clarified.

Stakeholder engagement and consultation:

We will be engaging with a variety of organisations through different forums including Public Sector Organisations (BWH, BCH, S&WB, CCGs, NHSE) Independent sector, Third party/Voluntary sector e.g. Healthwatch.

Engagement with the local communities also forms a vital part of our strategy.

Risk	RAG	Mitigation
Single HEFT / UHB organisation business case not approved		Close working with NHSI/NHSE/ local stakeholders
Lack of cross organisational commitment to transformation		Improved collaboration between organisations to the built upon through STP
Resistance from local communities to any change in service provision		Stakeholder engagement /Communication Strategy
Insufficient available finances at the sufficient time, particularly for any investment that may be required		STP financial modelling and early discussions with NHSE regarding capital to support system integration
Failure to deliver an integrated health and social care model.		Full engagement of BCC / Solihull Council in the STP. Coherent strategy and programme management

13. Maternity and Newborn (page 1/2)

SRO: David Melbourne

Relevant leads: Professor Helen Young **(**Programme Director), Dr Dianne Reeves (Accountable Officer BSC CCG)
Each workstream has a named chair, highly regarded in their field.

Organisations involved: BWH, BCH (inclusive of FTB), HEFT, SandWB, BCHC, BSMHFT, BCC/SMBC, CCG's NHSE, Primary Care Services

Strategic objective:

'Deliver a consistent world class holistic service that empowers women and families to make informed choices and who can access high quality care from a range of providers most suited to their personal choice and clinical need.

The workstream will deliver BUMP (Birmingham and Solihull Maternity Pathway):

by 2018:

- A single point of access for all women
- One stop model offering women greater choice and involvement in their care
- Continuity of carer for the woman throughout
- A uniform model of care delivering consistent pathways
- Appropriate capacity across the STP to support choice of delivery
- Community care delivered from Multidisciplinary Midwifery Team Hubs
- The MMT's would include specialists in:
  - Home birth
  - Sonography
  - Safeguarding
  - Intermediate care pathways including perinatal MH
- A uniform electronic patient record
- Revised contracting and funding model

Once successful in BSol we will review and implement the system across the West Midlands (2020 +). We have submitted a Pioneer bid for early adopter status to deliver Better Births which, if successful, means we will receive additional financial support.

Outcome	Metric inc. baseline	Delivery
Decrease in Mortality (Perinatal/Infant)	20% reduction	2020
Increase in homebirths and MLU births	Of total deliveries • Home birth rate ≥ 5% • MLU birth ≥ 25%	2020
Improved patient experience	• CQC rating of good or outstanding • % of women achieving their chosen place of birth • % of women actively using their PMCB (personalised budget)	2020 2018 2020
A skilled MDT/workforce to deliver the model	• Safe staffing • Use of agency/locums	2020
Consistent criteria, guidelines, pathways across the system	Implementation of policies within each trust	2018

Context:

Our current challenges include:

- A complex population that leads to increased Perinatal Mortality
- The West Midlands has a high rate of stillbirths, early neonatal and infant deaths compared to England and Wales
- Perinatal mortality rates were significantly worse in the West Midlands than for England throughout the fifteen year period 2000 to 2014 ((Birmingham has 7.1 deaths under the age of 1 per 1,000 births compared to national average of 4.0)
- Poor maternal physical and mental health
- Current maternity models are fragmented, inflexible and based on traditional models of care, with higher than average consultant led births, and little involvement of mothers in planning care
- Capacity difficulties due to rising birth rate, complexity of pregnancy, reputation and patient flows
- Inconsistent, inequitable and inefficient services impacting on quality and choice
- Outcomes for children beyond year 1 for children in Birmingham are poorer than comparable cities
- We have workforce shortages and an ageing workforce
- There are capacity issues which means the choice of where women give birth is currently affected by capacity and postcode

Key Milestones:

In Year 1 we will:

- Revise contracts enabling co – commissioning Maternity and Neonatal Services
- Implement consistent criteria, guidelines, pathways across the system

In Year 2 we will:

- Implement Single point of access/Community Hubs
- Deliver the revised care model within BSol
- Deliver a uniform EPR across the system

In Year 3 we will:

- Have appropriate capacity in the right places
- Deliver of the model across West Midlands

Critical Decisions to support next steps:

- Confirmation that both Trusts providing maternity services commit to delivering the programme at pace through a lead provider contracting model
- Confirmation with the Community Care First workstream regarding co-location of staff within Community Hubs, anticipation that SPA will be within 1 such HUB
- Confirmation of a co-commissioned and contracted approach with specialised commissioning for Maternity and Neonatal services
- Discussion regarding affordability of current Maternity Unit estate and alignment with the clinical vision

13. Maternity and Newborn (page 2/2)

SRO: David Melbourne

Relevant leads: Professor Helen Young (Programme Director), Dr Dianne Reeves (Accountable Officer BSC CCG). Each workstream has a named chair, highly regarded in their field.

Organisations involved: BWH, BCH (inclusive of FTB), HEFT, SandWB, BCHC, BSMHFT, BCC/SMBC, CCG's NHSE, Primary Care Services

Estimated financial benefits:

Benefits will be realised through a variety of activity shifts. At this stage our financial insight is fairly limited and we have focused on potential savings from a move to more home births and midwifery led births. We are exploring other areas around estate and rates of surgical intervention and induction of labour but this is in the early stages.

Importantly, we believe our programme will deliver long term health and well-being outcomes for the population.

Impact on capacity:

Impact on workforce by 2020/21:

- There will need to be an increase in midwives, sonographers and obstetricians
- Workforce plan needs to address different models to ensure increased capacity needs can be met

Impact on bed base by 2020/21:

- Modelling exercise to be completed

Stakeholder engagement and consultation:

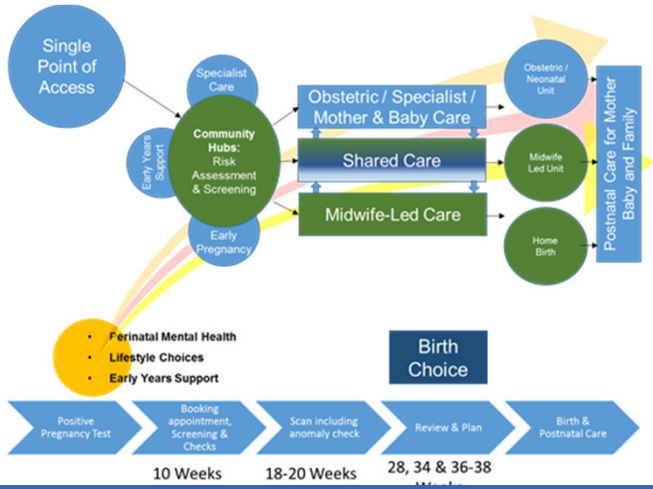
We recognise that engagement with our stakeholders is vital, especially with our women and families. We will be engaging with a variety of organisations through different forums including Public Sector Organisations (BWH, BCH, HEFT, Sandwell and West Birmingham, BSMHFT, BCC/SMBC, CCGs, NHSE, Primary Care,) Independent sector, Third party/Voluntary sector e.g. Healthwatch.

Investment requirements:

Investment requirements are not clear as the activity modelling to support this needs to be developed

Birth	Number of deliveries	Target number of deliveries	Baseline	Target	Target number of deliveries	Average cost per delivery (£)	Future costs (£)	Potential saving (£)
Home births	156	5.0%	0.8%	5.0%	942	166,296	1,004,439	838,143
Midwifery led	2,209	15.0%	11.7%	15.0%	2,827	3,227,349	4,129,882	902,533
Obstetric led	16,480	80.0%	87.5%	80.0%	15,076	26,878,880	24,588,956	2,289,924
Totals	***18,845***				***18,845***	***30,272,525***	***29,723,276***	***549,249***

Our new model:



Risk	RAG	Mitigation
Lack of support by stakeholders for the revised model of care		Strong engagement of all stakeholders and development of engagement and communications strategy
Lack of cross organisational commitment to transformation		17/18 contracts in NHS Trusts/Early adopter site,/MDT programme board
Lack of professional buy in to drive change and culture		Clinical engagement/involvement at every level
Insufficient available finances at the sufficient time, particularly for investment		We are a national pioneer site for choice and personalisation but we have applied for Early Adopter (vanguard)
Workforce shortages and an ageing workforce may limit implementation		Development of a strategic workforce plan Support from academic partners/HEE

14. Paediatrics (page 1/2)

SRO: Matthew Boazman

Relevant leads: Mary Montgomery, BCH - plus links in to CCF paediatric programme

Organisations involved: Birmingham Children's Hospital NHS FT, Birmingham South Central CCG, Sandwell and West Birmingham Clinical Commissioning Group, Birmingham Health and Wellbeing Board, Birmingham City Council, Heart of England NHS FT, Birmingham Children's' Community Health Foundation Trust

Strategic objective:

To deliver healthcare to children and their families closer to home, and to support families to be able to manage their own care at home wherever possible.

This will be delivered through the following objectives:

1. Prevent

- Keeping CYP (children and young people) and families healthy.
- Prevent need for multiple attendances

2. Protect

- Reduce admissions and length of stay in hospital

3. Manage

- Deliver integrated pathways of high quality care across BSol in order to ensure that CYP and families receive the same standards of care wherever they access thereby utilising secondary and tertiary care more effectively for those children who need it

4. Recover

- Deliver more secondary and tertiary care outside the hospital environment

By 2018 we will develop and implement a new **Children's Network** across BSol.
To achieve this we will undertake the following:

- Assess capacity and demand across BSol, initially focussing on high volume acute services
- Embed the pathways for the most common conditions children present with for urgent care 'Big 6', creating a mini- network
- Implement of telephone triage and advice service to provide additional community support
- Redistribute the delivery of paediatric surgical care more appropriate across the footprint
- Determine workforce requirements and capacity
- Create a uniform model of care delivering consistent pathways
- Redistribute the delivery of services more appropriately across the STP

Out of Scope

Specialist orthopaedic surgery

Investment requirements:
The programme will require a dedicated project management resource, clinical leadership time (backfilled PAs) and access to transformation support.

The longer term requirements will not be clear until the initial modelling and impact assessment of the "Big 6" work is underway

Context/ Description:

There is high demand for paediatric services across the footprint. As noted in the CCF programme, BSol have one of the youngest and most deprived populations of children in the country – there is a CYP population of 330,000 (19.8% of population) and 1 in 3 live in poverty.

As well as increasing demand, there are a number of key issues for paediatric acute services:

- 40-50% of GPs have limited formal paediatric training. This and other factors leads to GPs having limited confidence to assess and treat children, with referral to secondary care for many CYP who could be managed in primary care
- Families are frequently choosing to bypass their local A and E services to present for treatment at BCH as it is a recognised leading specialist paediatric hospital
- Consequently there are high rates of paediatric A and E attendances (0-4 year olds: 585.9 per 1,000 compared to the national average of 540.5)
- This impacts on the capacity available to provide speciality tertiary activity at BCH – a major regional, national and international provider for paediatric tertiary care
- There is clinical variation in both access and management for the common conditions presented within the A and E departments across the STP
- At certain times of year there is inefficient utilisation of the capacity across the system

Outcome	Metric inc. Baseline	Timeframe
Reduce A and E attendances	• 38% reduction in acute paediatric admissions • 39% reduction in OPDs, • 22% reduction in A and E attendances	2020
Reduce in hospital length of stay	TBC	
Increase capacity for tertiary services	TBC	
Share demand and capacity across BSol	TBC	
Reduce admissions	TBC	

14. Paediatrics (page 2/2)

SRO: Matthew Boazman

Relevant leads: Mary Montgomery, BCH - plus links in to CCF paediatric programme

Organisations involved: Birmingham Children's Hospital NHS FT, Birmingham South Central CCG, Sandwell and West Birmingham Clinical Commissioning Group, Birmingham Health and Wellbeing Board, Birmingham City Council, Heart of England NHS FT, Birmingham Children's' Community Health Foundation Trust

Key milestones:

In 6 months we will:
- Assess capacity and demand across BCH and HEFT for high volume acute services
- Establish a shared telephone triage and advice service for General Paediatrics
- Embed the 'Big 6' pathways of care management protocol across the STP – (mini network)
- Deliver increased paediatric surgical care at centres other than BCH

In 9 months we will:
- Establish a project for the development of a larger Children's Hospitals Network across BSol
- Assess workforce capacity and demand across BSol
- Further assess acute service capacity and demand across BSol

In 12 months we will:
- Demonstrated joint working across the key Big 6 pathways in paediatric medicine and surgery across HEFT and BCH
- Have reduced the management of some of the conditions within the tertiary centre compared to the baseline*

In Year 2 we will:
- Implemented the Children's Hospital Network across BSol
- Shown a step change in terms of conditions being managed within primary care and conditions not managed at the tertiary centre

* *Note savings for these are largely described already within the CCF work stream*

Critical Decisions to support next steps:

- Approval of work stream by STP programme Board
- Approval of work programme by HEFT, BCH, BCHC and commissioning leads
- Agreement and resourcing of project infrastructure

Estimated financial benefits:

:

The financial benefits are largely realised through reducing the reliance on secondary care acute delivery of care as outlined within the CCF paediatric programme.

The additional benefits relate to the ability to free up capacity for the provision of tertiary care in line with the NHS England development of prime provider models across a range of specialist services, including congenital heart disease, specialist paediatric surgery etc.

Stakeholder engagement and consultation:

- Through existing CYP YPAG group within BCH
- GPS Network
- JCCG
- NHSE
- ROH

Impact on capacity:

:
- Detailed modelling exercise on bed capacity will need to be completed but expected to reduce demand on acute bed provision which will either be closed or used to support delivery of increased tertiary demand
- Increased provision within community and primary care (linked to CCF programme)

Key risks:

Risk	RAG	Mitigation
Stakeholders fail to engage in proposed changes to system (local politicians, staff and public)		Robust engagement strategy to be developed including staff and where required public consultation. Stakeholder communication plan to be developed.
There may be insufficient resource capacity in line with the optimal (most efficient) target model		Main risk relates to establishing primary and community care offer to support the shift in provision and this is mitigated through the CCF programme
Unable to achieve target outcomes within projected timeframes due to commissioning being undertaken by other partners		CCG commissioning bodies will maintain an active dialogue with NHS England about the objectives for the local BSol population
Anticipated financial benefits may not be realised		Financial modelling to be completed and timescales for cost realisation to be mapped and monitored.

