The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 11 January 2017

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 11 January 2017 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** 11 January 2017: 1100h – 1300h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair & Non Executive Director	(TP)
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

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 – Frances Kirkham	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	Staff story - HDU	Presentation	GM
1130h	4	Minutes of Public Board Meeting held on the 2 November 2016: *for approval*	ROHTB (11/16) 015	Chair
1135h	5	Trust Board action points: *for assurance*	ROHTB (11/16) 015	SGL
1140h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (1/17) 002 ROHTB (1/17) 002 (a)	YB/JC
		QUALITY & PATIENT SAFETY		
1155h	7	Patient Safety & Quality reports: *for assurance*	ROHTB (1/17) 003	GM
1205h	8	Safe Staffing Report: *for assurance*	ROHTB (1/17) 004 ROHTB (1/17) 004 (a)	GM

FINANCE AND PERFORMANCE				
1215h	9	Finance & Performance overview: *for assurance*	ROHTB (1/17) 006	PA
RISK AND COMPLIANCE				
1230h	10	Board Assurance Framework – Quarter 3 update: *for assurance*	ROHTB (1/17) 008 ROHTB (1/17) 008 (a)	SGL
UPDATES FROM THE BOARD COMMITTEES				
1240h	11	Quality & Safety Committee	ROHTB (1/17) 009	KS
1245h	12	Audit Committee & terms of reference (for approval)	ROHTB (1/17) 010 ROHTB (1/17) 011	RA
1250h	13	Finance & Performance Committee	ROHTB (1/17) 012	TP
1255h	14	Revised Board & Committee meeting schedule	ROHTB (1/17) 013 ROHTB (1/17) 013 (a) ROHTB (1/17) 013 (b) ROHTB (1/17) 013 (c)	SGL
MATTERS FOR INFORMATION				
1300h	15	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 1st February 2017 at 0900h, 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 Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.4

Venue Boardroom, Trust Headquarters **Date** 2 November 2016: 0900h – 1100h

Members present

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair	(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	(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	(ACh)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	Paper Reference
1 Apologies	**Verbal**
Apologies for absence were received from Richard Phillips.	
2 Declarations of Interest	**Verbal**
There were no declarations of interest notified in advance.	
3 Patient Story	**Presentation**
Evelyn O'Kane introduced her team: Alison Wharram, the new clinical matron for	

Paediatric services, Jayne Forsythe and Clare Hinwood. A patient story was presented which concerned transitional care; this related to the movement of individuals from a Paediatric care environment to an adults care environment. There was reported to be national guidance around this but the work in the Trust was also informed by the patients themselves who had been involved in the developments. There were reported to be a number of roadshows planned to develop the transitional care service. The 'Ready, Steady, Go' initiative was also to be used. The Board was shown a video of a patient who had undergone scoliosis surgery who had been treated on an adult ward and the patient described the way in which her transition had been managed. The Board noted it was a positive story. Although there was further development planned to improve the processes, the team were congratulated on the successful outcome. The Board was advised that new Paediatric matron would bring experience from her time at the Birmingham Children's Hospital to further develop the transitional care offering. In terms of the facilities and equipment necessary for the transition, the Board was advised that the Teenage Cancer Trust supported two rooms for Oncologty patients. Other areas were to be assessed to see if they could be adapted. The Trust's ROHBTS charity was also campaigning for materials for Paediatric patients. Prof Southwood suggested that the work needed to be proportionate to the healthcare needs of the patients, particularly given that there may not be a need for any form of chronic care support. After Oncology, the next area of focus was Spinal services. It was agreed that the work needed to be patient-centred, with a 'read across' all patients and carers. The Director of Operations, Nursing & Clinical Governance noted that there was an enthusiasm over this work by the team and that the external regulators had praised the quality of the Trust's transitional care policies and procedures.	
4 Minutes of Public Board Meeting held on 5 October 2016	**ROHTB (10/16) 017**
The minutes of the previous meetings held on 5 October 2016 were accepted as a true and accurate record of discussions held.	
5 Trust Board action points	**ROHTB (10/16) 017 (a)**
The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern.	

6 Chairman's and Chief Executive's update	**ROHTB (11/16) 002** **ROHTB (11/16) 002 (a)**
The Chief Executive asked the Board to receive and accept her update. She reported that the Single Oversight Framework had been launched and the Trust had been placed in Segment 2, this being the second highest category possible. In terms of the recent adverse publicity regarding the Trust's food standard ratings, the media was to be advised that the information published was not up to date and the matter would also be qualified on the website. The current food standard rating was a Level 4; not a 2 as reported. In terms of the media contact, all of this was through the Communications Team and all staff had been asked to direct enquires through this route if needed. In terms of the Chairman's update, the Board was advised that: • The main focus during the last month had been on attending a range of STP-related meetings, particularly as the deadline for submission of the plan approached (21 October) • An induction meeting had been held with Professor David Gourevitch, who would join the organisation as a new Non Executive Director from the new year • The Chairman was planning to spend the afternoon with Mr Grainger in theatres • Ed Smith, Chair of NHSI 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. • The next Harrison Lecture is being held on 17 November when Prof Sir Keith Porter will talk on from 'Bastion to Birmingham'. There had been much work to build links with some local schools to encourage those who were interested in a medical career to attend these lectures and an earlier slot from 6.00pm – 7.00pm might be run for these students to help them to better understand what was involved.	
7 Patient Safety & Quality report	**ROHTB (11/16) 003** **ROHTB (11/16) 003 (a)**
The Director of Operations, Nursing & Clinical Governance reported that there had been seven serious incidents in September, all of which were VTEs. The Root Cause Analyses were underway and any matters of escalation would be presented to the	

Quality & Safety Committee. There had been deterioration in the Safety Thermometer results for the month; one patient had experienced two harms. In terms of pressure ulcers, some data from the Royal National Orthopaedic Hospital NHS Trust and Robert Jones & Agnes Hunt NHS Foundation Trust had been reviewed to benchmark the organisation. Conversations were also underway about how these organisations reported pressure ulcers. There had been an unannounced visit from the Clinical Commissioning Group around pressure ulcers, the informal feedback from this being positive and demonstrated good document management. In terms of the WHO checklist compliance, it was suggested that completion was variable and remained under close scrutiny by the Quality & Safety Committee. The Medical Director noted that the magnitude of the variation was c. 0.5%, therefore variation was not marked. It was noted that completion remained a matter of good practice, however there was no guarantee of harm being totally averted even if the checklist was completed. The Chairman asked whether there was any apparent impact on quality & safety given the current hard focus on activity & financial recovery. The Chair of the Quality & Safety Committee reported that the assurances received by her Committee suggested that there was no compromise at present. A standing item on the agenda of the meetings was around the divisional governance performance which would create an alert for the Committee should it be evident that quality & patient safety was deteriorating. Additionally, the Director of Operations, Nursing & Clinical Governance was to be asked to provide a view of the effectiveness of balancing the nursing and operations elements of his role in early 2017. The Chief Executive commented that there was no deliberate separation in thinking and focus between the quality, safety and finance matters. There had also been no direction from the Executive to trade off activity and finance recovery at the expense of quality and safety. It was noted that there were some gaps in terms of quality roles at present and as assurances were needed it had been agreed that this was a matter that would be picked up by the Quality & Safety Committee.	
8 Safe Staffing Report	**ROHTB (11/16) 005** **ROHTB (11/16) 005 (a)**
It was reported that there were some areas that had fallen below 90% fill rates, but this had been offset with additional care staff on duty and therefore the Trust had met the minimum NICE standards. There were reported to be c.23 vacancies, however the status of the vacancies was reviewed by the Nursing Workforce Group, which showed that many had been advertised, there was a start date and	

the recruitment was progressing well. In terms of agency staffing this had increased to 17.6% in September. There had been an increase on Ward 11 particularly to deliver the RCPCH guidance and Ward 2 which was carrying a number of vacancies which had required additional temporary nurse staffing; individuals to fill many of the posts had been identified. E-rostering roll out was reported to be continuing and the benefits of oversight of the rosters were coming to bear. In terms of incidents, the Chief Executive noted that a significant number of agency staff had been with the Trust some time and therefore the suggestion that there was a correlation between use of agency staff and incidents might be erroneous. The Director of Operations, Nursing & Clinical Governance agreed that there did not appear to be a correlation and the nurse in charge of the ward was never an agency member of staff, therefore there was always substantive staff oversight. If there was an incident involving agency members of staff, the Trust was quick to act and make contact with the agency to advise them of the issue. The Director of Finance reported that there was a clear understanding of the financial impact of using nurse staffing in theatres.	
9 CQC Action Plan	**ROHTB (11/16) 006** **ROHTB (11/16) 006 (a)**
It was reported that there was a November delivery date for reducing waiting times, this being linked to job planning in Oncology. The Board was advised that the learning disability strategy was yet to be developed, however the Trust was about to recruit a Learning Disabilities nurse who would help with this. This was noted to be a 'Should Do' action. In terms of the red action associated with the finalisation of the Service Level Agreement with Birmingham Children's Hospital NHS FT, it was suggested that this may not be an accurate reflection of the true status of this action as it was not a significant risk to the organisation and mitigations were in place in the form of a competency document.	
10 Finance & Performance overview	**ROHTB (11/16) 007** **ROHTB (11/16) 007(a)**
The Director of Finance & Performance noted that the Trust had not met the 92% target for 18 weeks Referral to Treatment (RTT) target. The Divisional General Manager for Division 3 would address this. In terms of mandatory training & appraisals completion rates, there had been deterioration and there was a risk of incurring a Contract Performance Notice on	

this basis, pending the provision of trajectories. The Chief Executive noted that given the lower level of activity, there would have been an expectation that staff could be more readily released to attend Mandatory Training. The Director of Workforce reported that there was a fundamental issue over planning by managers, which was being challenged by the HR Managers and was also being picked up at Divisional Performance Clinics. Additional capacity in terms of training was being provided over the winter period.	
11 Quality & Safety Committee assurance & annual reports	**ROHTB (11/16) 008** **ROHTB (11/16) 009**
These were received and noted.	
12 Audit Committee assurance & annual reports	**ROHTB (11/16) 010** **ROHTB (11/16) 011**
The Chair of Audit Committee reported that the meeting had been difficult in that the stock report and internal audit into 18 weeks RTT practice had been considered, both of which had highlighted serious failure in control. In order to reassure the Board, progress against these action plans would be picked up at the December meeting of the Audit Committee. Of particular concern was 18 weeks RTT performance and external audit was maintaining a close focus on this. The actions to rectify the theatre stock issue would also be reviewed closely. The Director of Finance reported that actions continued to be implemented and a new physical store in theatres had been introduced which had assisted; the new electronic stock management system was still to be implemented however. The whole process of auditing and regularly stock counting at an individual area was underway to ensure that data entered onto the new system was accurate. There was still further work to do to gain assurances around the effectiveness of the process though. There were also some manual reconciliation processes in place as detailed in the action plan, although again further assurances that this was robust were needed. The Director of Strategy & Transformation commented that it was reassuring that there was now a single point of stock control in theatres, although it was noted that the process for signing implants out in theatres would build in some delays for the present. In terms of consignment stock, there was further assurance needed in terms of the reconciliation and to gain an understanding of the financial impact of the changes. There was however, greater control over representatives in theatres which was positive. The Controlled Drugs internal audit feedback showed continued areas of improvement but there remained some further work to do to address the actions. The report had provided 'reasonable assurance'. The Trust remained compliant with drugs management regulations, but to gain 'full assurance' additional action was needed.	

The Deloitte audit fees for 2016/17 were presented as being £61-£64k, a reduction on the previous year. On this basis, the fees were accepted. It was suggested that care needed to be taken around using auditors for work other than auditing. It was reported that Going Concern remained a focus and the external auditor had met with the Chairman recently to discuss this. There had been a good discussion about the relationship between the auditors and the management team.	
13 Finance & Performance Committee	**ROHTB (11/16) 012**
The assurance report from the Finance & Performance Committee was received and noted.	
14 Transformation Committee	**ROHTB (11/16) 013**
It was reported that the meeting had been delayed, which reflected the relative priorities of the organisation.	
15 Birmingham & Solihull Sustainability & Transformation Plan	**ROHTB (11/16) 014**
The Birmingham & Solihull Sustainability & Transformation Plan submitted on 21 October 2016 and subsequently published was formally received and noted.	
16 Any other business	**Verbal**
There was none.	
Details of next meeting	**Verbal**
The next meeting is planned for 7 December 2016 at 1600h in the Boardroom, Trust HQ.	

PUBLIC SESSION

Next Meeting: 11 January 2016, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

2 November 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: Anne Cholmondeley (AC)

Apologies: Richard Phillips (RP)

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	The PAs to the Directors and some Directors have recived a demosntration of Content Locker, an electronic document management system, which has the potential to manage Board papers in a paperlite way. Suggested names of NEDs to trial the system have been provided and contact will be made in due course.	
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	~~05/12/2016~~ 01/02/2017	Action also raised by Quality and safety Committee and will be reported back in ~~December~~ February (there was no meeting of the Quality & Safety Committee in December to discuss this issue)	
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 provided on the agenda of the January 2017 meeting, which reflects a number of risks around sustainability	

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:	**11 January 2017**

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:

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 11 January 2017

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 December 2016.

2 RECOVERY PLAN

2.1 Members of the Board attended a meeting with NHS Improvement (NHSI) on 20 December 2016 to discuss the Trust's revised financial recovery plan submitted on 21 November 2016. NHSI were assured by the Trust's plan, and the actions being taken to reduce the year-end deficit position. There is significant work to be undertaken to deliver the required improvements, in particular to ensure that from 9 January 2016 we meet the required step change in activity and associated POAC capacity.

2.2 On 14 December 2016, a series of all staff briefings were held to inform staff of the Trust's recovery plan, and key schemes to drive forward the required savings. There are additional proposed cost saving measures such as implant rationalisation and holding corporate vacancies, and the overall corporate structure will be streamlined to further reduce overhead costs.

2.3 Most notably, the Trust plans to run a set of 'Recovery Days' between now and the end of March (dates listed below). The most significant contribution to the Trust's Recovery Plan is the recovery of lost income associated with the theatres closures in June 2016. These Recovery Days are intended to ensure that we treat all the patients that we planned to treat during the year and will see additional theatre sessions planned over five weekends. Some staff have already volunteered to participate in the recovery work. The Recovery Days are scheduled for the following dates:

- Sunday 22nd January
- Sunday 5th February
- Sunday 26th February
- Sunday 12th March
- Saturday 25th March

3 OPERATIONAL IMPROVEMENTS

3.1 Whilst staff continue to work toward improving efficiencies and productivity, we are beginning to see real progress in certain areas of the Trust, including in Oncology where considerable improvements have been implemented in developing our processes, including a centralised referral pathway for all patients.

3.2 In addition, our spinal team with support from theatre, HDU and ward teams, managed to successfully undertake two scoliosis cases in December 2016. This represents 100% additional productivity as typically only one case is carried out. This was as a result of excellent planning, communication and teamwork throughout the day. Both patients are doing well and on the back of this test day, five further dates are being planned to repeat the additional cases.

3.3 Our Rapid Recovery programme has seen over 20 patients successfully discharged from hospital within 24 hours of their surgery, and feedback has been incredibly positive. It is hoped that this programme will be rolled out across all surgeons and all specialties where 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:

- Attended a networking event with the Association of British Healthcare Industries and heard about the ambition of the Greater Birmingham Local Enterprise Partnership.
- WM CEO Meeting
- Meeting with Debbie Thwaites (Director of Business Improvement – Midlands & Lancashire CSU) & Mark Seaton (Director of Commissioning, South East Staffordshire CCG)
- Introduction meeting with Richard Beeken (Delivery and Improvement Director, NHS Improvement)
- West Midlands Public Service Board meeting
- Birmingham and Solihull STP Board meeting
- Meeting with colleagues at the University of Birmingham to discuss joint bid to Greater Birmingham and Solihull Local Enterprise Partnership
- Partnership meeting with Sarah-Jane Marsh, CEO of Birmingham Children's Hospital and Birmingham Women's Hospital

5 UPDATE FROM TRUST MANAGEMENT COMMITTEE

5.1 The Trust Management Committee (TMC) did not meet in December 2016 to enable the senior management team to focus on developing the recovery plan. An update will be provided to February Board once TMC has been held on 25 January 2017.

6 RECOMMENDATION(S)

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

6.2 Note the contents of the report.

Jo Chambers
Chief Executive
6 January 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

November 2016

EXECUTIVE DIRECTOR:	Garry Marsh	Director of Operations, Nursing & Governance
AUTHOR:	Mustafa Ahmed	Head of Governance

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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.

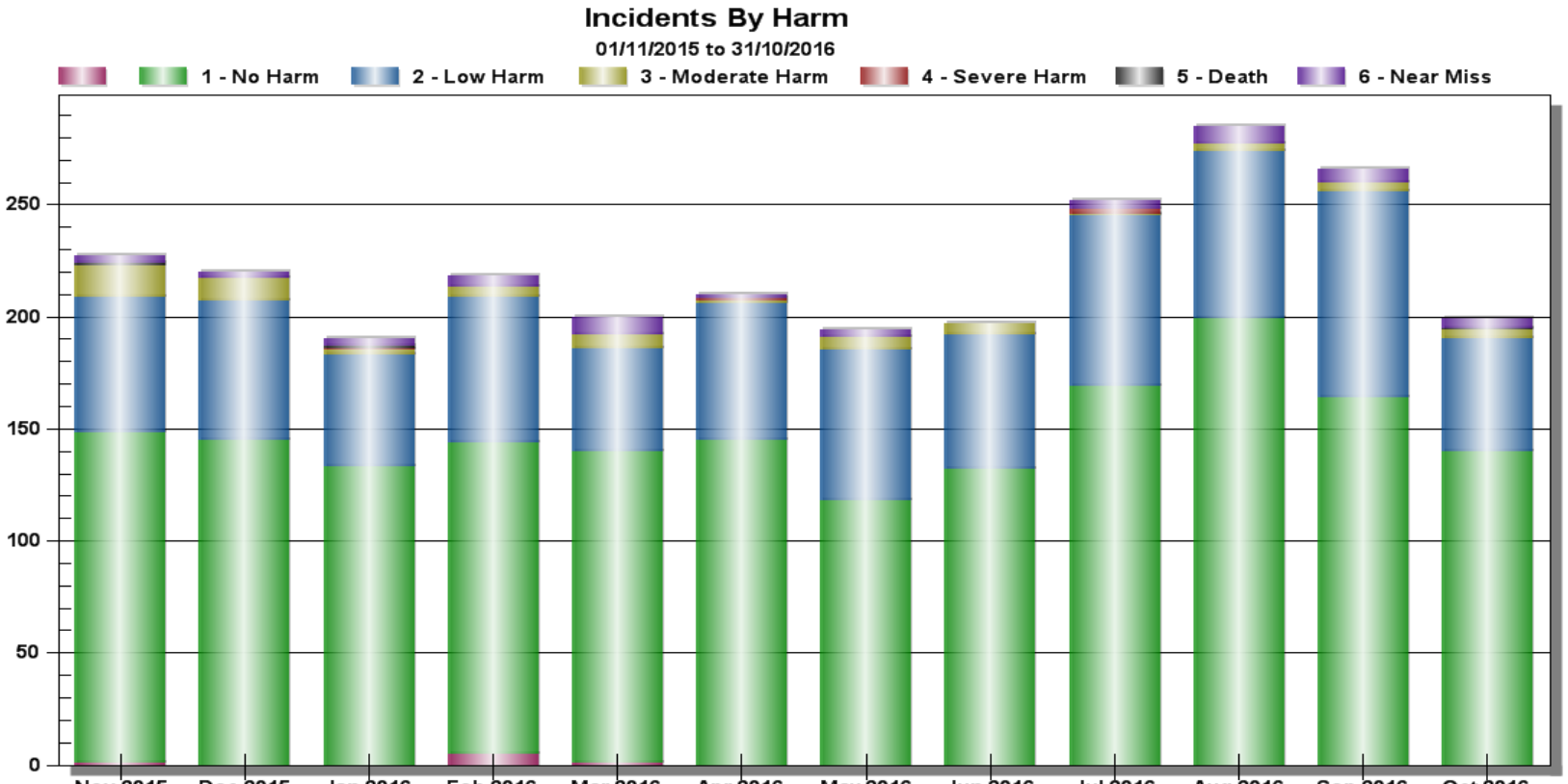
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: 0121 685 4000 (ext. 55641)

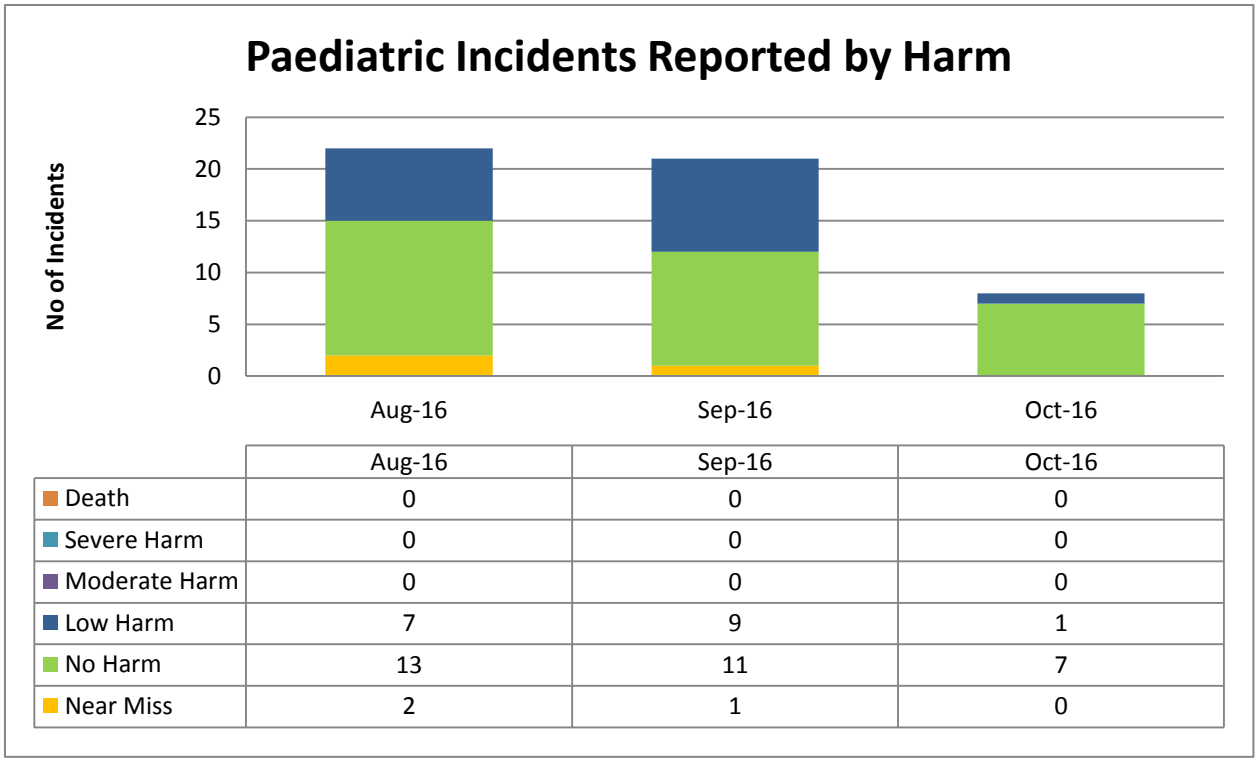
2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.



Month and Year	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016
1 - No Harm	147	145	133	139	139	145	118	132	169	199	164	140
2 - Low Harm	61	62	50	65	46	61	67	60	76	75	92	50
3 - Moderate Harm	14	10	2	4	6	1	6	5	1	3	4	4
4 - Severe Harm	0	0	1	0	0	1	0	0	2	0	0	0
5 - Death	1	0	1	0	0	0	0	0	0	0	0	1
6 - Near Miss	3	3	3	5	8	2	3	0	4	8	6	4

INFORMATION
There were 199 incidents reported in October 2016, including a death and four moderate harms.
ACTIONS FOR IMPROVEMENTS / LEARNING
Ulysses has been upgraded to provide improved services and graphics as displayed by the Incidents by Harm graph. Training has also been provided to key personnel in Governance to aid in achieving the best results from the upgrade.
RISKS / ISSUES
Incidents are not being reviewed by managers in a timely manner. Reports are being developed on Ulysses to identify these managers and the length of the delays with a view to providing them with support review their incidents accordingly.

Paediatric Incidents – This illustrates all incidents relating to Paediatric Patients that have been reported at ROH on Ulysses by members of staff during the previous 3 months (since when Ulysses was configured to capture the data). The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.

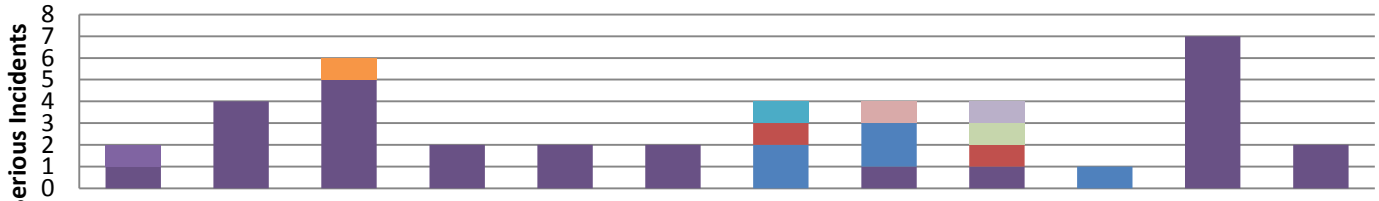


	Aug-16	Sep-16	Oct-16
Death	0	0	0
Severe Harm	0	0	0
Moderate Harm	0	0	0
Low Harm	7	9	1
No Harm	13	11	7
Near Miss	2	1	0

Eight incidents were reported in October 2016 involving Paediatric Patients. A breakdown was provided to the Children's Board in November and these were discussed in detail. The low harm incident was a Grade 1 pressure ulcer which is being investigated.

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 to October 2016



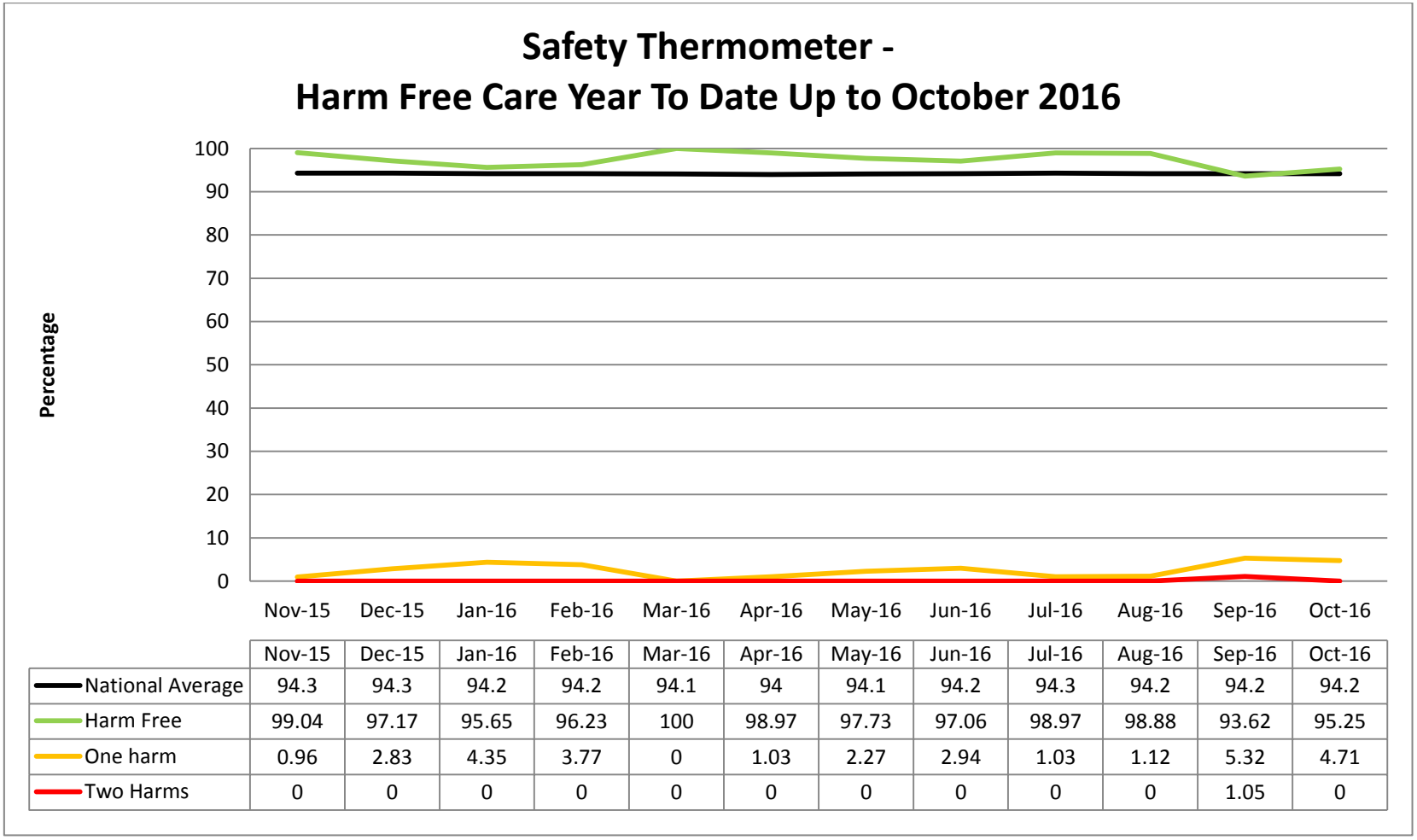
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Wrong Site Incision									1			
Wrong Implant									1			
Suspension to services								1				
Delayed diagnosis			1									
Wrong side injection							1					
Unexpected deaths	1											
Staff conduct incidents												
Slips, trips & falls							1		1			
Pressure Ulcers							2	2		1		
Emergency transfer out of Trust												
VTE meeting SI criteria	1	4	5	2	2	2		1	1		7	2
Surgical incident meeting SI criteria												
Emergency transfer to HDU												
Failure to act on test results												

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

INFORMATION
There were two SIs declared in October 2016. These are due for submission with the Commissioners in January 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
One Serious Incident report was submitted to the Commissioners during October 2016. This was a grade 3 pressure ulcer. Lessons Learned; Although there was some very good documentation of pressure area care within the nursing documentation, detail regarding key preventative requirements e.g. off-loading were not always evident. The repositioning chart was at times inaccurately completed and the SSKIN assessment tool was not consistently completed as per expected standards. There was no documentation by medical staff regarding pressure damage either at the time of review and subsequent cutting of plaster or prior to discharge. The amount of assessment, prevention documentation relating to pressure ulcers within the Trust is significant and is currently in different booklets, this may increase the risk of sections being missed or not completed in full. All patients with any form of cast should be given written information on how to care for a cast at the earliest opportunity. This will empower them to question practice if necessary.
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.**



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
National Average	94.3	94.3	94.2	94.2	94.1	94	94.1	94.2	94.3	94.2	94.2	94.2
Harm Free	99.04	97.17	95.65	96.23	100	98.97	97.73	97.06	98.97	98.88	93.62	95.25
One harm	0.96	2.83	4.35	3.77	0	1.03	2.27	2.94	1.03	1.12	5.32	4.71
Two Harms	0	0	0	0	0	0	0	0	0	0	1.05	0

There were four harms reported during October. There were three new pressure ulcers and one fall with harm.

Children and Young Persons' Safety Thermometer

The Trust has started to submit data to the Children and Young Persons' Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. The table below illustrates the data that is recorded. The Governance Department will seek to collate National data and data from our comparable specialist Providers for the purposes of benchmarking. Further understanding of how to interpret the data is required to give meaningfulness.