15. Mental Health (Page 1/2)

SRO: John Short (BSMHFT)

Relevant leads: Joanne Carney (Programme Director) with support from John Lees (Children and Young People)

Organisations directly involved: Birmingham and Solihull Mental Health NHS FT, Birmingham Children's Hospital NHS FT, Forward Thinking Birmingham, Birmingham Cross City CCG, Birmingham South Central CCG, Solihull CCG, Sandwell and West Birmingham CCG, Birmingham Health and Wellbeing Board, Birmingham City Council, National Probation Service, Staffordshire and West Midlands Community Rehabilitation Company, West Midlands Police, Solihull Metropolitan Borough Council

Strategic objective:
"We all want to provide better help for people who are suffering from, or who are at severe risk of, mental health problems." In line with the 5YFV the overarching objective is to ensure that mental health is considered as important as physical health. This will be delivered through the following objectives:

1. **Prevent–** preventing mental health problems and getting help earlier, for people starting to suffer poor mental wellbeing
2. **Protect**– protecting, those who are most vulnerable from the adverse effects of mental health problems including management of the relationship between mental and physical health and ensuring parity of esteem
3. **Manage**– preventing mental health crises and managing them better when they do occur
4. **Recover**– helping people with mental health problems to recover back into everyday life

Outcome	Potential metric	Time-frame
OAT and least restrictive environment (18yrs+) Out of area placements will be eliminated for acute mental health care 5YFV	Number of acute MH Out of Area Treatments (OATs -outside 30m radius) in 2015/16 Baseline: ~12 OAT beds/month in Birmingham, ~2 OAT beds/month in Solihull; Target: 0	2018/ 19
Care within least restrictive environment (<18yrs) Reduction in tier 4 admissions for mental health FiM/5YFV	Number of tier 4 admissions for mental health Baseline and target to be developed in next 6 months following further discussion with health and social care commissioners	2020/ 21
Recovery- (18 +) Increase in proportion patients with MH conditions in paid employment 5YFV	% patients with MH conditions (on CPA) in paid employment Baseline: 4.9% (Birmingham), 9.7% (Solihull) Target: 8.9% (min Birmingham), 9.9% (min Solihull)	2020/ 21
Increase access (<18) In number of CYP with a diagnosed mental health condition receiving treatment from an NHS funded community Mental Health service. FiM	% receiving treatment (baseline to be developed in 16/17 as per Mental Health Five Year Forward View) Target: % increase from baseline to at least 35%	2020/ 21

Context/Description:
BSol faces a high prevalence of psychosis within the local population and a high number of Mental Health Act detentions. Birmingham and Solihull MH Trust has a consistently high occupancy rate of 95% and across the system there are a high number of Out of Area Treatments (OAT) in comparison to peers. Delays to discharge are multi-faceted but partially influenced by demand to non-acute inpatient services and step-down provision. In 2015/16 BSol spent £15.7 million on children with complex needs thus representing a low volume, high cost cohort. As noted in the Future in Mind report, collaborative plans need to be developed with specialised commissioners in line with the new waiting standards and national ambition to reduce usage of tier 4 CAMHS beds. Birmingham already have a home treatment service and 24/7 crisis care so there is now a need to make this consistent across the BSol footprint. Providers and commissioners are committed to tackling known inequalities, including the disproportionate impact of MH conditions on years of life lost and the over-representation of BME groups (specifically young black men) within detained environments.
BSol STP has decided to focus on ensuring care is provided in the least restrictive setting as part of a wider review to ensure that capacity is better aligned to resources and care is provided in the least restrictive setting. This will be enabled by the following areas of work:

- System capacity modelling exercise
- Development of a shared bed management function for 18 years+ across 4 local MH providers (MERIT Vanguard)
- ACO for low and medium level secure services across the West Midlands (REACH OUT)
- Scoping alternatives to admission for <16yrs and 16-18 years e.g. PDU
- Review of Children and Young People (CYP) complex care packages and required improvements to local services.
- Reviewing and improving systems of care in areas including personality disorder, complex trauma, neurodevelopmental conditions and eating disorders

There is an underpinning principle that a recovery focus will reduce reliance on the heath and care system, therefore the second transformation area will involve embedding recovery, employment and training. As the CPA employment rate is lower than comparators, there is an ambition to go above and beyond the national target and achieve radical expansion of the IPS scheme. For young people, this relates to a need to prevent the longer-term consequences associated with not being in education, employment or training (NEET).
These outcomes are being supported by a number of additional initiatives and pilots to further improve MH outcomes for the BSol population including transforming care for people with learning disability and autism and extending IAPT and EIP services. As a footprint, BSol currently spend £250m on MH services (2015/16 recurrent spend). In line with national guidelines, we will review benchmarked data to ensure MH services receive the necessary proportion of total CCG expenditure.
There is an awareness that MH parity of esteem needs to feature across STP programmes and other workstreams, therefore the Programme Board will also monitor the following interdependencies:

- CCF: enhanced general medical practice, LTC management (including dementia), urgent care planning
- Maternity: perinatal MH MDT teams within home treatment/primary care
- Secondary and tertiary care: Psychiatric liaison and dementia/frailty care
- Transforming Care Programme for Learning Disabilities and Autism

Key milestones:
In 6 months we will:

- Complete mapping exercise of alignment of MH projects/pilots to transformation outcomes
- Review of governance arrangements to support MH programme
- Conduct a review of workforce capacity and capability
- Scope evidence base for MH patients in paid employment
- Develop baselines for Birmingham and Solihull the proportion of CYP with MH conditions accessing NHS funded community mental health services
- Put in place a plan for collaborative Tier 3/4 CAMHS commissioning

In 9 months we will:

- Completion of independent capacity modelling exercise
- Confirm strategic direction for MH prevention and wellbeing offer and priorities for Years 2-5

In 12 months we will:

- Agree target operating model based upon insights from capacity modelling exercise
- Submit application for any targeted funding for IPS/forensics
- Approve standardised approach to admissions across 4 MH acute adopting the shared bed management function
- Complete redesign of recovery and employment service model

In Year 2 we will:

- Negotiation with providers on future operating model complete based upon capacity modelling exercise
- Procurement for respite provision/crisis housing complete
- Review and refresh of crisis care concordat complete

15. Mental Health (Page 2/2)

SRO: John Short (BSMHFT)

Relevant leads: Joanne Carney (Programme Director) with support from John Lees (Children and Young People)

Organisations involved: Birmingham and Solihull Mental Health NHS FT, Birmingham Children's Hospital NHS FT, Forward Thinking Birmingham, Birmingham Cross City CCG, Birmingham South Central CCG, Sandwell and West Birmingham CCG, Birmingham Health and Wellbeing Board, Birmingham City Council, National Probation Service, Staffordshire and West Midlands Community Rehabilitation Company, West Midlands Police, Solihull Metropolitan Borough Council

Estimated financial benefits: The MERIT vanguard will support work to deliver efficiencies in areas (Out of Area and A and E) where there are cost pressures through standardised approaches to care and combined bend managements functions.
Areas for potential savings include;

- Supporting earlier discharge/reduction in acute LOS (to national benchmarks levels)
- Savings from treatment within area compared to out of area non-NHS beds, enabled by the MERIT vanguard looking at a shared bed management system (Estimated average cost of out of area treatment per day £500, equating to a £2m cost for non-NHS beds and £429k in PICU beds in 15/16 in Birmingham and £363k in Solihull)

Enabling people with MH conditions to find and/or retain education, employment or training:
Linkage of local ONS data to national statistics suggests the indirect costs of mental health to be ~£731 million, and the direct costs to be ~£514 million. Modelling cannot be completed at this time but areas for potential savings include:

- People with MH conditions securing employment
- Preventing people with MH conditions from falling out of employment
- Reduction in GP attendances, A and E attendances, social care packages upon gaining employment

Critical Decisions to support next steps:
Agree how capacity and resource are best aligned to support the recovery focus and reduce out of area placements – this will be enabled by the independent capacity modelling exercise.
Await recommendation of West Midlands Commission (due to report in Autumn 2016) and integrate findings into programme going forward.

Investment requirements:
In line with the national commitment to increase investment in MH and LD, we must ensure MH receives the appropriate proportion of total NHS spend within the footprint.
In line with the transformation areas, potential areas for future investment include:

- Investment in community capacity, workforce recruitment and workforce training to reduce acute inpatient admissions
- Enabling people with severe mental illness to find and retain employment and additional support for young people
- Pathway redesign for neurodevelopmental conditions

Impact on capacity:
Impact on workforce by 2020/21:
Shift of workforce to community settings inc. delivery of BSol's share of 3000 practice based MH therapists = additional 68.4 (MH FYFV)

Impact on bed base by 2020/21:
To be determined based upon better alignment of acute and community capacity across all age groups

Stakeholder engagement and consultation:
To date there has been strong stakeholder engagement around the strategy including engagement events and system wide representation at Mental Health Programme Board and Delivery Group

Further stakeholder analysis will take place in the next fortnight in order to advance the stakeholder engagement strategy moving forward

Key risks:

Risk	RAG	Mitigation
Stakeholders fail to engage in proposed changes to system (local politicians, staff and public)		Robust engagement strategy to be developed including staff and where required public consultation. Stakeholder communication plan to be developed.
Ability to resource capacity in line with the optimal (most efficient) target model		The capacity modelling exercise will be completed by an independent contractor to reduce any conflicts of interest. The target operating model will be co-designed by stakeholders and potential misalignment between resource and capacity will be highlighted at the earliest opportunity.
Pace and scale of change is not sustainable giving current workforce capacity		Stakeholder engagement strategy to be developed. Robust Mental Health Programme governance to be implemented.
Unable to achieve target outcomes within projected timeframes due to commissioning being undertaken by other partners e.g. NHSE commissioning tier 4 beds		CCG commissioning bodies will maintain an active dialogue with NHS England about the objectives for the local BSol population
Anticipated financial benefits may not be realised		Financial modelling to be completed and timescales for cost realisation to be mapped and monitored

16. Tertiary Care Prime Provider Models

SRO: Sarah-Jane Marsh | **Relevant leads:** Andrew McKirgan (UHB), Jo Chambers / Prof Phil Begg (ROH), John Short (BSMHFT), Matthew Boazman (BWH/BCH)

Organisations involved: ROH, UHB, HEFT CCG's Primary Care, NHSE, BCH, BWH, BSMHFT

Strategic objective:
We will develop prime provider models across a range of key specialised services which will support the emerging NHS England strategy for specialised services within the West Midlands. This will link directly with other STP programmes within BSol which are seeking to reduce the non-specialist demand on tertiary providers and will ensure that the capacity that is released is used in order to manage the increased demand for tertiary access. The prime provider models will ultimately support the standardisation of care, address quality issues and improve access and utilisation for specialised services both within the BSol STP and beyond focussing on the areas where there is significant expertise nationally within BSol:

- Orthopaedics (Including specialist orthopaedic surgery for children)
- Mental Health
- Adult tertiary care including cancer
- Maternity and Paediatrics (congenital heart disease, PICU, neonatal care and specialist paediatric surgery

To work across STPs through West Midland Alliances.

Context:
Areas to be addressed:

- High concentration of specialist tertiary care providers within the BSol STP
- Capacity challenges associated with tertiary care access due to competing secondary care demand and poor availability of key elements – PICU/ICU
- There are long waits for some complex orthopaedics, including paediatric spinal deformity
- NHS England specialised strategy across West Midlands is developing prime provider concept for a range of speciality areas
- Model is dependent on other STP work streams (CCF etc.) reducing demand on tertiary centres
- Variations in quality and outcomes
- The Royal Orthopaedic Hospital NHS Foundation Trust is part of the National Orthopaedic Alliance, a national vanguard which is developing evidence-based quality standards aimed at reducing clinical variation and improving outcomes for patients at all providers of orthopaedic care

Investment required:
The level of investment required will need to be identified once the confirmed specialties for developing a prime provider model have been agreed with NHS E and modelling completed

Estimated financial benefits:

- ✓ Improved utilisation with tertiary providers
- ✓ NHS E commissioner benefit across the agreed prime provider models through reduced clinical variation and better outcome

Impact of Capacity:
Workforce:

- Detailed modelling needs to be completed and is dependent on the agreed prime provider models that are developed

Outcome:	Metric inc. baseline	Timeframe
Standardised care, consistent across BSol	Performance against service standards.	2018
Improved patient outcomes	KPI metrics	2018
Improved utilisation of resources within each prime provider network (reduction in out of area placements for MH)	Activity delivered against each prime provider network financial envelope	2020

Top 5 Milestones	2016/17	2017/18
Agree "Top 5" Priority areas with NHS E where they wish to commission a prime provider model	X	
Agree standards of care within each prime provider model	X	
Complete baseline assessment of existing providers	X	
Establish contractual models and phasing for prime provider model		X

Risk	RAG	Mitigation
Agreement with NHS E on prime provider model		Early engagement with NHS England on developing model and fit with emerging strategy
Lack of cross organisational commitment to transformation		Support from NHS England commissioning approach for specialised
Inadequate capacity as tertiary centres to support prime provider model		Link to CCF programme and workstreams and development of managed clinical networks

Critical Decisions to support next steps: Agreement with regional specialised team on prime provider pathways of care that will be supported, discussion and Board approval within individual tertiary providers to support the strategy of developing themselves as a prime provider
Stakeholder engagement and consultation: NHS England, provider organisations within agreed prime provider networks, patient groups

Measuring progress

The following sets out what success will look like for our programmes in 5 years:

Objective	Programme	What Will Success Look Like?
1. Creating Efficient Organisations and Infrastructure	Provider CIP Delivery, Commissioner CIP, STP Wide Estate Reconfiguration and Rationalisation, Stabilisation and Transformation of Social Care, Commissioning Reform	• Improved top 10 productivity and efficiency KPIs • Achievement of CIPs • Financial balance (within system control total) • Reduced estates running costs and square footage • Reduced variation in quality of estates across the footprint • Optimised use of estates facilities which meet the future needs of the population for health and social care • More effective and efficient commissioning processes – fewer gaps and less duplication
2. Transformed primary, social and community care ***(Community Care first)***	Improving Health and Wellbeing Stabilised and Enhanced General Practice LTC Management and Maintaining Independence Urgent Care Children and Young People Stabilisation and Transformation of Social Care Commissioning Reform	• More integrated primary, social and community health services, focussed on prevention and maximising independence as well as high quality care provision. • Increase in readiness for school • Increase in proportion of vulnerable groups in meaningful work • Increase in people with LTC feeling supported to manage their conditions through self management and use of digital technology • Improved access to general practice in and out of hours with more patients able to get an appointment to see or speak to someone • Reduction in DTOCs • Reduction in emergency admissions and A and E attendances that can be managed in other settings • Increased community and individual resilience • Greater focus on outcomes based commissioning
3. Fit for future secondary and Tertiary Services	Adult Care Maternity and Newborn Paediatrics Mental Health Tertiary Care prime provider models Stabilisation and Transformation of Social Care Commissioning Reform	• Improvement in key selected clinical outcomes • Out of area placements will essentially be eliminated for acute mental health care (18yrs+) • Increase in proportion patients with MH conditions in paid employment • Reduction in perinatal/infant mortality • Increase in home births and MLU births • Greater focus on outcomes based commissioning

Overarching Programmes

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

17a. Stabilisation and Transformation of Social Care (Page 1/4)

Birmingham

SRO: Peter Hay | **Relevant leads: Alan Lotinga**

Organisations involved: Birmingham City Council and partner organisations

Strategic objective:

The national Better Care policy calls for integration between health and social care by 2020/21, albeit it does not define what this means in practice. Across BSol, we are developing local solutions reflecting our two Local Authorities, at pace, to commission and provide integrated health and social care services across the footprint. A number of our STP programmes, including CCF and Commissioning Reform, also support and underpin the overall stabilisation and transformation of social care.

In Birmingham this means:

Stabilising and transforming social care which responds to the needs of our local population to produce better outcomes for individuals. Our key focus areas are to:

- Enable people to stay as independent and well as possible, for as long as possible. When people do need long term support this is timely, responsive, good quality and enables people to continue to live their lives the way they want to.
- Continue to promote transparency and citizen involvement by building on the local democratic mandate given to City Councillors, leadership by the Health and Wellbeing Board, and support by the Overview and Scrutiny process. Starting from clear, relevant and up-to-date Joint Strategic Needs Assessments, linking directly to and from individual needs assessments specifically and personalised care and support more generally
- Support people to fully participate in their health and care through initiatives including co-production, personal budgets, and developing enabled individuals
- Supporting communities to become resilient in order to reduce unnecessary demand on services
- Ensure effective integration between social care and health services to support people to remain independent and in a crisis to return to independence
- Manage long-term assessment of needs and support delivery to ensure that our citizens receive support, appropriate to their needs
- More widely to use social care as a vehicle to the Local Authority's extensive partnerships to ensure a co-ordinated, system-wide approach to public sector reform and developing an effective interface with the public

Supporting data

- Delayed Transfers of Care attributable to the NHS and social care across the STP is 17.39 per 100,000 population (worst performing quartile nationally). This was much higher than the average of 12.5 in similar authorities.
- Delays attributable to adult social care have increased from 10.7 per 100,000 in 2013/14 to 11.3 in 2014/15. This was much higher than the average of 5.1 in similar authorities.
- 348 reviews for long-term services were carried out in 2014/15 for adults aged 18-64 and 2,672 for adults aged 65+ per 100,000, compared to 310 and 2,876 reviews respectively in the Council's comparator group
- There has been a decrease in adults 18-64 living in long-term nursing or residential services per 100,000 in 2013/14 from 190 to 162 in 2014/15, and an increase in adults aged 65+ from 1,905 in 2013/14 to 1,927 in 2014/15 per 100,000 population.
- 380 people aged 18-64 and 2,717 aged 65+ were accessing community based services (such as home care and day care) in 2014/15 per 100,000 population, compared to 416 and 2,814 respectively in the Council's comparator group.
- There was a decrease in adults aged 18-64 going into permanent residential care from 20 per 100,000 population in 2013/14 to 16 in 2014/15, compared to 14.1 nationally [in 2014/15].

Context/Description:

- The BSol footprint includes 2 Local Authorities, BCC and SMBC, which have very different populations, political priorities, and key drivers.
- Both Authorities have previously developed initiatives that have been tried locally to transform social care and within this context are currently working on their own approaches to social care, which are aligned to the above strategic objectives.
- However for both, integral to managing demand in health and social care is the vision to develop a whole Council approach to building stronger communities and resilient community relationships
- Both Authorities also face significant capacity / workforce challenges across the care sector, reflecting a range of issues, including the perception of the sector, low pay and an ageing workforce

Birmingham

- It is well documented that BCC is currently under the scrutiny of an Improvement Panel following the Kerslake Review which oversees its decisions and actions, including a significant financial deficit of c.£130m by 2020/21. Of this, £123m is apportioned to Birmingham and covers Adults, Children's and Public Health services, assuming that demand continues to increase. Part of the oversight is to ensure the long-term strategy for adult social care is developed in short timescale, within FY 2016/17
- The demography, age profile and population trends, and deprivation and health equality challenges for the City are also well-documented elsewhere within this plan. It is a matter of record and fact that cities such as Birmingham have been hit particularly hard by austerity measures in that area circumstances are such that citizens are more reliant on publicly funded services
- Birmingham adult social care has a strong track record of major transformation and modernisation since 2008, and regular confirmation from vulnerable citizens that they feel safe and supported. But we do need to major on and are now focussed on helping people to help themselves more to remain independent, support communities to become more resilient, and stretch significantly our ambition to support far more eligible people to receive direct payments / self-directed care and continue our recent positive trends to place less people into permanent residential care
- We are particularly mindful that we need to continue to support more younger adults to move from expensive residential care placements into supported living and other community situations, as Birmingham has been relatively high cost in the area for a number of years
- In addition, we need to prepare appropriately and at pace for effective and efficient front-line integration with the NHS and seek strategic partners to develop future plans with. More internally, we also need to strengthen our financial controls, processes and information for managers and ensure that our front-door and assessment process is as tight and consistent as it can be to best manage demand.

17a. Stabilisation and Transformation of Social Care (Page 2/4)

Birmingham

SRO: Peter Hay | **Relevant leads: Alan Lotinga, Louise Collett**

Organisations involved: Birmingham City Council and system partners

Understanding the Gap

We have expended significant effort in establishing the BCC position for adult social care in order to provide a firm foundation from which we will measure progress and success in stabilising and transforming adult social care services across the footprint. To do this, we have undertaken analysis on social care expenditure and activity, and will continue our work to model the impact and benefits in shifting activity into home and community services, and are aligning our BCF schemes with our STP programmes. We will also identify additional strategic options to further manage demand and maximise efficiencies, and have recently put in place a new strategy with UHB to manage and reduce delays in transferring patients to appropriate lower acuity settings, or home.

BCC expenditure on Adult Social Care

Expenditure (£'000)	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Council spend (excl. Education)	941,989	937,806	902,590	862,812	823,953	812,320
Adult Social Care	287,834	276,885	263,298	232,556	216,255	226,867
% of the Council's overall spend	**31%**	**30%**	**29%**	**27%**	**26%**	**28%**

Figures based on net expenditure

Current position

As at 30th June 2016, the People's Directorate reported a £51.2m overspend projection, bringing the Council's overall cost pressures to c.£60m in 2016/17, resulting from externally driven cost pressures, significant challenges in delivering annual savings agreed by the Council, and additional growth in care packages and prices.

A significant level of savings (£28.4m) was apportioned to be achieved in 2016/17 via whole system reform plans with Health. On the 4th July 2016 a strategy was supported by BSol partners to seek to gain NHSE support to utilise the retained 1% CCG contingency (estimated at £13m) if this were possible to alleviate identified financial gaps in the system. Even If the total of the contingency were to be released into the system by NHSE and made available for adult social care alone this would still leave a £15m gap in that saving which the council would commence plans to save under the principle of 'least harm to the system'. It is now clear that given a thorough review of system finances and NHS pressures the utilisation of the £13m will not be possible under the current NHS priorities. Therefore, extrapolating the savings gap to 2020/21, Birmingham Council faces an overall gap of £123m within the BSol STP footprint for Adults, Children's, and Public Health services.

Requests for Support

Requests for Support	2014/15	2015/16	Increase / (Decrease)
Short Term Enablement	2,837	3,473	22.4%
Nursing Care	148	150	1.4%
Residential Care	310	281	(9.4%)
Community Care	1,207	1,604	32.9%
Low Level Support	7,009	6,068	(13.4%)
Short Term Support	81	128	58.0%
Universal Services	13,301	13,143	(1.2%)
No Services provided	10,830	10,340	(4.5%)
TOTAL	**35,723**	**35,187**	**(1.5%)**

Pressures on Adult Social Care services

There are a number of drivers which are placing increased pressure on our social care services. These include:

Demographics

- The trend between funding and the net effect of demographic growth is on the rise. Between 2015/16 and 2016/17, the level of client need attributable to demographic pressure has been forecast to increase by £12.5m, of which only ££6.5m is funded placing increased pressure on the system.
- Demographic pressures are also more complex than pure population growth statistics. Poverty and sickness are widely accepted as drivers of earlier onset of the effects requiring Social Care, and there is also growth in the number of younger adults with complex care needs where there is little opportunity to reduce these high package costs. Both these factors increase the intensity of demand on Adult Social Care within Birmingham.

Rising Pressures in the Care Market

- There is increasing pressure on the independent sector care home and home support sectors, most recently from the introduction of the national living wage and increasing reliance on sector funding. In Birmingham, one of our largest care home providers has served notice to close 166 beds. Alternative placements will invariably be significantly more expensive, adding increased pressure to our system.

Deprivation of Liberty Safeguarding (DoLs)

- Following the Cheshire West Judgement, the number of referrals and assessments continues to rise resulting in financial pressures. Additional costs resulting from this include; training of and/or recruiting specialist staff (Best Interest Assessors (BIAs)), and a requirement for Section 12 doctor reports to be accessed for each referral. The additional funding made available for this in 2016/17 was c.£625k however despite this injection of additional funds, there remains a c£1.5m cost pressure to the Council.

Public Health Review

- The Government announced reductions in the level of Public Health funding for 2015/16, 2016/17, and further reductions in future years. The service continues to fund Early Years, Wellbeing, Environmental Health and other services provided by the Council, however revised plans for the commissioning of lifestyle services in response to grant changes have been implemented. Major re-commissioning exercises have been embedded and a review of budgets has revealed that a further c.£1m is available to contribute on a one-off basis to support services in the People Directorate. The use of the Public Health Grant will be closely monitored by Public Health England however and any proposals will need to meet the requirements of the grant conditions.

17a. Stabilisation and Transformation of Social Care (Page 3/4)

Birmingham

SRO: Peter Hay | **Relevant leads: Alan Lotinga, Louise Collett**

Organisations involved: Birmingham City Council and system partners

Closing the gap

In order to close the Adult Social Care gap, we are considering a range of options and initiatives in Birmingham to further address and manage demand more effectively, and identify further efficiencies. This will be crucially dependent on local system collaboration, and making rapid joint progress with healthcare services towards a much larger, more extensive integration and transformation of the city's health and social care system.

Further Demand Management and Efficiencies:

A number of potential savings initiatives have been identified to close the gap.

These include the closure of adults day services, the reduction in residential respite etc. all underway. However these are dealing with an overspend that is continuing to grow and requires support from the council reserve. We would only propose to add items into this list at the point at which we could show clear net gain.

These are a work in progress and will need to be further validated, and new initiatives identified wherever possible.

A summary position is outlined below:

Proposals (Savings) / New Pressures	2016/17 (£)	2016/18 (£)
Possible Reductions Identified	**(12,547,000)**	**(30,927,000)**

Better Care Fund (BCF) schemes:

We are planning to increase our overall investment in BCF schemes in 2016/17, with a total investment of £101.6m for the year. Investments in these schemes will not only help to stabilise primary and community care services but will provide a strong platform to enable transformation which will help to close the social care gap. We will continue our work to fully align these schemes with our STP programmes, including modelling the benefits and impacts to ensure our resources are focused in the right areas to deliver greatest benefit.

The table opposite outlines the total areas of BCF spend, not just those directly attributable to supporting adult social care.

Delayed Transfers of Care (DTOC):

Across BSol, the delays attributable to adult social care have increased from 10.7 per 100,000 in 2013/14 to 11.3 in 2014/15, and is considerably higher than our comparator group average of 5.1 days.

To address this, we have recently implemented a new approach to discharge and transfers with UHB, our main provider of services, and where the majority of our delays are attributed. DTOC rates will be monitored and reviewed over the next 12 months to manage and improve performance and take appropriate mitigating actions to ensure the expected improvements are delivered.