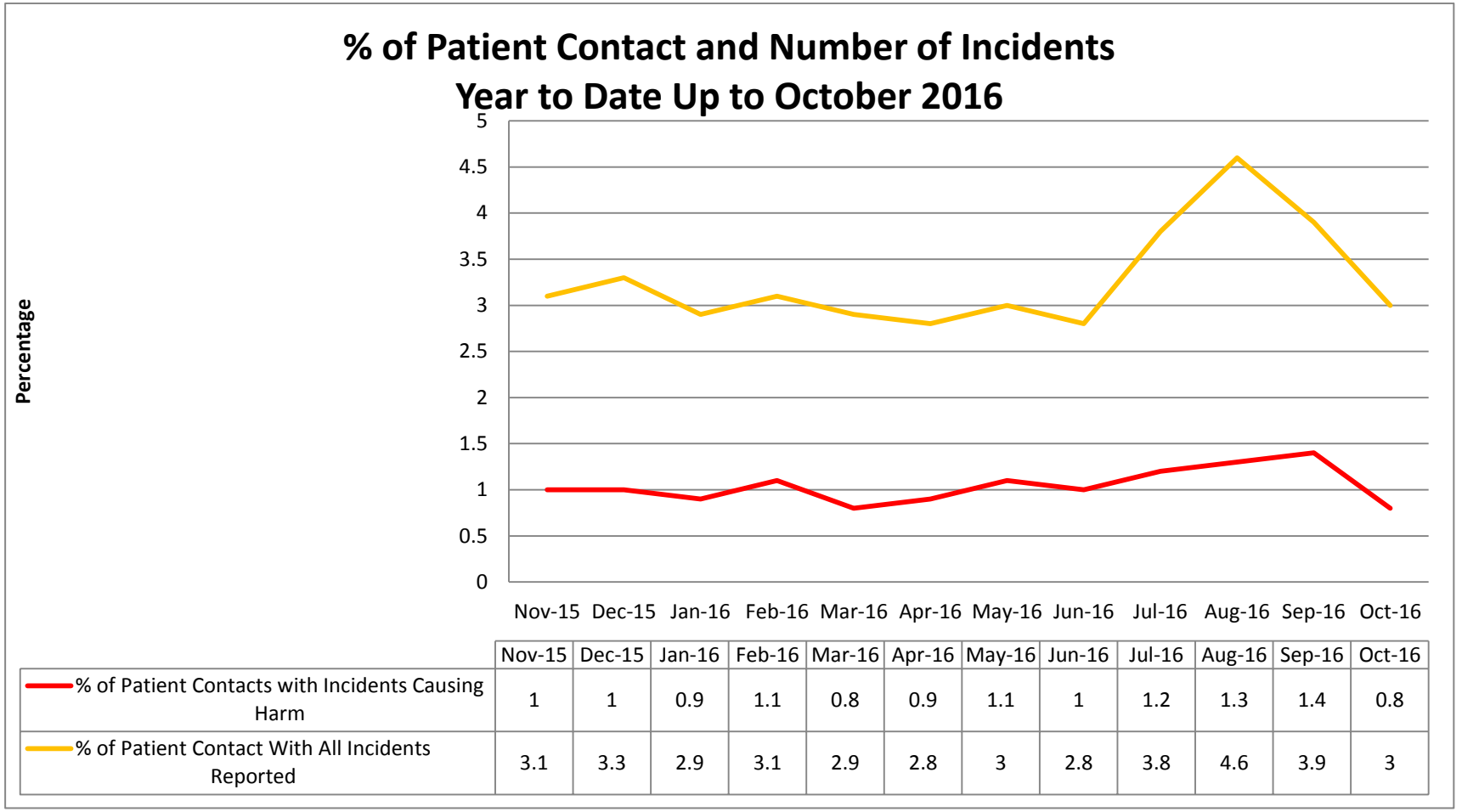
October 2016

	Local Reference	Gender	Age Group	EWS Completed	Extravasation	Patient in pain?	Pressure ulcer?	Moisture Lesion
1	1	Female	10-14 years old	Yes	No	No	No	No
2	2	Female	10-14 years old	Yes	No	No	No	No
3	3	Male	10-14 years old	Yes	No	No	No	No
4	4	Male	5-9 years old	Yes	No	No	No	No
5	5	Female	1-4 years old	Yes	No	No	No	No
6	6	Female	15-19 years old	Yes	No	No	No	No
7	7	Female	15-19 years old	Yes	No	No	No	No
8	8	Female	5-9 years old	Yes	No	Yes	No	No

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
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
Oct-16	50	4	0	1	55	201	6728

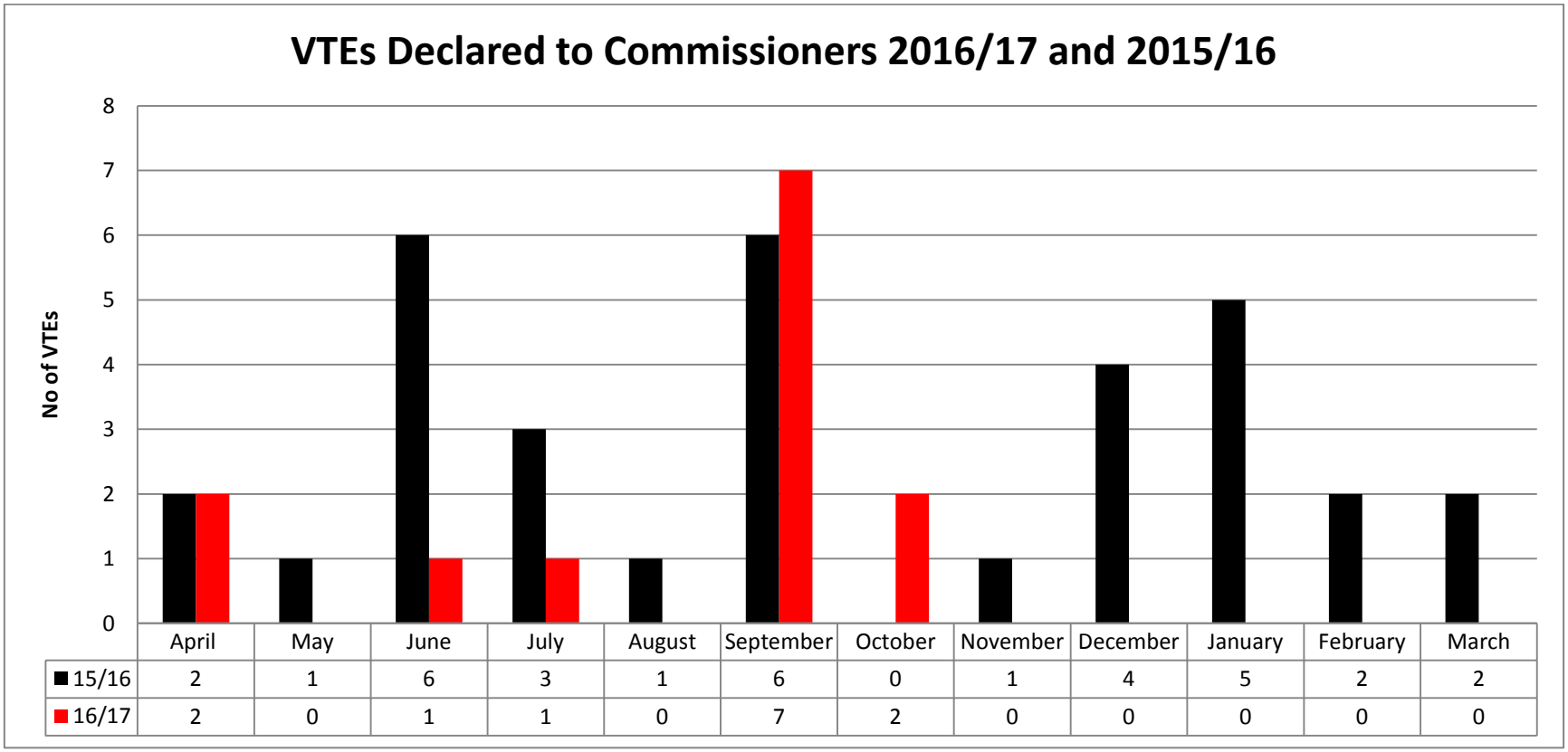
In October 2016, there were a total of 6728 patient contacts. There were 201 incidents reported which is 3 percent of the total patient contacts resulting in an incident. Of those 201 reported incidents, 55 incidents resulted in harm which is 0.8% of the total patient contact.



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
% of Patient Contacts with Incidents Causing Harm	1	1	0.9	1.1	0.8	0.9	1.1	1	1.2	1.3	1.4	0.8
% of Patient Contact With All Incidents Reported	3.1	3.3	2.9	3.1	2.9	2.8	3	2.8	3.8	4.6	3.9	3

There has been an approximate 20% reduction in the number of incidents reported this month from September 2016. 0.8% of total patient contacts resulted in an incident with harm. 3% of total patient contacts for the month resulted in an incident.

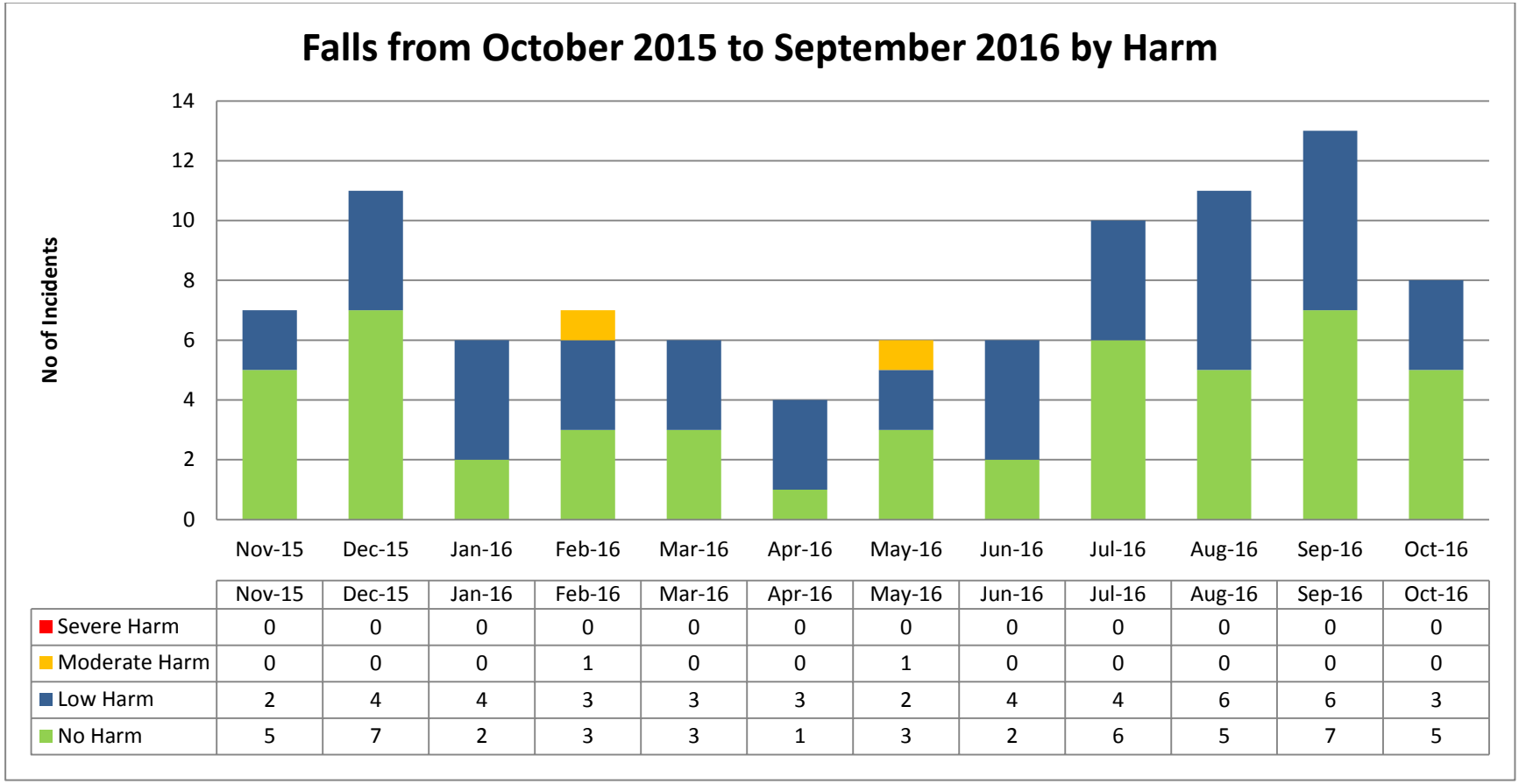
6. **VTEs - A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (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).**



	April	May	June	July	August	September	October	November	December	January	February	March
15/16	2	1	6	3	1	6	0	1	4	5	2	2
16/17	2	0	1	1	0	7	2	0	0	0	0	0

INFORMATION
There were two VTEs that have been declared as SIs in October 2016. These are due for submission with the Commissioners in January 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
A questionnaire is now in use to collate patient feedback when completing post discharge VTE RCAs. 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, 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.
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.**



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	1	0	0	1	0	0	0	0	0
Low Harm	2	4	4	3	3	3	2	4	4	6	6	3
No Harm	5	7	2	3	3	1	3	2	6	5	7	5

INFORMATION

There were 8 falls incidents in October 2016;

- Four falls on Ward 1, three resulting in no harm and one resulting in low harm
- Three falls on Ward 2, one resulting in no harm and two resulting in low harm
- One fall on Ward 12 resulting in no harm

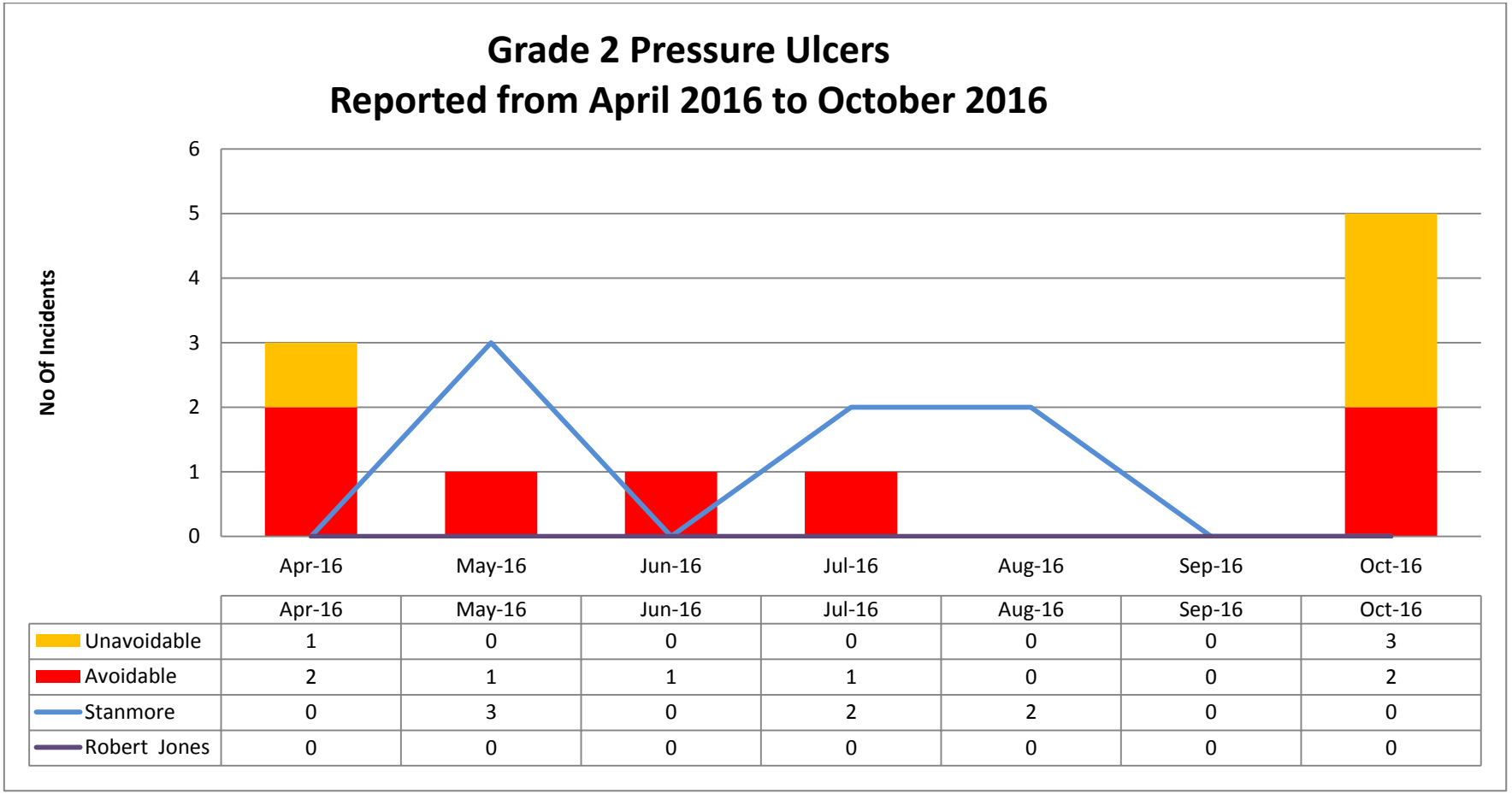
ACTIONS FOR IMPROVEMENTS / LEARNING

- 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). Training on the Hoverjack is now completed in the manual handling trainingprovided at the Trust.
- There is continued ongoing work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care. Review of this work has been extended and the aim is that this will be ready for consideration by the falls prevention and reduction committee in December 2016.
- Cross auditing will commence in November 2016.

RISKS / ISSUES

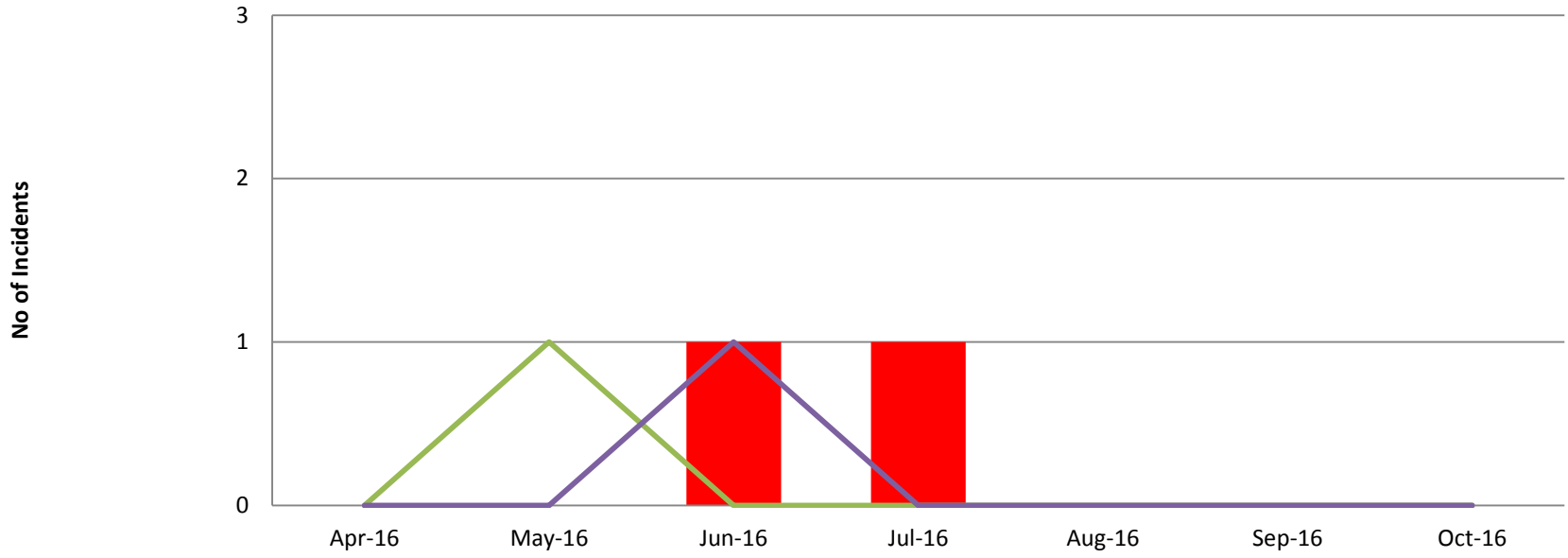
The falls agenda at the Trust requires a relaunch. Over the summer months the previous falls lead was on long term sick and the new falls lead, the Head of Nursing (Div 1), was new to post. The falls committee will be re-established and projects such as the 'Throne' project will receive new focus.

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	Oct-16
Unavoidable	1	0	0	0	0	0	3
Avoidable	2	1	1	1	0	0	2
Stanmore	0	3	0	2	2	0	0
Robert Jones	0	0	0	0	0	0	0

Grade 3 & 4 Pressure Ulcers reported April 2016 to October 2016



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Grade 4 (Avoidable)	0	0	0	0	0	0	0
Grade 3 (Avoidable)	0	0	1	1	0	0	0
Robert Jones	0	1	0	0	0	0	0
Stanmore	0	0	1	0	0	0	0

INFORMATION

There were eight grade 2 pressure ulcers reported in October 2016;

- Two were deemed avoidable.
- Three were deemed unavoidable, two in theatres and one on Ward 1. This was because all preventative measure were in place.
- Three are under investigation and are awaiting confirmation.

ROH contractual limit for Pressure Ulcers in 2016/17

- **Grade 2 Avoidable Limit is 15** - at October 2016 = 8 (avoidable)
- **Grade 3 Avoidable Limit is 0** - at October 2016 = 2
- **Grade 4 Avoidable Limit is 0** - at October 2016 = 0

ACTIONS FOR IMPROVEMENTS / LEARNING

There was an SI that was submitted to the Commissioners, approved and closed in October 2016. The lessons learnt have been detailed in the Serious Incidents section above.

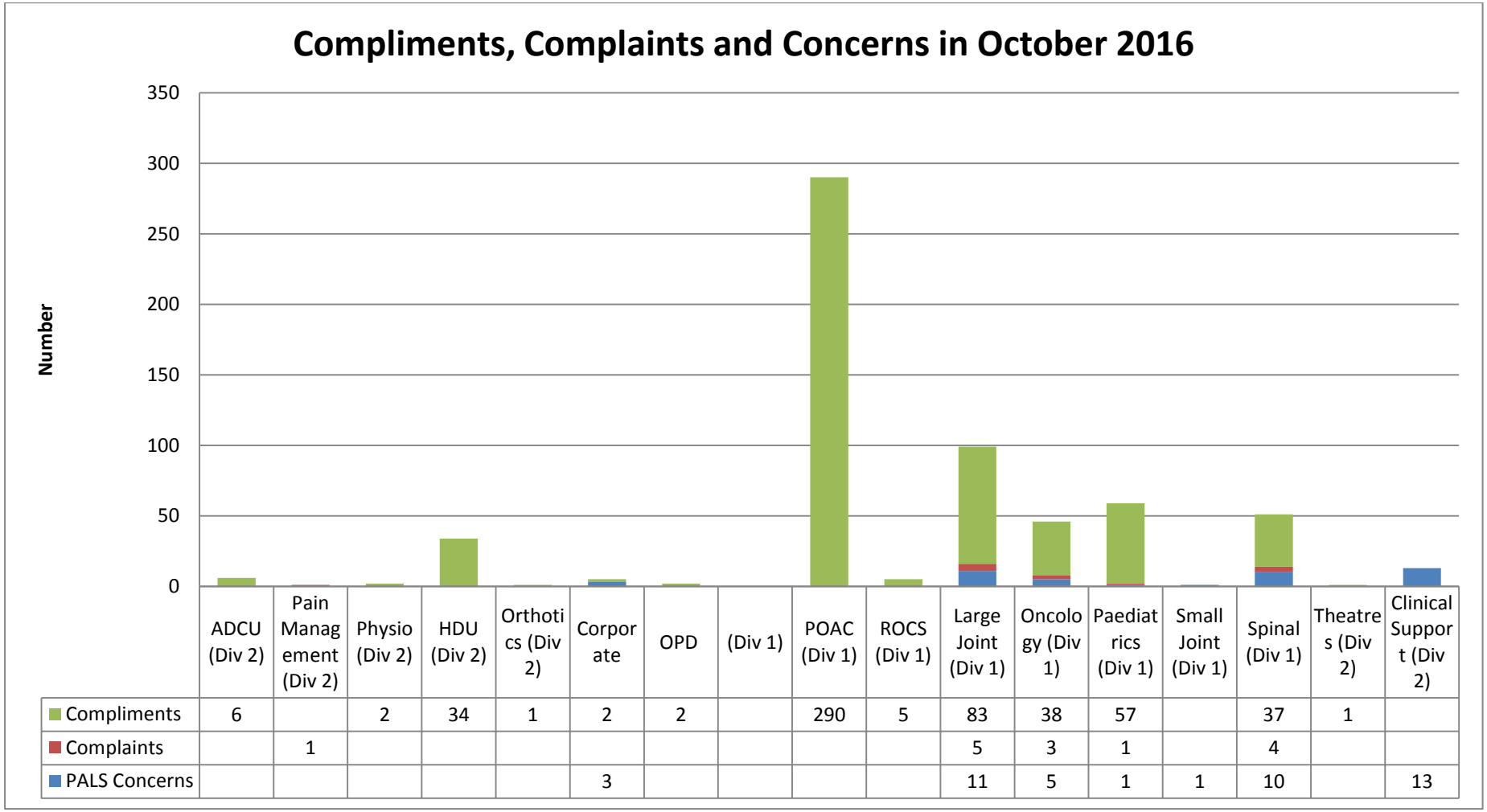
RISKS / ISSUES

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

The pressure ulcer data sources will be reviewed from the beginning of the financial year to ensure accuracy and consistency. This is due to the identification of a data quality issue.

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)	Physio (Div 2)	HDU (Div 2)	Orthotics (Div 2)	Corporate	OPD	(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)	Clinical Support (Div 2)
Compliments	6		2	34	1	2	2		290	5	83	38	57		37	1	
Complaints		1									5	3	1		4		
PALS Concerns						3					11	5	1	1	10		13

INFORMATION

There were 14 formal complaints, 44 concerns and 558 compliments received in October 2016;

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 19 complaints closed in October 2016, all of which were closed within the agreed timescales. This gives a 100% completion on time rate and meets the KPI.

- 7 were upheld
- 5 were partially upheld
- 7 were not upheld

Learning / Actions from complaints

Learning identified and actions taken as a result of complaints closed in October 2016 include;

- Approach of Junior Doctor was inappropriate and unhelpful
  Action: Professional conversation and mentoring initiated

- There is a lack of knowledge in some clinical areas with regard to provision for patients with an additional need
  Action: Training has been refreshed and presentation has been undertaken at the Senior Nurse meeting

- Communication of action being taken whilst is SIRI is in process is not always communicated to the family
  Action: Review of the SIRI process has been undertaken to ensure communication at key points

- Perception of nursing care generally continues to appear to be more negative
  Action: Review of last 6 months of complaints with regard to nursing input has begun and information will be shared at Divisional meetings and Clinical Quality Group

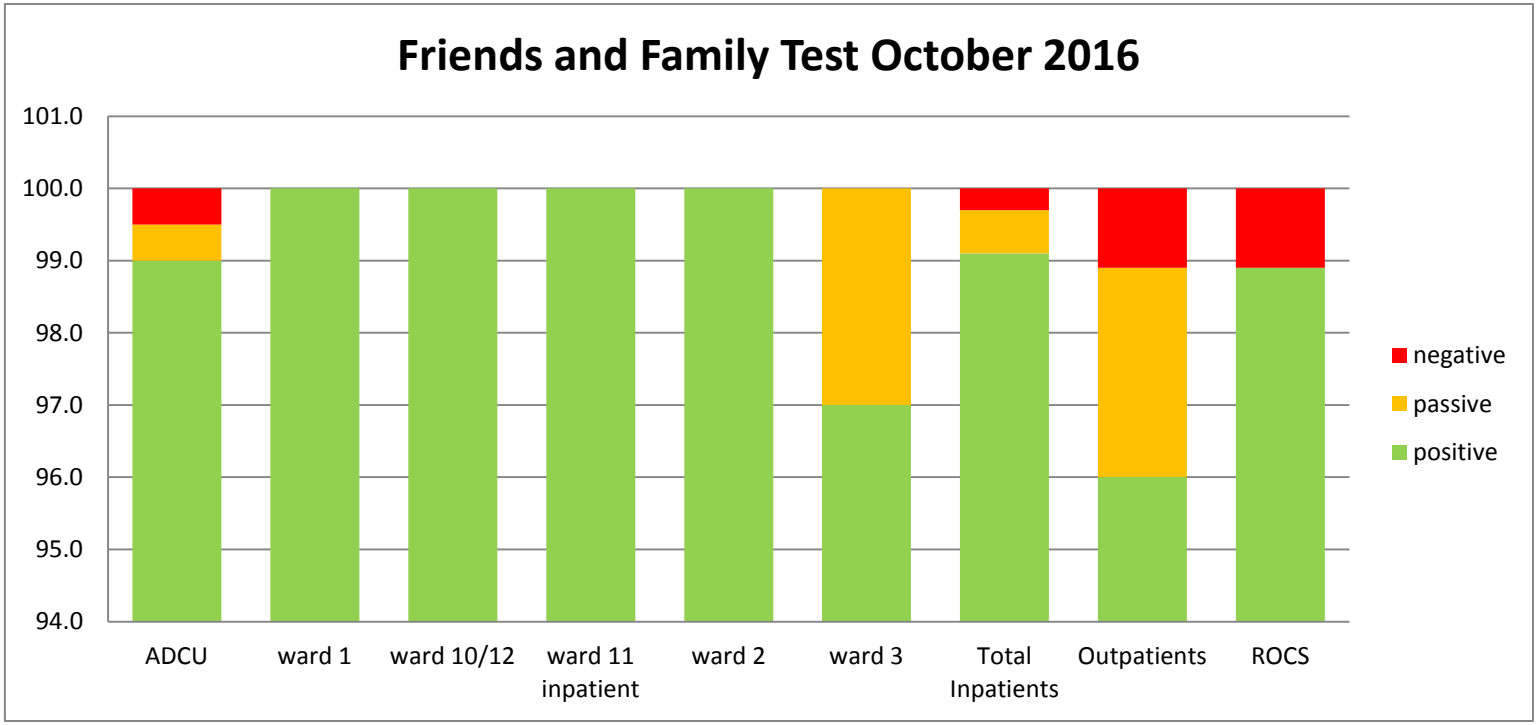
RISKS / ISSUES

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.

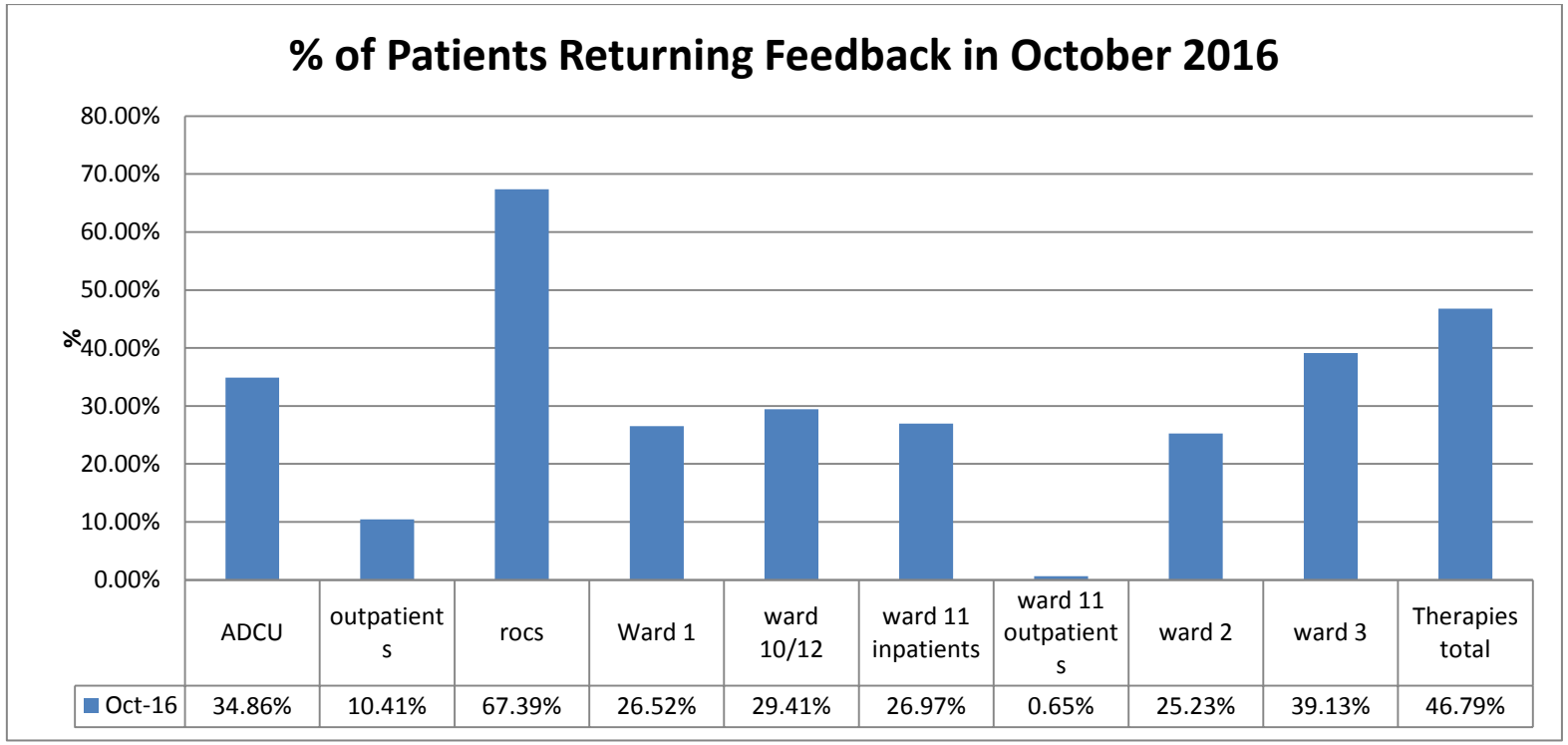
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting 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 96.91% of those who responded would promote ROH.



	ADCU	outpatients	rocs	Ward 1	ward 10/12	ward 11 inpatients	ward 11 outpatients	ward 2	ward 3	Therapies total
Oct-16	34.86%	10.41%	67.39%	26.52%	29.41%	26.97%	0.65%	25.23%	39.13%	46.79%

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.

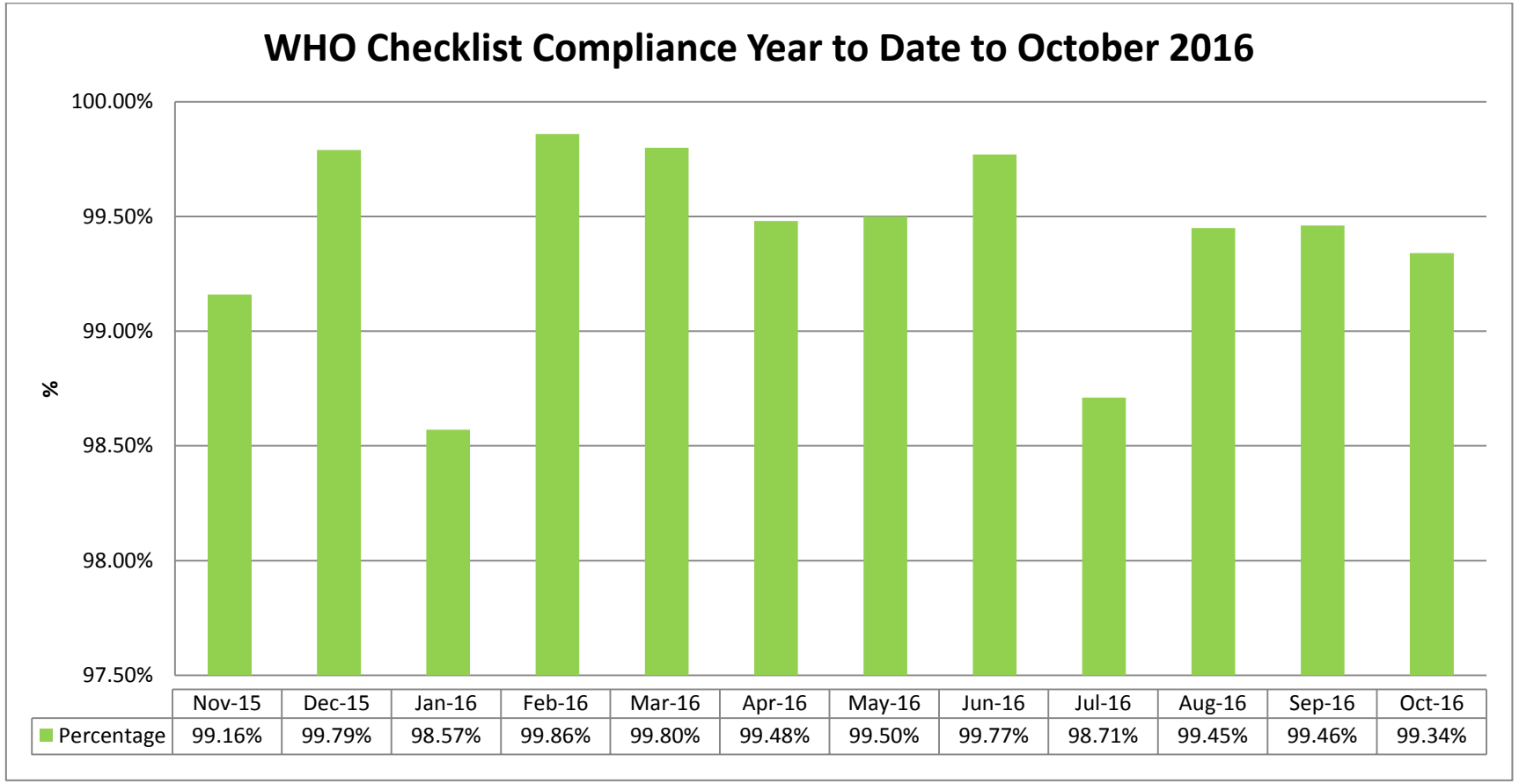
There are currently 19 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

12. Litigation

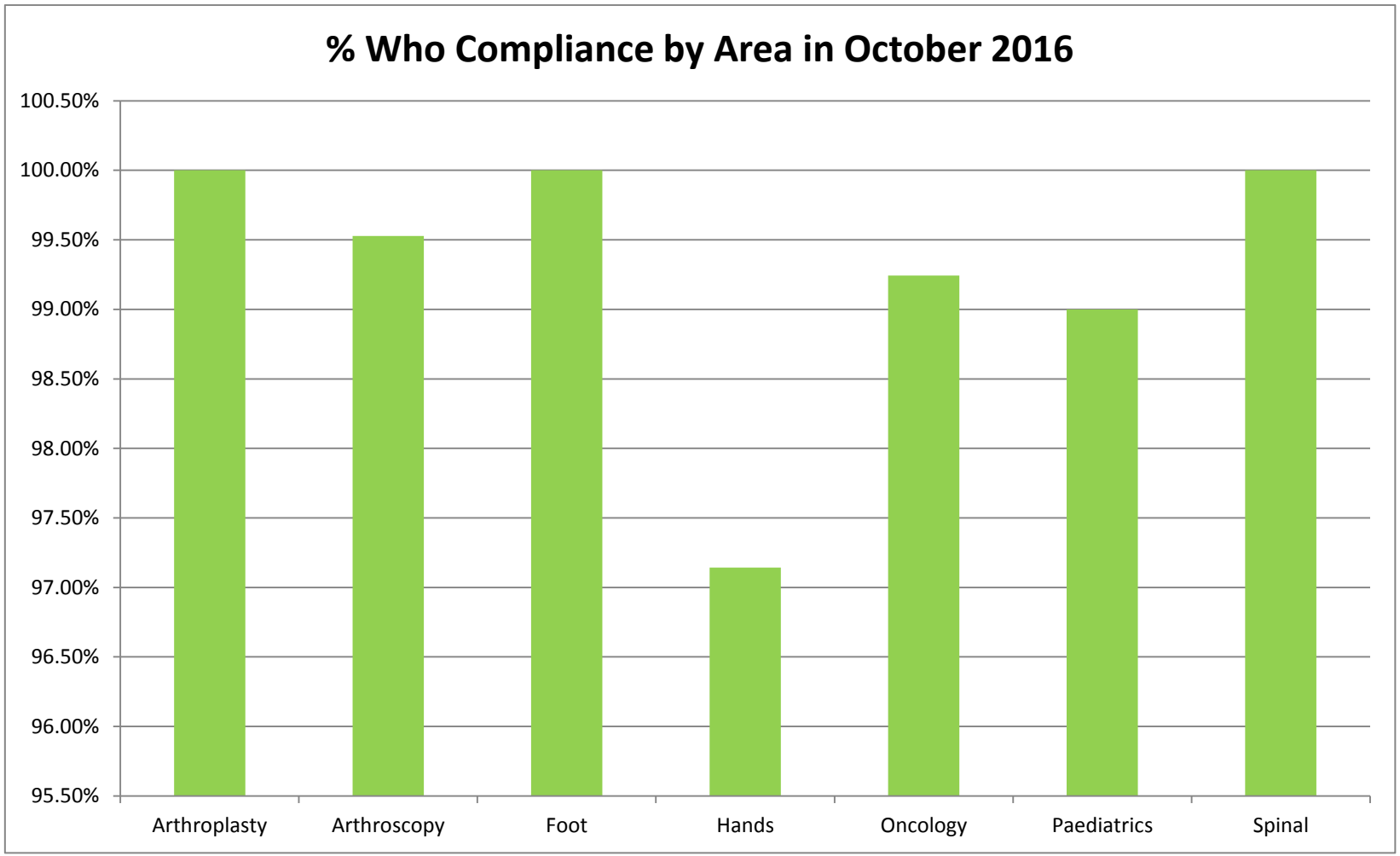
The Trust has received 1 new claim in October 2016;

Defence experts have been instructed to inform decision on liability ahead of drafting the formal Letter of Response.

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.**



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Percentage	99.16%	99.79%	98.57%	99.86%	99.80%	99.48%	99.50%	99.77%	98.71%	99.45%	99.46%	99.34%


% Who Compliance by Area in October 2016
100.50%
100.00%
99.50%
99.00%
98.50%
98.00%
97.50%
97.00%
96.50%
96.00%
95.50%
Arthroplasty
Arthroscopy
Foot
Hands
Oncology
Paediatrics
Spinal

INFORMATION

Total Cases in October 2016 = 756

Total Non-Compliance = 5

Total Compliance = **99.34% 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.
6. Audit results are also discussed as a standing agenda item at the Theatre User Group meetings

RISKS / ISSUES

Due to the Clinical Standards Lead being off sick, a detailed analysis was not available for October.

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (1/17) 004

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:	**11 January 2017**

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 October 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.
- Children's Nurse recruitment remains challenging with 5.0 WTE vacancies, the advert is currently under review and the posts will be re-advertised in November 2016 to interview in December 2016.
- Paediatric interviews for Recovery are scheduled for November 2016.
- New staffing controls have been put into place to reduce nurse staffing spend
- Agency use has decreased in October 2016 compared to 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		

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 has been added to Divisional board Meetings from August 2016. Trust Board receives a monthly report on safe staffing.

ROHTB (1/17) 004

Nurse Staffing Report

REPORT TO TRUST BOARD: October 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 October 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 October 2016 is shown in Table 1 below; this figure is inclusive of Registered Nurses (RN) and Health Care Assistants (HCA) during both day and night duty periods. The actual staffing levels for October 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 October 2016. The Unify upload for October 2016 is provided in Appendix 1. In the absence of national guidance, ROH will RAG rate 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) October 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	89.9%	96.4%	96.8%	112.9%
2	94.7%	99.7%	96.9%	96.8%
3	88.0%	89.0%	90.3%	106.5%
12	94.6%	96.7%	97.4%	94.0%
11	103%	90%	97.8%	
HDU	99.6%	91.3%	103.5%	-

The reason for the above exceptions to the standard required are due to the proactive reduction in staffing levels at times of low patient numbers and low acuity on the Wards. To note: All wards have had minimum safe staffing numbers with this reduction.
It is not feasible or possible for the ward templates to be adjusted for this day-to-day variance on the e-rostering system due to the administration time this would take and the potential for error with the templates..

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 October 2016, CHPPD were calculated by ward as detailed in Table 2 below, with the totals in brackets representing September 2016 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	524 (601)	4.6(3.9)	2.9(2.7)	7.6(6.6)
2	562(652)	4.3(3.6)	2.3(2.0)	6.7(5.6)
3	523(581)	4.5(4.2)	2.5(2.3)	7.1(6.5)
12	697(732)	4.1(4.0)	2.8(2.7)	6.9(6.8)
11	168(204)	13.0(10.6)	1.8(1.4)	14.7(11.9)
HDU	146(162)	19.3(24.1)	1.4(1.1)	20.7(25.2)

The data shows that with a decrease in patient numbers in October 2016 recorded each day at 23.59 hrs, there is an overall increase in the care hours per patient. It should be noted that this is not a dependency tool.

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 and Band 2 WTE Vacancy position as on 7th November 2016

(To note: The figures in brackets denote vacancies recruited to)

Ward/Department	Band 5 Funded Establishment (WTE)	Band 5 Vacancy (WTE)	Band 2 Funded Establishment (WTE)	Band 2 Vacancy (WTE)
ADCU	TBC	3.0	TBC	Nil
OPD	4.43	2.0 (1.0)	8.48	1
POAC	5.6	Nil	3.15	Nil
Ward 1	13.57	1.0	10.32	Nil
Ward 2	13.80	7.72 (5.0)	9.05	Nil
Ward 3	14.16	Nil	7.81	Nil
Ward 12/10	18.61	2.28 (2.2)	13.91	2.59 (2.0)
Ward 11	15.96	2.0	1.8	1.2 (held)
HDU (Includes Band 6)	23.32	3.5 (3.5)	1.8	Nil
HDU Paeds	9.69	3.0	Nil	Nil
Totals	119.14	24.5 (11.7)	56.32	4.79 (2.0)

Table 4 Band 5 vacancies, recruited staff in recruitment process and recruited staff with start dates.

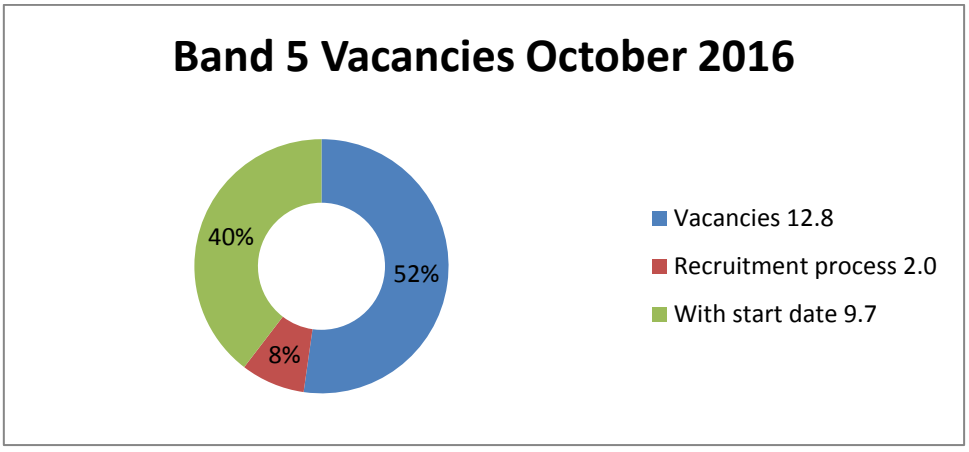
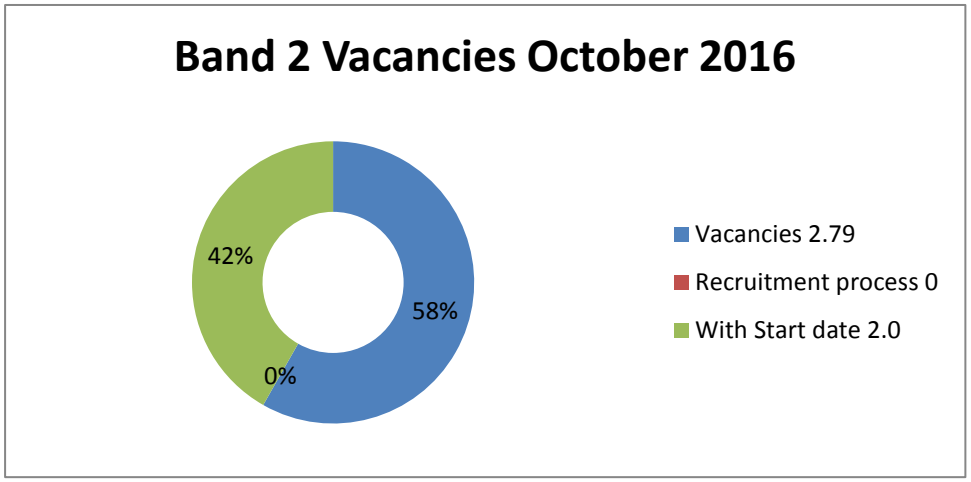


Table 5 Band 2 vacancies, recruited staff in recruitment process and recruited staff with start dates.



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 continuing to join 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 Nursing workforce group has agreed to investigate the possibility of holding an open day at the end of January 2017/beginning of February 2017.
- The group is also looking at rewriting job adverts to include the opportunity of the Trust offering rotational posts for both adult nurses and paediatric nurses.
- The vacancy template that was developed is completed monthly by Ward sisters/ Charge Nurses to ensure accuracy in vacancy reporting. The template will be developed further to include leavers, maternity leave and long-term sickness to give an overall view of the amount of bank shifts required for wards to staff to establishment/ template.
- The advert for registered nurses closes on 25th November 2016 and interviews are planned for 12th December 2016. A paediatric advert will be placed in November 2016, to close and interviews to take place in December 2016 (date to be confirmed)
- ADCU have interviews planned for 30th November 2016 (to cover Mat leave and vacancies)
- Recovery have interviews planned in November 2016 for paediatric registered nurses. HDU are jointly interviewing with recovery to offer HDU paediatric posts or rotational posts.

2.3 Acuity data

2.3.1 Paediatric Areas

Trust Board is asked to note that Division 1 team had initially supported the use of the PANDA tool and the source of funding had been agreed and approved by DGM. The next step was to identify the IT requirements and agree timescale for implementation. However, following discussion at Children's Board in November 2016 the use of this tool will be reviewed. A meeting is planned with staff from BCH on 22nd November 2016 to review the use of this tool against other possible tools.

2.3.2 Adult areas

The safer nursing care tool has been used previously and has shown no concerns with acuity. However with the introduction of Allocate eroster system the 'safe care' module will be used, going forward, for acuity purposes. So the decision has been made not to repeat the safer nursing care audit tool.

2.4 Safe Staffing and Efficiency

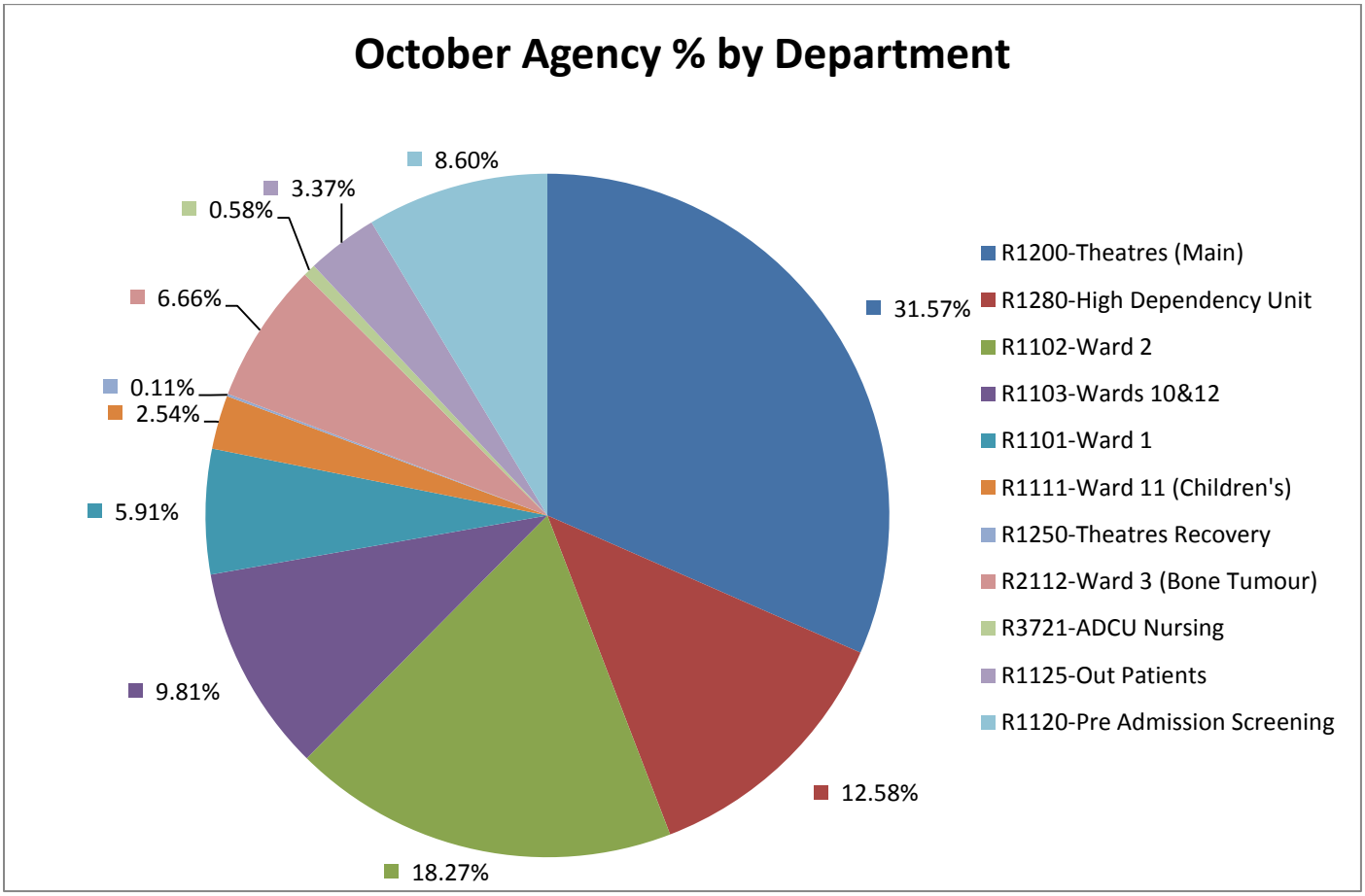
Caps on agency spend for Registered Nurses, mandated by NHS Improvement, have been in place at ROH since 1 October 2015. The ceiling for ROH has been set at 10% which is a reflection of the relatively high use of agency staff at the Trust. During October 2016 overall nurse agency use at ROH was 14.5% which is a significant decrease of 3.1% from the previous month. Table 8 shows total nurse agency use across the Trust since November 2015.

Table 6: Registered Agency use as a % of total cost (Whole Trust)

Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	April 16	May 16	June 16	Jul 16	Aug 16	Sept 16	Oct 16
13.5 %	15.9 %	13.7 %	14.2 %	10.7 %	11.2 %	10.9 %	8.6 %	12.4 %	17 %	17.6 %	14.5 %

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 recovery and HDU has decreased for the second month from August 2016 data. To note: HDU have reduced capacity of 1 bed during building works.
- Ward 11 use of agency has decreased by 2.52% as the recruited staff have commenced.
- 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. The reliance on

agency on Ward 2 will reduce from December when one member of staff commences and then further in February with two new starters with two more members to start after this (currently in recruitment process)

- A decrease in agency spend has been seen in ADCU which may be due to there not having been a requirement to keep this area open and staffed for in patients overnight in October 2016

3.0 Staffing controls:

- Twice weekly meetings continue to review staffing numbers against activity and acuity of patients.
- Weekend plans for reduction of staffing where safe, dependent on patient numbers and acuity continue
- Prospective planning for ADCU closing at weekends if not required
- 'Cohorting' of empty beds in one area to facilitate reducing staffing numbers
- Christmas rota planning has been completed,
- All bank shifts and agency shift requests are being authorised by Head of Nursing at present to ensure robust reviews regarding site staffing, patient numbers and acuity are taking place before authorisation
- From November 2016, no agency HCA will be authorised except in exceptional circumstances such as 1:1 care.

4.0 Progress against E–Rostering at ROH

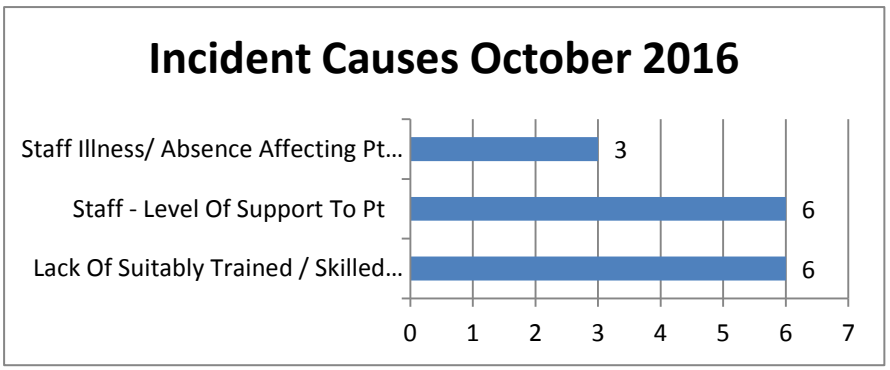
- The roll out commenced on 17th October 2016 and is progressing as per plan.
- The e-rostering policy is now being reviewed to incorporate the new authorisation process for bank and agency and will be circulated for comments and it is proposed to bring this policy to TMC in January 2017.

5.0 Incident Reporting and Levels of Harm

5.1 Reported Staffing Incidents

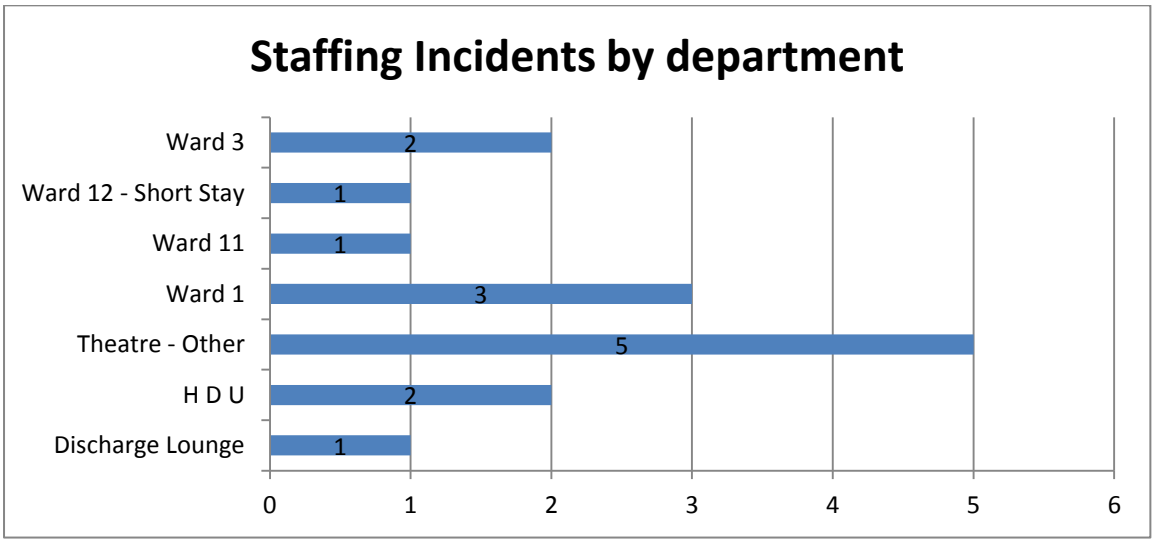
In addition to the Safer Nurse Staffing tool being used and interpreted, clinical areas are encouraged to report all Safe Staffing incidents.
An analysis and review of the 15 nursing related safe staffing incidents reported during the period of October 2016 has been undertaken and is represented in the graph below.

5.2 Incident Categories

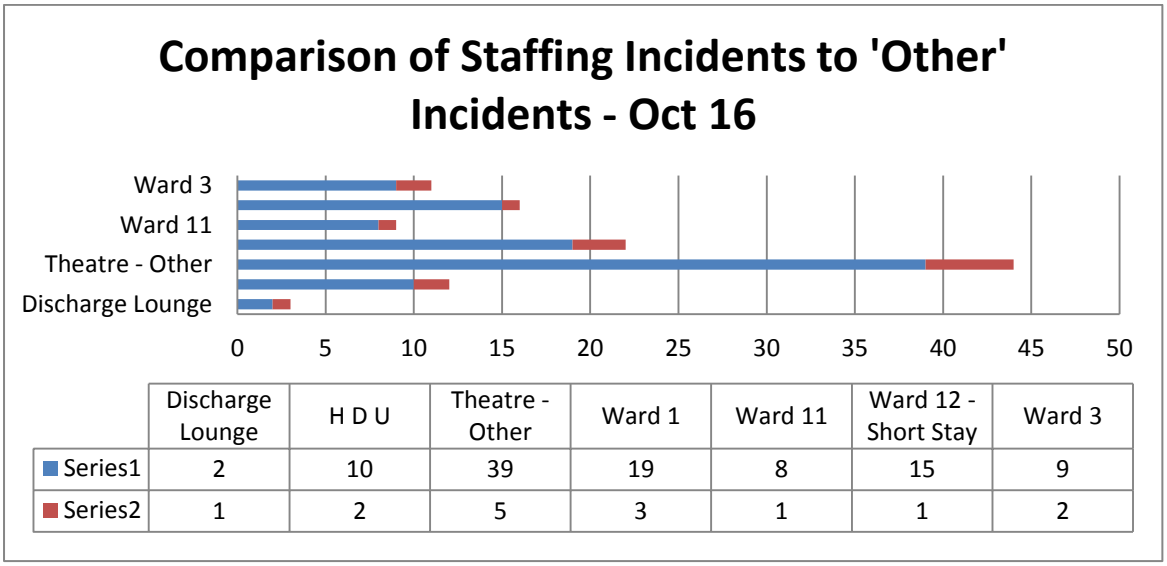


5.3 Incidents by area/ward:

Below highlights the departments the incidents were raised



5.4 Comparison of total incidents to staffing incidents



	Discharge Lounge	H D U	Theatre - Other	Ward 1	Ward 11	Ward 12 - Short Stay	Ward 3
Series1	2	10	39	19	8	15	9
Series2	1	2	5	3	1	1	2

5.5 Level of harm

1 staffing incident (18973) was graded as 'low harm' however after investigation there were no patient safety incidents raised during this shift.

5.6 Red Flag Shifts Questionnaire

Five Incidents triggered red flags – attached in appendix 2
The themes are:
Delayed Pain Relief and Patient vital signs not assessed or recorded as outlined in care plan

6.0 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.
- Children's Nurse recruitment remains challenging with 5.0 WTE vacancies, the advert is currently under review and the posts will be re-advertised in November 2016 to interview in December 2016.
- Paediatric interviews for Recovery are scheduled for November 2016.
- New staffing controls have been put into place to reduce nurse staffing spend.
- Agency use has decreased in October 2016 compared to September 2016.

Garry Marsh
Director of Operations, Nursing & Clinical Governance

5 January 2017

ROHTB (1/17) 004

Appendix 1

Only complete sites your organisation is accountable for			Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
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
	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		1603.5	1441	1203	1160	1023	990	341	385	89.9%	96.4%	96.8%	112.9%	524	4.6	2.9	7.6
Ward 2	110 - TRAUMA & ORTHOPAEDICS		1534	1452.5	978.5	975.5	1023	991	341	330	94.7%	99.7%	96.9%	96.8%	562	4.3	2.3	6.7
Ward 3	800 - CLINICAL ONCOLOGY	110 - TRAUMA & ORTHOPAEDICS	1747.5	1537.5	1110	988	930	840	310	330	88.0%	89.0%	90.3%	106.5%	523	4.5	2.5	7.1
Ward 10 & 12	110 - TRAUMA & ORTHOPAEDICS		1744.5	1649.5	1292.5	1249.5	1254	1221	737	693	94.6%	96.7%	97.4%	94.0%	697	4.1	2.8	6.9
Ward 11	110 - TRAUMA & ORTHOPAEDICS		1141.5	1176	331.5	298.5	1023	1001	0	0	103.0%	90.0%	97.8%	-	168	13.0	1.8	14.7
HDU	110 - TRAUMA & ORTHOPAEDICS		1517.5	1511	224.5	205	1265	1309	0	0	99.6%	91.3%	103.5%	-	146	19.3	1.4	20.7

Appendix 2

Ward 3	01/10/2016	18948	Lack Of Suitably Trained / Skilled Staff	6 - Near Miss	INCIDENT DATES: 27/09/2016 - EARLY SHIFT (SICKNESS). 29/09/2016 - LATE SHIFT - DID NOT ATTEND. 30/09/2016 - LONG DAY - DID NOT ATTEND. Agency Nurses booked to cover shifts. Each occasion failed to attend or called in sick (27/09/2016). Agency Nurses that did not attend, had been confirmed by agencies and nurse bank, however, failed to attend the shifts. This posing a danger to patient safety and staff resilience. Ward worked short on each occasion.	01/10/2016 - MG, WARD 3 MANAGER. Incident reviewed prior to incident being submitted. Staffing vs acuity. NO further action to be taken - no requirement to refuse or decline admissions. Theatre cases continued and no cancellations to patients. Apologies to patients for any delays. Review of off duty and staffing. Attempt to reduce the amount of off duty. No more than minimum of 3 substantive staff on a shift unless absolutely necessary

Ward 3	16/10/2016	19045	Lack Of Suitably Trained / Skilled Staff	1 - No Harm	agency nurses attended ward 2 for shift when was booked for ward 3 accidently sent home by CN on call as thought was not needed anywhere to work CN on call contacted agency to recall member of staff but they refused advised to ask other wards for help if needed left with 2x band 5 staff nurses and 2x HCA's to cover ward 17 patients (4 of them admissions)	agency booking process

Ward 1	04/10/2016	18973	Staff - Level Of Support To Pt	2 - Low Harm	2 trained nursed on night shift, 3rd bank trained nurse booked for ward 1 and 2 2 confused patient	Poor communication between the permanent ward nurse and the bank nurse. Having rechecked the off duty the bank nurse was on both the regular staff off duty and also on the bank sheets for both the 4th and 5th October 2016. It is vital that the off duty is kept clear and legible to ensure that all staff is able to read it.

Discharge Lounge	20/10/2016	19080	Staff Illness/ Absence Affecting Pt Care	1 - No Harm	Agency nurse went off sick which left me in the lounge. I bleeped on call sister who advised me to bleep matrons. I did speak to the matron who got cover from 11 until 3. Staffing is a major concern in the discharge lounge at present as we are running a 5 day service on three staff members. None of which are full time. Many shifts don't get covered which means alone working. Which isn't ideal for the trust as less discharges get through the lounge and also not good for staff in lounge as we are band 5 and shouldn't be working alone. Checking drugs has been a problem this shift relying on staff from wards two to support.	There were no delayed discharges during day. Establishment review to be undertaken.

Ward 1	07/10/2016	18998	Staff - Level Of Support To Pt	1 - No Harm	Agency Nurse (Band 5) didn't turn up for night shift and left ward short staffed and the ward was so busy. The ward has 21 patients in total with 6 immediate post-op & 2 from HDU. Patients were complained that they are not receiving their pain medication in time. I feel like the ward is so unsafe and the care that patient's requiring were not met as they should.	To make sure that the agency is recorded on the nurse request sheet so that the agency can be contacted to check if the nurse is going to come in.

FINANCE & PERFORMANCE REPORT

DECEMBER 2016

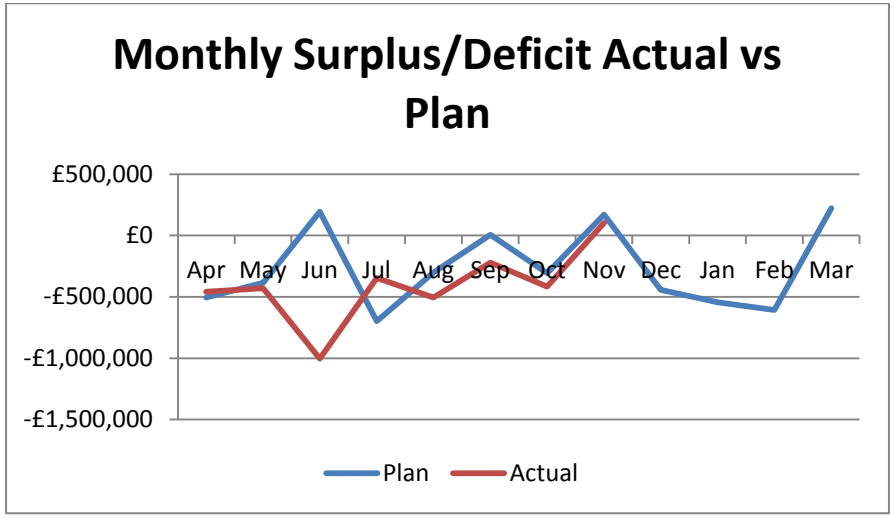
CONTENTS

INTRODUCTION

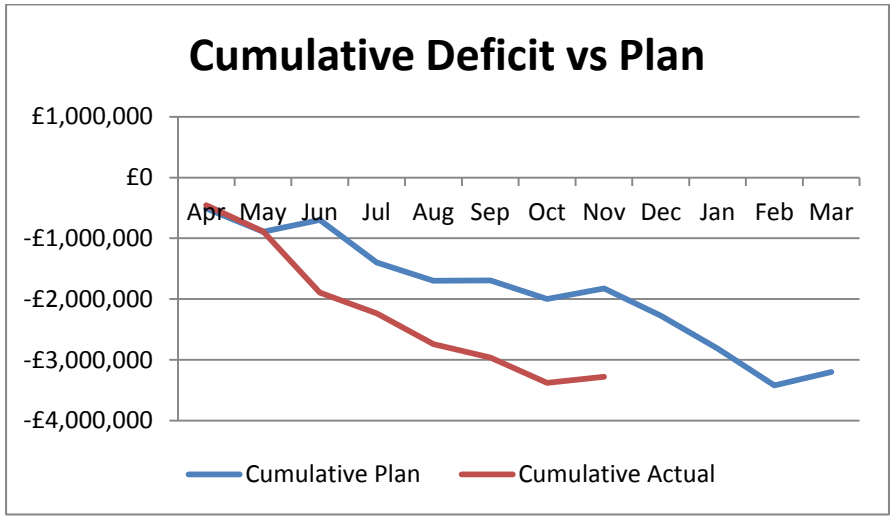
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

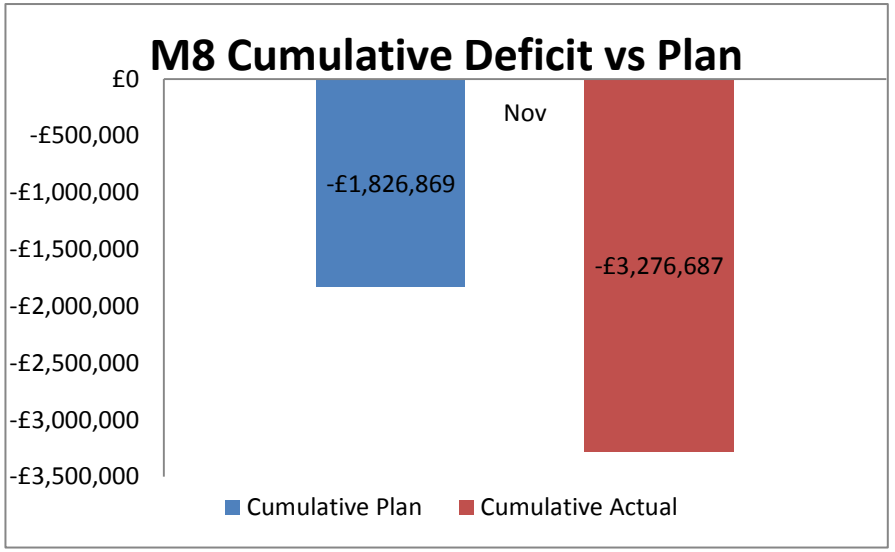
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

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 £3,276,000 as at the end of November against a planned deficit of £1,827,000. In month, the Trust delivered a surplus of £104,000 against a planned surplus of £171,000. This represents the first monthly surplus achieved at the ROH since November 2014!

The Trust is therefore £1,449,000 behind plan at the end of M8. 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 £495,000. Further detail on the key drivers of the financial position is provided in the income and expenditure sections below.

As at the end of Month 8, the Trust has recognised £1,897k of CIP savings, against a plan of £2,276k. £579k (31%) of savings to date are non-recurrent. The in-month savings recognised were £246k against a November target of £349k.

With regards to the Trust's Use of Resources Risk Rating (UOR), the deficit position results in the Trust achieving ratings of 4 for Capital Service Cover, I&E Margin metrics and I&E Margin Metrics against plan. In addition, the Trust's liquidity position is rated as a 2 instead of a 1, as was the case 2 months ago. 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 metric. The overall Trust score has been capped to a 3.

Work on the final operational plan submission is ongoing. The forecast position for 2017/18 and 2018/19 is dependent on the outcomes of negotiations with both NHS England and the local CCGs, which are being led by the Director of Finance.