BCF Scheme	2016/17 Proposed Budget (£)	2015/16 (£)	Increase / (Decrease) (£)
BCF04 – Equipment & Technology (Medequip)	4,649,000	4,584,000	65,000
BCF04 – Equipment & Technology (Medequip)	1,300,000	1,732,000	(432,000)
BCF05 – Care in Crisis / Intermediate Care – Bed Based Provision	1,379,000	1,360,000	19,000
BCF05 – Care in Crisis / Intermediate Care – Social Care Provision	1,415,000	1,395,000	20,000
BCF05 – Care in Crisis / Intermediate Care – Reablement	1,265,000	1,247,000	18,000
BCF05 – Care in Crisis / Intermediate Care – CUR Tool	710,000	700,000	10,000
BCF06 – 7 Day Services	369,000	364,000	5,000
Care Act	3,012,000	2,970,000	42,000
Carer Strategy	1,824,000	1,799,000	25,000
Eligibility Criteria	20,328,000	20,044,000	284,000
Management of Programme	1,025,000	1,011,000	14,000
Community Services	43,163,000	42,530,000	633,000
Reablement – RAID	1,705,000	1,681,000	24,000
Reablement – Communications	47,000	46,000	1,000
Reablement – OPAT	34,000	34,000	0
Non Elective Admission Reduction	6,575,000	6,483,000	92,000
Disabled Facilities Grant	8,803,000	7,764,000	1,039,000
BCF03 – Place Based Integration & Accountable Community Professional – Wellbeing Coordinator	452,000		
BCF03 – Place Based Integration & Accountable Community Professional – Route to Wellbeing	55,000		
BCF03 – Place Based Integration & Accountable Community Professional – MDTs in Primary Care	101,000		
BCF04 – Equipment & Technology	0		
BCF05 – Care in Crisis / Intermediate Care – Enablement	1,113,000		
BCF05 – Care in Crisis / Intermediate Care – Admission Avoidance	1,581,000		
BCF05 – Care in Crisis / Intermediate Care – Bed Based Provision	528,000		
BCF05 – Care in Crisis / Intermediate Care – Implementation of CUR Tool	106,000		
BCF09 – Dementia	65,000		
TOTAL	**101,602,000**	**95,744,000**	**1,858,000**

17a. Stabilisation and Transformation of Social Care (Page 4/4)

Birmingham

Estimated financial benefits:
Adult social care services are under increasing pressure across the footprint, with demand for services increasing steadily year-on-year. We will work closely as a system, across health and social care, to first stabilise existing services and then transform the way that we provide care to cope with the increasing demand from our citizens. As well as internal Local Authority actions, there needs to be a shift in funding into adult social care to be able to maintain the sector, or a solution from outside of the footprint i.e. national policy to deliver sustainability in the context of the wider health and care system and local demographics.

Outcomes	Draft Metric	Delivery timeframe
Reduction in DTOCs to 5 per 100,000 (tbc figure needs to be same as UC)		
Reduction in permanent residential admissions	40	[2015/16]
Increased effectiveness of reablement	18	[2015/16]
Reduction in non-elective admissions (general & acute) by 3.5%	3.5%	[2015/16]

Key milestones: Birmingham

In 6 months we will:
- Achieve a common level of understanding across the footprint regarding the statutory requirements for social care
- Complete financial and activity modelling, which will include social care
- Complete a clinical audit of people in beds to establish a baseline and identify the required future level of care
- Understand the confidence levels required in partner organisations to release resources,
  and identify areas on which to focus that will have the biggest impact
- Explore options for risk and gain share across the system (and agree as appropriate)
- Commence the pilot for the agreed model of care at UHB
- Deliver current programmes to support efficiency, demand management and preparation for integration, re-scoping where necessary

In 12 months we will:
- Develop options/appraise future funding and service delivery models for social care
- Agree the preferred option(s) for future funding and delivery
- Commence implementation of preferred funding and service delivery option(s) that will shift activity 'left'

In 2 years we will:
- Fully deliver the new models
- Review the impact and benefits

Investment requirements:
It is anticipated that investment is essential to maintain current social care services, and build on these to deliver improvements to people's wellbeing and independence such that demand on healthcare services is reduced. In Birmingham, we are already planning to increase our overall investment in BCF schemes in 2016/17, with a total investment of £101.6m.

Investment requirements for adults social care will be determined in detail following the finance and activity modelling, discussions regarding risk and gain share arrangements across the footprint, and an analysis of the provider market resilience and our response to this.

Impact on capacity:
Impact on workforce by 2020/21:
Capacity in this sector will be a long term challenge. Recruitment challenges will be partly improved by introducing more appealing roles (e.g. Local Area Co-ordinators) and increased use of technology to replace the need for some staff capacity. Workforce strategy will therefore be key.

The workforce impact will be determined following finance and activity modelling, and an analysis of market resilience and our response to it.

Impact on acute hospital bed base by 2020/21:
The required impact is defined in the health plans.

Critical Decisions to support next steps:
- Response to national policy direction for social care
- Agreement of the Councils' approach to FY17/18 budgets and beyond
- Agreement on the future model of activity and cost to reduce demand
- Agreement regarding the future commissioning model
- Agreement by all parties for strategic objectives, model(s) of delivery, and investment approach (where investment is needed to facilitate whole system improvements)
- Agreement in regard to risk and gain share arrangements across the BSol footprint, and Solihull place based area.
- Approach to address the current high waiting lists for Deprivation of Liberty Safeguards (DOLs), which relate to hospital and residential settings, as well as Community DOLs. These are a key risk area.

Stakeholder engagement and consultation:
There is strong recognition that continued engagement with stakeholders is vital if we are to succeed in transforming social care services across our footprint. In particular, engagement with service users, and their families and carers who receive support, and well as engagement with and direct involvement of Council Leaders, relevant portfolio holders and wider members to deliver our plans.

Engagement with faith based and other community based organisations will also be key to driving the changes required given our diverse population across BSol (where 42% of our residents in Birmingham, and 11% of residents in Solihull, identify with BAME groups).

Engagement will be through a planned programme and a variety of forums to include the above identified stakeholders, as well as other relevant public sector organisations (e.g. UHB/HEFT, BSMHFT, BCHCFT, ROH, CCGs, NHSE, CQC, Primary Care), Healthwatch, the independent social care sector, community and third / voluntary sectors.

Key Risks	RAG	Mitigation
Risk of Local Authorities having to take in-year spend reduction measures with significant unintended consequences for the wider healthcare system		Engage, understand, and plan jointly in advance of action, with local NHS partners within the agreed STP governance
Lack of available finance at the appropriate time, to maintain current service levels and to build further capacity to support health in diverting to lower cost solutions		Engage with health partners to determine and agree the investment model that will protect / maintain social care and benefit health organisations and service users. Push for change to national funding model
Lack of cross organisational commitment and effective stakeholder engagement and buy-in to drive change and culture		Work in partnership to identify a clear, evidence-based, appealing model for future delivery and continue engagement and involvement throughout ongoing development and delivery
Workforce recruitment and engagement is insufficient to mobilise at pace		Increase workforce engagement, including with Unions
Independent social care market stability continues to deteriorate, so capacity and responsiveness reduces		As part of transformation plans, identify alternative models for long term support, for example, extra-care housing, assistive technology, LA direct development of care homes

17b. Stabilisation and Transformation of Adult Social Care (Page 1/4) Draft v10 18.10.16 | **Solihull**

SRO: Jenny Wood | **Relevant leads: Sue Dale / Karen Murphy**

Organisations involved: Solihull Metropolitan Borough Council and system partners

Strategic objective:
'To enable people to stay as independent and well as possible, for as long as possible. When people do need long term support this is timely, responsive, good quality and enables people to continue to live their lives the way they want to.'
To support this ambition, transformation programmes are already underway and will work in alignment with the wider STP plan deliverables to:

- Support people and communities to support themselves as much as possible
- Ensure an effective, integrated approach to commissioning and delivery between social care, health services and wider partners, utilising social care as a vehicle to the local authority's extensive partnerships (e.g. Fire, Police, Housing, Economic Development) thus enabling co-ordinated, system-wide approach to public sector reform and effective interface with the public.
- Embed digital and self-service solutions where it makes sense to do so (e.g. blue badges)
- With health partners, define & deliver an admissions avoidance and hospital discharge model which is resilient, responsive & tailored to improving lives and outcomes.
- Ensure Adult Safeguarding is responsive, effective & works collaboratively with other agencies.
- Develop a clear, integrated approach to supporting children and young people with additional needs to prepare for and move to adulthood ('transitions'), with improvements to health, wellbeing and independence.
- All administrative processes (e.g. invoice payments/customer charging) are streamlined, digitalised and automated where-ever it makes sense to do so.
- Local response to pending National Carer's Strategy, with local change where needed.

Outcomes	Propose Metric (vs15/16)	Delivery timeframe
Reduction in DTOCs to 2 per 100,000 (System-wide target)	2 (17.3)	20/21
Long term support needs of 65+ met by admission to residential care (ASCOF 2A(ii) and BCF indicator)	517 (560)	20/21
Proportion of adults with Learning Disability who live in their own home or with family (not residential care (ASCOF 1-G)	80% (71.4%)	20/21
People who use services who say their quality of life is very good / good	69% (58%)	20/21

Context/Description:

- The BSol footprint includes 2 Local Authorities, BCC and SMBC, which have very different populations, political agendas, and key drivers. The ambition to deliver personalised, quality support and to enable people to maintain independence is a common goal.
- Solihull Adult Social Care has a recent history of good performance, outcomes and financial management. All remaining in-house provider services are CQC rated good and despite delivery of significant savings through the current medium term financial plan, complaints have remained steady and there has been a significant increase in compliments.
- Integral to managing demand in health and social care is our vision to develop a whole Council approach to building stronger communities and resilient community relationships
- We are keen to build on our strong history of engagement and co-production with our citizens, including our online Local Account, our Community Interest Company of Experts by Experience, & driving forward our 'Gold Standard' for Making Safeguarding Personal.
- However, the national funding position for adult social care is now having a significant impact and this is indicated in the emergence of a financial deficit in future years and performance challenges in key areas, e.g., hospital delayed discharges and the responsiveness and capacity in the independent sector market.
- There are significant market fragility, quality and workforce challenges across the sector reflecting a range of issues, including the perception of the sector; a need to better balance quality, market stabilisation and cost; and workforce challenges such as low pay, limited appeal of direct care roles, and an ageing workforce.
- Whilst significant anticipatory and innovative work is continuing to respond to the challenges, there is no doubt that these will not fully address the future funding gap for social care as set out in the finance section.
- Examples of innovation and change include the introduction of Local Area Co-ordinators, an evidenced-based approach to building more sustainable and resilient community networks, with indicated health and social care financial benefits. Another example is the decision to initiate a council-led, care home build for dementia care, recognising that the independent sector market capacity is not likely to provide affordable solutions to the capacity challenge, in the near future.

Key milestones: *In year 1 we will*:

- Progress financial, outcome and activity modelling, to better understand impact of own and wider STP financial and outcome-based plans.
- Jointly with health partners, define and agree the areas of joint or integrated commissioning and delivery and specify the approach to future delivery of functions in these areas. Explore options for risk and gain share across the system (and agree as appropriate)
- Deliver current in-year projects to support demand management for adult social care and the delivery of the current Medium Term Financial Plan savings. Ensure local policy and guidance underpins delivery of strategic objectives.
- Re-scope (where needed) the Adult Social Care Transformation Programme and the Solihull Together integrated health and care programme, to provide a governance vehicles under the STP structure, to ensure an ongoing focus on both BSol and Solihull-place based delivery.

In year 2 we will:

- Agree investment models and options with partners and tailor future service delivery models for social care in light of the results of this, focusing on ongoing delivery of strategic objectives.
- Deliver in-year agreed projects and evaluate new developments e.g., Local Area Co-ordinators.

In year 3 we will:

- Fully deliver the new models
- Review the impact and benefits

17b. Stabilisation and Transformation of Social Care (Page 2/4)

Solihull

SRO: Jenny Wood | **Relevant leads: Sue Dale and Karen Murphy**

Organisations involved: Solihull Metropolitan Borough Council and system partners

Supporting data and outcomes: Solihull

- The proportion of Solihull people who receive adult social care services, who are satisfied with those services is 93% (15/16). Comparator range is 84-95%, from annual survey.
- 64% of Solihull respondents, who receive adult social care services, say either they are able to spend their time as they want, doing things they value or enjoy. This is second lowest against comparator councils, with range of 58-74% and we want to improve this. From annual survey.
- Just over 76% of Solihull respondents say that they have either as much control over their daily life as they want, or adequate control. This is below comparator authority average (79%)
- Of those respondents who said that they had tried to find information and advice over the last year 75% said that they found it easy to do so. This is above the England average (73%) and in-line with that for the comparator authorities (range 65%-80%). From annual survey.
- Delays attributable to social care (ASCOF 2Cii) need improving. 15/16 outturn was 7.9 per 100,000.
- Historically low rates of admission to residential care (65+) mean limited scope for further reduction. 560.3 per 100,000 compared to comparator average of 625 (15/16).
- Proportion of adults with a learning disability in paid employment (ASCOF 1E) is low 2.58% compared to comparator performance of 7%. This is an area for improvement.
- There is a large self-funder market in Solihull, which means that the unit costs of independent sector provision are heavily influenced by this.

Solihull MBC expenditure on Adult Social Care:

Expenditure (£'000)	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Council spend (excl. Education)	150,559	143,626	142,790	137,884	138,932	138,268
Adult Social Care	54,099	52,905	51,011	51,243	51,153	51,839
% of the Council's overall spend	**36%**	**37%**	**36%**	**37%**	**37%**	**37%**

Figures based on net expenditure

Current position:

Expenditure (£'000)	2016/17	2017/18	2018/19	2019/20	2020/21	Total
Current Overspend Projection against above Adult Social Care Budget	**1,739**	**1,739**	**1,739**	**1,739**	**1,739**	
Savings at Risk (Red)		2,777	2,085	2,868	2,868	
Cumulative Forecast Deficit against above Adult Social Care Budget	**1,739**	**4,516**	**6,601**	**9,469**	**12,337**	**34,662**

The Adult Social Care budget in the first table above assumes that all budget pressures are dealt with and that all the Adult Social Care savings targets are delivered. The second table shows the current forecast deficit against the adult social care budget . In addition, savings rated as red indicate significant concerns about deliverability or significant delayed delivery. The table assumes that all savings rated as green or amber will be delivered in full (see details of savings on page 2).

Savings at risk for 2019/20 and 2020/21 represent the adult social care savings targets for those years, for which no plans have yet been made.

Planning work is continuing, to attempt to improve the current and future financial position, which if successful will reduce the gap. It is anticipated that the majority of the 2016/17 deficit will need to be covered from one-off adult social care reserves. All adult social care reserves will be exhausted by 31st March 2017.

The Council's budget plans assume that the maximum 2.0% adult social care council tax precept will be levied in all years and this funding has been accounted for in the above tables.

Pressures on Adult Social Care services:

There are a number of drivers which are placing increased pressure on our adult social care services. These include:

Demographics/Demand for Services/Rising Pressures in the Care Market:

- There are significant additional costs for inflation, demographics and the impact of the National Living Wage in 2016/17.
- £2.464m of additional funding has been made available to support these costs but despite this, an underlying budget pressure is currently forecast.
- There are additional costs relating to the increasing cost and complexity of care packages. Residential and Nursing spot contracted rates have typically risen by between 3% and 7% in 2016/17 to date, whilst the number of hours of care required for homecare clients has risen by 2.5% on average in this period.
- In addition there has been a significant increase in the number of younger adults with complex care requirements entering the system this year.

Deprivation of Liberty Safeguarding (DoLs):

- Following the Cheshire West Judgement, costs relating to DoLs have increased by £449,000 in 2016/17.

Reduction in funding streams:

- A number of one off funding streams (e.g. Care Act Burdens monies) that were available in previous years to offset pressures are no longer available in 2016/17.
- Solihull's Health & Wellbeing Board has agreed to a £1.1 million reduction to the amount of the Better Care Fund allocated to adult social care (in 2016/17 only) in order to assist with Solihull CCGs financial position. This has however added an equivalent pressure to the adult social care budget for this year.

All of the above contribute to the current underlying budget pressure of £ 1.739 million on Solihull's Adult Social Care budget.

17b. Stabilisation and Transformation of Social Care (Page 3/4)

Solihull

SRO: Jenny Wood | **Relevant leads: Sue Dale and Karen Murphy**

Organisations involved: Solihull Metropolitan Borough Council, and system partners

Closing the gap: Solihull

The Council's published three-year Medium Term Financial Strategy 2016-17 to 2018-19 sets out the specific actions that the Council intends to take to deliver savings in adult social care. The savings rated as green and amber are assumed to be deliverable and do not therefore form part of the funding gap on the previous page. The savings rated as red are included in the funding gap. As with Birmingham, the savings are crucially dependent on local system collaboration and a more integrated health and social care system.

Further Demand Management and Efficiencies:

The Council will attempt to make the following savings in adult social care. To the extent that any savings rated as red are delivered, these will help to close the funding gap.

Proposals (Savings) / New Pressures	2016/17 (£)	2017/18 (£)	2018/19 (£)
Supporting People	(135)	(100)	
Review contracts for VCS services			(125)
			(656)
Community Recovery Team	(57)		
Fairer Charging Review	(500)		7
Review of Spot Contracts			
Assistive Technology and Telecare	(84)		
Information and Advice Grants			
Redesign of Day Care	(344)	(69)	(600)
		(372)	
Development of Extra Care		(55)	(165)
Review of support where costs are high		(500)	
Review of Transport			
Small Homes Review		(375)	(147)
Review Internal Reablement Service	(268)		
Review of RAS model and support planning approach	(152)		
	(189)		
	(394)	(380)	
Integrated Care Partnership and Reablement			TBC
Connect Service, Promoting Independence and Demand Management			TBC
Alternative Savings to meet Reduction in ATT Targets			TBC
Release of ASC Directorate specific reserve (one-off)	50		
Release of Chelmsley Wood Primary Care Centre specific reserve (one-off)	15		
Contribution to ASC Reserves	(214)	159	55
Improved working with the NHS		(300)	
Better targeting of Promoting Independence Service		(153)	
Support Planning and Review Staffing		(100)	
		(330)	
Promoting Direct Payments and the Personal Assistant Market		(550)	
Further Development of Domiciliary Care Market		(300)	(250)
Review spot and block contracts for the provision of Mental Health care and support services.			(118)
			(132)
Make better use of CHC for people with continuing health care needs.			(300)
Corporate Savings - Proportion of cross-cutting staff savings	(250)		
Possible Reductions Identified	**(2,522)**	**(3,425)**	**(2,431)**

Summary of RAG Ratings

Red	(394)	(2,777)	(2,085)
Amber	(189)	(385)	(165)
Green	(1,939)	(263)	(181)
TOTAL	**(2,522)**	**(3,425)**	**(2,431)**

Better Care Fund (BCF) schemes: The Council and the CCG have allocated the BCF as follows, spread across council and health expenditure:

BCF Scheme	2016/17 Budget (£)	2015/16 (£)	Increase / (Decrease) (£)
Local Delivery Resource Plan	792,000	792,000	-
Carers Strategy	350,000	350,000	-
Joint Equipment Stores	1,126,000	1,126,000	-
s256 NHS Transfer	4,170,000	4,170,000	-
Disabled Facilities Grant	1,696,000	910,000	786,000
ASC Capital Grant	-	485,000	(485,000)
Care Act Implementation	537,000	537,000	-
Scheme 1: Integrated Care Team	2,996,000	2,996,000	-
Scheme 2 : Discharge to Assess	400,000	400,000	-
Scheme 3 : Falls Prevention	281,000	281,000	-
Scheme 4 : Support to Care Homes	334,000	334,000	-
Scheme 5 : Care Navigation/Information Advice	200,000	200,000	-
Scheme 6 : Ambulatory	670,000	670,000	-
Scheme 8 : Protecting Adult Social Care & Care Act *	763,000	1,763,000	(1,000,000)
Scheme 9 : Implementing Dementia Strategy	100,000	100,000	-
Contingency - For CCG Use against Cost Pressures	1,000,000		1,000,000
CCG Minimum Contribution Increase	278,000		278,000
TOTAL	**15,693,000**	**15,114,000**	**579,000**

* Note - This is a one year only reduction to Protecting Adult Social Care. From 2017/18 the figure will revert to £1.763m plus national uplift factors. Uplift factors will also be applied to other adult social care projects in 2017/18.

17b. Stabilisation and Transformation of Adult Social Care (Page 4/4)

Solihull

SRO: Jenny Wood | **Relevant leads: Sue Dale and Karen Murphy**

Organisations involved: Solihull Metropolitan Borough Council and system partners

Current Financial Position*:

The table opposite outlines current pressures. These are based on a forecast deficit position plus savings targets currently rated red (which means indicative of non-delivery or significantly delayed delivery.) The table does not include savings plans anticipated to deliver in full. A rise in inflation or increase in National Living Wage above the current forecast will reduce the budget available for demographic growth and therefore create additional pressure. Modelling assumes Council Tax 2.0% precept and 1.99% council tax annual uplifts. Planning work is continuing, to improve current and future financial position which if successful will reduce the gap. It is anticipated majority of 16/17 deficit will be covered from one-off council funds.

**Status as of 7 October, 2016*

	2016/17	2017/18	2018/19	2019/20	2020/21	Total
	£m	£m	£m	£m	£m	£m
Current Deficit	1.739	1.739	1.739	1.739	1.739	
Savings at Risk (Red)		2.777	2.085	2.868	2.868	
Cumulative Forecast Deficit	1.739	4.516	6.601	9.469	12.337	34.662

Critical Decisions to support next steps:

- Response to national policy direction for social care
- Agreement by all parties for strategic objectives, model(s) of delivery, and investment approach (where investment needed to facilitate whole system improvements)
- Agreement in regard to risk and gain share arrangements across the BSol footprint, and Solihull place based area.
- Manage the significant risks / pressures around meeting statutory responsibilities of Deprivation of Liberty Safeguards (DOLS) in care settings and around Community DOLS, whilst being responsive to developments to be set out by Law Commission in 2017.

Investment requirements:

- It is anticipated that investment is essential to maintain current social care services, and build on these to deliver improvements to people's wellbeing and independence such that demand on health care services is reduced. This will be determined following the finance and activity modelling and discussions regarding risk and gain share arrangements across the footprint. Also, through an update of the adult social care, joint strategic commissioning intentions for the period and associated analysis of the provider market resilience and response.

Impact on capacity:

Impact on workforce by 2020/21:

- Capacity in care sector (in-house and independent) will be a long term challenge. Recruitment challenges will be partly improved by introducing more appealing roles (e.g. Local Area Co-ordinators) and increased use of technology to replace need for some staff capacity. Workforce strategy key.

Impact on acute hospital bed base by 2020/21:

- The required impact is defined in the health plans

Stakeholder engagement and consultation:

- There is strong recognition that engagement with stakeholders throughout, is vital. Especially families and carers who receive support and importantly, engagement and direct involvement of council leader, relevant portfolio holders and wider members.
- Engagement will be through a variety of forums and includes relevant public sector organisations (UHB/HEFT, CCGs, NHSE, CQC, Primary Care, Healthwatch, independent social care sector, third / voluntary sector and faith based and other community based organisations), to drive changes together.

Risk	RAG	Mitigation
Lack of available finance at the appropriate time, to maintain current service levels and to build further capacity to support health in diverting to lower cost solutions.		Engage with health partners to determine and agree the investment model that will protect social care and benefit health organisations and service users. Push for change to national funding model.
Lack of cross organisational commitment and stakeholder buy-in to drive change and culture.		Work in partnership to identify a clear, evidence-based, appealing model for future delivery and continue engagement and involvement throughout ongoing development and delivery.
Workforce recruitment and engagement is insufficient to mobilise at pace		Increase workforce engagement, including with Unions
Independent social care market stability continues to deteriorate, so capacity and responsiveness reduces		As part of transformation plans, identify alternative models for long term support, for example, extra-care housing, assistive technology, LA direct development of care homes.
Risk of local authorities having to take in-year spend reduction measures with significant unintended consequences for the wider health-care system		Remain sighted on national directions and plan jointly in advance of action as far as possible, with local NHS partners, within the agreed STP governance

18. Commissioning Reform

SRO: Nick Page with CCG AOs

Relevant leads: Stephen Munday, Angela Probert, Rhod Mitchell, and Alison Tonge

Organisations involved: Solihull Metropolitan Borough Council, Birmingham City Council, Birmingham Cross City CCG, Birmingham South and Central CCG Solihull CCG, NHSE

Strategic objective:

Whole system and place based approach to commissioning – greater integration and alignment of CCG, NHSE (including specialised services) and LA commissioning, strategy development; focussed on cross-sector priorities and outcome framework.

Aims:

- Improved health and social care outcomes
- Improved quality of care
- Efficient use of resources
- Commissioning demonstrates added value

Outcomes:

The Commissioning Reform Group have identified a number of high level goals including:

- Effective system management underpinned by comprehensive information system
- More effective and efficient commissioning processes – fewer gaps and less duplication
- Greater focus on outcomes based commissioning
- Better value through improved efficiency and reduced costs of commissioning function
- Simpler and more effective governance of commissioning and decision making
- Stronger service transformation approaches, decommissioning and re-commissioning
- Aligned budgets (as a minimum) and agreed risk share arrangements

Context:

There is a need for the BSol footprint to deliver greater service integration and integrated commissioning across the health and social care system. Over recent years, the policy environment has altered the relationships and roles between health and social care commissioners and providers. Across England, commissioning reform is taking place in response to challenges faced by local health and care systems.

The decision of the 3 CCGs to establish a single commissioning voice and the BCC decision to establish a children's commissioning function in response to the development of an arms length Children's Trust provides further impetus to the commissioning reform work.

This work is an expansion of numerous existing joint commissioning arrangements e.g. cohort-focussed programmes between councils and CCGs and integrated commissioning units.

Impact on capacity:

- *Impact on workforce by 2020/21*:
- Consolidation of management structure and back office staff.
- *Impact on bed base by 2020/21* (if applicable): not applicable.

Key milestones: (to be confirmed)

In 6 months we will:

- Assess benefits and scope of greater integration and agree project scope – Sept 16
- Establish Project Delivery Arrangements – Sept 16
- Map and assess existing commissioning arrangements and support functions, incorporating outcome of phase 1 – Oct 16
- Structured conversations and activity with Commissioners to develop thinking – Nov 16
- Workshop to define approach and phasing – Nov 16
- Develop how the function will be delivered with regard to leadership, structure and support – Nov 16
- Develop proposals for new function and structures – Jan 17
- Scope milestones for Phase 2 (delivery of commissioning function)

Key risks:

Risk	RAG	Mitigation
There are insufficient system wide incentives to foster agreement between organisations about the organisational form required		Robust options appraisal based upon recent local data, case studies and strong stakeholder engagement
Lack of stakeholder engagement delays programme as agreements are not reached		Collaborative design of the commissioning function based upon the agreed vision and strategic objectives of the BSol STP. Robust engagement plan.

Stakeholder engagement and consultation:

- SMBC and BCC leadership teams and Cabinets, Directors of Children's Services, Health and Wellbeing Boards, CCG and LA Commissioning teams, CCG senior management and Boards, NHSE, NHSE Specialist Services Commissioning Teams, NHS Improvement, LA Leaders/CP Holders BCC and SMBC, General Practice, Primary Care, Public Health England, NHS Provider Trusts, Schools, Police and Crime Commissioner.
- Detailed engagement plan timetable to be developed. Ambition is to meet with a wide group of stakeholder to understand possible future models.