ACTIONS FOR IMPROVEMENTS / LEARNING

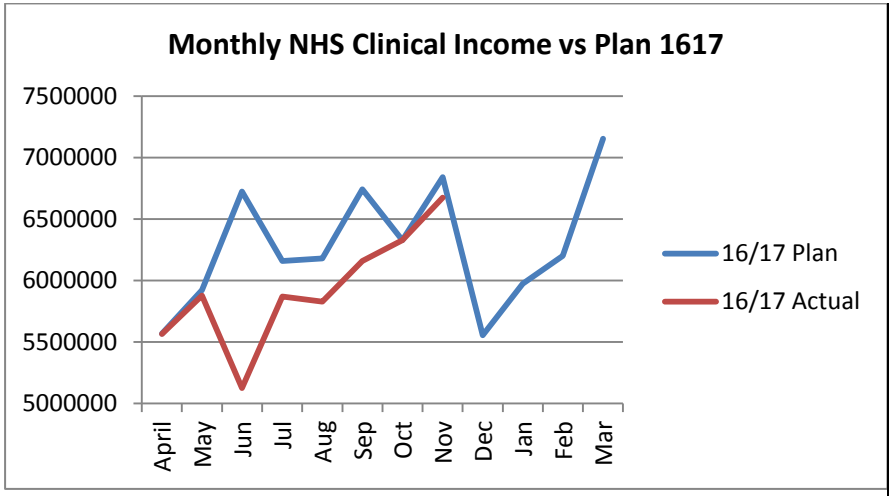
The Trust Executive have set up a weekly Recovery Board where progress against the action plans of the five recovery workstreams (POAC, theatre efficiency, discharge planning, agency reduction and cost control) is monitored and challenged. The Chief Executive has also briefed the organisation on a number of key schemes that will drive improvement in the financial position for the remainder of the year and beyond. These schemes include the introduction of 5 recovery days, a Mutually Agreed Resignation Scheme (MARS) and the sale of annual leave.

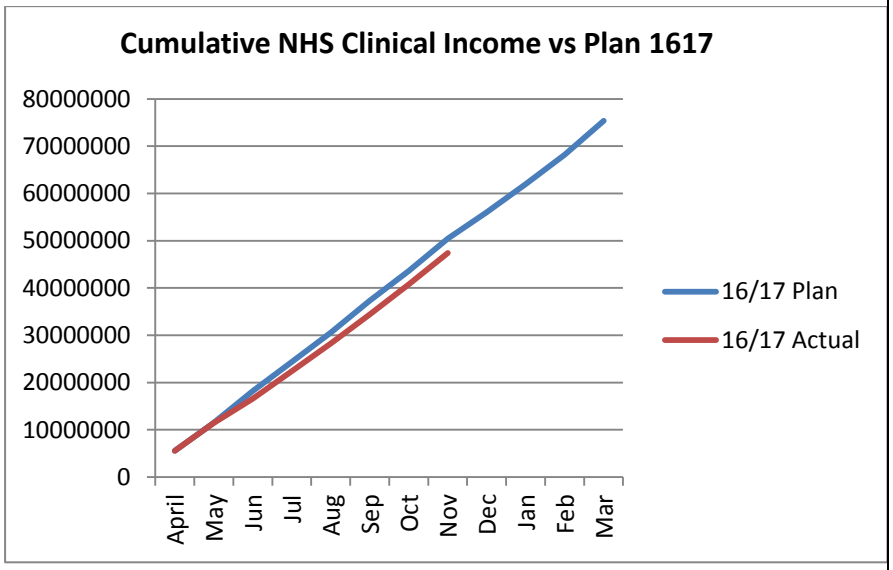
RISKS / ISSUES

The activity targets for the coming months will be challenging, and will result in pressure on theatres and wards in addition to the Trust's support services to ensure that patient flow runs smoothly with no excess capacity in the system.

Buy-in and progress against the schemes set out in the workstream action plans, and by the Chief Executive will be vital in achieving improvement in the Trust's financial position and its long-term sustainability.

2. Income – This illustrates the total income generated by the Trust in 2016/17, including the split of income by category





NHS Clinical Income – November 2016			
	Plan	**Actual**	**Variance**
Inpatients	3,290	3,353	63
Excess Bed Days	278	252	(26)
Day Cases	820	829	9
Outpatients	747	689	(58)
Critical Care	256	252	(4)
Therapies	253	236	(17)
Pass-through income	219	207	(12)
Other variable income	418	382	(36)
Block income	559	527	(32)
TOTAL	**6,840**	**6,727**	**(113)**

NHS Clinical Income – YTD 2016			
	Plan	**Actual**	**Variance**
Inpatients	24,116	22,175	(1,941)
Excess Bed Days	2,039	2,008	(31)
Day Cases	6,012	5,511	(501)
Outpatients	5,588	5,149	(439)
Critical Care	1,878	1,871	(7)
Therapies	1,887	1,929	42
Pass-through income	1,647	1,802	155
Other variable income	3,109	3,028	(81)
Block income	4,183	4,216	33
TOTAL	**50,459**	**47,689**	**(2,770)**

INFORMATION

NHS Clinical income underperformed against plan by 1.7% in November, although elective income over-performed by 1.9%. Admitted patient care activity was significantly up on prior month (1342 vs 1199).

Outpatients continued to under-perform from an income point of view, driven by a significant reduction in the number of outpatient follow ups undertaken in month. Year to date there is an underperformance in outpatient procedures that 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 this workload has been transferred to other services including therapies, which has resulted in an over-performance in that service for the year to date.

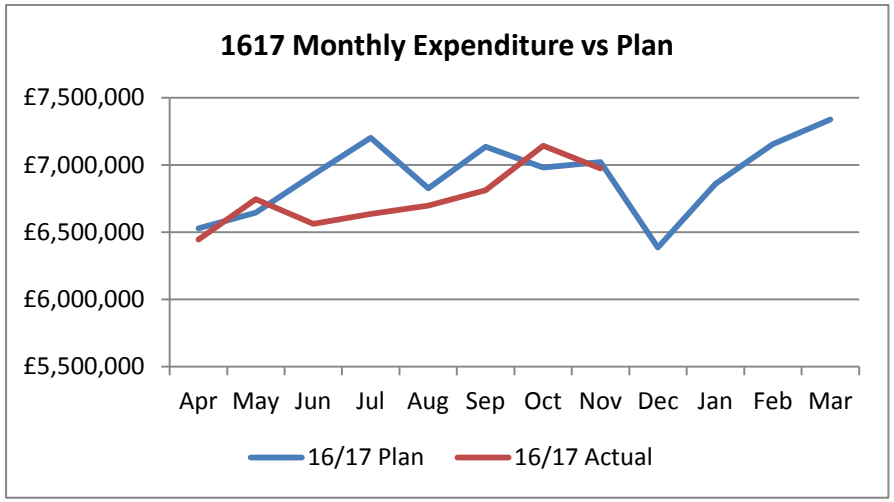
ACTIONS FOR IMPROVEMENTS / LEARNING

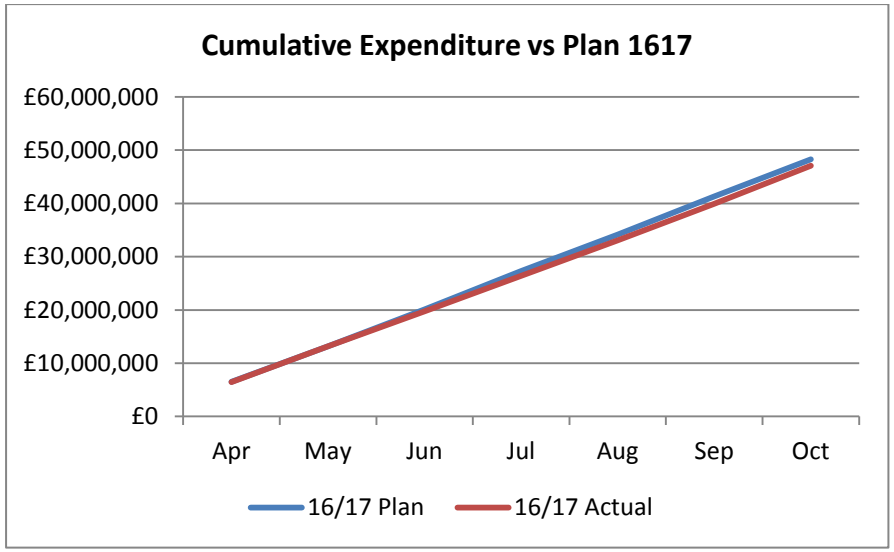
Continued daily focus is taking place to ensure inpatient activity is maximised, by following the actions outlined in the detailed action plans for the POAC, Theatre efficiency and Discharge Planning work streams. As reported earlier, the workstreams are being monitored on a weekly basis through Recovery Board, attended by the Trust Executive.

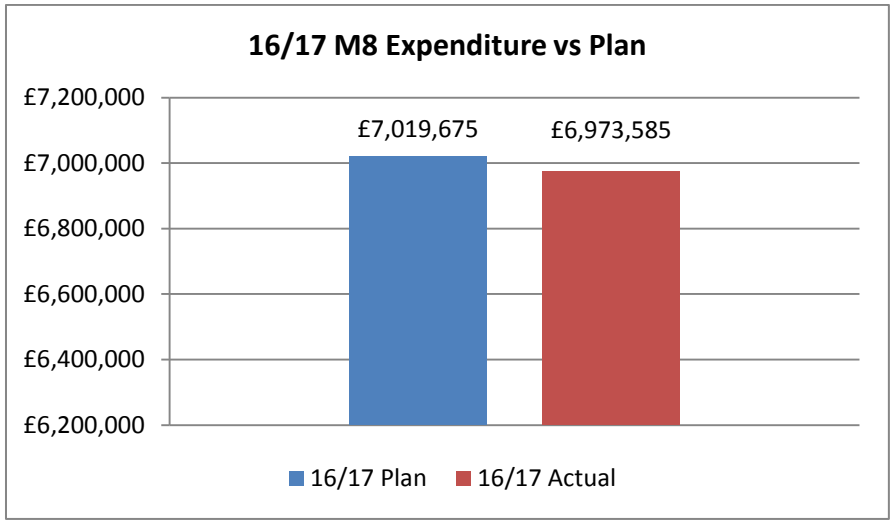
RISKS / ISSUES

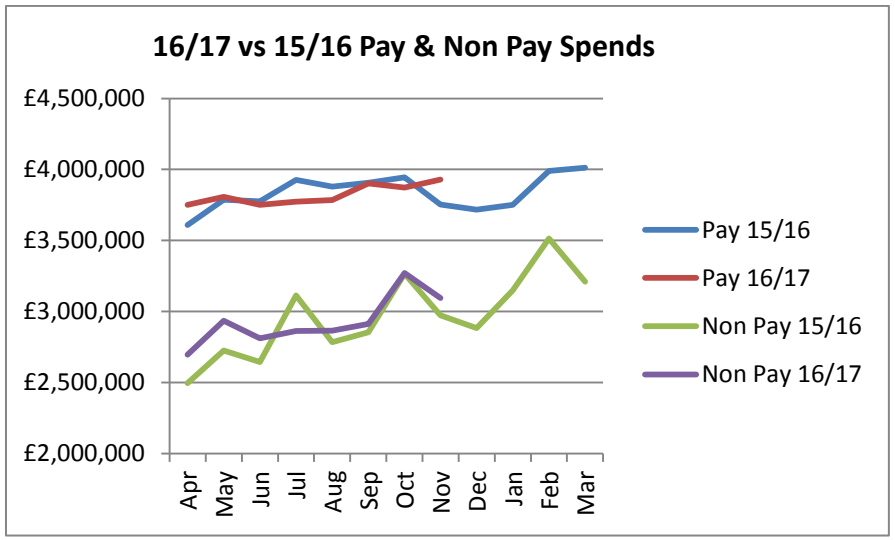
The level of activity required to deliver the Trust's revised forecast remains challenging, particularly from 9th January where there is expected to be a significant uplift in planned activity as a result of key actions with the recovery workstreams becoming fully live (e.g. POAC slot availability). Should the required actions not be taken on a timely basis, and those actions translated into additional activity being delivered by the Trust then there is a risk the revised forecast will not be met.

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 £1.25m below plan.

Pay increased slightly in month, driven by an increase in bank and substantive spend, with agency spend decreasing.

Non pay expenditure decreased slightly on prior month, as last month contained some one-off costs such as the replacement of theatre equipment. The non-pay expenditure is still being controlled to a level below that predicted in the original operational plan.

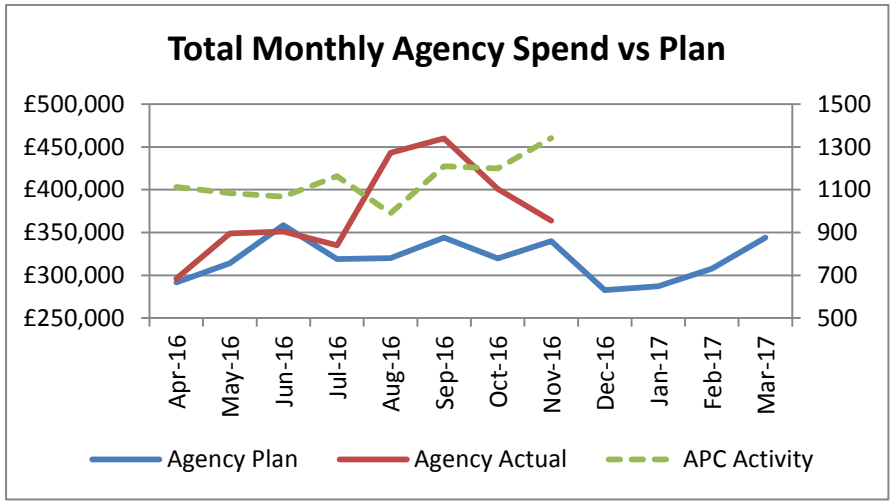
ACTIONS FOR IMPROVEMENTS / LEARNING

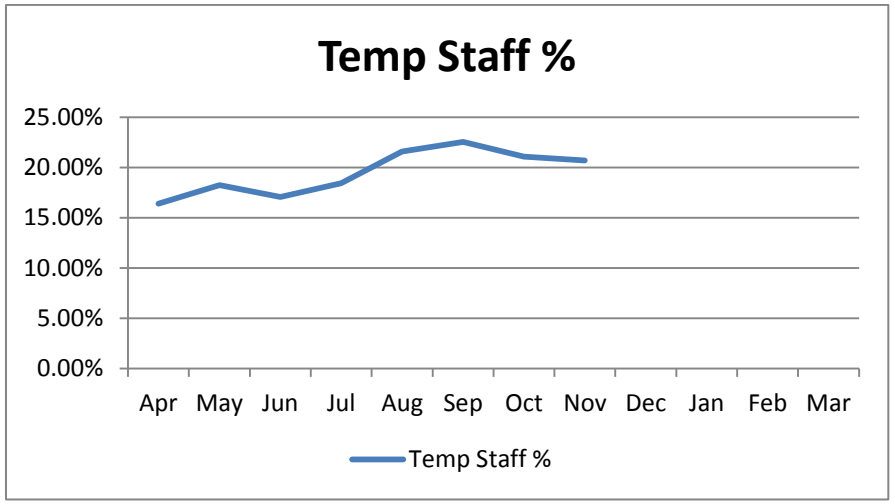
Costs will continue to be scrutinised and minimised. One of the 5 recovery workstreams is cost control, with actions being tracked through the Recovery Board on a weekly basis.

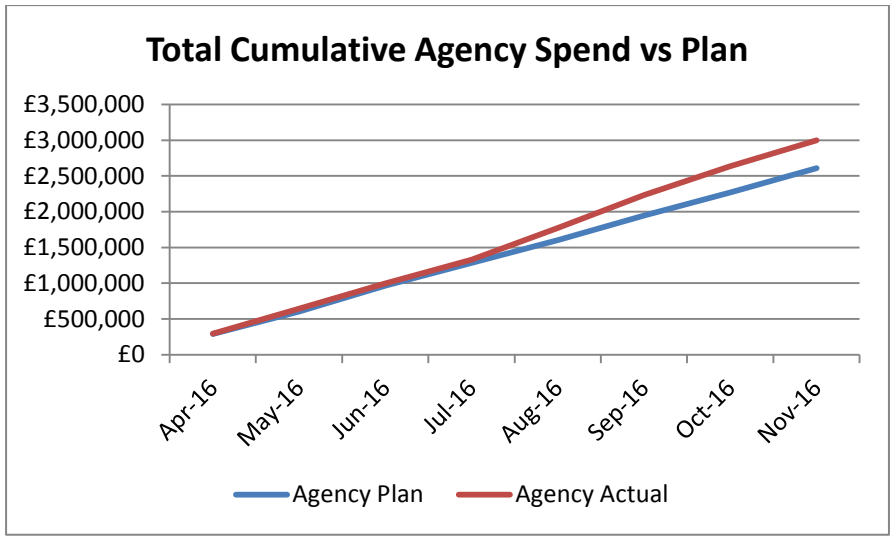
RISKS / ISSUES

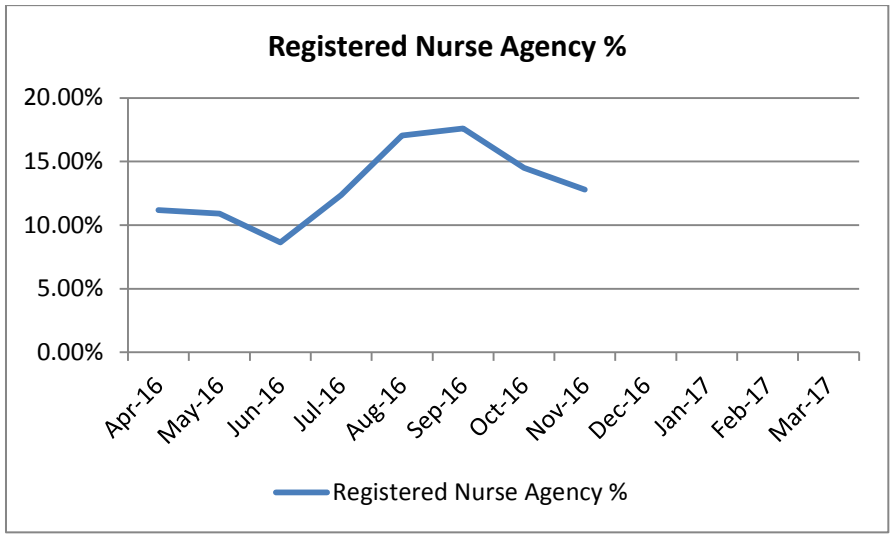
The implementation of recommendations relating to the review into theatre stock control and processes continues, however until full cyclical stock takes are completed, there remains a risk around the robustness of non pay spend within the ledger. The theatres team have moved all prosthesis stock into a new controlled location 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. EDC Gold has also gone live in month with the first line being piloted onto the system.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2016/17, and performance against the NHSI agency requirements









INFORMATION

November showed a significant reduction in agency spend (from £401,000 to £364,000), this being the second month in a row with agency spend reduction. This reduction is seen across nursing and corporate spend, although there was a £30k increase in locum spend. Despite the reduction, the spend remained above plan (£340,000).

ACTIONS FOR IMPROVEMENTS / LEARNING

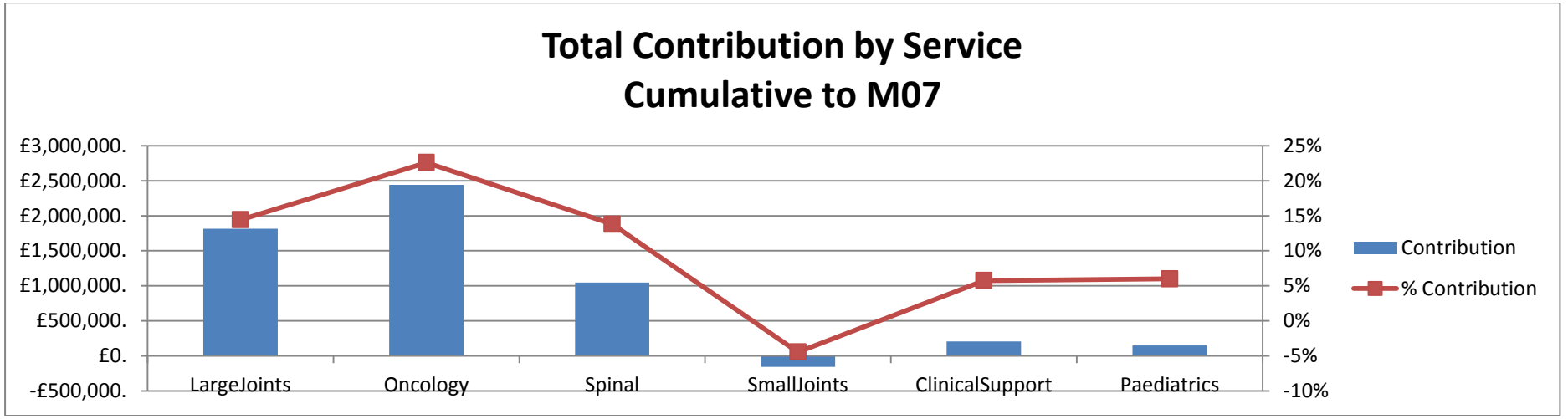
One of the 5 recovery workstreams is reduction in agency spend, and as such a detailed action plan is being reported against on a weekly basis to Recovery Board. This is in addition to the agency group run by the DOWOD and DOONCG. Ongoing actions to reduce agency spend include workforce redesign, e.g. the POAC workforce model, in addition to reviewing the outputs of Healthroster.

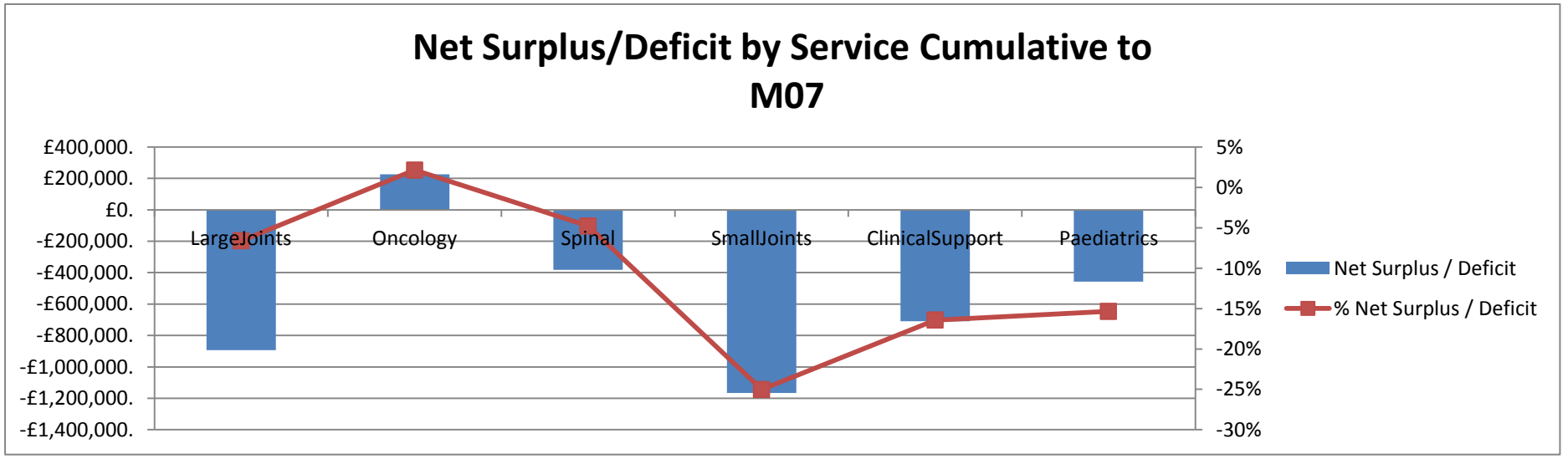
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios.

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 financial year 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 October 2016. Small Joints is the only service to have provided a negative contribution of -£155K. 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 apart from Oncology are then running at a net loss, this is reflected in the overall Trust position of £3.38m deficit up to October 2016.

Large Joints is currently second highest gross loss producing service, due to theatre utilisation, case mix and increased direct costs in relation to HRG tariff funding.

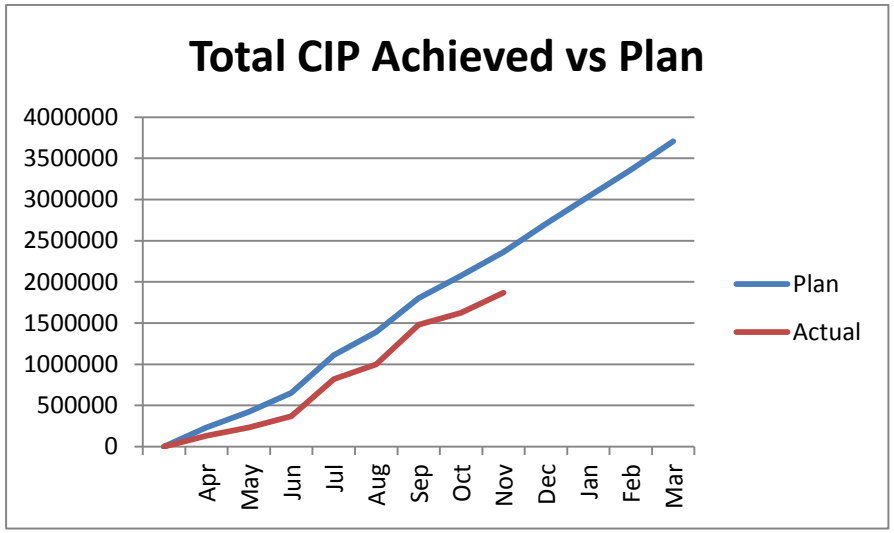
Currently services are being reviewed in terms of session planning for certain operation types to improve theatre utilisation and patient throughput.

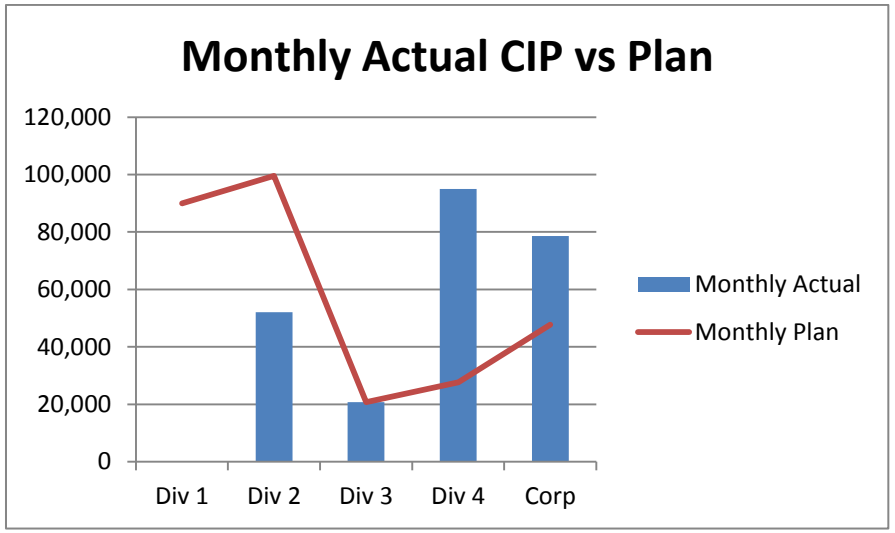
ACTIONS FOR IMPROVEMENTS / LEARNING

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

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2016/17





INFORMATION

As at the end of Month 8, the Trust has recognised £1,897k of CIP savings, against a plan of £2,276k. £579k (31%) of savings to date are non-recurrent. The in-month savings recognised were £246k against a November target of £349k.

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.
- Negotiations are ongoing with implant suppliers to achieve best value for money, in addition to consultants changing their implant usage in a number of areas.
- Business cases have been approved and recruitment in ongoing to support the transfer of anaesthetic and theatre staffing costs from agency to substantive.
- Review of the operational and executive structure.

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.

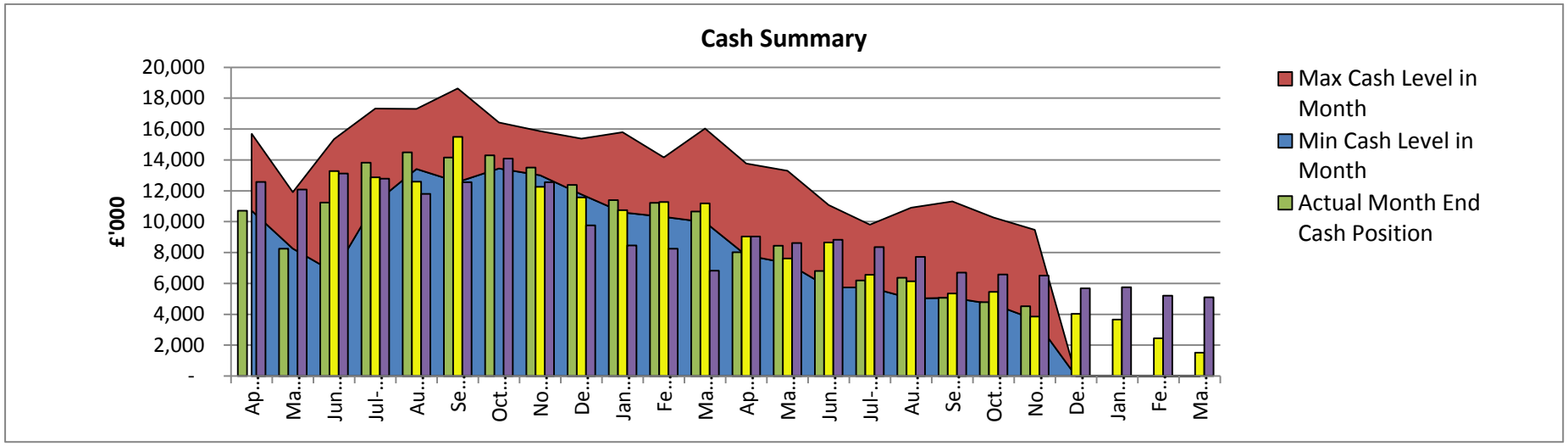
ACTIONS FOR IMPROVEMENTS / LEARNING

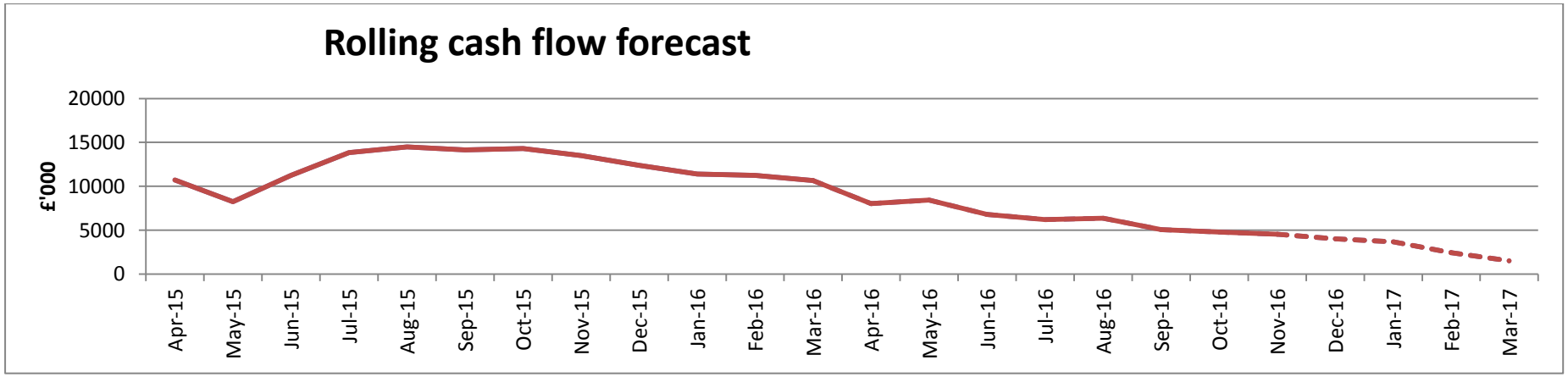
There are still gaps in some areas with regards to the required CIP documentation, largely relating to implementation plans and QIAs in Division 2. The Divisional Heads are progressing signoff with the Director of Operations, Nursing and Clinical Governance and the Medical Director.

RISKS / ISSUES

The CIP target of £3.67m represents a significant challenge to the Trust. It is vital that we remain on target despite increased pressures on costs as the Trust increases its activity in the remaining months of 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 £1.98m million lower than planned levels at the end of November 2016. The Trust is forecasting an end of year cash balance of circa £1.5m, which relies upon the delivery of our revised deficit plan and the control of capital spend within the budget that has been set.

Liquidity levels within the Use of Resources Rating remain at a 2, with cash likely to dip below £nil early in 2017/18.

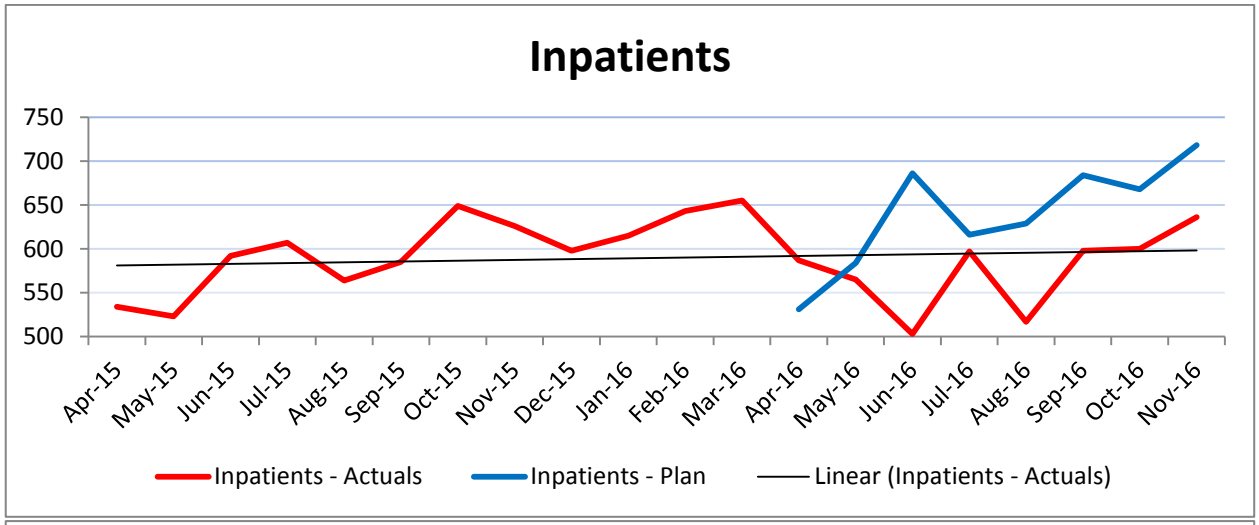
ACTIONS FOR IMPROVEMENTS / LEARNING

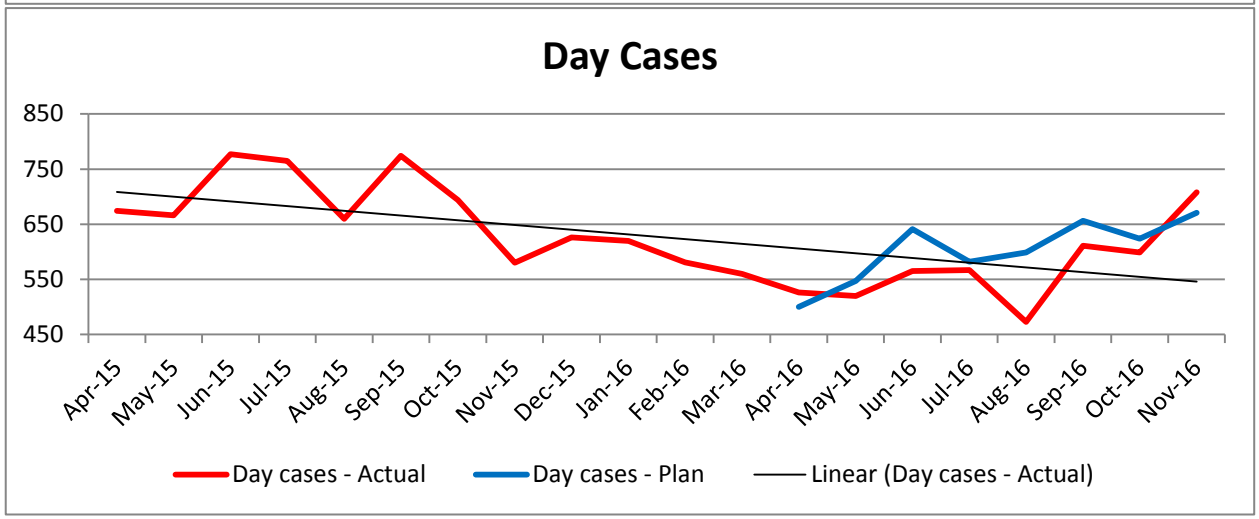
The Director of Finance is reviewing options for the receipt of a cash loan to support the running of the hospital in the new year.