Critical Decisions to support next steps:

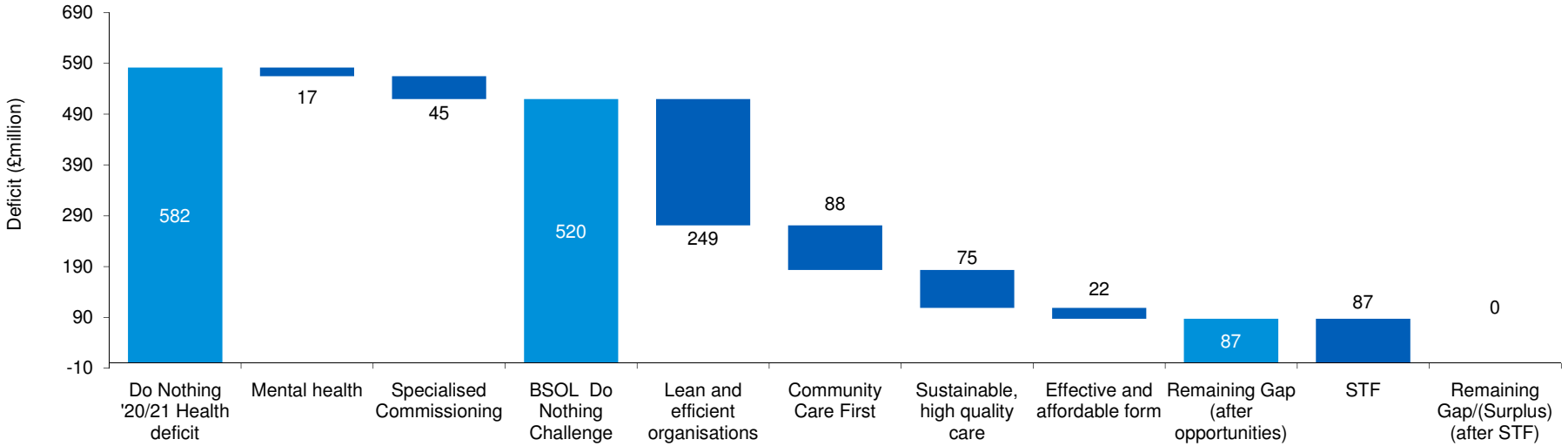
- Identifying those areas where there were realisable benefits in joining commissioning budgets
- Agreement upon preferred enabling system governance model that will deliver an integrated health and care commissioning function
- Agreement upon principles around risk and reward to ensure focus on system wide benefit

Solutions and impact

	Assumptions and target	Net impact of scheme	Solution Type
1	Mental Health: • Savings to be achieved through Mental health Five Year Forward View initiatives in access to IATp, crisis response home treatment teams and SMI physical health which will reduce health expenditure but not necessarily direct Mental Health expenditure.	£17m	Mental Health
2	Specialised Commissioning: • QIPP Programme	£45m	Specialised Commissioning
3	Improving Productivity: • Reduce inefficiencies in support services and back office function (this includes HEFT Recovery Plan) • Reduce variation in clinical service delivery and performance outcomes • Reduce incidents of unplanned care	£249m	Lean and efficient organisations
4	Buy Better: • Improve market management and take a whole systems approach to commissioning to mitigate against anticipated increases such as CHC and prescription cost growth	£35m	New Models of Care/Commissioning
5	Right Care: • Identify areas for improvement from the nationally available spend and outcome indicators • Savings will be produced from reducing unwanted variation and ensuring all commissioning arrangements represent value for money	£18m	New Models of Care/Commissioning
6	Community care: • Develop new models of care for: • High cost patients • End of life care • Long term conditions • Improve use of the 3rd sector to keep people well in the community	£35m	New Models of Care/Commissioning
7	Better Management of Demand: • Reduce demand for acute services through development of proactive out of hospital community based care • Embedding the prevention agenda	£30m	Sustainable, high quality care
8	Fit for Future Primary and Secondary Services: • Reduction in variation in clinical service • Improvements in clinical outcomes, especially when combined with definition of new clinical pathways	£30m	Sustainable, high quality care
9	Better management of bed capacity: • Identify opportunities to better match demand with supply through improved integration of acute, community and social care • This should enable the better management of bed capacity	£15m	Sustainable, high quality care
10	Rationalisation of estate: • Analysis of the utilisation of commissioner and provider estate has identified some estate that is currently unoccupied • Collaboration across the footprint to progress the development of a shard approach to estate utilisation	£13m	Effective and affordable form
11	Organisational Consolidation: • Additional saving beyond 2% productivity saving delivered by merger of BCH and BWH and potentially UHB and HEFT, if the case for change is supported by both Boards	£3m	Effective and affordable form
12	Commissioning reform: • Saving from the consolidation of the 3 CCGs into 1 CCG • Establish an effective commissioning function across the STP that will maximise efficiencies and drive the system wide transformation programmes	£6m	Effective and affordable care

The solutions and potential opportunities

The Solutions & Additional Opportunity Areas



The ‘Do Nothing’ 2020/21 deficit of £582m is reduced by identified Mental Health and Specialised Commissioning savings of £17m and £45m respectively. The remaining BSOL ‘Do Nothing’ challenge amounts to £520m.

The amount attributed to ‘lean and efficient organisations’ is £249m, with £88m attributed to ‘Community Care First’. Together with £75m attributed the impact of ‘sustainable high quality secondary and tertiary care’ and £22m attributed to ‘effective and affordable form’, this leaves a remaining gap of £87m. This remaining gap is closed by £87m of STF funding.

Delivering the plan

Solihull Metropolitan Borough Council

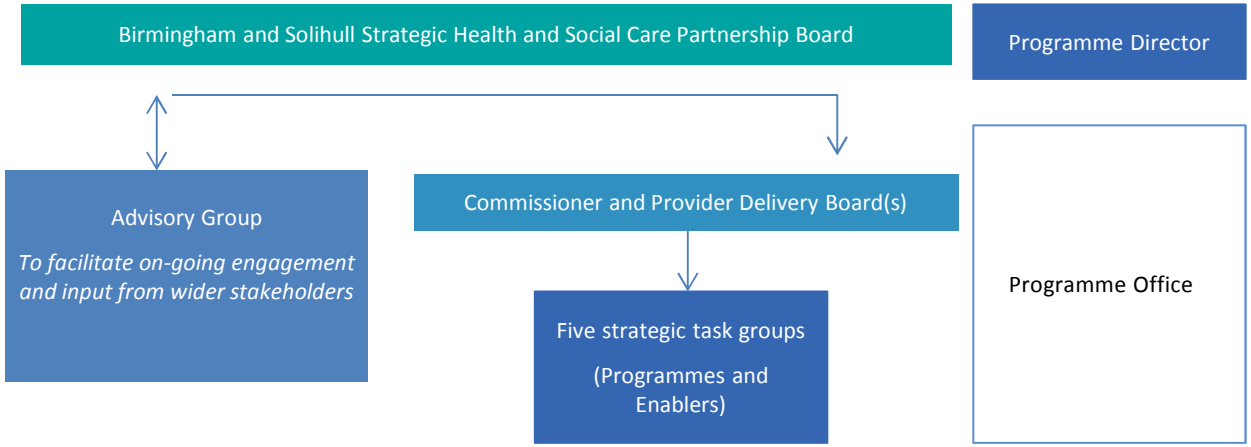
Birmingham City Council

NHS

A new governance approach and strong programme office to drive delivery of the Sustainability and Transformation Plan

EQUIPPING THE SYSTEM TO LEAD THE CHANGE REQUIRED CONFIDENTLY, AT PACE AND ACCOUNTABLE TO PARTNERS AND PUBLIC	Delivering the ambitions set out in our STP requires over twenty major change projects over four to five years involving the combined talents of dozens of organisations and thousands of public servants and private suppliers. Maintaining focus, coherence and pace demands strong leadership, clear accountability, agreed methodologies for change and improvements and transparent reporting. A new trusting culture of partnership and reciprocation will be essential, and new governance approaches and structures will be required to create and embed this new culture. The interdependencies across the system and across the service change projects set out in the STP are complex. A strong programme office capable of linking strategy, investment, delivery and change agenda will enable individual organisations, new joint bodies and the system as a whole to deliver better outcomes through improved services and better use of resources. In developing our governance and programme management infrastructure for our delivery phase we are building on the foundations that we have put in place as a health economy in preparing this submission. There has been valuable learning from this process, what works and what needs to change both in terms of the governance infrastructure and the programme management approach that bests fits the BSol health and social care system. These structures are supported by a strong programme office led by a highly credible and experienced Director. We are currently finalising our work on the governance structure (including such issues as subsidiarity of decision making) – this is being led by Jacqui Smith – Chair of University Hospitals Birmingham NHS Foundation Trust / Heart of England NHS Foundation Trust. A draft of the structure is included on the following page. This is complemented by a parallel piece of work on developing a sustainable programme and project management structure that provides consistency and clarity across the programme, is embedded within the health and social care community, develops a jointly owned financial and activity model and is affordable.

A Proposed new governance structure across BSol



PROPOSED MEMBERSHIP

Birmingham and Solihull Strategic Health and Social Care Partnership	Executive and non-executive health and local authority commissioner and provider representation to enable decision making
Commissioner and Provider Delivery Board(s)	Identified representatives of 3 CCGs, 2 LA, NHS England, Acute, Community, Mental Health, Ambulance, Primary Care, Social Care, Public Health
Strategic Task Groups	Identified SROs for each of the identified themes – will chair inter-discplinary teams that provide high support / high challenge to individual project work-streams
20 individual programmes and enablers	Programme area SROs with project teams built from across the health and social care economy. Utilising consistent project management methodology and reporting.
Programme Office	Led by system wide Programme Director with appropriate support to ensure appropriate support and consistency across the major programmes and change projects

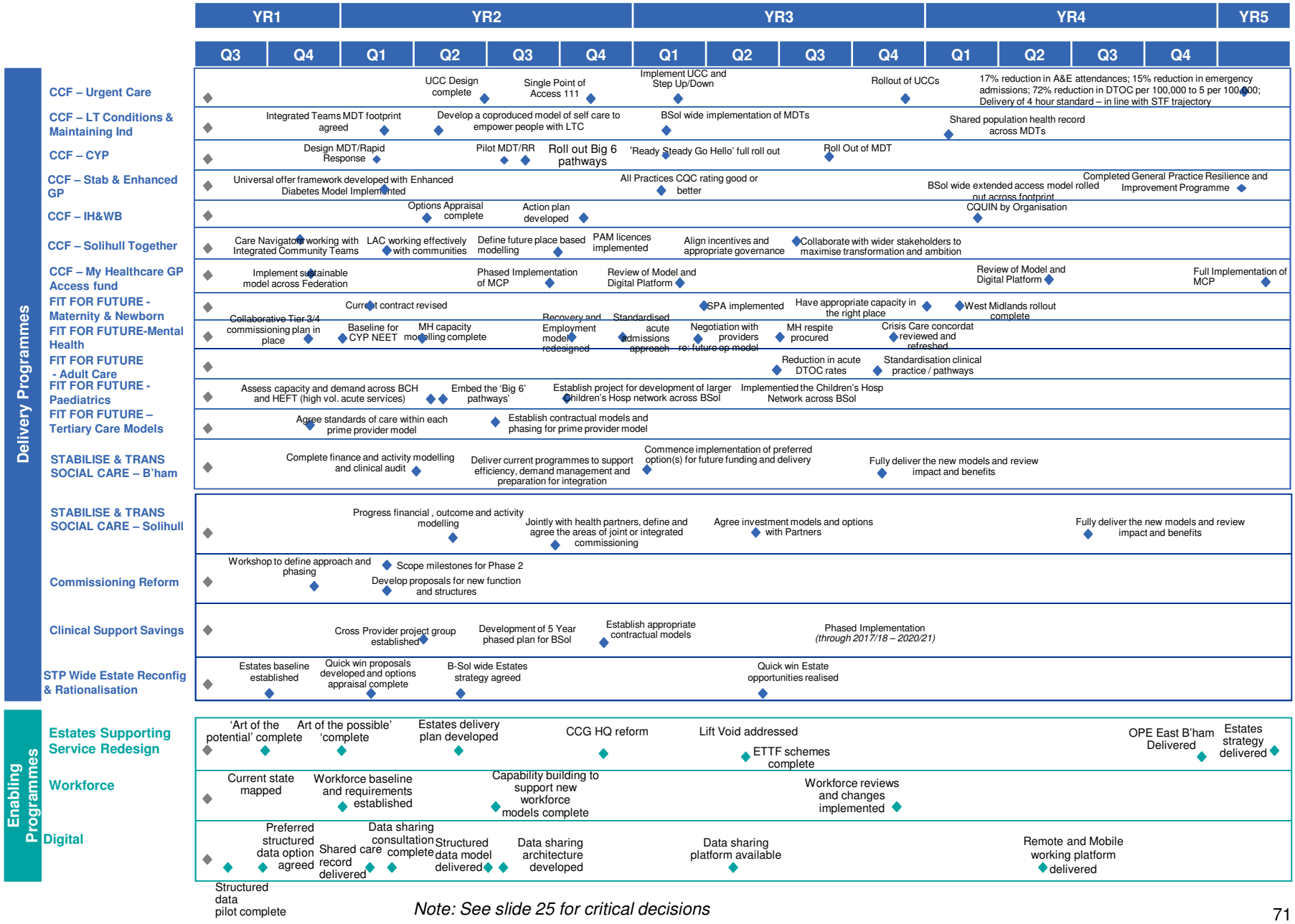
Guiding Principles and Accountabilities

- All decisions made will be in the best interests of our citizens and patients, the impact of the health of the population and the sustainability of the system
- All decisions will support our strategic objectives: efficient and lean organisations across the footprint, transformed primary, social and community care; sustainable high quality acute, secondary and tertiary services; and an effective and affordable system.
- The Strategic Health and Social Care Partnership Board will have joint accountability for delivering the STP plan
- All organisations retain sovereignty over decisions - decisions within the STP programme need ratification within each organisations governance arrangements.
- Matters that are soley the concern of a subsidiary party will not be the business of the STP.
- Small Strategic Task Groups will co-ordinate the implementation and interdependencies of the change projects embedded within their theme.
- The Programme Director and Programme Office will be accountable to the BSol Health and Social Care Partnership Board..

The principles behind our programme management approach

WHAT?	WHO?	OUTCOME
A comprehensive activity and financial model, owned by all, embedded in our planning process that links to individual organisational requirements.	SRO – efficient and lean providers	Ability to plan scenario's and support and identify the system wide impact of change projects.
A fully owned methodology for tracking progress across the five key themes and 20 plus change management projects.	Programme Director - PMO	Consistency in reporting, early identification of issues and key dependencies.
A consistent and transparent risk management and assurance framework for each level of the governance infrastructure.	Programme Director - PMO	Ownership and clarity of risks, mitigations and those areas where the risk is accepted.
A clear business model for the PMO – including funding agreement across all the organisations, development of clear reporting standards and KPIs for the function.	Chief Executive(s).	A resilient, strong and responsive PMO function for the BSol STP.
A secretariat function to ensure best practice in terms of compilation and delivery of Board paper, minute taking etc.	Programme Director	Support good decision making through timely supply of information, comprehensive minutes and action logs.
Identify our management capacity, capability and approaches to support the change management projects within the BSol programme	Programme Director	Develop our change management capacity across the BSol health and social care system.
An agreed communication and public engagement strategy and methodology and structure to support the BSol programme.	Programme Director	Clarity and consistency of message for specific stakeholder groups (staff, citizens etc.)