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 in November was the highest it has been at an APC level since October 2015, although this is being significantly driven by an increase in day cases. Inpatient activity was the still the highest it has been this year, but remains below the levels delivered in February and March 2016.

ACTIONS FOR IMPROVEMENTS / LEARNING

3 of the 5 recovery workstreams relate to increasing activity, through increasing POAC capacity, increasing theatre efficiency and making discharge more efficient. These workstreams are being monitored against their detailed action plans and KPIs on a weekly basis through Recovery Board.

Some of the actions taken include the continue work in the "6,4,2" meeting 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.

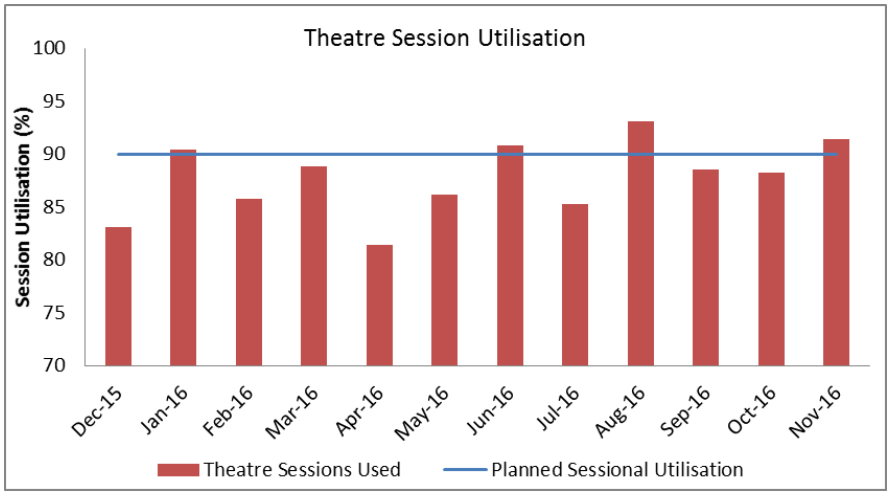
Significant engagement work is required across the clinical body and wider workforce to appreciate the scale of the challenge that is now facing the Trust to deliver the activity and associated income each week, in order to deliver the Trust's agreed financial control total.

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.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are planned (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we strive to cover at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis. We continue to fall well short of this due to surgeon annual and study leave and lack of prospective cover.

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 over time.

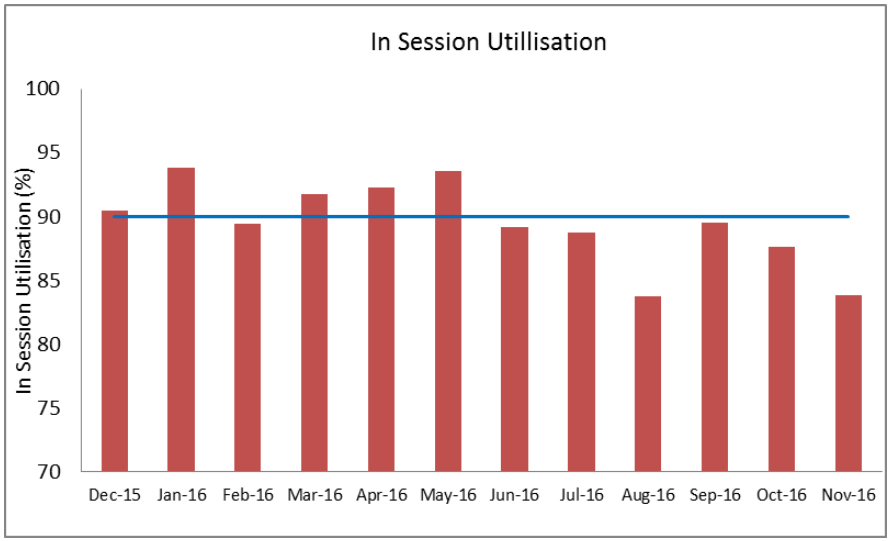
Some theatre lists are now being taken down in order that surgeons can do additional clinics, because some surgeons who are timetabled in theatres have now run out of patients. All reasonable efforts are made to recycle, including where it is deemed appropriate the use of sessions additional to job plan (paid ADHs.) Where lists are not recycled, the theatre staffing and anaesthetist are removed 1 week ahead, to reduce agency costs.

Over November, due to intensive scrutiny via 642, there has been an improvement in the recycling of sessions to above 90%; however, it should be noted that this was a month with lower surgeon leave (no school holidays) and a lower level of absence for study / professional leave.

RISKS / ISSUES

Engagement in the job planning process and delivery of timescales in Division 1. Notice required to establish buddying timetable arrangements and co-ordination of leave for surgeons evenly through the year.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained consistently above the target 85% (target adjusted as per methodology change below.) However, the previous measure (pre June) 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.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are a range of actions being undertaken to work towards improvement in theatre in session utilisation, focussing on start time, turnaround, optimal list composition and the eradication of unplanned overruns. Unfortunately, in session utilisation has dropped to below 85% in November, and with the exception of August is the worst performance in the last year. This has been due to a number of very late starts, and booking practices and last minute cancellations such that a number of lists have not been used to their maximum potential.

The implementation of the new Theatre Management System (Theatreman) now planned for February 2016 (slipped due to PAS interfacing issues) will be a further vehicle to ensure that lists are optimally booked based on the available time. Scrutiny and challenge is via the weekly 642 meeting, with instructions back through to the surgical teams to book lists to their maximum potential and to identify patients well in advance so that specific requirements can be planned for to reduce cancellations.

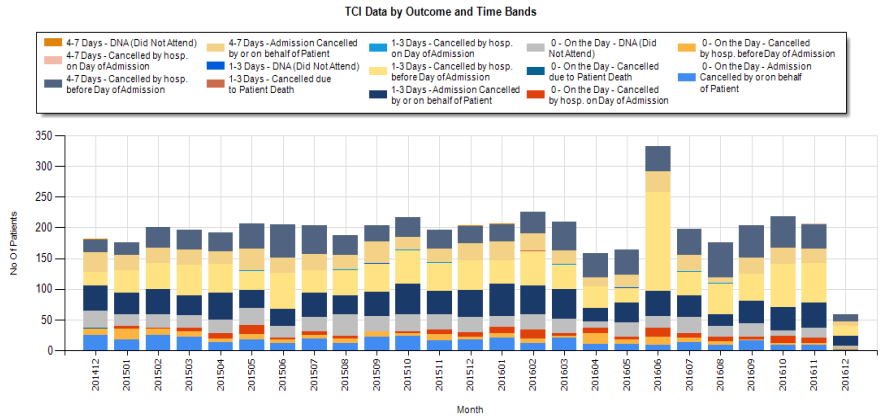
A new interim Head of Nursing with extensive experience of The Productive Operating Theatre is due to join the team from early January. Additionally, the Associate Medical Director Division 2 / CCIO has launched a new reporting suite that demonstrates individual theatre / consultant utilisation, and this was shared at Theatre User Group on 12th December.

RISKS / ISSUES

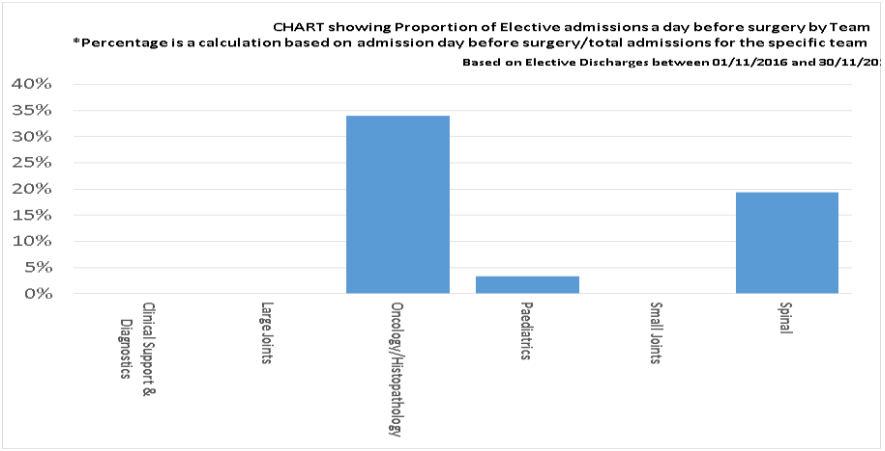
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (eg experience in spinal scrub) to ensure the best possible use of available operating time. Availability of radiographers (additional support now in place via agency.) Willingness of surgeons to fully book lists. Decentralised administrative arrangements leading to a lack of tactical control and grip. Gaps in experience in the operational management structure.

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

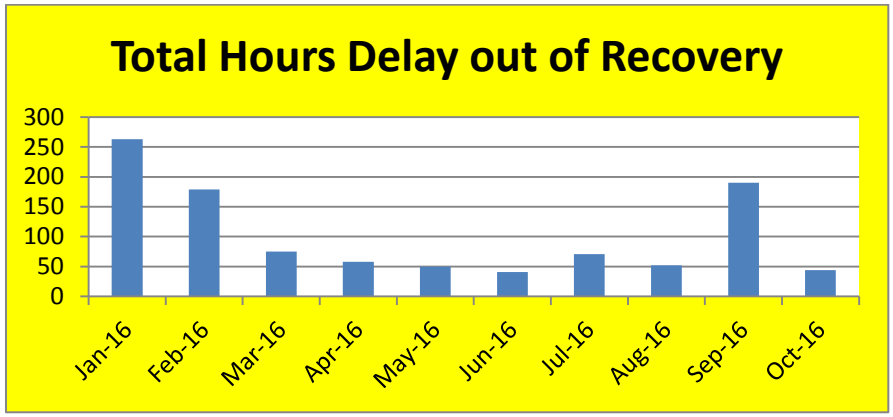
Cancellations by patient / hospital



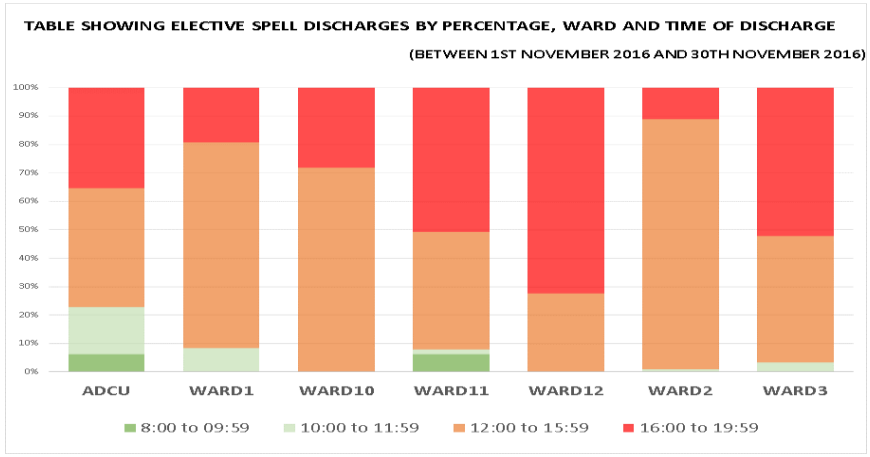
Admission the day before surgery



Delays out of recovery – TO UPDATE



Time of day patients discharged



INFORMATION

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Patients continue to be booked at very short notice, and well outside the expectation of 3 week's notice and 2 reasonable offers as per national guidance and our recently approved Access Policy. The booking of patients continues to follow a decentralised model with individual secretaries liaising with surgeons.

Short notice creates inefficiency, re-work and churn. It creates challenges at patient level (kit, HDU beds, imaging) if their requirements cannot be planned for in advance, creating delay and potential cancellation. 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.) The DGM Division 2 has led on a new SOP for cancellations and the escalation process to be followed, followed a CCG Contract Performance Notice with regard to the Trust's failure to achieve the 28 day rebook guarantee.

There continues to be great disparity with regard to waiting times between surgeons, and very limited pooling of patients for common procedures and pathways, as would be expected as part of normal business in other Trusts. 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. Good progress in transferring patients out of Recovery in a timely way has stalled in recent months because of staffing on the wards.

There have been no further breaches of the HDU / Recovery 4 hour mixed sex accommodation standard during October or November.

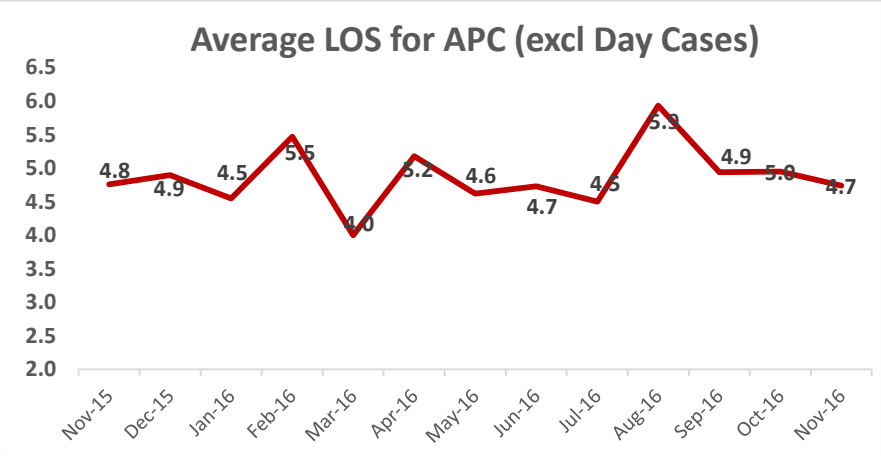
ACTIONS FOR IMPROVEMENTS / LEARNING

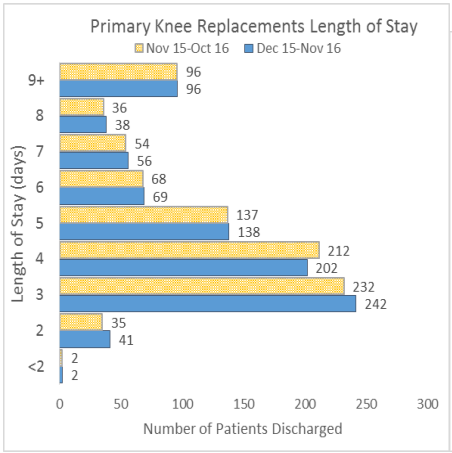
Continued work is required to ensure that all specialties have a pool of patients who are pre-op'd and available to be called in at short notice to fill cancellation slots. The concept of pooling of appropriate patients between consultants also needs to be undertaken to maximise efficiency.
Work is still required to agree criteria for admission the day before, to use beds more effectively and reduce length of stay. As activity increases in line with the Recovery Plan profile, it is important that these issues are addressed so that bed availability does not become a constraint to delivery. Pre-op improvements are also vital to increase productivity.

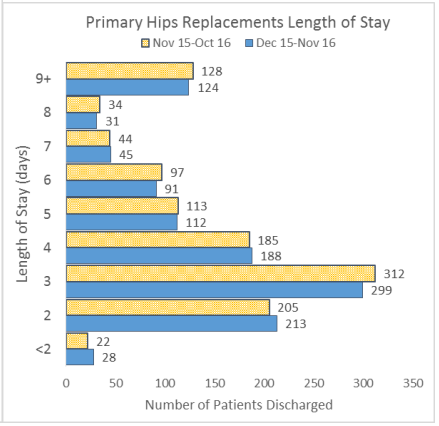
RISKS / ISSUES

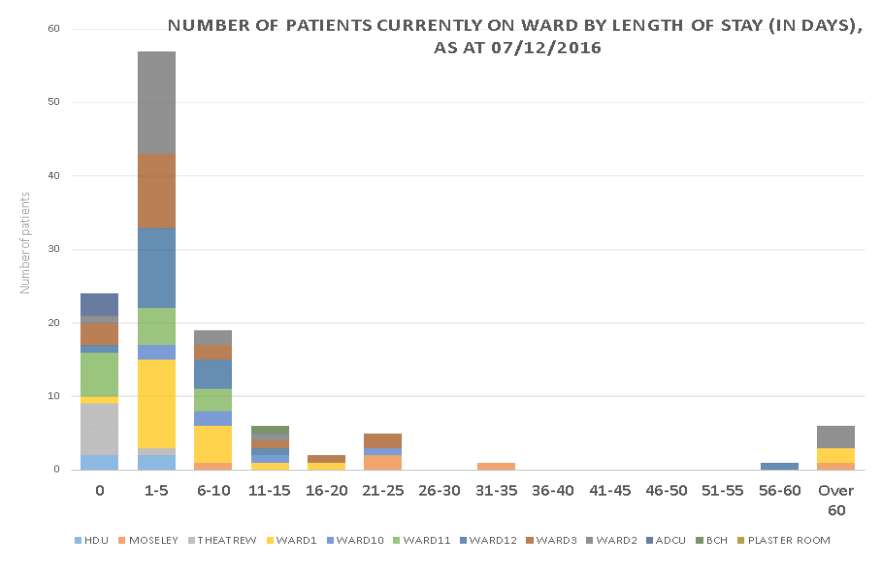
As activity increases in line with the profiled plan, it will become increasingly difficult to sustain admission before the day of surgery, and necessary to achieve a higher level of discharges before midday. There is no demonstrable progress as yet with "home before lunch", as can be seen from the graph. The increased capacity within POAC is required to ensure that sufficient numbers of patients are fit and ready for surgery. The prescribing pharmacists to support the model have been recruited and will start in post in the new year.
Given the high number of weekend lists being organised to deliver the required activity, there is a significant risk of staff burnout and fatigue, particularly given the high number of vacancies within theatres, as well as a financial risk if the number of cases and income achieved does not offset the increased costs.

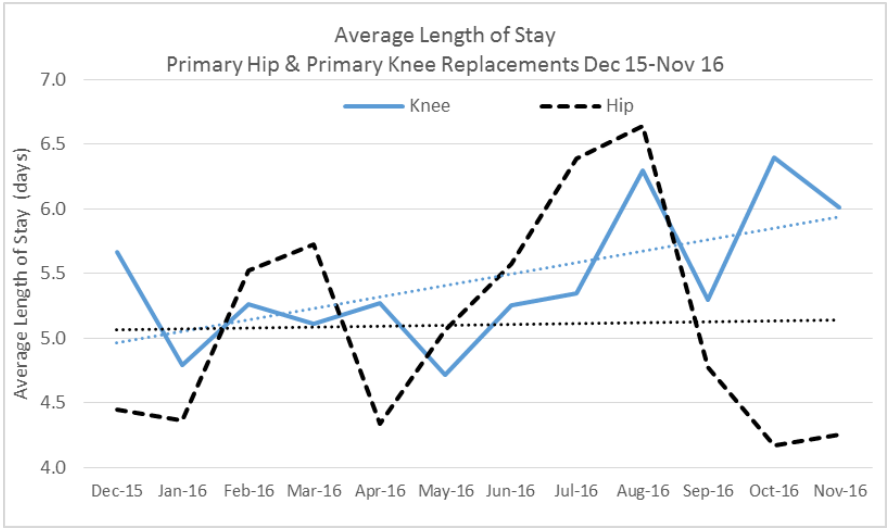
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Length of stay of for primary hips has shown early signs of improvement, and it is hoped that this links to the Rapid Recovery initiative. However, the linear trend primary knees remains upward, which is disappointing.

As at the end of November, 26 patients were being managed by the Trust's discharge nurse specialist. It is not clear whether this is good news as a result of earlier escalation by ward teams, or is a worrying sign of pressure in the system and constraints with regard to exit routes out of hospital for some of our more complex patients.

ACTIONS FOR IMPROVEMENTS / LEARNING

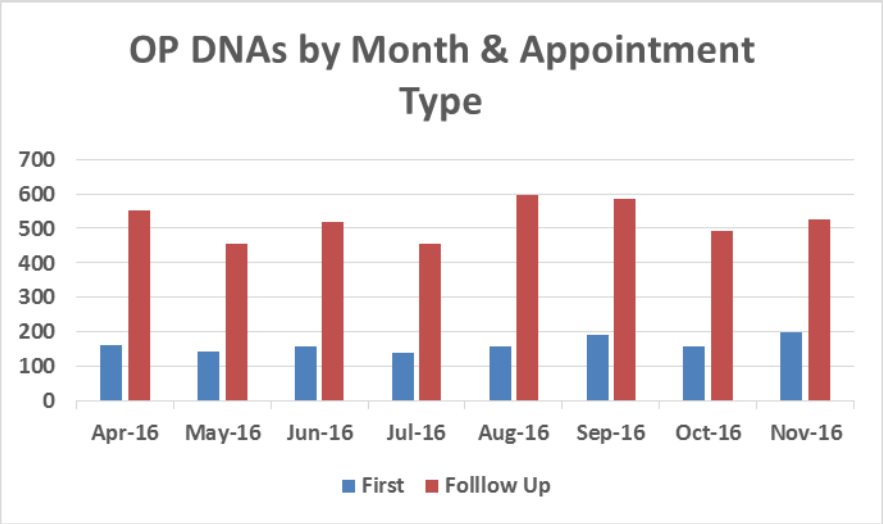
Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.

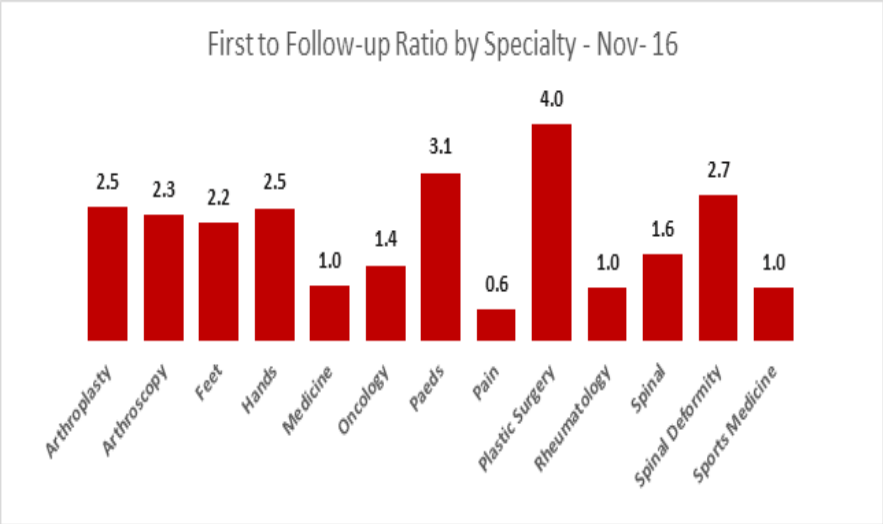
More formalised ward reviews should be part of consultant job planning discussions, which will be helpful in speeding up decision making and therefore shaving days off individual patient length of stay, or bringing discharge earlier in the day so that the bed can be recycled for incoming patients.

RISKS / ISSUES

With a defined bed stock, these changes need to happen at pace in order to deliver the level of activity required as part of the Trust's Recovery Plan.

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.

ACTIONS FOR IMPROVEMENTS / LEARNING

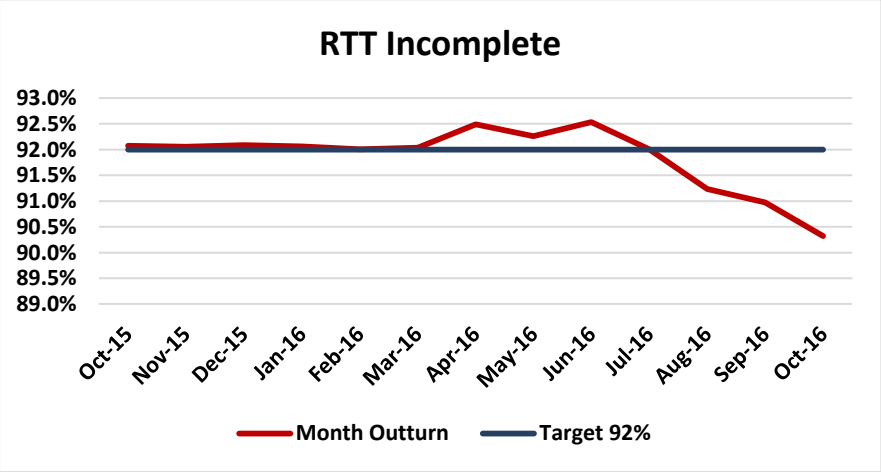
There are a range of actions as part of the CQC action plan and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

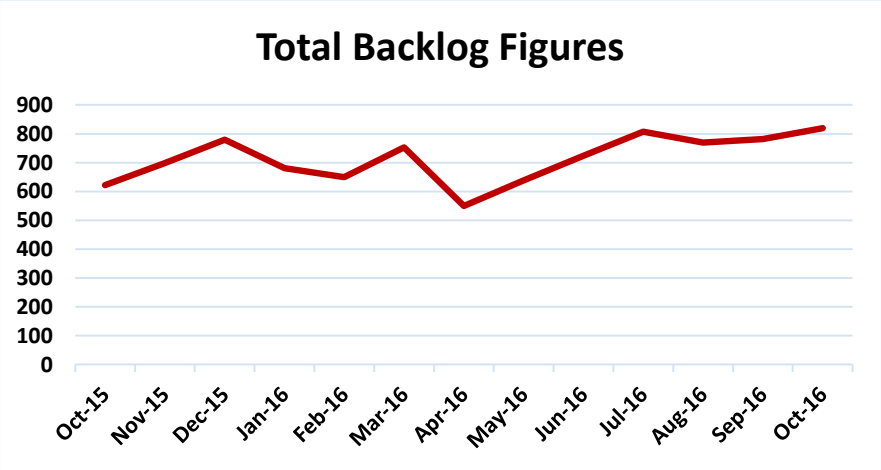
As part of the Trust's RTT recovery work, there will be a focus on outpatient pathways and any patients who are in the system awaiting a follow up appointment and have become overdue, for whom a new active RTT clock should be started in line with national guidance. Significant work is required with clinic templates to address the historic issue of "block booking" in the Oncology service, and so improve patient experience.

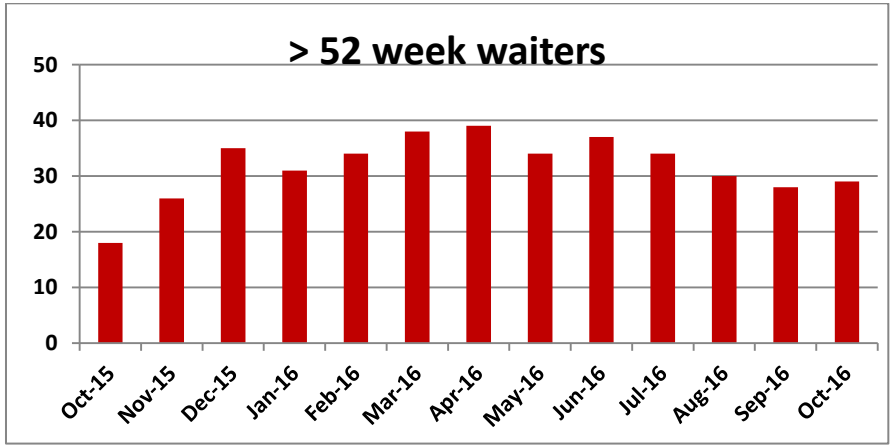
RISKS / ISSUES

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 - RTT	Target / Trajectory	Actual (October)	Actual (YTD)
52 Weeks Waiters	-	29	231
18 Weeks Incomplete	92%	90.32%	91.66%
NHSI Performance Targets - Cancer	**Target / Trajectory**	**Actual (November)**	**Actual (YTD)**
Cancer (2 week wait)	93%	100%	100%
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	98.11%
Cancer (31 days for 2nd or subsequent treatment)	94%	87.50%	95.71%
Cancer (62 days)	85%	No data	N/A

INFORMATION

RTT open pathway performance continues to be the main concern. The backlog continues to increase at a rapid rate for both admitted and non admitted pathways. The most recent externally reported performance is as follows:

- October: 90.3%
- November: likely to be no worse than 89%, but figure to be confirmed after validation. However, there are concerns around the robustness of pathway measurement.

The main issues (based on reported performance) are within arthroscopy, foot & ankle and spinal. The number of breaches within the pain service have increased due to consultant manpower, but a rectification plan is in place for this speciality.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are significant concerns with regard to data quality and the measurement of RTT waiting times. This has been escalated to NHS Improvement and other stakeholders, and was discussed at December Trust Board.

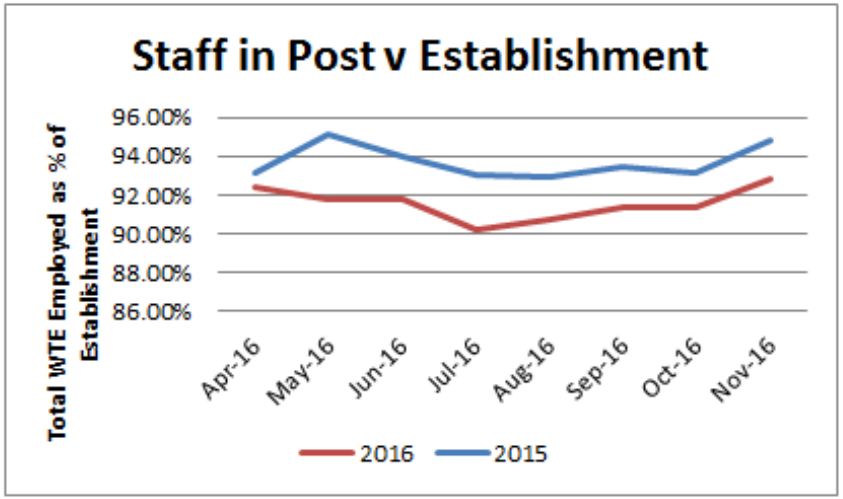
RISKS / ISSUES

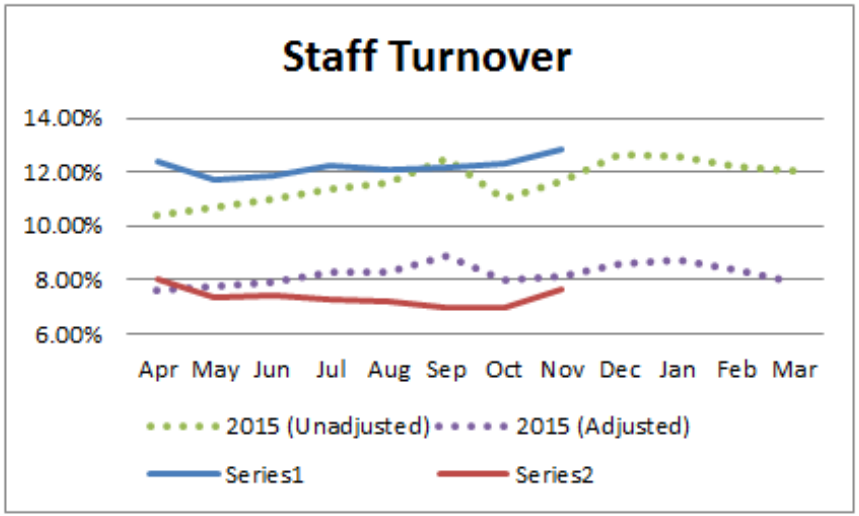
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further (end of November position to be confirmed, but likely to be 31.) Discussions continue with BCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern.

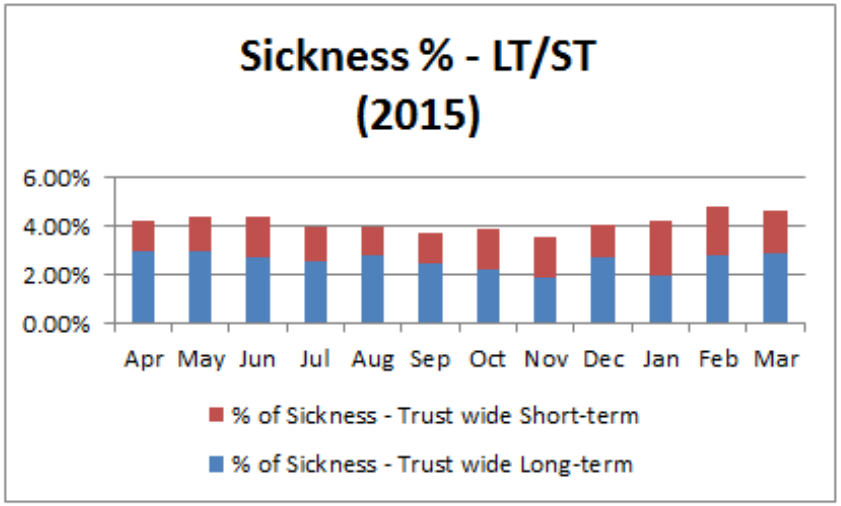
18 weeks: Significant work is underway to understand the scale of the challenge with regard to open pathways, and the extent of data quality concerns. The Trust welcomes the input and expertise of NHS Improvement in this area.

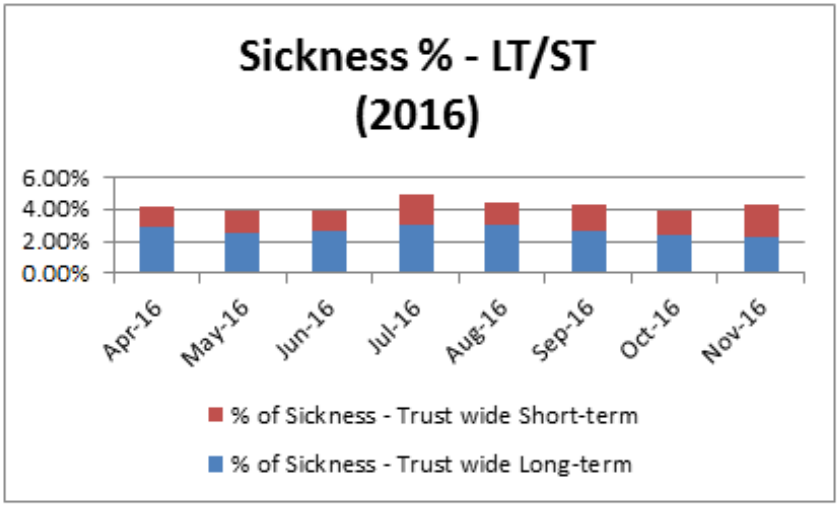
Given the concerns around RTT measurement robustness, the Divisional General Manager Division 2 is now undertaking some assurance work looking at cancer waiting times.

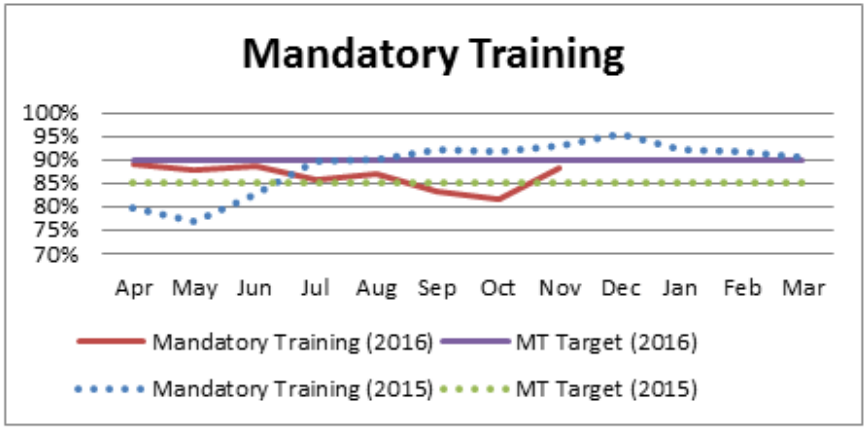
15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training.

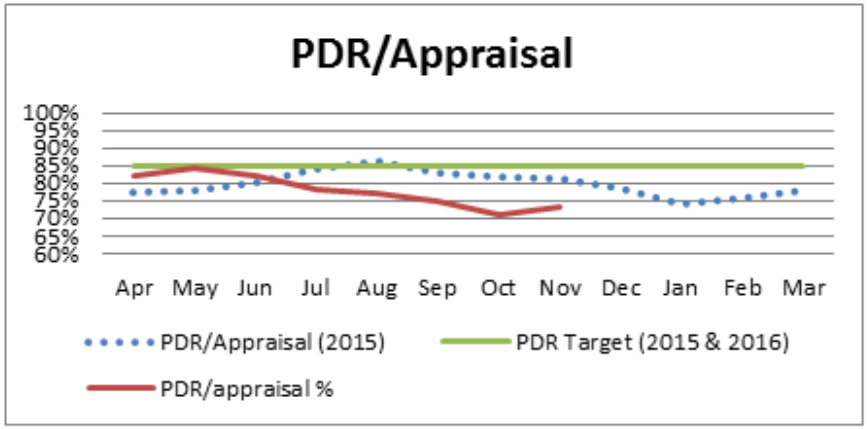












INFORMATION

The vacancy position saw a reduction in November to 7.2%. This is the 5th consecutive month where the gap has been closed and reflects good progress.

November has seen an increase in sickness absence by 0.37% versus the reported October position. Whilst progress in reducing long term sickness absence has been maintained for the 5th consecutive month, November saw an unusual amount of short term sickness which has caused the deterioration.

Mandatory training increased by a significant 7% in month. This has been achieved by provision of an additional session (increase in training capacity) together with release of appropriate staff. This is good progress.

PDR/appraisals has increased this month by 2%, so the decline of the last 5 months has stopped – but the Trust is still red and needs to improve its performance in this area.

Unadjusted turnover figure (all leavers except junior doctors in training and retire/ returners) and the adjusted turnover figure ("true leavers") were both higher than last month. Further work is being undertaken to analyse reasons for leaving to identify any causes for concern in the unadjusted figure because this is now red, but the "true leavers" remains green, despite the increase.

Turnover does tend to increase slightly in November and December at ROH but good performance in 2015 has been replaced with more typical figures in 2016, reflecting a worsening position.

ACTIONS FOR IMPROVEMENTS / LEARNING

Divisions will be asked to explain their plans for appraisal progress in their performance review meetings to improve their position.

RISKS / ISSUES

The Trust have now been issued with a compliance notice from our commissioners in relation to statutory and mandatory training and appraisal.

ROHTB (1/17) 008

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Quarter 3 2016/17 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**11th January 2017**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at December 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 two new risks 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 1074 – Risk of utilising the cash reserves of the organisation, resulting in a risk to going concern and a requirement to seek funding to allow continued organisational operation.

  Risk 1048 – Poor administration of 18 weeks RTT due to lack of understanding of current national guidance, a PTL that is not fit for purposes and data quality issues with the administration of patient pathways

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

ROHTB (1/17) 008

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	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 October 2016

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK Q3 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	January 2017: The Trust has in place a recovery plan which has been approved by the Trust Board and NHS Improvement. Several workstreams underpin this plan, aimed at controlling costs and eliminating inefficiencies.	F&P overview; Monthly Performance Reviews; Transformation Board Reports; Audit Committee – Review of contract risk; Weekly activity / income reports at Exec Business Meeting ; Monthly Performance Reviews;	4	4	16	↔	The Trust continues to pursue efficiency gains through its Recovery Programme. Further discussion regarding the impact of tariff is underway with regulators and commissioners as part of the contract 2017/18 - 18/19 negotiations.	Ongoing	2	4	8
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	January 2017: Progress made on management programmes. MSP programme due to start mid Jan 2017. Work currently being undertaken on consultant induction (onboarding) programme and CSL development programme. 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	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.	Q4 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	January 2017, September 2016: Existing work engaging staff in strategy development and communication. 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).	Q4 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	January 2017 & October 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, we are still optimistic 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	5	15	↔	Development of the data warehouse and ongoing development of in house intelligence	Q4 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	January 2017: 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. The Trust is a key partner within the Birmingham & Solihull STP.	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: NHSI 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 financial overview considered by the FPC & Trust Board. Papers on STP involvement & progress to Trust 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	January 2017, September 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	Q4 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	January 2017: Throughout 2016 the Trust board has been involved in a review and refresh of the 5 year strategy. This has been reviewed at a Board away day in May, and subsequently at the board meetings in July and October. The Board decision was taken that the refresh should be slowed to enable external factors such as the STP and the National Vanguard to be an integral part of the future strategy. The strategy will form part of the future work package, once the STP has been refreshed and accepted by NHSE. This work will continue into 2017/18 financial year.	Transformation Committee meetings and regular reports to Trust Board; Staff satisfaction; Patient satisfaction; Clinical engagement	3	3	9	↔	This will continue to be shaped as the STP is developed and signed off, following major review and re-write in the light of feedback from NHSE.	Ongoing	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	January 2017: 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 recovery programme & operational plan for 2017/18 - 18/19 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 delivery of recovery plan workstreams and continuing to engage with local, national and international partners (where possible) to pursue growth and innovation opportunities.	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. New strategic alliances expected to come to fruition during 2017/18 and further discussions on the impact of the new orthopaedic tariff are underway.	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	January 2017: The tariff for 2017/18 - 18/19 has been received and has been modelled for impact. The risks associated with operating with this tariff have been made clear in discussions with regulators & commissioners and outlined within the Trust's operational plan submission for 2017/18 - 18/19.	Reference costs submissions Audit report on costing process 2017/18 NHS contracts Director of Finance sits on national PbR technical working group to influence tariff development.	3	4	12	↔	SOA has written to the CEO of NHS Improvement to ask for support on resolving the long standing problems with the orthopaedic chapter. This support has been endorsed by the CEO of NHS Providers. Discussions are continuing with the Pricing Unit.	Mar-17	2	4	8

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	January 2017: The Governance Team have good presence at divisional management board meetings. Incident reporting has improved and risk management is being strengthened. Quality of Root Cause Analyses has markedly improved, a view supported by Commissioners.	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	↔	New Governance Facilitator recruited and due to start in Quarter 4 2016/17. Head of Governance role filled. Corporate Governance Officer started in post from September 2016 and is working to strengthen and educate on risk management and litigation. 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 is filled by a Fixed Term Appointment.	Q4 2016/17	1	3	3
S832	Ops	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	January 2017: Membership of Birmingham & Solihull STP arrangements; 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; Strategy refresh approved by the board in October 2016.	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	January 2017: Patient Quality Report reviewed by the Board in public sessions. CoG review of performance reports and quality metrics. 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. Governor representative regularly attends Quality & Safety Committee meetings.	Representation from the CCG at Q&S Committee. Patient quality report to QS every month. Patient safety & Quality Report; 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.	Q1 2017/18	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	January 2017: HDU requires 10.6 FTE nurses. Recruitment has been successful to achieve 6.6 FTE from Jan 17 with an additional long term agency nurse secured to give 7.6 WTE. The mitigation of adult nurses with Paed competencies continues to be used in the absence of two registered Paed nurses on duty.	Paed nurses recruitment plan. CQC action plan; SOPs; critical care passport evidence portfolio; presentation for CQC Quality Summit. RCPCH action plan.	3	3	9	↔	• E –rostering has been implemented and will be embedded over coming months. This 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.	Q4 2016/17	2	2	4
269	Fin	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	5	4	16	January 2017: Fines removed for waits in excess of 18 week RTT. Recovery plan has been developed and approved by Trust Board and NHSI. Recovery days organised, aimed at recovering lost ground during the theatre closures in June 2016. A weekly executive-led Recovery Board is in place to add additional scrutiny to recovery arrangements & progress.	Recovery plan; minutes of Trust Board & Finance & Performance Committee; Finance overview; outputs from daily huddles.	4	4	16	↓	Relentless focus on recovery during Quarter 4, with ongoing monitoring of & challenge on progress.	Q4 2016/17	3	4	12
7	OPS	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	January 2017: At present ROH are not seeking extra capacity with private partners. Plans progressing with BCH to fully utilise the additional lists.	Activity reports to the Board on a monthly basis within Finance Overview; correspondence with NHS England and BCH. Minutes from Finance & Performance Committee.	4	4	16	↔	Discussions with NHSE and BCH are ongoing. Board decision to be taken in Q4 2016/17 regarding the future direction of spinal deformity services.	Q4 2016/17	3	4	12
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	January 2017: Expenditure has decreased by £100K (20%) in 2 months. Actions continue to be taken to reduce demand and ensure optimum temp workforce supply at best rate. October 2016: Agency spend and usage continues to be a concern. Bank and Agency forum now established to review temporary staff usage. Director of Nursing, Operations & Clinical Governance taking more direct oversight.	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. Weekly reports to recovery board. Weekly action log from BARG	3	3	9	↔	POAC workforce model to be implemented from Jan-17. Finalising mid-level cover workforce model. Implementation of revised Theatre bank rates from 1 February 2017. Continuation of Theatre recruitment	Q4 2016/17	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	January 2017 & 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 'Clinical Audit' 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 given to Quality & Safety Committee in Autumn 2016, with further plans to roll out using innovative technology & approaches. This is a Quality Priority within the 2016/15 Quality Account for the current year.	Q4 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	January 2017 & October 2016: PROMS data is released by NHS digital on a quarterly basis next due on 10th November, at the moment there is no update to the risk as there has been no new data since the last update. PROMs is also discussed at the Clinical Audit and Effectiveness Committee but there was no changes to the risk at the last meeting.	Report to QSC; national comparative data; PROMs scores by consultant	3	3	9	↔	Continued monitoring by the Clinical Audit & Effectiveness Committee	Q4 2016/17	2	3	6
770	Ops	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	January 2017, November & October 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	Estates maintenance schedule	4	4	16	↔	This continues to be a risk to the operations of the organisation. The theatre maintenance programme for 2015/16 will give a degree of longevity to the equipment. Because of the age of theatre 1, 2 and 4 it is not possible to mitigate the engineering risk as the equipment is no longer produced in the UK. This cannot be mitigated fully until new theatres are built. Capital programme reviewed by the Executive Team, led by the Director of Finance	Q4 2016/17	2	2	4
1028	Fin	Tony Eardley	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	December 2016: No reported to change to network access - no users logging faults. Migration to HSCN becoming clearer and Trust is in discussion with the LDR group about procurement options. Need to respond to NHS Digital later this month with preferred route.	IM & T Programme Board minutes	3	4	12	→	Business case to be considered by the Trust Boa	Q4 2016/17	2	4	8
1030	Ops	Neil Rogers	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	January 2017. Capital bids for 2017 have been submitted and prioritised, and the outcome of funding awards is awaited. All individual risks associated with individual items of equipment will be reviewed based on the outcome of the capital round. August 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	↔	None identified	Ongoing	2	2	4

1031	Ops	Neil Rogers	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/F & PC	4	4	16	January 2017. Good progress has been achieved with the implementation of EDC Gold as the Trust's new stock management system. The electronic feeds are working and the Biomet Zimmer shoulder range is on the system. There is a plan in place to have all Biomet Zimmer range on system by end January, followed by all other implants based on the implant rationalisation programme outcomes. October 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.	Audit Committee minutes from December 2016; Finance Overview	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. Implementation of EDC Gold is expected to mitigate this risk to target level.	Q1 2016/17	2	2	4
1074	Director of Finance	Alex Gilder	NEW RISK ADDED: Risk of utilising the cash reserves of the organisation, resulting in a risk to going concern and a requirement to seek funding to allow continued organisational operation.	Safe and efficient processes that are patient-centred	F & PC	4	4	16	Monthly scrutiny of cash balance and Use of Resources rating (which includes liquidity) through F&P finance report, with additional oversight through TMC and Board. Spending controls through the use of Scheme of Delegation and delegated limits for individuals throughout the Trust. External audit completed at each year end reviews cash and going concern assumption	Finance Overview. Operational Plans for 2017/18 - 18/19	4	4	16	NEW	Continued focus on efficiency and cost control t	Q4 2016/17	4	2	8
1048	Director of Operations, Nursing & Clinical Governance	Jo Phillips	NEW RISK ADDED: Poor administration of 18 weeks RTT due to lack of understanding of current national guidance, a PTL that is not fit for purposes and data quality issues with the administration of patient pathways	Safe and efficient processes that are patient-centred	Trust Board/TMC	4	4	16	Development continues on the web based Patient Tracking List (PTL). The reporting function is being developedand will be required before existing PTL is 'switched off'. Some data quality and administration practices have been uncovered that put the Trust's 18 week RTT performance at risk. This is being managed through a significant programme of validation using external expertise.	Updates on 18 weeks RTT to Trust Board in December & to TMC and Executive Team.	4	4	16	NEW	An action plan is being developed to address issues raised through RSM Audit. Action plan will be monitored through Data Quality Committee and TMC.	Q4 2016/17	3	3	9

The Royal Orthopaedic Hospital NHS
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QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	30 November 2016
Guests	Dr Bill Rea – Chair of the Drugs & Therapeutics Committee
Presentations received	None
Major agenda items discussed	• Upward report from the Drugs and Therapeutics Committee • Upward report from Clinical Quality Committee • Upward report from the Children's Board • Quality & Patient Safety report • Internal audit into compliance with Controlled Drugs regulations • Corporate Risk Register • Divisional governance update • Quality & Safety Committee terms of reference
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Board	• Consent was discussed, where it was noted that the policy needed to be updated to reflect that gaining consent is also undertaken by non-medical staff. • There appeared to be lack of visibility around ownership of the annual quality priorities; work was planned by the Director of Operations, Nursing & Clinical Governance to address this. • A Central Alerting System (CAS) alert around storage of injectable drugs was discussed in some detail as part of the upward report from the Drugs & Therapeutics Committee. From September 2017, storage of solutions such as saline and chlorohexidine would need to be kept in closed systems and not in receptacles such as gallipots. The impracticalities and preparation for this change in practice were the subject of debate between Committee members and the Chair of the Drugs & Therapeutics Committee. • A risk assessment around unlocked drugs cabinets in theatres had been completed and the positon adopted was in line with the requirements of the Royal College of Anaesthetists. • It was reported that the Trust does not record exceptions on drugs fridges robustly. The financial implications of this needed to be considered by the Trust management

	Committee and the use of Charitable Funds for this purpose also needed to be considered. • The Committee was made aware that there remained long waiting times in spinal deformity and was appraised of a particular situation when a child's operation had been cancelled several times. The Board would be asked to debate the practicalities around continuing to accept referrals onto an increasingly lengthy waiting list. • The Committee was updated on a patient death which had occurred when an individual had been transferred to another acute provided following an operation at the ROH. • The internal audit into Controlled Drugs handling was reviewed. The report had provided 'reasonable assurance' however the Committee was satisfied with the assurances provided on progress with addressing the recommendations, a matter which would be considered by the Audit Committee at its meeting on 9 December. • The Committee was advised that the 18 weeks referral to treatment time target had not been met for the third consecutive month and there were some data quality concerns which would need to be validated. The Board would receive a more comprehensive update at its meeting on 7 December. • It was reported that the Trust had received two contract performance notices; one around readmissions within 28 days in the event that the Trust cancelled an operation and the second being around mandatory training.
Positive assurances and highlights of note for the Board	• The long standing risk around blood management was closed, given that the blood fridges had been relocated. • A new Deputy Director of Nursing had been appointed and would commence work in the Trust in spring 2017. • Good progress was reported in terms of developing the Children's Board. Several workstreams of improvement are underway including development of specific Paediatric patient policies and improving the visibility of risks around Paediatrics.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A further update on progress with preparing for the new standards around storage of injectable medicines was requested for the next meeting. • An update on consent was requested for the next meeting. • An update on the Trust's adherence to national guidance around pre-operative starvation was requested for the next meeting. • Letters sent to parents of children waiting for spinal deformity procedures are to be shared at the next meeting.
Decisions made	• The Committee approved its revised terms of reference which had been updated as part of the annual review and

	agreed that they should go forward to the Trust Board for ratification.

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

For the meeting of the Trust Board scheduled f

or 7 December 2016

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	9 December 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 progress report • Counterfraud update • Review of progress against stock action plan • Review of progress against 18 weeks referral to treatment time action plan • Recommendation trackers • Contract risk review • Audit Committee terms of reference • Audit Committee self-assessment • Quality & Safety Committee feedback
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• As part of the update on external audit matters, it was reported that cash modelling had indicated that cash support for the next year might be needed; NHS Improvement had been approached in this respect. The Trust's Going Concern status remained an area of focus for the auditors. • Contracts needed to be signed with commissioners by 23 December, although negotiations were complex given the alteration of funding allocations from previous years. • The Committee received a presentation on progress against the stock action plan, which provided both positive assurances on the process for managing theatre stock and some continued areas of risk, these including settling on a valuation for theatre trays in the system, agreement of set prices for stock, residual issues with defining consignment and non-consignment stock, storage space & facilities and the need to better forward plan kit required as part of setting theatre lists. The highest risk to robust stock management and to addressing the issues highlighted in the internal audit report appeared to be the reliance on the implementation of new systems, namely EDG Gold, the

	stock management system and Integra 2, the electronic procurement system. • The Committee received an update on the progress with the 18 weeks referral to treatment target action plan which had been developed following an advisory piece of work undertaken by Internal Audit. There were some data quality issues that had appeared to have surfaced, which needed to be investigated further. There had also been a failure to meet the 18 weeks RTT position for a number of consecutive months. The position needed to be reflected in the Quality Account when it was produced. • The Committee reviewed the audit recommendation trackers. It was of concern that there appeared to be a number of actions that had not been closed in a timely manner, although there was some further work to do to understand progress with completing these. It was agreed that the trackers needed to be revisited at the next meeting and in the meantime there should be good attention on ensuring that those responsible closed their actions or attend the next meeting to be held to account. • The Director of Finance guided the Committee through a set of risks to the contract with commissioners for 2017/18, including fines and achieving the income associated with CQUIN schemes which were more challenging than in previous years. • The Chair of Quality & Safety Committee advised that a new standard was due to come into force around injectable material from September 2017. It was suggested that an audit on the implementation plans for this was needed to confirm the robustness of the arrangements.
Positive assurances and highlights of note for the Board	• The internal audit plan was reported as being on track for delivery as planned. • The presentation on stock management highlighted a number of areas of improved assurance, including the plans to implement an electronic stock management system which was currently being trialled on one of the lines of stock and would be rolled out to other materials by the end of March 2017. There was good progress with stock rationalisation. A representatives policy had been agreed through the Trust Management Committee adding additional rigour to the presence and activities of reps in the organisation. Enhanced access controls to theatres had been introduced and better arrangements for sign out of stock had been put into place, including the establishment of a physical counter. A report was in place to report on stock wastage, to give greater visibility to this. • The Controlled Drugs audit had been discussed by the Quality & Safety Committee, which suggested that there

	appeared much better assurance on the arrangements and therefore a reaudit should be undertaken to reassess the level of assurance that could be provided. • The Committee was comforted by the work being undertaken to address the issues raised by the review of 18 weeks RTT management, including the validation work underway to confirm the extent of the data quality issues, the plans to create a more robust patient tracking list and the introduction of a revised Patient Access policy.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Further updates were requested for the next meeting on the implementation of EDG Gold, 18 weeks RTT action plan and recommendation tracking • The Associate Director of Governance & Company Secretary was asked to arrange a meeting between the Chair of Audit Committee, Vice Chair and the new Freedom to Speak Up Guardian ahead of the report on whistleblowing due to be presented at the meeting in February 2017. • The self-assessment of the effectiveness of the Audit Committee would be presented at the February 2017 meeting
Decisions made	• The Audit Committee agreed that its revised terms of reference should be presented to the Board for approval at its next meeting - the changes proposed are predominately cosmetic and minor in nature, reflecting a change to the Committee's secretariat and an insertion to clarify that the Committee is able to request the attendance of any director or manager to help it with its discussions and assurance seeking. The terms of reference are attached to this report for approval.

Rod Anthony
NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Trust Board scheduled 11 January 2017

The Royal Orthopaedic Hospital NHS
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Royal Orthopaedic Hospital NHS Foundation Trust

Audit Committee

1 Constitution

The Board hereby resolves to establish a Committee of the Board to be known as Audit Committee. The Committee is a non-executive
Committee and as such has no delegated authority other than that specified in these Terms of Reference

2 Delegated Authority

The Committee has the following delegated authority:
2.1.1 The authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee;
2.1.2 The authority to take decisions on behalf of The Trust Board on matters relevant to the objective of the Committee; and,
2.1.3 The authority to establish Sub-committees. The Committee shall determine the membership and terms of reference of those Sub-committees.
2.1.4 The authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

3 Accountability

The Trust Board

4 Reporting Line

The Trust Board and Council of Governors (for specific matters)

5 Objective

To provide independent oversight and scrutiny of compliance and effectiveness across the whole organisation and all its functions. Internal and external auditors are a key means to providing that assurance**.**

6 Duties

The Committee will deliver its Objectives by seeking assurance across the following areas:

6.1 Internal control and risk management

6.1.1 To ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance.
6.1.2 To maintain an oversight of the foundation trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control related disclosure statements.
6.1.3 To review the adequacy of the policies and procedures in respect of all counter-fraud work.
6.1.4 To review the adequacy of the foundation trust's arrangements by which foundation trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.
6.1.5 To review the adequacy of underlying assurance processes that indicate the degree of achievement

of corporate objectives and the effectiveness of the management of principal risks.

6.1.6 To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

6.2 Internal audit & counter fraud

6.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

6.2.2 To oversee on an on-going basis the effective operation of internal audit in respect of:

- Adequate resourcing
- Its co-ordination with external audit
- Meeting mandatory Public Sector Internal Auditing Standards.
- Providing adequate independent assurances;
- Meeting the internal audit needs of the foundation trust.
- Delivering the agreed internal audit programme.

6.2.3 To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.2.4 To consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.

6.2.5 To conduct an annual review of the internal audit function and market test at least every 5 years.

6.2.6 To ensure that appropriate processes and resources are in place to support the detection and prevention of fraud.

6.2.7 To consider the major findings of counter fraud investigations and management's response and their implications and monitor progress on the implementation of recommendations.

6.3 External audit

6.3.1 To make recommendations to the Council of Governors in respect of external auditors covering:-

- Appointment
- Reappointment
- Removal

To the extent that recommendations are not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendations were not adopted.

In support of the above the Audit Committee will make a report to the Council of Governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable the Council of Governors to consider whether or not to re-appoint them.

The Audit Committee will approve the remuneration and terms of engagement of the external auditor. Consideration should be given to assessing the auditors work and fees on an annual basis, and there should be a market testing exercise at least once every 5 years.

6.3.2 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

6.3.3 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

6.3.4 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

6.4 **Review of Annual Report & Accounts, incorporating the Quality Account**

6.4.1 To review the annual statutory accounts, before they are presented to the board of directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes
- Areas where judgment has been exercised
- Adherence to accounting policies and practices
- Explanation of estimates or provisions having material effect
- The schedule of losses and special payments
- Any unadjusted statements
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
- The Trust's going concern status and any disclosures associated with this

6.4.2 To review the annual report and statement of internal control before they are submitted to the board of directors to determine completeness, objectivity, integrity and accuracy.

6.4.3 To receive the Annual report and associated annual opinion from the HOIA and to consider the AES is consistent with this opinion.

6.4.4 To review the annual quality account before it is submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

6.5 **Standing orders, standing financial instructions and standards of business conduct**

6.5.1 To review on behalf of the board of directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

6.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

6.5.3 To review the scheme of delegation.

6.6 Other

6.6.1 To review performance indicators relevant to the remit of the audit committee.

6.6.2 To examine any other matter referred to the audit committee by the board of directors and to initiate investigation as determined by the audit committee.

6.6.3 To annually review the accounting policies of the foundation trust and make appropriate recommendations to the board of directors.

6.6.4 To develop and use an effective assurance framework to guide the audit committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

6.6.5 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health (and social care) sector and professional bodies with responsibilities that relate to staff performance and functions.

6.6.6 To review the work of all other foundation trust committees in connection with the audit committee's assurance function.

6.6.7 To produce an annual report for Trust Board covering the activity and effectiveness of the Audit Committee.

6.6.8 To report to the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

7 Permanency

The Committee is permanent

8 Membership

Chair

A suitably qualified non-executive Director. 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

At least two other NEDs

9 Quorum

The Chair and one other NED.

10 Secretariat

~~PA to Director of Finance~~ Associate Director of Governance & Company Secretary

11 In attendance, by invitation

Regular attendance

Director of Finance
Internal Auditors
External Auditors

Occasional attendance

Chief Executive
Chairman

The Committee may request the attendance of any director or manager to seek assurance on progress of key pieces of work or plans to address audit recommendations.

12 Internal Executive Lead

Director of Finance

13 Frequency of meetings

Not less than 5 times per annum

14 Work programme

The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document which steers the agenda for the committee. Progress should be updated for each meeting via rolling action notes

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15 Review of terms of reference

This should be undertaken annually.

16 Date of adoption

17 Date of review ~~October 29th 2014~~ 9 December 2016

The Royal Orthopaedic Hospital NHS
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FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	20 December 2016
Guests	None
Presentations received and discussed	None
Major agenda items discussed	• Stock & standardising materials (matter arising) • Sharing consultant-level information (matter arising) • HR framework & optimising vs. safe staffing levels (matter arising) • Finance & Performance Overview – Month 08 • Financial recovery: workstream update • Cancellations • Operational & Financial Plans 2017/18 – 2018/19
Matters presented for information or noting	• Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• It was noted that there was further work to do to robustly enforce leave rules across the consultant body, such that there was adequate cover for all theatre lists • As part of the monthly finance & performance overview, it was reported that there remained underperformance against the original activity target. The CIP savings were noted to have flattened, although there remained confidence that the overall target would be achieved by the year end. Theatre utilisation in November was poor, as the theatre scheduling process was not yet robustly embedded. Admission on the day before surgery remained a challenge and impacted adversely on the bed day cost per patient. Performance against the 18 weeks Referral to Treatment target remained below par at 89.5%. • The Committee received an update on cancellations, which showed that the positon was still unacceptably high. The majority of cancellations were due to patients being medically unfit for surgery and therefore work was underway to understand the processes in the Pre Operative Assessment Unit that prevented patients being admitted when they were not for surgery. It was agreed that addressing this position needed to be a priority. • The operational & financial plans for 2017/18 – 2018/19 were reviewed and the risks associated with meeting the

	set control totals and other performance targets were noted. The impact of the changes tariff for orthopaedics was highlighted to be impacting significantly on the position. Additional cost pressures were noted to be associated with increased NHSLA premia, costs associated with implementing the Royal College requirements and new IT systems. • Contracts with commissioners remained to be finalised, therefore the risk of submitting an operation plan ahead of this was highlighted, particularly in terms of forecast activity
Positive assurances and highlights of note for the Board	• Good progress continued with stock and implant rationalisation; a specific piece of work was underway with the large joints firm which was yielding good results in terms of eliminating variation • Consultants were being provided with detailed information to help them make decisions. Comparative and benchmarking data was also beginning to become available. • A small surplus had been made during the month, with the trust over performing against the recovery trajectory • Pay costs had declined, particularly in agency spend, which had reduced to £360k from a high of £450k. • There had been encouraging improvement in activity undertaken during the month. • There was overall good engagement across the organisation with the recovery work, including by ancillary groups such as portering. • A weekly Executive-led recovery board was in place to challenge and scrutinise the recovery position. • Targeted work was being undertaken with the Oncology team to revise and reinvigorate existing processes within the team.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Further progress with sharing consultant-level information and generally engaging clinicians with eliminating variation & the recovery work to be presented at the next meeting • Update on progress with reducing agency spend in theatres is due in February 2017
Decisions made	• The Committee agreed, using the delegated powers from the Trust Board, to sign up to the control total of £6.6m, acknowledging that there were a set of assumptions that underpinned this decision, including tariff adjustment and the need to implement efficiency changes within the organisation • The Committee on behalf of the Board approved the capital plan which had been reviewed extensively by the Executive Team. The risk register needed to capture the

	risk around the decisions taken to continue operating with equipment that had initially due to be replaced during the forthcoming year, but had delayed this until future years

Mr Tim Pile
VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 11 January 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Trust Board & Board Committees 2017/18**
SPONSOR:	**Dame Yve Buckland, Chairman**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**11 January 2017**

EXECUTIVE SUMMARY:

The attached presents a draft schedule for Board & Committee meetings for 2017/18, which aims to streamline the number of meetings within the corporate calendar, while still ensuring adequate oversight of Board business and matters delegated to Board committees.

The schedule sees a reduction in the number of formal Board meetings from every month to a pattern where the Board meets largely on alternate months, with a number of Board workshops included to allow for more reflective time and Board Development opportunity. The Board Committees will generally meet in the months where Trust Board does not sit. This schedule replaces other meeting dates previously set and circulated.

Also attached is a proposal to establish a new Committee, to be known as the Major Projects & Organisational Development Committee. The Committee's business captures in part, some of the business considered by the Transformation Committee, which is proposed is dis-established to reflect that a good proportion of its remit is now given oversight through Finance & Performance Committee and the Board itself, for more strategic & transformation issues.

The proposed membership of the Committees is also provided, which takes into account the changes in the Non Executive cadre, following the conclusion of the terms of office of HH Frances Kirkham and Prof Tauny Southwood and the commencement of Richard Phillips and Prof David Gourevitch.

A parallel piece of wort is underway to consider the Executive & operational oversight structure, which will support the discussions and upward reporting into the Board & its Committees.

REPORT RECOMMENDATION:

Trust Board is asked to consider the attachments and:

- APPROVE the revised Board & Committee schedule
- APPROVE the establishment of a Board Committee, to be known as the Major Projects & Organisational Development Committee and APPROVE its proposed terms of reference
- APPROVE the proposed membership of the Board Committees

The Royal Orthopaedic Hospital NHS
NHS Foundation 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	**x**

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:
Good governance
PREVIOUS CONSIDERATION:
The proposed changes were referenced at the Board meeting in December 2016.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

SCHEDULE OF MEETINGS - APRIL 2017 – MARCH 2018

2017	April	May	June	July	August	September	October	November	December	Jan	Feb	Mar
Council of Governors **Wednesday 14.00 - 16.00** Chair: YB, Secretariat SGL-L		17					Thurs 5*			17		21
Trust Board **Wednesday 09.00--13.00** Chair: YB, Secretariat: SG-L	5	Tues 30#	7	5 W/S		6	4	1 W/S	20##	10	7 W/S	
Quality & Safety **Wednesday 09.00 – 12.30** Chair: KS, Secretariat: SG-L		31		26		27		29		31		28
F&P **Tuesday 08.00 – 10.00** Chair:TP, Secretariat:SG-L		16		18		19		21		16		20
Audit **Friday 08.30 - 12.30** Chair: RA, Secretariat: SG-L	Mon 24	Tue 30#				29			1		23	
Charitable Funds **Friday 13.00 - 15.00** Chair: , Secretariat:JG	Mon 24					29			1		23	
Major Projects & Org Dev Wednesday 9.00 - 11.00 Chair: RP, Secretariat: SG-L	26		28				25				28	

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

Council of Governors - 4 meetings * CoG meeting followed by AMM
Board - 5 Board and 3 Workshops plus # Special meeting to approve annual accounts
Special meeting to sign off annual plan
F&P - 6 meetings
Major Projects & Innovation - 4 meetings
QSC - 6 meetings
Audit - 4 meetings plus #Special meeting to approve the annual accounts
Charitable Funds - 4 meetings

MAJOR PROJECTS AND ORGANISATIONAL DEVELOPMENT COMMITTEE

Terms of Reference

1. CONSTITUTION

1.1 The Board hereby resolves to establish a Committee of the Board to be known as the Major Projects and Organisational Development Committee (The Committee). The Committee has no executive powers, other than those specifically delegated in these Terms of Reference. Its terms of reference are set out below and can only be amended with the approval of the Trust Board.

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 is authorised by the Board to instruct professional advisors and request the attendance of individuals and authorities from outside of the Trust with relevant experience and expertise if it considers this necessary or expedient to carrying out its functions.

2.3 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. PURPOSE

3.1 The purpose of the Committee is to provide the Board with assurance concerning the arrangements for the delivery of major projects and key initiatives in support of the Trust's strategic plan.

4 MEMBERSHIP

4.1 The Committee will comprise of not less than three Non-Executive Directors, the Director of Strategy & Transformation [NOTE: from 1 April 2017 this post will no longer exist and the new role of Executive Director of Strategy and Delivery will replace it], Chief Executive and the Executive Director of Finance & Performance

4.2 The Chair of the Committee will be a Non-Executive Director and will be appointed by the Trust Chair. If the Chair is absent from the meeting then another Non-Executive Director shall preside.

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

4.4 Members should make every effort to attend all meetings of the Committee

5 ATTENDANCE

5.1 Other Executive Directors or any other individuals deemed appropriate by the Committee may be invited to attend for specific items for which they have responsibility.

5.2 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 the lead director, this being the Executive Director of Strategy and Delivery [from 1 April 2017] 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 quarterly, with additional meetings where necessary.

7 REPORTING AND ESCALATION

7.1 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 private Trust Board meeting for information.

7.2 The Chair of the Committee will provide an assurance report to the next Trust Board after each Committee meeting, highlighting the key points of the discussions at the meeting, any matters of concern or risk and matters of positive assurance for the Board.

7.3 The Committee will provide an annual report to the Trust Board on the effectiveness of its work and its findings, which is to include an indication of its success with delivery of its work plan and key duties.

7.4 In the event that the Committee is not assured about the delivery of the work plan within its domain, it may choose to escalate or seek further assurance in one of five ways:

(i) insisting on an additional special meeting;
(ii) escalating a matter directly to the full Board;
(iii) requesting a chair's meeting with the Chief Executive and Chairman;
(iv) asking the Audit Committee to direct internal, clinical or external audit to review the position

8 REVIEW

8.1 The terms of reference should be reviewed by the Committee and approved by the Trust Board annually.

9 DUTIES

9.1 To seek assurance on the robustness of the plans to deliver the Trust's key strategies, including but not limited to:

- IM & T strategy, covering major projects including electronic patient medicines administration (EPMA) system, Patient Administration System (PAS) replacement and network upgrade
- Communications and Engagement strategy, including GP engagement, community involvement and membership strategy
- Workforce strategies, including Leadership, People and Staff engagement
- Development of the Knowledge Hub to create an integrated approach to education, research, development and innovation
- Other strategies in support of the Trust's overall long term plan

9.2 To receive progress updates on the delivery of the above

9.3 To seek assurance on the robustness of the plans to deliver any major project, initiative or reconfiguration that is directly in support of the Trust's long term plan.