High level milestone plan



Note: See slide 25 for critical decisions

Engagement and communications strategy

The STP presents a real opportunity for health and social care across Birmingham and Solihull to work together differently for the benefit of our people. By choosing to operate as a system and to take a system wide view rather than an organisational view, we will be able to put our people at the heart of what we do, plan better for the long term and ensure that any decisions that are taken are made with the agreement of all partners and the engagement of our local communities. We are committed to engaging with our stakeholders at every stage of the development process of the development and implementation of the STP

Stakeholder mapping completed

Development of overarching key messages

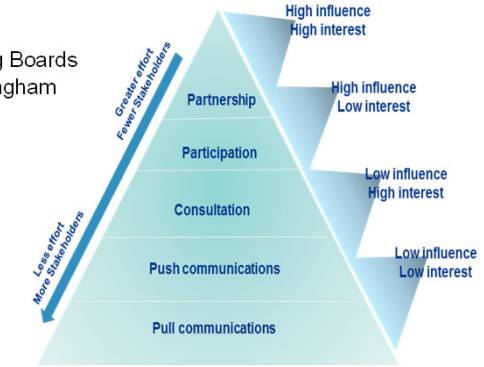
Development of the STP engagement and communications strategy

Our over-arching key messages are:

- We need to talk about our plans for better health and social care in Birmingham and Solihull, and demonstrate why we need to make a whole-scale change
- The STP is a planning tool for helping organisations to work together to make this change – it is not a separate service or organisation
- We need to work together to make sure we can continue to offer the health and social care services that you need.
- We will work with local people to help them prevent becoming ill and support them to live longer and better lives
- We are committed to working with our partners across the NHS, social care, wider public sector and voluntary sector to improve the health and wellbeing of local people.
- We continually work to improve the quality of healthcare services
- We always encourage feedback from local people and will act on it wherever possible
- We make our best efforts to use the funding and resources we have wisely, ensuring value for money

Planned activities:

- Briefings for staff and politicians
- CCGs have been regularly communicating with staff regarding a single commissioning voice for Birmingham and Solihull;
- Using social media to start conversations, including survey monkey questionnaire to baseline activities
- Create single webpage/area for hosting information
- Twitter # campaign
- Targeted Facebook activity
- Video/animation content
- Consider best use of traditional media channels e.g. organisational newsletters, different media etc.
- Ensure opportunities to take part in reference groups are shared widely
- Clinical champions
- Ensure regular, ongoing communications are provided through pre-existing communication channels
- Build relationships with local and trade media to build a positive narrative
- Secure a media partner – STP feature to engage with local people
- Respond reactively, in a timely way
- Continue to implement media protocol
- Stakeholder reference group (including wider partners - e.g. Social Housing and Fire Service)
- Creation of stakeholder bulletin
- Meetings for Birmingham and Solihull local councillors
- Specific briefings
- Attend meetings on request
- Regular engagement and updates at Health and Wellbeing Boards
- Regular meetings with GP alliance members across Birmingham and Solihull
- Communications and engagement toolkit:
  - Agreed narrative and key messages
  - Standard power-point presentation
  - Template press release/response
  - Copy for websites
  - Standard and agreed FAQs
  - Opportunities log created and maintained
  - Engagement template created and completed
  - Audit of existing communications and engagement channels
  - Case studies
- Engagement with HealthWatch
- Consultation with stakeholders and patient groups within individual workstreams



- **Stakeholder reference group meetings 27th and 29th September and 14th October**

Key risks - Individual programmes have identified their own risks, however the table below outlines key risks at BSol level:

Key Risks	Mitigating Actions
The health and care system is destabilised if BCC need to reduce social care services in response to financial pressures	Development of plan on a page and further discussion with NHS organisations and central government. **This risk cannot be fully mitigated within the system.**
Planned savings are not delivered	Programme management arrangements and internal governance processes
The planned level of transformation is insufficient to deliver the scale of results required to close the gaps	The organisations will challenge themselves to set ambitious but achievable trajectories and targets. These will be closely monitored through appropriate governance arrangements.
Plans may not be supported by local communities which could impact the timeline and the scale of transformation	The STP programme board will work with local government and local MPs to engage residents in BSol STP strategic conversations. Each work stream will be required to actively engage patients and public in co-production early on in the process. This will be supported by an effective BSol wide communications strategy and public champions.
Insufficient workforce capacity and/or capability to deliver whilst transforming to the new models of care	Development of an overarching workforce strategy based upon future requirements of STP programmes and operational models. Work with HEE and the LWAB to ensure proposals encompass best practice and proposals have been agreed with all relevant stakeholders.
Individual organisations unable to drive the change required due to localised priorities and constraints	The organisations will agree and work towards a clear vision with strategic objectives and targets are owned by all representative organisations. The organisations will establish principles around risk and reward that enable system-wide transformation.
Organisational cultures and directions not aligned with BSol wide goals	Effective system leadership to ensure full organisational involvement supported by an effective engagement strategy that captures innovative practice from staff and develop buy-in for collective transformational change. Staff OD programmes are developed as required.
Lack of resource, time, or leadership capability to deliver the required change at pace	Leadership development initiatives for aspiring directors or senior clinicians e.g. coaching, mentoring schemes. Establish an effective PMO to drive programme delivery, manage risk and monitor progress.
Resistance and lack of buy-in from staff to develop and implement the transformation, particularly service reconfigurations	Each STP sub-programme will actively engage staff in co-production early on in the transformational process Effective communications strategy and the development of staff champions in order to ensure there is a consistent message
Lack of agreement at BSol level for changes across the footprint	Effective leadership and engagement via STP programme board coupled with full organisational engagement in system redesign process. Any proposed changes will be the product of a robust options appraisal, cost benefit analysis and aligned to national and local priorities for the STP.
Inequalities will become greater as plans are implemented without detailed analysis and tracking outcomes in real time	Robust monitoring processes with a commitment to take mitigating action if current planned activities are not seen to be working.
If we fail to deliver desired outcomes demand will rise and it will be very difficult to manage	Robust monitoring processes with a commitment to take mitigating action if current planned activities are not seen to be working.
The scale, complexity and pace is so significant that it is not possible to deliver everything required at the same time	Robust STP Programme-wide planning, alignment of milestones linked to areas of identified greatest opportunity. Detailed PMO processes in place with monitoring of risks, issues and dependencies.

Immediate next steps - to end of March 2017

DATA

- Agree approach to develop a more granular demand, capacity and cost model to generate a more detailed picture to support further planning over next 8 weeks
- Develop and refine analysis on all STP programmes to enable an options appraisal on preferred models
- Establish evaluation criteria
- Support prioritisation by identifying what will make a difference

Delivery and Programme management

- Strengthen central PMO for the STP programme including additional capacity to support the future governance arrangements and further develop the STP, the delivery plan and implementation at a BSol level
- Identify and communicate working groups for STP programme and enabling workstreams
- Further develop the various STP priority initiatives into detailed project delivery plans to support programme solutions and operational planning requirements
- Develop a collective programme plan to monitor progress of key milestones
- Include 90 Day Plan for immediate delivery

Finance

- Agree the social care financial gap and the impact on the delivery of social care services, and knock on impact on other organisation
- Identify opportunities to address remaining financial gap across health and social care
- Agree finance support for the further development of plans
- Develop business cases on priority STP programmes including return on investment

Engagement

- Further develop communications strategy for the STP and commence programme of activities to support wider engagement
- Obtain feedback on proposed solutions across STP programmes
- Agree key messages for STP programmes to support wider engagement including workforce, public, and political stakeholders

Governance

- BSol leaders and other key stakeholders to develop and formalise governance arrangements
- Define governance roles, responsibilities and terms of reference
- Agree and communicate governance arrangements
- Roll out of future governance arrangements

Appendices

A. Key enablers – Estates
B. Key enablers – Digital
C. Key enablers – Workforce
D. How do our solutions address the 10 key STP questions?

Solihull Metropolitan Borough Council

Birmingham City Council

NHS

Appendix A: STP Enabler - Estates (Supporting Service Redesign)

SRO: Paul Sheriff

Relevant leads: Guy Carson (Programme Manager), John Guggenheim (Finance), Graham Seager (Acute), Mike Lyden (Primary Care) and Phil Andrews (Local Authority)

Context:

- Birmingham and Solihull is an ever expanding conurbation, with over 1.8m citizens across 446km^2. Across the BSol footprint, there are currently circa 650 properties, 1,000+ property interests, 460 care homes and 271 housing developments. There is variation between geographic areas on quality, and the use and volume of estate from which health and care services are delivered.
- Our STP provides the opportunity to re-evaluate the use of estate across the footprint – to support the delivery of high quality care and services from modern, fit-for-purpose buildings, situated in the right places to serve our local populations. This will include implementing changes to the estate that will provide flexibility and support new models of care and ways of working (including 7 day services) across primary, community, acute, and social care settings, enable more advanced use of technology to reduce reliance on physical estate, and improve the working environment to support staff health and wellbeing.
- Poor quality and sub-optimal estate will be addressed through a planned programme of rationalisation and investment; under-utilised buildings (e.g. our LIFT buildings) which provide a high quality environment will be reviewed to enhance multi-disciplinary and integrated services across primary and community care, and further opportunities to maximise the use of our estate and its efficiency across local government and health will be pursued through the One Public Estate initiative and the West Midlands Combined Authority.

Vision/Aims:

- The vision is to have an efficient, high quality estate across the BSol footprint which supports our ambition of delivering high quality services to our local populations.
- Our aims, through exploring opportunities such as One Public Estate and joint organisational working are to:
  - Reduce the known areas of estate void and dispose of unused, surplus land
  - Address the poor condition of our primary care estate in order to provide fit-for-purpose buildings to deliver care and services
  - Increase the estate utilisation and plan its use of a BSol-wide basis, including maximising the use of our LIFT buildings
  - Integrate health and social care to align the transformation of health with the ambitions for public sector reform
  - Optimising the benefits from other initiatives e.g. East Birmingham regeneration

Workstream Summary and Key Milestones: The proposed plan is:

- **Phase 1 (end Sept 16)** – System review "art of the potential" – consolidate existing data sets and analyse the scale of the deficiencies in information. This will identify the more simple solutions to be implemented asap. This will be substantially based on assumptions to underpin missing datasets. Tasks include gathering all existing data, identify gaps and deficiencies, categorising facilities, and developing initial benefits plans and next stage management plans
- **Phase 2 (Oct 16 – Mar 17)** – Programme consolidation "art of the possible" – working with the programme's 4 clinical programmes, the Estates workstream will identify the demand profile for the estate based on the planned activity levels of the clinical workstreams and calculate which properties fit within the following categories: Core, Near Core, Marginal, Redundant. Tasks include: alignment of estates thinking into clinical workstreams, identification of shortfalls in capacity and demand, and calculating gap costs
- **Phase 3 (Mar 17 – Aug 17)** – Detailed preparation "phased delivery and finance plan" – following incorporation of the suggested draft health economy strategy into each organisation's individual strategies, this stage will focus on the works required to: build system capacity, transition, and realise programme benefits. This will include development of the associated suite of documents
- **Phase 4 (Apr 17 – Mar 21)** – Implementation phase will consist of 3 work packages: Building system capacity, Transitioning, and Decommissioning and benefit realisation. Tasks include on the ground delivery of estates change. The baseline for benefits will need to be understood and fed into the clinical model so that there is alignment between these areas.

N.B. The work will need to continue in this workstream for a 10-15 year implementation cycle as following 2021 there will be a series of large redevelopments and all estate planning will need to be cognisant of these planned changes.

Key Assumptions:

- A Local Estates Forum will be repurposed to drive the Estates strategy, with a unified and system-wide view
- All organisations within the BSol footprint buy-in to the estates strategy and fully support delivery to achieve maximum benefits as quickly as possible. System-wide benefits (from estate and service) will outweigh individual organisational gains
- Any residual risks through changes to the estates portfolio will be shared across the organisations within the BSol footprint
- BSol has an over supply of buildings which are not maximised in terms of utilisation. Existing high quality long term estate will be maximised and poor quality estate will be vacated and disposed of.
- Benefits will be incremental and are likely to accelerate in later years of the programme

Key Challenges:

- Ensuring the estate supports care closer to home so that patients do not have excessive travel
- Shifting services based on estate location and the subsequent impacts on staffing
- All organisations signing up to system estates change irrespective of financial impacts and changes to foot fall
- Ensuring that any changes support legislation, regulation and policy
- Timescales to achieve the changes
- Ensuring links to other enabling workstreams support the STP delivery
- Ensuring political buy in to potentially radical solutions

Key Interdependencies:

Other Enablers

- Digital as there are technology requirements i.e. wireless access, new IT systems in support of the new estates form
- Contracting as there will be impacts on contract and commissioning requirements if new estate is needed or decommissioned
- Workforce as there will be impacts on place of work if teams move/merge
- National frameworks/guidance such as Carter, DH and Property service STP requirements, forward view and the outcomes from Vanguard sites

System

- Wider capital and revenue areas such as relevant public estate, enterprise partnerships and the potential value of these. Organisations subscribing to data/information sharing agreements and future team/resource form across the footprint i.e. duplication in resource.
- Other system projects and programmes. These need to be understood so that any potential risks and conflicts can be mitigated.