9.4 To seek assurance on behalf of the Board that the key risks to the delivery of any strategy, major project, initiative or reconfiguration are adequately mitigated

9.5 To seek assurance on the adequacy of the development, agreement and implementation of communication plans that ensure staff and stakeholders are informed and engaged in delivery of the strategy, major project, initiative or reconfiguration.

Date of adoption:

Date of review:

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROH Board Committee Membership - April 2017 - March 2018

Board	**F&P**	**QSC**	**Audit**	**Major Projects &Org Dev**	**Charitable Funds**
Yve Buckland (Chair)	Tim Pile (Chair)	Kathryn Sallah (Chair)	Rod Anthony (Chair)	Richard Phillips (Chair)	Yve Buckland
Tim Pile	Rod Anthony	David Gourevitch	Tim Pile	Rod Anthony	Tim Pile
Rod Anthony	Richard Phillips	Richard Phillips	Kathryn Sallah	David Gourevitch	Rod Anthony
Kathryn Sallah	Yve Buckland *	Yve Buckland*			Kathryn Sallah
Richard Phillips					Richard Phillips
David Gourevitch					David Gourevitch
Chief Executive	Chief Executive	Chief Executive	Director of Finance & Performance[#]	Chief Executive	Chief Executive
Director of Patient Services	Director of Patient Services	Director of Patient Services[#]	Director of Patient Services	Director of Strategy & Delivery[#]	Director of Patient Services
Director of Finance & Performance	Director of Finance & Performance[#]	Medical Director		Director of Finance & Performance	Director of Finance & Performance[#]
Medical Director					Medical Director
Director of Strategy & Delivery					Director of Strategy & Delivery
In attendance:					
Head of HR	Medical Director	Alison Hughes (CCG)		Head of HR	Patient Representative
	Head of HR	Sue Arnott (Observer)		Head of Communications	Public Governor
	DGM				
By invitation:					
			Chairman		
			Chief Executive		

* Standing Invitation to attend

[#] Executive Lead for Committee

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AGENDA

COUNCIL OF GOVERNORS

Venue Board Room, Trust Headquarters **Date** 18 January 2017: 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 meetings on 14 September 2016	ROHGO (9/16) 008	Chair
1410h	4	Update on actions arising from previous meetings	Verbal	SGL
1415h	5	Non Executive recruitment - recommendation to appoint	ROHGO (1/17) 002 ROHGO (1/17) 002 (a)	Chair
1425h	6	Chief Executive's update	ROHGO (1/17) 003 ROHGO (1/17) 003 (a)	PA
1440h	7	STP update	Verbal	YB/PA
	8	Membership Plans	ROHGO (1/17) 009 ROHGO (1/17) 009 (a)	SX-B
1450h	9	NHS Finances – training session	Presentation	AG
1510h	10	Finance & Performance Committee update including financial & activity recovery	ROHGO (9/16) 004	TP
1525h	11	Operations update including divisional management structures and plans	Verbal	GM
1535h	12	Quality & Safety Committee update	ROHGO (9/16) 005	KS
1545h	13	Update from the Patient & Carers' Council	Verbal	SN
1550h	14	Governor updates including governor elections	Verbal	ALL
1600h	15	For information: • Finance & performance update • Quality & Patient Safety update • Dates of forthcoming meetings	ROHGO (1/17) 006 ROHGO (1/17) 007 ROHGO (1/17) 008	Chair
	Date of next meeting: Wednesday 15 March 2017 @ 1400h – 1600h in Trust Headquarters			

MINUTES

Council of Governors - Version 0.3

Venue Boardroom, Trust Headquarters **Date** 14 September 2016 @ 1400h

Members present

Yve Buckland	Chairman	YB
Alan Last	Lead Governor	AL
Brian Toner	Public Governor	BT
Marion Betteridge	Public Governor	MB
Sue Arnott	Public Governor	SA
Jean Rookes	Public Governor	JR
Anthony Thomas	Public Governor	AT
Karen Hughes	Staff Governor	KH
Lynda Hindley	Staff Governor	LH
Paul Sabapathy	Stakeholder Governor	PS

In attendance

Tim Pile	Vice Chair and Non Executive Director	TP
Kathryn Sallah	Non Executive Director	KS
Rod Anthony	Non Executive Director	RA
Jo Chambers	Chief Executive	JC
Phil Begg	Director of Strategy & Transformation	PB

Minutes	**Paper Ref**
1 Exclusion of the press and public	**Verbal**
RESOLVED: The Council of Governors 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.	
2 Trust Chairman's appraisal	**Verbal**
Dame Yve Buckland was not present for this item. *CONFIDENTIAL INCLUSION IN VERSION OF MINUTES TO GOVERNORS* Tim Pile left the meeting.	

3 Non Executive Director appraisals	**Verbal**
Dame Yve Buckland joined the meeting and presented feedback from the recent NED appraisals. *CONFIDENTIAL INCLUSION IN VERSION OF MINUTES TO GOVERNORS*	
4 Apologies and welcome	**Verbal**
The Council received apologies from Changese Khan, Rob Talboys, Carol Cullimore, Petro Nicolaides, Alex Gilder and Mel Grainger.	
5 Declarations of interest	**All**
There were none.	
6 Minutes of the previous meeting on 11 May 2016	**ROHGO (10/15) 006**
The minutes of the meeting held on 11 May 2016 were accepted as a true and accurate record of discussions held.	
RESOLVED: The Council of Governors approved the minutes of the meeting held 11 May 2016	
7 Update on actions arising from previous meetings	
It was noted that an update on the divisional structure would occur in 2017 when operations model under Garry marsh had settled. The Governor quality indicator was highlighted in the Finance & Performance report as requested but on discussion it was agreed that this should be pulled out further for the next meeting.	
8 Non Executive Recruitment	**ROHGO (9/16) 002** **ROHGO (9/16) 002 (a)**
A proposal to appoint a non-clinical Non Executive Director was received by the Council of Governors. The Chairman highlighted that by managing the recruitment in house and a saving of c. £45k had been achieved. Although the process had been laborious, a good list of quality candidates had been created for shortlisting. The Council was asked to approve the appointment of Richard Phillips as Non Executive Director. This appointment was approved.	

The clinical Non Executive recruitment would occur on 19 September.	
9 Chief Executive's update	**ROHGO (9/16) 003** **ROHGO (9/16) 003 (a)**
The Chief Executive, Director of Strategy & Transformation, Tim Pile, Rod Anthony and Kathryn Sallah joined the meeting. The Chief Executive reported that in terms of the replacement Patient Administration System (PAS), work would be undertaken to develop interoperability and digital technology would be used where possible going forward. It was noted that the NHS deficit was significant and projected figures suggested a worsening position. Management of the position both at Trust level and nationally would need to be collaborative in future and the System needed to be dovetailed into others in due course. The Chief Executive was asked for the detail of the Associate Director of Turnaround post. She advised that this position was to be occupied by Nicky Lloyd, an experienced finance director who had previously acted as Assistant Chief Executive. The Guardian of Safe Working was reported to be Mr David Marks. It was noted that the introduction of an Associate Director of Turnaround was in place of an externally imposed individual and Nicky Lloyd with her skills and experience, was crucial to the organisations' work to recover the operational and financial position. This was a fixed term appointment, finishing at the end of March 2017.	
10 STP update	**Verbal**
The Chairman reminded the governors of the plan to join with local authorities in a Sustainability and Transformation Plan (STP). They were guided through a presentation outlining the key features and development of the STP, the key points being: • There was a significant financial deficit in social care budgets regionally and nationally, which was a major consideration for the STP. • It was likely that as a result of the STP, care pathways would be changed over the coming months and years. • The ROH was a key lead for the Orthopaedics element of the STP • The capacity to take on more work needed to be considered by the ROH and possibly a larger orthopaedic specialist Trust might need to be formed. A franchise model might also be considered as part of this strategy.	

• The risk of University Hospital Birmingham NHSFT (UHB) and Heart of England NHSFT (HEFT) matters overshadowing some of the issues in the STP that concerned the ROH was highlighted. • Sandwell & West Birmingham NHS Trust was separate to the discussions and was facing out into the Black Country through a separate STP. The Trust was also part of the Black Country Alliance, however the Trust was an associate member of the Birmingham & Solihull footprint in recognition of the continued importance of the relationship with the Trust. • There were opportunities for the ROH around the plans, including developing the Trust as a centre of excellence. The Trust's CQC rating at present was poorer than some other local providers, therefore this needed to change to be able to justify itself as a centre of excellence. IT investment would help with making the organisation better and adapting the way we work. Practice at the ROH was not up to speed in some areas, some of this being down to cultural change. Clinicians were central to this change. It was agreed that this remained a key challenge and was within the gift of all members of staff to play their part. • The Vanguard presented a good opportunity for influencing within the STP and nationally. The Trust's profile was being raised separately however. • System collaboration was key to the future operation of the organisation. • The contractual model in the new environment would evolve through System working and the thinking around this was developing. • Collaboration with BCH was positive and discussions had started with HEFT and UHB.	
11 Strategy refresh update	**Presentation**
The Director of Strategy & Transformation delivered a short presentation on the strategy refresh. It was reported that the Trust already had a plan and there was no plan to create a completely new strategy. A timescale and responsibility would be allocated for each outcomes. It was suggested that there was a need to review how judgements could be made that the Trust was on target with the delivery of the strategy. It was noted that by delivery of the strategy, there would be no duplication of current work but some aspects would be accelerated.	

The strategy extended the timeline of the original strategy by one year to the original strategy. This was a rolling five year view. Some benchmarking of cultural change was needed.	
12 Finance & Performance Committee update, including financial and activity recovery	**ROHGO (9/16) 004**
Tim Pile discussed how the organisation was addressing the key challenges in respect of financial and activity recovery. The key points he made were: • There had been a massive step forward in terms of understanding the position and accurate monitoring of progress with recovery was now in place • The focus was distinct in terms of its remit so there was no duplication; intensive focus was on short term recovery • A recovery plan was now in place and a delivery plan was under development • There were some major levers to drive change, these including increasing volumes of activity; the number of day cases was below where it needed to be and below the levels in 2015. Reducing length of stay was also an area of attention. There were a number of challenges put forward by the Governors, these being whether there was certainty that a plan was in place and that timescales for the work were clear. Given that theatre utilisation was below where it should be the point was made that given that as it was now September, a few months had been wasted in achieving a better position. There had been assurances provided to the Governors previously that work was underway yet this did not seem to have gained traction. In response, the Chief Executive advised that her intervention had been needed to better seek assurance that work was underway to achieve recovery; she was confident now that this was the case. The original plan required a step change in the second part of the year therefore significant improvement was not expected to have been seen yet. If the week of lost income and activity due to theatre closures in June was excluded from the overall position, the Trust was more or less on plan. The work from June needed to be recovered, which made the recovery work a big challenge. Theatre schedules would need to be reordered to recover the position. The Governors asked in terms of retirements planned, whether a system was in place to replace the individuals. They were advised that a process was in place, however the issue in Pain Management had not been fully anticipated and therefore there remained a gap in service delivery at present while new individuals were recruited. The service delivery model in Pain Management also needed to be changed. The challenge in theatres had been a shortage of staff, which had been addressed to some degree by the recruitment of a number of overseas nurses, including Filipino staff. It was acknowledged that slightly less than the original number of staff than anticipated had been recruited. The recruitment locally was reported to be improving; it was suggested that apprentices could be being used where possible. The HR function and the People Strategy would pick up recruitment in a planned way.	

13 Quality & Safety Committee update	**ROHGO (9/16) 005**
Kathryn Sallah, Chair of Quality & Safety Committee guided the Council through the discussions at the recent Quality & Safety Committee meetings. It was reported that the entire area of clinical governance and patient safety had much improved recently, with better input from clinical groups and representative from the Clinical Commissioning Group (CCG) and a public Governor also attended meetings routinely. It was suggested that better medical input was needed. The Governors were advised that rather than have a gap in assurances in August by not meeting, an assurance review was undertaken by a subset of the Committee. Of particular issue was the improved function of the Clinical Quality Committee and the appropriateness of attendance at this meeting. It had also been identified that the downward flow of information needed to be strengthened. Pressure ulcers had been discussed and assurance had been sought that actions to ensure that the incidence of avoidable pressure ulcers were taking place. Completion rates of the Friends & Family Test (FFT) were discussed and these would be reviewed in more detail to see if the questions asked were as appropriate as possible. Outpatients was good performance compared to other areas. It was noted that previously volunteers undertook real time patient experience surveys on the ward, which was a useful observation. There was reported to be a concern over the WHO checklist completion. Handling of major incidents was also of concern. It was noted there appeared a disconnect between the WHO checklist and Never Events. A full review of these had been undertaken and an external review had been commissioned, with active challenge having been applied. It was suggested that the Committee might direct its focus on the quality & patient safety impact of the stock and implants rationalisation in future. It was noted that an electronic stock system needed to be put in place, which would reduce human error. Sue Arnott who attended the meetings on behalf of the Council of Governors reported that there was lack of ownership of actions needed to drive improvements at times although this was improving.	
14 Governor Feedback	**Verbal**
It was noted that Stella Noon would be joining the next meeting to present an update on the Patient & Carers' Council.	
15 Matters for information	**ROHGO (9/16) 006** **ROHGO (9/16) 007**

The reports provided were received and noted.	
16 Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 18 January 2017 at 1400h – 1600h in the Boardroom, Trust HQ.	

ROHGO (1/17) 002

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Proposal to Recruit a Non Executive Director (Clinical Experience)**
SPONSOR:	**Dame Yve Buckland, Trust Chairman**
AUTHOR:	**Mr Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**18 January 2017**

EXECUTIVE SUMMARY:

The attached paper outlines the process that has been followed last Autumn to recruit and select a Non Executive Director (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.

The work to identify a candidate to fulfil the Clinical NED vacancy is outlined and the Council is asked to consider the Nomination & Remuneration Committee's proposal that Professor David Gourevitch be appointed into this role.

REPORT RECOMMENDATION:

The Council is asked to:

- NOTE the recruitment process for Non Executive Director followed
- APPROVE the Nomination & Remuneration Committee's proposal that Professor David Gourevitch be appointed as a 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 and approved the recommended appointment of the non-clinical Non Executive at the September meeting.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PROPOSAL TO APPOINT A NON-EXECUTIVE DIRECTOR

REPORT TO THE COUNCIL OF GOVERNORS – 18 JANUARY 2017

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 on 31 January 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 had been organised, which concluded in September 2016, when interviews for the clinical Non Executive were held.

1.2 The Committee approved the appointment of Richard Phillips at its last meeting, who took up post as an Associate Non Executive Director from October 2016 with the agreement that, following the conclusion of Frances' Kirkham's term of office, voting rights would be conferred on him.

2.0 RECRUITMENT AND SELECTION

2.1 The appointment of Richard Phillips has provided the commercial focus required for the Board going forward, however the recruitment process that was held in September focussed on securing candidates with a clinical background who would replace the experience currently provided by Tauny Southwood.

2.2 Again the use of an external agency to help with the recruitment was considered, however given the continued stringent financial environment it was agreed to manage the process in house by the Chairman, Company Secretary and the Chairman's PA. The Council was previously advised that by managing the process in this way it was estimated to have delivered savings for the Trust of 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 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 five individuals with appropriate clinical background who were suitable for interview.

2.7 Interviews for the clinical post were held on 19 September, 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 Professor David Gourevitch as the most suitable candidate for the role and his summary biography is as below:

Professor David Gourevitch
• Professor/Consultant Sarcoma Surgeon & General/Upper GI Surgery at UHB • Previously worked at Sandwell & West Birmingham Hospitals NHS Trust as consultant surgeon • Member of the Clinical Reference Group for commissioning sarcoma services • Honorary Professor, Institute of Cancer & Genomic Studies, UHB

2.9 David 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, David would commence in post as an associate NED, with voting rights being conferred when Tauny Southwood's term of office concludes on 31 January 2017. In view of the length of time between offer of appointment and approval by the Council of Governors, David has already spend some time in the organisation attending Trust Board and Quality & Safety Committee meetings in an observation capacity.

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 Professor David Gourevitch 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

12 January 2017

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:	**18 January 2017**

EXECUTIVE SUMMARY:

This report provides an update to the Council of Governors on the national context and key local activities.

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 11 January 2017.

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Council of Governors on 18 January 2017

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 during December 2016.

2 RECOVERY PLAN

2.1 Members of the Board attended a meeting with NHS Improvement (NHSI) on 20 December 2016 to discuss the Trust's revised financial recovery plan submitted on 21 November 2016. NHSI were assured by the Trust's plan, and the actions being taken to reduce the year-end deficit position. There is significant work to be undertaken to deliver the required improvements, in particular to ensure that from 9 January 2016 we meet the required step change in activity and associated POAC capacity.

2.2 On 14 December 2016, a series of all staff briefings were held to inform staff of the Trust's recovery plan, and key schemes to drive forward the required savings. There are additional proposed cost saving measures such as implant rationalisation and holding corporate vacancies, and the overall corporate structure will be streamlined to further reduce overhead costs.

2.3 Most notably, the Trust plans to run a set of 'Recovery Days' between now and the end of March (dates listed below). The most significant contribution to the Trust's Recovery Plan is the recovery of lost income associated with the theatres closures in June 2016. These Recovery Days are intended to ensure that we treat all the patients that we planned to treat during the year and will see additional theatre sessions planned over five weekends. Some staff have already volunteered to participate in the recovery work. The Recovery Days are scheduled for the following dates:

- Sunday 5th February
- Sunday 26th February
- Sunday 12th March
- Saturday 25th March

3 OPERATIONAL IMPROVEMENTS

3.1 Whilst staff continue to work toward improving efficiencies and productivity, we are beginning to see real progress in certain areas of the Trust, including in Oncology where considerable improvements have been implemented in developing our processes, including a centralised referral pathway for all patients.

3.2 In addition, our spinal team with support from theatre, HDU and ward teams, managed to successfully undertake two scoliosis cases in December 2016. This represents 100% additional productivity as typically only one case is carried out. This was as a result of excellent planning, communication and teamwork throughout the day. Both patients are doing well and on the back of this test day, five further dates are being planned to repeat the additional cases.

3.3 Our Rapid Recovery programme has seen over 20 patients successfully discharged from hospital within 24 hours of their surgery, and feedback has been incredibly positive. It is hoped that this programme will be rolled out across all surgeons and all specialties where 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:

- Attended a networking event with the Association of British Healthcare Industries and heard about the ambition of the Greater Birmingham Local Enterprise Partnership.
- WM CEO Meeting
- Meeting with Debbie Thwaites (Director of Business Improvement – Midlands & Lancashire CSU) & Mark Seaton (Director of Commissioning, South East Staffordshire CCG)
- Introduction meeting with Richard Beeken (Delivery and Improvement Director, NHS Improvement)
- West Midlands Public Service Board meeting
- Birmingham and Solihull STP Board meeting
- Meeting with colleagues at the University of Birmingham to discuss joint bid to Greater Birmingham and Solihull Local Enterprise Partnership
- Partnership meeting with Sarah-Jane Marsh, CEO of Birmingham Children's Hospital and Birmingham Women's Hospital

5 UPDATE FROM TRUST MANAGEMENT COMMITTEE

5.1 The Trust Management Committee (TMC) did not meet in December 2016 to enable the senior management team to focus on developing the recovery plan. An update will be provided to February Board once TMC has been held on 25 January 2017.

6 RECOMMENDATION(S)

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

6.2 Note the contents of the report.

Jo Chambers
Chief Executive
12 January 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	20 December 2016
Guests	None
Presentations received and discussed	None
Major agenda items discussed	• Stock & standardising materials (matter arising) • Sharing consultant-level information (matter arising) • HR framework & optimising vs. safe staffing levels (matter arising) • Finance & Performance Overview – Month 08 • Financial recovery: workstream update • Cancellations • Operational & Financial Plans 2017/18 – 2018/19
Matters presented for information or noting	• Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• It was noted that there was further work to do to robustly enforce leave rules across the consultant body, such that there was adequate cover for all theatre lists • As part of the monthly finance & performance overview, it was reported that there remained underperformance against the original activity target. The CIP savings were noted to have flattened, although there remained confidence that the overall target would be achieved by the year end. Theatre utilisation in November was poor, as the theatre scheduling process was not yet robustly embedded. Admission on the day before surgery remained a challenge and impacted adversely on the bed day cost per patient. Performance against the 18 weeks Referral to Treatment target remained below par at 89.5%. • The Committee received an update on cancellations, which showed that the positon was still unacceptably high. The majority of cancellations were due to patients being medically unfit for surgery and therefore work was underway to understand the processes in the Pre Operative Assessment Unit that prevented patients being admitted when they were not for surgery. It was agreed that addressing this position needed to be a priority. • The operational & financial plans for 2017/18 – 2018/19 were reviewed and the risks associated with meeting the

	set control totals and other performance targets were noted. The impact of the changes tariff for orthopaedics was highlighted to be impacting significantly on the position. Additional cost pressures were noted to be associated with increased NHSLA premia, costs associated with implementing the Royal College requirements and new IT systems. • Contracts with commissioners remained to be finalised, therefore the risk of submitting an operation plan ahead of this was highlighted, particularly in terms of forecast activity
Positive assurances and highlights of note for the Board	• Good progress continued with stock and implant rationalisation; a specific piece of work was underway with the large joints firm which was yielding good results in terms of eliminating variation • Consultants were being provided with detailed information to help them make decisions. Comparative and benchmarking data was also beginning to become available. • A small surplus had been made during the month, with the trust over performing against the recovery trajectory • Pay costs had declined, particularly in agency spend, which had reduced to £360k from a high of £450k. • There had been encouraging improvement in activity undertaken during the month. • There was overall good engagement across the organisation with the recovery work, including by ancillary groups such as portering. • A weekly Executive-led recovery board was in place to challenge and scrutinise the recovery position. • Targeted work was being undertaken with the Oncology team to revise and reinvigorate existing processes within the team.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Further progress with sharing consultant-level information and generally engaging clinicians with eliminating variation & the recovery work to be presented at the next meeting • Update on progress with reducing agency spend in theatres is due in February 2017
Decisions made	• The Committee agreed, using the delegated powers from the Trust Board, to sign up to the control total of £6.6m, acknowledging that there were a set of assumptions that underpinned this decision, including tariff adjustment and the need to implement efficiency changes within the organisation • The Committee on behalf of the Board approved the capital plan which had been reviewed extensively by the Executive Team. The risk register needed to capture the

	risk around the decisions taken to continue operating with equipment that had initially due to be replaced during the forthcoming year, but had delayed this until future years

Mr Tim Pile
VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Council of Governors scheduled for 18 January 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	30 November 2016
Guests	Dr Bill Rea – Chair of the Drugs & Therapeutics Committee
Presentations received	None
Major agenda items discussed	• Upward report from the Drugs and Therapeutics Committee • Upward report from Clinical Quality Committee • Upward report from the Children's Board • Quality & Patient Safety report • Internal audit into compliance with Controlled Drugs regulations • Corporate Risk Register • Divisional governance update • Quality & Safety Committee terms of reference
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Board	• Consent was discussed, where it was noted that the policy needed to be updated to reflect that gaining consent is also undertaken by non-medical staff. • There appeared to be lack of visibility around ownership of the annual quality priorities; work was planned by the Director of Operations, Nursing & Clinical Governance to address this. • A Central Alerting System (CAS) alert around storage of injectable drugs was discussed in some detail as part of the upward report from the Drugs & Therapeutics Committee. From September 2017, storage of solutions such as saline and chlorohexidine would need to be kept in closed systems and not in receptacles such as gallipots. The impracticalities and preparation for this change in practice were the subject of debate between Committee members and the Chair of the Drugs & Therapeutics Committee. • A risk assessment around unlocked drugs cabinets in theatres had been completed and the positon adopted was in line with the requirements of the Royal College of Anaesthetists. • It was reported that the Trust does not record exceptions on drugs fridges robustly. The financial implications of this needed to be considered by the Trust management

	Committee and the use of Charitable Funds for this purpose also needed to be considered. • The Committee was made aware that there remained long waiting times in spinal deformity and was appraised of a particular situation when a child's operation had been cancelled several times. The Board would be asked to debate the practicalities around continuing to accept referrals onto an increasingly lengthy waiting list. • The Committee was updated on a patient death which had occurred when an individual had been transferred to another acute provided following an operation at the ROH. • The internal audit into Controlled Drugs handling was reviewed. The report had provided 'reasonable assurance' however the Committee was satisfied with the assurances provided on progress with addressing the recommendations, a matter which would be considered by the Audit Committee at its meeting on 9 December. • The Committee was advised that the 18 weeks referral to treatment time target had not been met for the third consecutive month and there were some data quality concerns which would need to be validated. The Board would receive a more comprehensive update at its meeting on 7 December. • It was reported that the Trust had received two contract performance notices; one around readmissions within 28 days in the event that the Trust cancelled an operation and the second being around mandatory training.
Positive assurances and highlights of note for the Board	• The long standing risk around blood management was closed, given that the blood fridges had been relocated. • A new Deputy Director of Nursing had been appointed and would commence work in the Trust in spring 2017. • Good progress was reported in terms of developing the Children's Board. Several workstreams of improvement are underway including development of specific Paediatric patient policies and improving the visibility of risks around Paediatrics.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A further update on progress with preparing for the new standards around storage of injectable medicines was requested for the next meeting. • An update on consent was requested for the next meeting. • An update on the Trust's adherence to national guidance around pre-operative starvation was requested for the next meeting. • Letters sent to parents of children waiting for spinal deformity procedures are to be shared at the next meeting.
Decisions made	• The Committee approved its revised terms of reference which had been updated as part of the annual review and

	agreed that they should go forward to the Trust Board for ratification.

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

For the meeting of the Council of Governors scheduled for 18 January 2017

FINANCE & PERFORMANCE REPORT

DECEMBER 2016

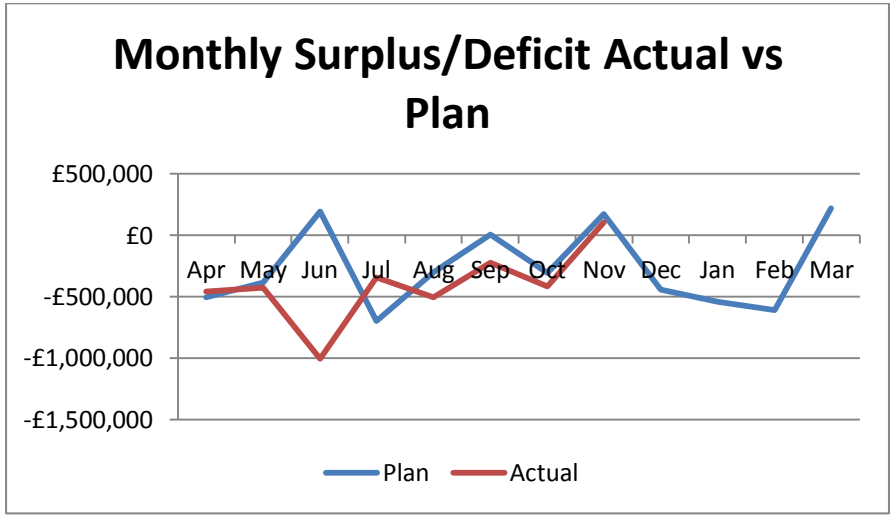
CONTENTS

INTRODUCTION

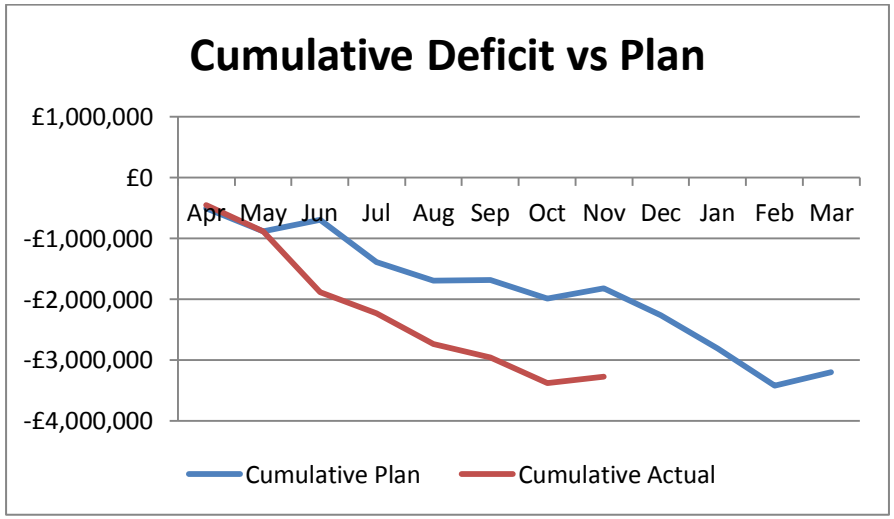
The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

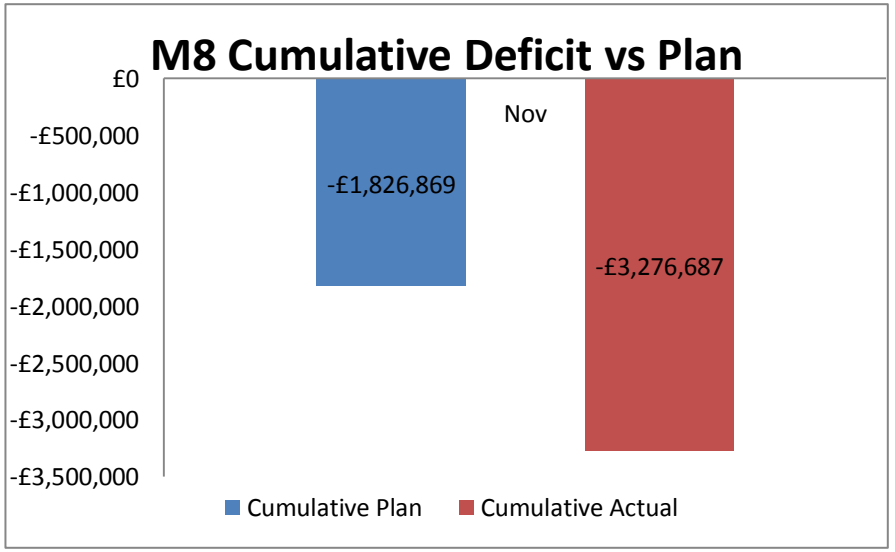
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

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 £3,276,000 as at the end of November against a planned deficit of £1,827,000. In month, the Trust delivered a surplus of £104,000 against a planned surplus of £171,000. This represents the first monthly surplus achieved at the ROH since November 2014!

The Trust is therefore £1,449,000 behind plan at the end of M8. 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 £495,000. Further detail on the key drivers of the financial position is provided in the income and expenditure sections below.

As at the end of Month 8, the Trust has recognised £1,897k of CIP savings, against a plan of £2,276k. £579k (31%) of savings to date are non-recurrent. The in-month savings recognised were £246k against a November target of £349k.

With regards to the Trust's Use of Resources Risk Rating (UOR), the deficit position results in the Trust achieving ratings of 4 for Capital Service Cover, I&E Margin metrics and I&E Margin Metrics against plan. In addition, the Trust's liquidity position is rated as a 2 instead of a 1, as was the case 2 months ago. 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 metric. The overall Trust score has been capped to a 3.

Work on the final operational plan submission is ongoing. The forecast position for 2017/18 and 2018/19 is dependent on the outcomes of negotiations with both NHS England and the local CCGs, which are being led by the Director of Finance.

ACTIONS FOR IMPROVEMENTS / LEARNING

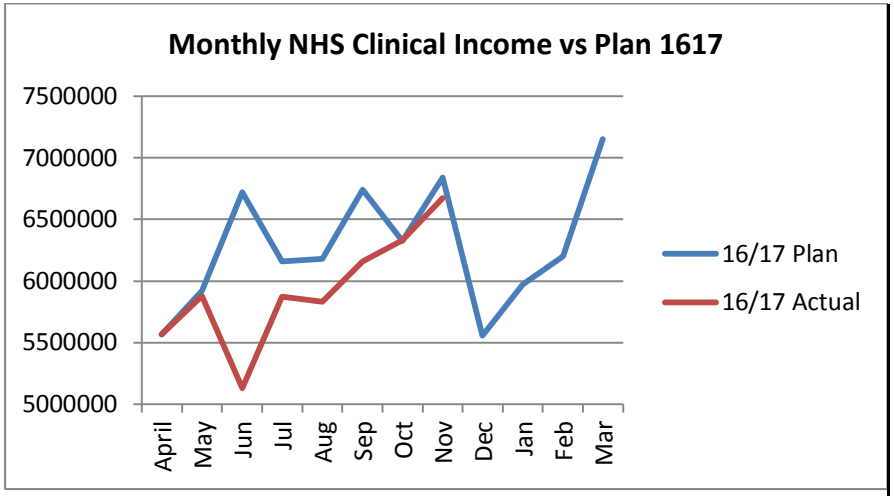
The Trust Executive have set up a weekly Recovery Board where progress against the action plans of the five recovery workstreams (POAC, theatre efficiency, discharge planning, agency reduction and cost control) is monitored and challenged. The Chief Executive has also briefed the organisation on a number of key schemes that will drive improvement in the financial position for the remainder of the year and beyond. These schemes include the introduction of 5 recovery days, a Mutually Agreed Resignation Scheme (MARS) and the sale of annual leave.

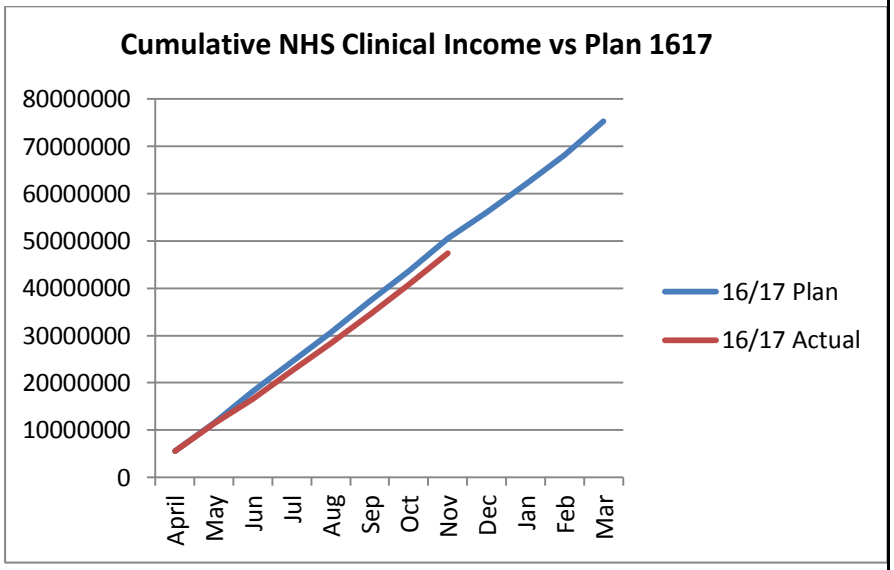
RISKS / ISSUES

The activity targets for the coming months will be challenging, and will result in pressure on theatres and wards in addition to the Trust's support services to ensure that patient flow runs smoothly with no excess capacity in the system.

Buy-in and progress against the schemes set out in the workstream action plans, and by the Chief Executive will be vital in achieving improvement in the Trust's financial position and its long-term sustainability.