Resource Requirements:

Exact resources requirements are to be confirmed. However:

- Clarification is required on capital resources to support delivery (e.g. ETTF or other funding), and
- Phases 2-4 will also require strategic estates support to plan and deliver this work

Appendix B: STP Enabler - Digital

SRO: Paul Sherriff | **Relevant leads:** Ciaron Hoye (Digital Lead), TBC (Finance Lead) and Dr Masood Nazir (Clinical Lead)

Context:

- Digital has the ability to radically transform the way in which health and care is delivered across the BSol footprint, and the way in which citizens and patients interact with care and public health services. Despite a complex and diverse citizen landscape, the local population has become increasingly tech-enabled with over 75% of citizens having access to mobiles and internet.
- This paves the way for technology to support new care models and ways of working, enable dynamic and innovative solutions to transform and improve health, quality, and outcomes, and make access to services more convenient for both health and care professionals and citizens and patients
- Our Local Digital Roadmap sets out 3 priority areas for the BSol footprint focusing on: 1. digital maturity across the economy, 2. paper free and information flow between the economy organisations, and 3. inclusion of patients, carers and citizens in the use of digital technology
- We are already transforming the way in which services are delivered across the footprint through integrating a myriad of disparate systems to enable effective information flow which follows the patient across organisational boundaries, and through innovative use of technologies for example, our Solihull Caradigm project. "Your Care Connected", "My Healthcare", and Electronic Document Transfer are other examples of ongoing initiatives that are providing the foundation for service transformation.

Vision/Aims:

Our Local Delivery Roadmap sets out our vision for care within the economy: care unobstructed by organisational boundaries and which delivers the concepts of personalised health and care by 2020 and the Five Year Forward View. Specifically, we aim to:

- Establish a combined care record which follows patients across sectors and care settings through the interoperability of existing patient administration systems to support more efficient diagnoses, discharges, transfers of care and referrals between organisations
- Underpin the patient journey through a multi-agency single care plan, defined by population outcomes (to support reduced variation in care and improve patient experience) that can be accessed by health and care professionals from any location, and will also help to support risk stratification
- Being able to deliver technology-enhanced health innovations through the use of digital healthcare, to support:
  - Patients and citizens to access information through e.g. websites, digital apps, and to access and interact with their own care digitally, and support self-management and prevention
  - remote and mobile working for staff, and use of virtual clinics

Workstream Summary and Key Milestones:

- Shared care record – this is a live initiative with 500,000 patients and 4 acute hospitals already signed up to/able to access shared care records. Further milestones include:
  - Deployment of shared care records to remaining acute providers (subject to funding) – 6 months
  - Shared care records rolled out across the full 1.8 million local population – 9 months
- Structured data transfer
  - Pilot (commencing in Oct-16) concluded to provide an evidence base for economy-wide adoption – 1 month
  - Options appraisal, final business case, and Board approval of preferred option – 2 months
  - Preferred model implemented (subject to funding) – 12 months
- Data sharing platform
  - Clinical and public consultation on data sharing completed and outcome published – 9 months
  - Data sharing architecture developed – 12 months
  - Platform tested, implemented, and delivered (subject to funding) – 24 months
- Remote and Mobile Working
  - City wifi delivered (subject to funding) – 24 months
  - Digital signs installed – 24 months
  - Impact of digital signage measured – 30 months

Key Assumptions:

- Engagement and agreement of all organisations to the local digital roadmap and transformation
- A local footprint committee will be established to ensure all proposals for digital systems are appropriate and in line with the vision
- There will be appropriate revisions to care plans and documentation
- Funding will be available to implement and deliver the digital vision and transformation
- Shared agreements and governance arrangements can be agreed and put in place to enable roll out

Key Challenges:

- STP programmes are currently planning in silos and therefore there is a limited understanding of holistic requirements
- Clarity of requirements is also required from the STP programmes
- A whole system funding shortfall requires invest-to-save models or system efficiencies in order to progress, and clarity is required re timescales to access new digital monies. This is a potential source of delay for economy-wide initiatives.
- Consistency of messaging to citizens regarding sharing of their data, e.g. SCR, Care.Data, and Local Health Records results in citizens and patients not understanding and opting out of all schemes
- Ability to integrate over 700 disparate systems within four years whilst preserving the specific needs and requirements of individual organisations
- Discrepancies in legal mandates and requirements between partners, will require time to identify and resolve

Key Interdependencies:

- Dependency on funding – to enable the new functionality and provide an appropriate base for other activities such as use of wearable technology or interactive care plans
- Training for workforce to ensure they know how to use and access new systems and devices
- Installation of devices and connection for all estates is set up for staff to support the development of the integrated referral and information system.
- Information sharing agreements between partners to move to a universal integrated PAS on a shared platform

Resource Requirements:

- There will be a need for additional digital resources to drive forward the digital strategy
- In addition, procurement resource, technical and telephony expertise, operational expertise, digital accessibility expertise and general project support will be required to achieve the aims of this initiative
- Patient engagement support will also be required to ensure they understand and have the ability to consent or refuse to their data being shared across providers and care settings

Appendix C STP Enabler - Workforce

SRO: Tracy Taylor | **Relevant leads:** Stuart Baird

Context:

- Birmingham and Solihull is a diverse conurbation with areas of high affluence and deprivation. The footprint has a changing demography with a young population (46% are under 30) and a growing transient and migratory population.
- Our key workforce characteristics include: an ageing workforce approaching retirement particularly within primary care; supply shortages within some health and social care professional groups; introduction of new roles e.g. physician associates; changes to policy and adoption of best practice e.g. the GP and Mental Health forward views; and changes to training and education funding, all of which contribute to the need to have a collaborative approach to workforce planning and development
- There are also contributory factors such as national staff shortages and rules regarding use of agency staff and spend, and locally the ability to retain staff, high sickness levels, low numbers of healthcare professionals per 1,000 population within BSol, and challenges with specific roles such as social workers which further obviates the need for a refreshed and collaborative approach to workforce.

Vision/Aims:

- Our vision is for a healthy, competent and sustainable integrated workforce that delivers services which meet the needs of patients, service users and carers across BSol, both now and in the future
- Through the LWAB as the main driver for workforce solutions, our aims for this workstream are to:
  - Create and agree annualised programmes of work which support national and local strategy, and translate these into local plans
  - Grow a local workforce thus creating real opportunities for local residents, given the Health and Wellbeing gap
  - Develop new ways of working as a joint system and drive new workforce models such as enhanced mobile working
  - Develop career pathways and an attractive employment offer which will lead to the retention of staff
  - Increase the use of technology and integrated roles within health and social care
  - Ensure funding is placed in the most appropriate sectors through collaborative working with HEIs and other training providers

Workstream Summary and Key Milestones:

The LWAB is developing and delivering the annual work programmes. The proposed focus areas for Year 1 of our journey are:

1. Reskilling and upskilling the primary and community care workforce to support the delivery of integrated out of hospital care models
2. New role developments including enhanced roles such as community pharmacy
3. Development of an apprenticeship academy model to deliver integrated health and social care apprenticeship programmes across BSol

As the programmes are taking shape, the main milestones will be:

- Short Term actions (within 6 months): Assigning a lead to each programme area; (clinical and managerial leads would be required.) Establish multi-partner workshops to agree approach to delivery and confirm areas to focus on and more detailed areas within these i.e. to develop and launch engagement; establish system workforce information sharing agreements to gather as a footprint numbers of staff by band, age, sickness, vacancy rates; undertake gap analysis, skills assessment on data to identify specific process areas to elevate and tackle; develop year 1 PIDS; identify year 2 and 3 focus areas.
- Medium Term actions (within 12 months): Focus on capability building and clinically agree what enhanced roles would look like; test and trial changes to specific role(s); engagement with schools and university on new courses to support new workforce models, wider integration of teams and roles supporting placed based care, development of MDTs.
- Long Term actions (within 18 months): ongoing workforce reviews and new configurations
- Underpinning the above will be the following assumptions: existing projects and programmes will continue unless they are in direct competition to the STP plans; all proposed change supports wider STP outcomes such as reduced costs
- There are some early measures being identified including: reduction in agency spend and numbers; more people going into health and social care courses and roles, and reduced system sickness rates

Key Assumptions:

- The LWAB will be the Board where workforce discussions, decisions and planning will take place
- LWAB will agree the rolling programme of work on an annual basis
- All organisations will support the aims and outcomes of the LWAB and subsequent workforce programmes
- Funding decisions and impacts will be agreed at the LWAB for each provider organisation to manage both individually and as a collective
- Data and information sharing agreements will be in place so that system data can be used to direct the enabler
- Networks e.g. UEC assumptions will be incorporated into the wider workforce discussions at LWAB

Key Challenges:

- Changing patient expectations i.e. the want to be seen locally 24/7 through different mediums such as technology
- The changing landscape of the workforce e.g. an ageing workforce and reduced numbers entering the profession. There are also shortfalls in staffing both nationally and internationally and therefore increased competition to attract and retain staff
- Supply and demand e.g. ability to recruit substantive staff in order to reduce the reliance on expensive agency staff
- The need to comply with national standards and requirements, for example, 7 day services and out of hospital care
- A general reduction in system funding
- Organisational mind-sets not supporting new staffing models e.g. Joint LA/Health Reablement/Rehabilitation roles
- Changing terms and conditions of employment to support new models of working

Key Interdependencies:

Other Enablers

- Digital as there are technology requirements e.g. mobile working in support of the new workforce form
- Estates as there will be the need to understand what the future estates form will need to be in support of the workforce i.e. co-locating health and social care teams
- Contracting reform as there will be impacts on contract and commissioning requirements if new workforce structures are needed

System

- Acute providers, Primary Care, CCGs, Local Authority and Community services to understand and ensure that local workforce considerations are in annual plans, including data sharing agreements, joint appointments and role development and integration
- HEE to support workforce plans
- Finance to supply staffing

Resource Requirements:

- One of the main LWAB tasks will be to identify what resources are required to support the delivery of the workforce element of the STP
- The LWAB launch meeting, planned in October 2016 will start to work through these issues

Appendix D: How our priorities address the 10 STP questions/NHS Planning Priorities

Question	Document location
1. How are you going to prevent ill health and moderate demand for healthcare? Including: • A reduction in childhood obesity • Enrolling people at risk in the Diabetes Prevention Programme • Do more to tackle smoking, alcohol and physical inactivity • A reduction in avoidable admissions	CCF: Health and wellbeing CCF: EGMP CCF: Urgent care and care in a crisis
2. How are you engaging patients, communities and NHS staff? Including: • A step-change in patient activation and self-care • Expansion of integrated personal health budgets and choice – particularly in maternity, end-of-life and elective care • Improve the health of NHS employees and reduce sickness rates	CCF: Health and wellbeing CCF: Long term conditions Maternity and newborn programme Workforce enabler
3. How will you support, invest in and improve general practice? (Planning Priority) Including: • Improve the resilience of general practice, retaining more GPs and recruiting additional primary care staff • Invest in primary care in line with national allocations and the forthcoming GP 'Roadmap' package • Support primary care redesign, workload management, improved access, more shared working across practices	CCF: EGMP Workforce enabler
4. How will you implement new care models that address local challenges? Including: • Integrated 111/out-of-hours services available everywhere with a single point of contact • A simplified UEC system with fewer, less confusing points of entry • New whole population models of care • Hospitals networks or groups to share expertise and reduce avoidable variations in cost and quality of care • Health and social care integration with a reduction in delayed transfers of care • A reduction in emergency admission and inpatient bed-day rates	Fit for Future Secondary and Tertiary Services CCF: urgent care and care in a crisis CCF Long Term Conditions
5. How will you achieve and maintain performance against core standards? Including: • A and E and ambulance waits; referral-to-treatment times	Fit for Future Secondary and Tertiary Services CCF: urgent care and care in a crisis Mental health programme Acute care programme
6. How will you achieve our 2020 ambitions on key clinical priorities? (Planning Priority) Including: • Achieve at least 75% one-year survival rate (all cancers) and diagnose 95% of cancer patients within 4 weeks • Implement two new mental heath waiting time standards and close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, and deliver your element of the national taskforces on mental health, cancer and maternity • Improving maternity services and reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries • Maintain a minimum of two-thirds diagnosis rate for people with dementia	Fit for Future Secondary and Tertiary Services CCF: Health and wellbeing CCF: EGMP Mental health programme Maternity and newborn programme

Appendix D: How our priorities address the 10 STP questions (cont'd)

Question	Document location
7. How will you improve quality and safety? Including: • Full roll-out of the four priority seven day hospital services clinical standards for emergency patient admissions • Achieving a significant reduction in avoidable deaths • Ensuring most providers are rated outstanding or good– and none are in special measures • Improved antimicrobial prescribing and resistance rates	CCF: EGMP CCFL urgent care and care in a crisis Fit for Future Secondary and Tertiary Services
8. How will you deploy technology to accelerate change? Including: • Full interoperability by 2020 and paper-free at the point of use • Every patient has access to digital health records that they can share with their families, carers and clinical teams • Offering all GP patients e-consultations and other digital services	Digital enabler
9. How will you develop the workforce you need to deliver? Including: • Plans to reduce agency spend and develop, retrain and retain a workforce with the right skills and values • Integrated multidisciplinary teams to underpin new care models • New roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice	Workforce enabler CCF: EGMP CCG: Long term conditions Fit for Future Secondary and Tertiary Services
10. How will you achieve and maintain financial balance? Including: • A local financial sustainability plan • Credible plans for moderating activity growth by c.1% pa • Improved provider efficiency of at least 2% p.a. including through delivery of Carter Review recommendations	Executive summary Solutions and impact (page 65) BSol financial plan

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 4 May 2016

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 4 May 2016 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.

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

Statement of Persons Nominated
The Royal Orthopaedic Hospital Foundation Trust
Council of Governors Election

As Returning Officer for the above election I hereby give notice that the following candidates have been nominated for the above election in the following constituencies / classes.

Candidate	Constituency / Class	Declaration of Interests:	
		Political Party	Financial Interest
Janti Champaneri OBE	Public – Birmingham and Solihull	-	-
Annette R Dickers	Public – Birmingham and Solihull	Conservative	-
Lindsey Hughes	Public – Birmingham and Solihull	-	-
Jane McKears	Public – Birmingham and Solihull	Green Party	-
Jean Rookes	Public – Birmingham and Solihull	-	-
Alan John Bennett	Public – Rest of England and Wales	-	-
Dr Saroj Duggal PHD	Public – Rest of England and Wales	-	-
Arthur Hughes	Public – Rest of England and Wales	-	-
Stewart Ross	Public – Rest of England and Wales	-	-
Rob Talboys	Public – Rest of England and Wales	-	-
Brian J Toner	Public – Rest of England and Wales	-	-

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Craig Poyser - Returning Officer
04/04/2016

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