2. Income – This illustrates the total income generated by the Trust in 2016/17, including the split of income by category





NHS Clinical Income – November 2016			
	Plan	**Actual**	**Variance**
Inpatients	3,290	3,353	63
Excess Bed Days	278	252	(26)
Day Cases	820	829	9
Outpatients	747	689	(58)
Critical Care	256	252	(4)
Therapies	253	236	(17)
Pass-through income	219	207	(12)
Other variable income	418	382	(36)
Block income	559	527	(32)
TOTAL	**6,840**	**6,727**	**(113)**

NHS Clinical Income – YTD 2016			
	Plan	**Actual**	**Variance**
Inpatients	24,116	22,175	(1,941)
Excess Bed Days	2,039	2,008	(31)
Day Cases	6,012	5,511	(501)
Outpatients	5,588	5,149	(439)
Critical Care	1,878	1,871	(7)
Therapies	1,887	1,929	42
Pass-through income	1,647	1,802	155
Other variable income	3,109	3,028	(81)
Block income	4,183	4,216	33
TOTAL	**50,459**	**47,689**	**(2,770)**

INFORMATION

NHS Clinical income underperformed against plan by 1.7% in November, although elective income over-performed by 1.9%. Admitted patient care activity was significantly up on prior month (1342 vs 1199).

Outpatients continued to under-perform from an income point of view, driven by a significant reduction in the number of outpatient follow ups undertaken in month. Year to date there is an underperformance in outpatient procedures that 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 this workload has been transferred to other services including therapies, which has resulted in an over-performance in that service for the year to date.

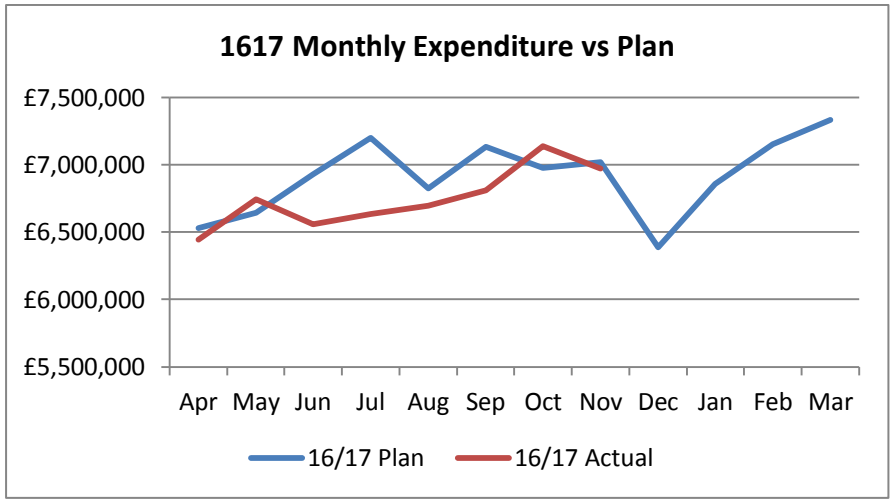
ACTIONS FOR IMPROVEMENTS / LEARNING

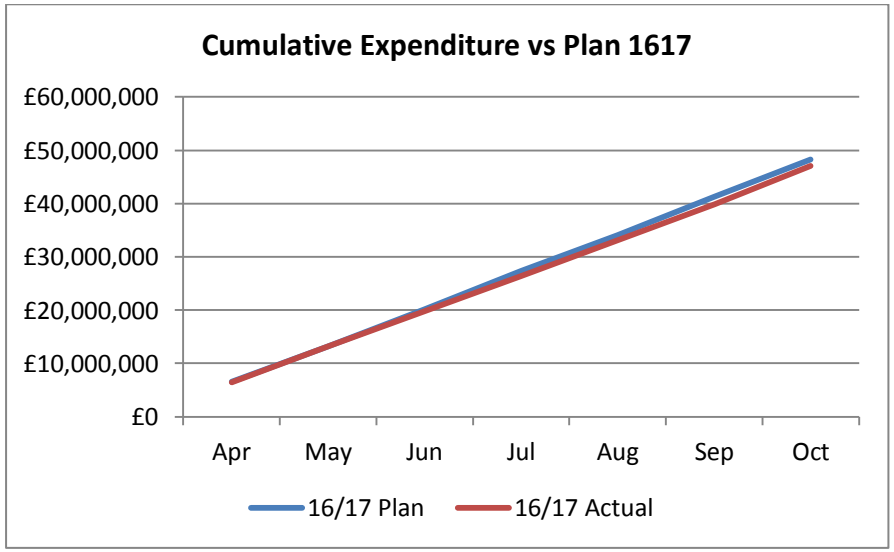
Continued daily focus is taking place to ensure inpatient activity is maximised, by following the actions outlined in the detailed action plans for the POAC, Theatre efficiency and Discharge Planning work streams. As reported earlier, the workstreams are being monitored on a weekly basis through Recovery Board, attended by the Trust Executive.

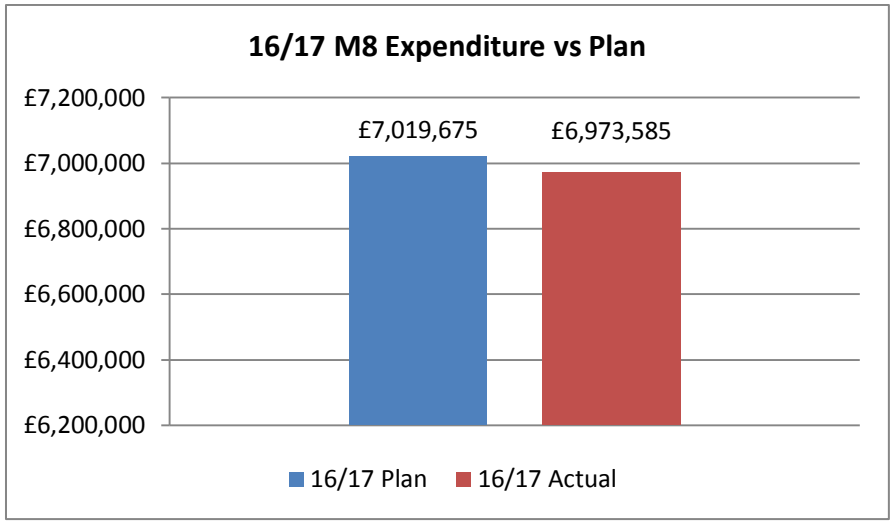
RISKS / ISSUES

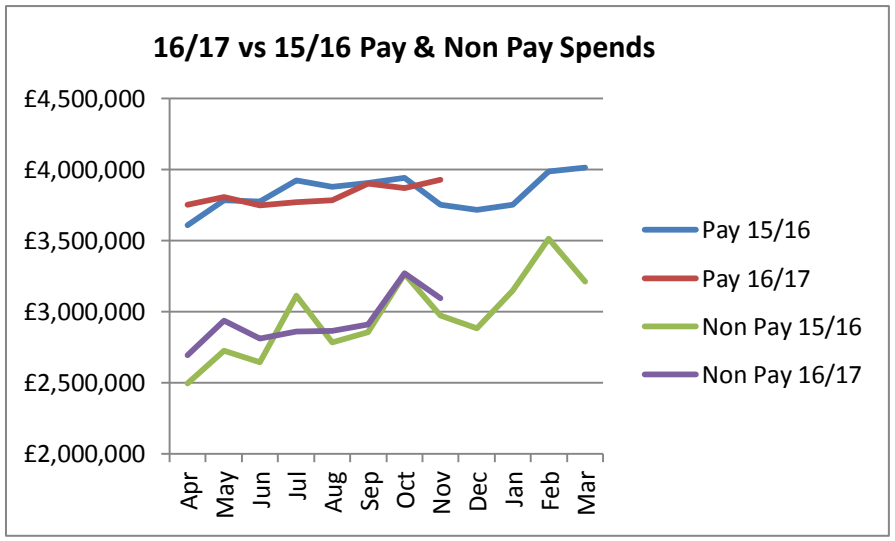
The level of activity required to deliver the Trust's revised forecast remains challenging, particularly from 9th January where there is expected to be a significant uplift in planned activity as a result of key actions with the recovery workstreams becoming fully live (e.g. POAC slot availability). Should the required actions not be taken on a timely basis, and those actions translated into additional activity being delivered by the Trust then there is a risk the revised forecast will not be met.

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 £1.25m below plan.

Pay increased slightly in month, driven by an increase in bank and substantive spend, with agency spend decreasing.

Non pay expenditure decreased slightly on prior month, as last month contained some one-off costs such as the replacement of theatre equipment. The non-pay expenditure is still being controlled to a level below that predicted in the original operational plan.

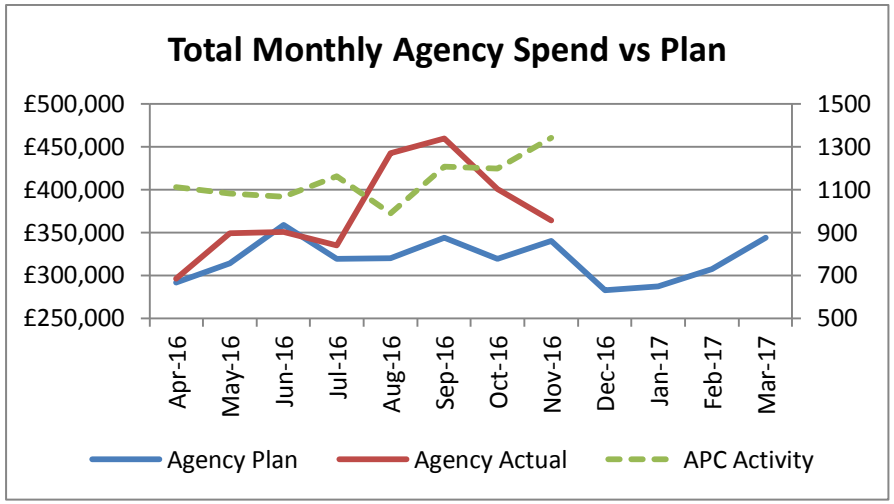
ACTIONS FOR IMPROVEMENTS / LEARNING

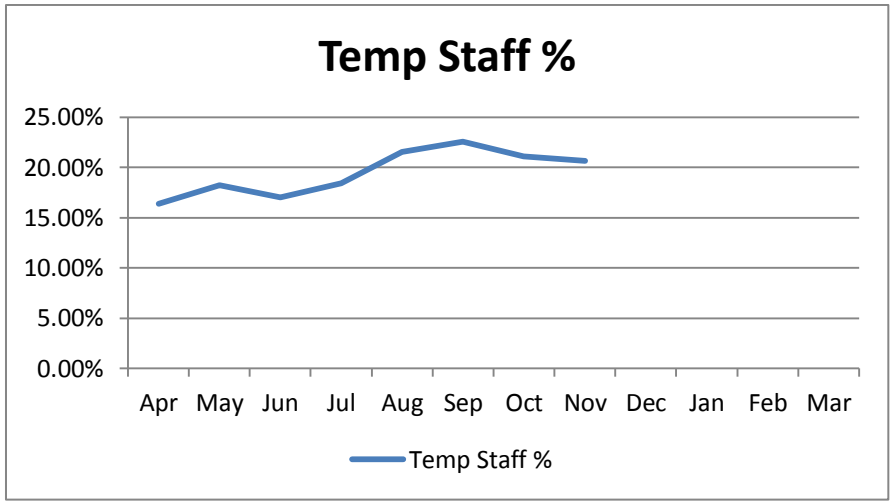
Costs will continue to be scrutinised and minimised. One of the 5 recovery workstreams is cost control, with actions being tracked through the Recovery Board on a weekly basis.

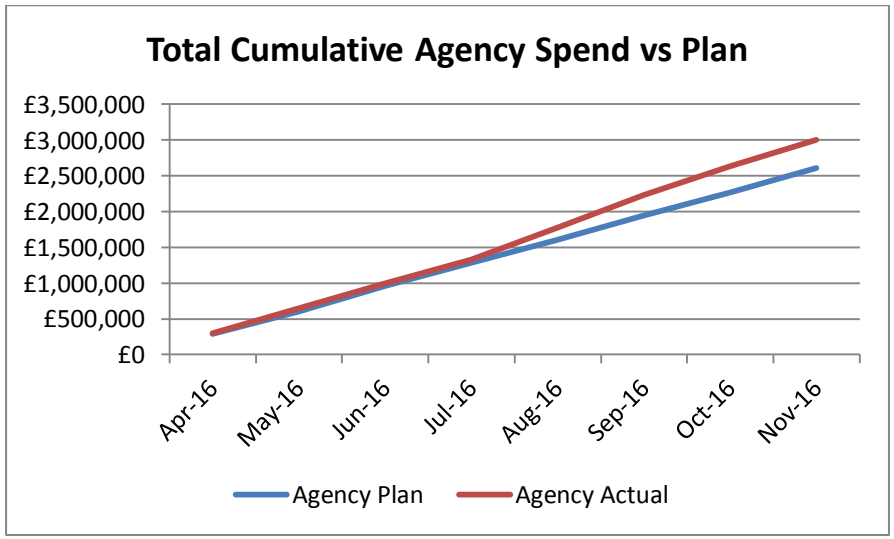
RISKS / ISSUES

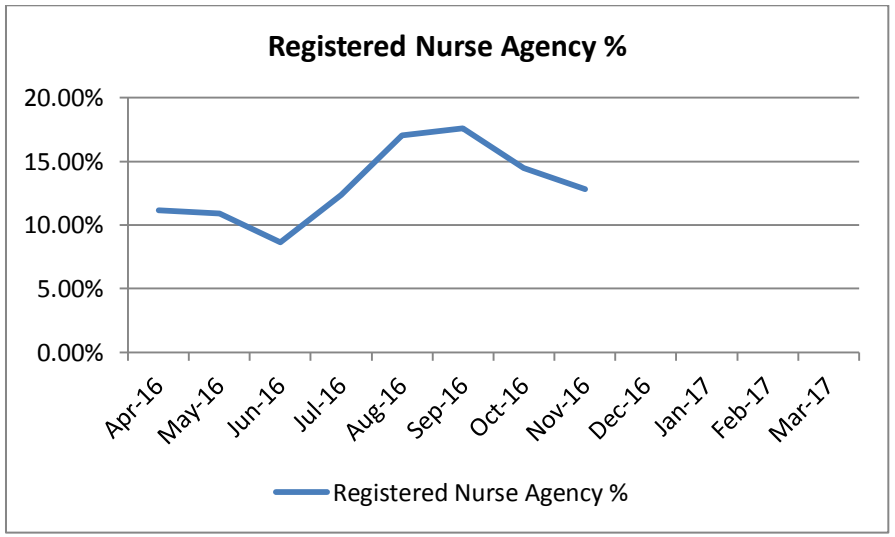
The implementation of recommendations relating to the review into theatre stock control and processes continues, however until full cyclical stock takes are completed, there remains a risk around the robustness of non pay spend within the ledger. The theatres team have moved all prosthesis stock into a new controlled location 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. EDC Gold has also gone live in month with the first line being piloted onto the system.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2016/17, and performance against the NHSI agency requirements









INFORMATION

November showed a significant reduction in agency spend (from £401,000 to £364,000), this being the second month in a row with agency spend reduction. This reduction is seen across nursing and corporate spend, although there was a £30k increase in locum spend. Despite the reduction, the spend remained above plan (£340,000).

ACTIONS FOR IMPROVEMENTS / LEARNING

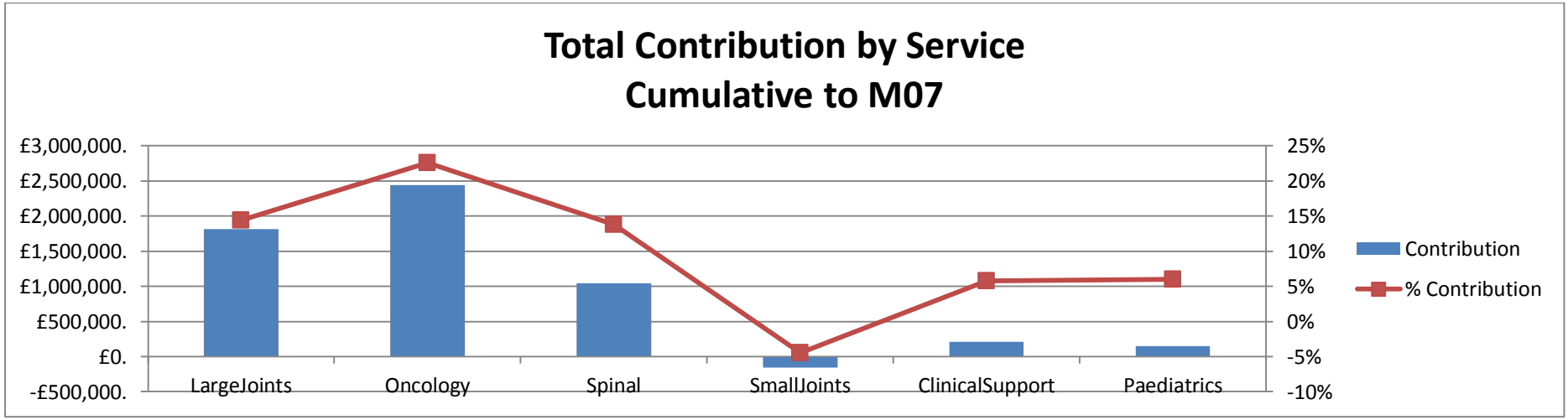
One of the 5 recovery workstreams is reduction in agency spend, and as such a detailed action plan is being reported against on a weekly basis to Recovery Board. This is in addition to the agency group run by the DOWOD and DOONCG. Ongoing actions to reduce agency spend include workforce redesign, e.g. the POAC workforce model, in addition to reviewing the outputs of Healthroster.

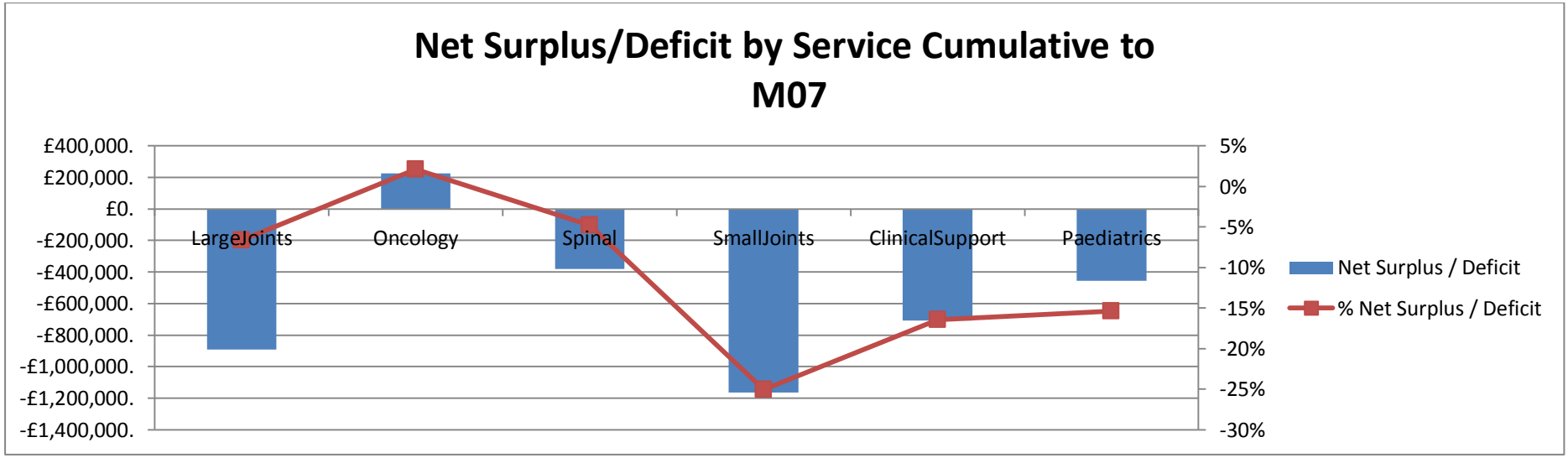
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios.

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 financial year 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 October 2016. Small Joints is the only service to have provided a negative contribution of -£155K. 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 apart from Oncology are then running at a net loss, this is reflected in the overall Trust position of £3.38m deficit up to October 2016.

Large Joints is currently second highest gross loss producing service, due to theatre utilisation, case mix and increased direct costs in relation to HRG tariff funding.

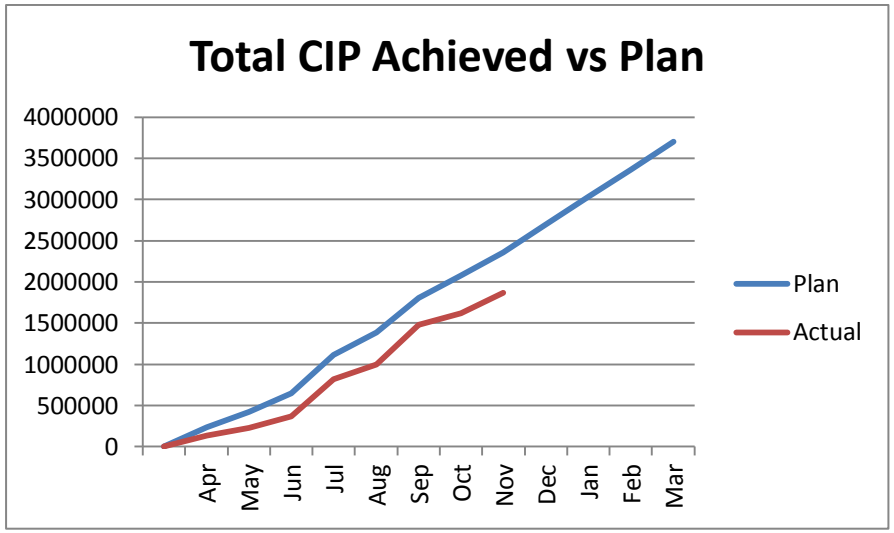
Currently services are being reviewed in terms of session planning for certain operation types to improve theatre utilisation and patient throughput.

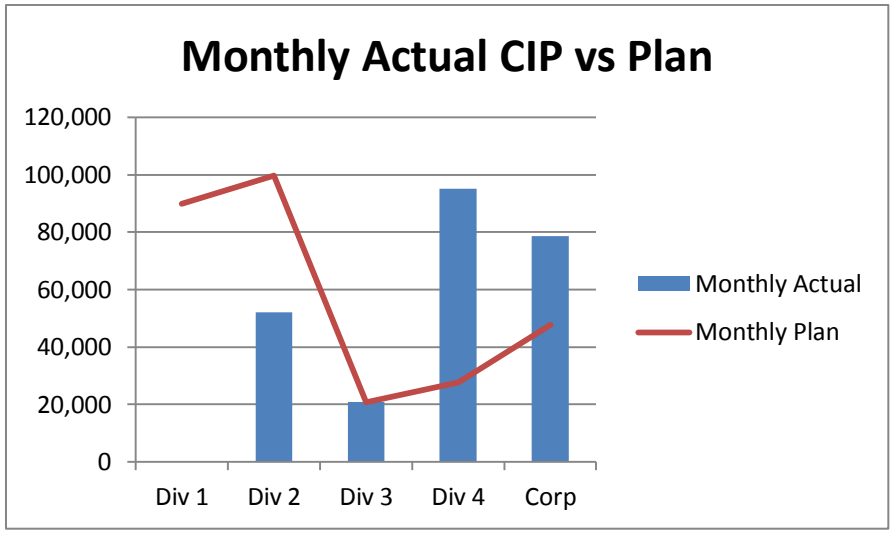
ACTIONS FOR IMPROVEMENTS / LEARNING

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

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2016/17





INFORMATION

As at the end of Month 8, the Trust has recognised £1,897k of CIP savings, against a plan of £2,276k. £579k (31%) of savings to date are non-recurrent. The in-month savings recognised were £246k against a November target of £349k.

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.
- Negotiations are ongoing with implant suppliers to achieve best value for money, in addition to consultants changing their implant usage in a number of areas.
- Business cases have been approved and recruitment in ongoing to support the transfer of anaesthetic and theatre staffing costs from agency to substantive.
- Review of the operational and executive structure.

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.

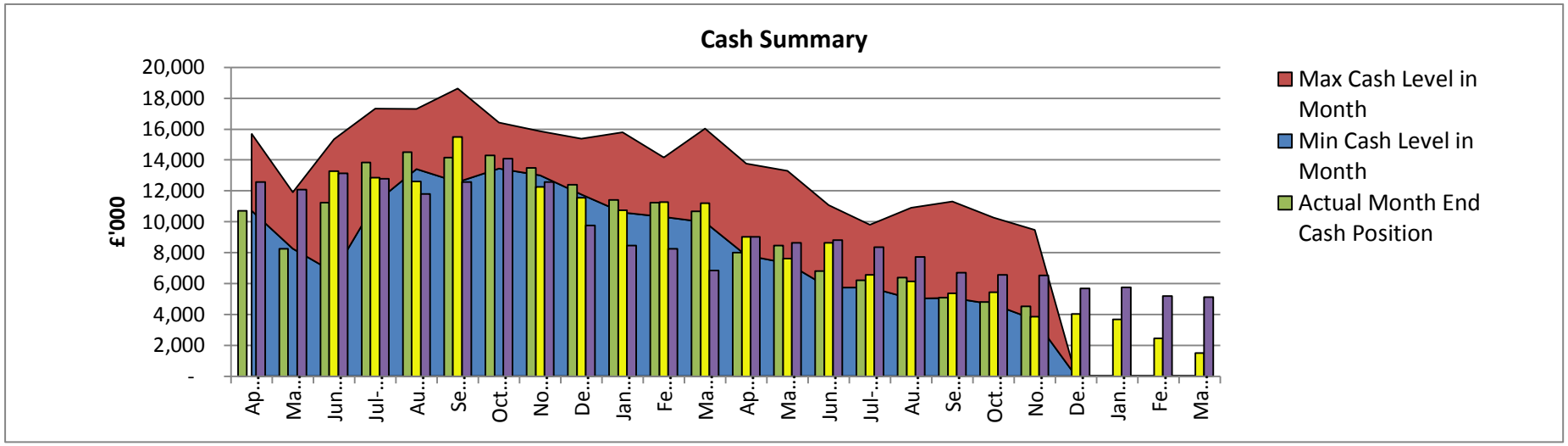
ACTIONS FOR IMPROVEMENTS / LEARNING

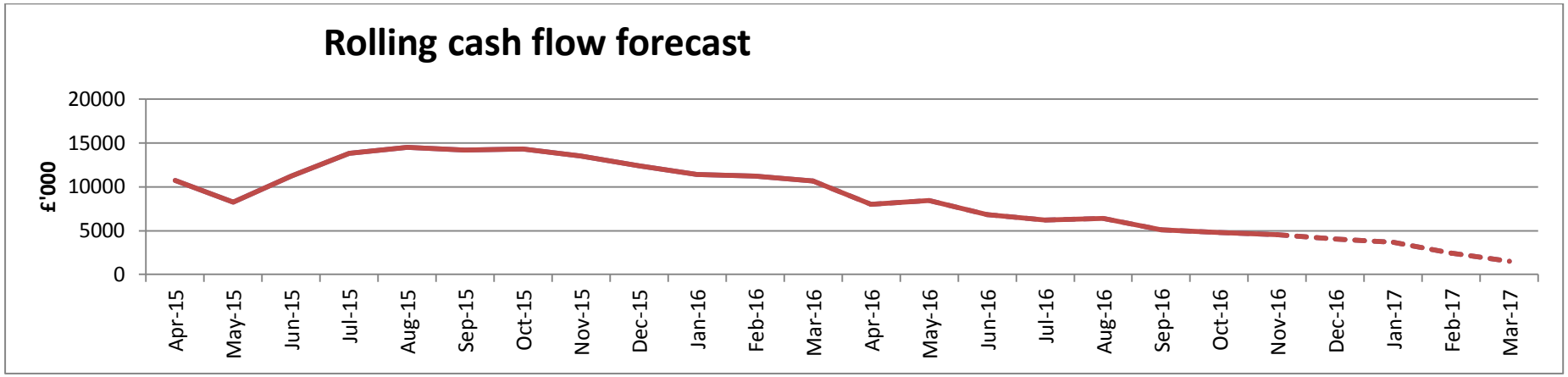
There are still gaps in some areas with regards to the required CIP documentation, largely relating to implementation plans and QIAs in Division 2. The Divisional Heads are progressing signoff with the Director of Operations, Nursing and Clinical Governance and the Medical Director.

RISKS / ISSUES

The CIP target of £3.67m represents a significant challenge to the Trust. It is vital that we remain on target despite increased pressures on costs as the Trust increases its activity in the remaining months of 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 £1.98m million lower than planned levels at the end of November 2016. The Trust is forecasting an end of year cash balance of circa £1.5m, which relies upon the delivery of our revised deficit plan and the control of capital spend within the budget that has been set.

Liquidity levels within the Use of Resources Rating remain at a 2, with cash likely to dip below £nil early in 2017/18.

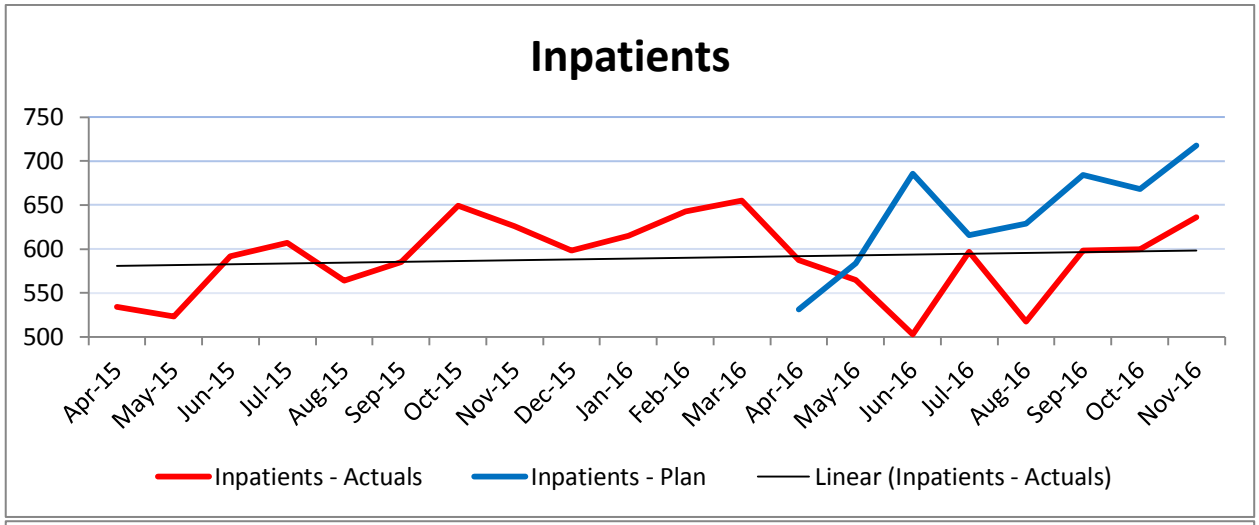
ACTIONS FOR IMPROVEMENTS / LEARNING

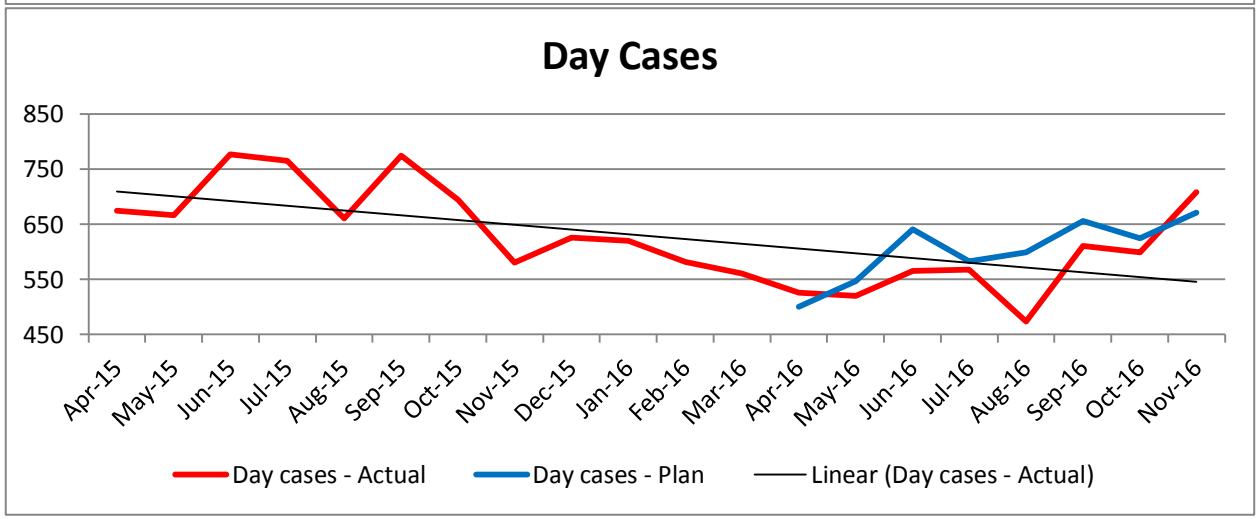
The Director of Finance is reviewing options for the receipt of a cash loan to support the running of the hospital in the new year.

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 in November was the highest it has been at an APC level since October 2015, although this is being significantly driven by an increase in day cases. Inpatient activity was the still the highest it has been this year, but remains below the levels delivered in February and March 2016.

ACTIONS FOR IMPROVEMENTS / LEARNING

3 of the 5 recovery workstreams relate to increasing activity, through increasing POAC capacity, increasing theatre efficiency and making discharge more efficient. These workstreams are being monitored against their detailed action plans and KPIs on a weekly basis through Recovery Board.

Some of the actions taken include the continue work in the "6,4,2" meeting 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.

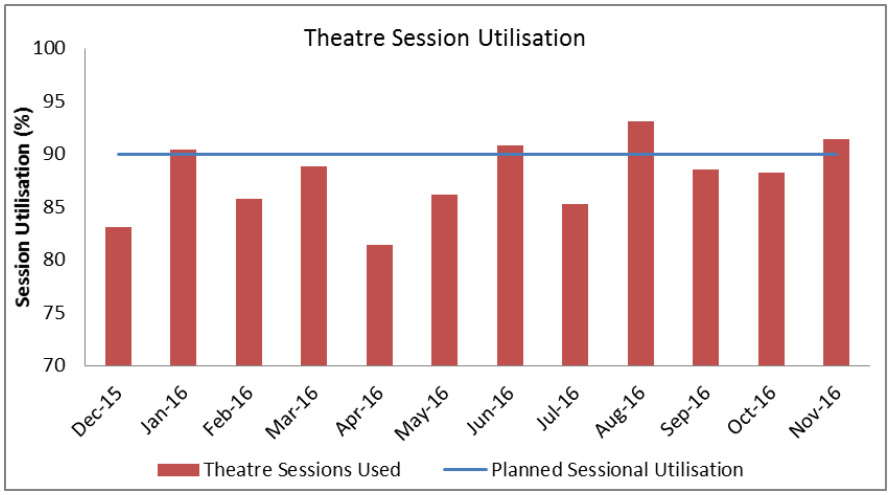
Significant engagement work is required across the clinical body and wider workforce to appreciate the scale of the challenge that is now facing the Trust to deliver the activity and associated income each week, in order to deliver the Trust's agreed financial control total.

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.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are planned (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we strive to cover at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis. We continue to fall well short of this due to surgeon annual and study leave and lack of prospective cover.

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 over time.

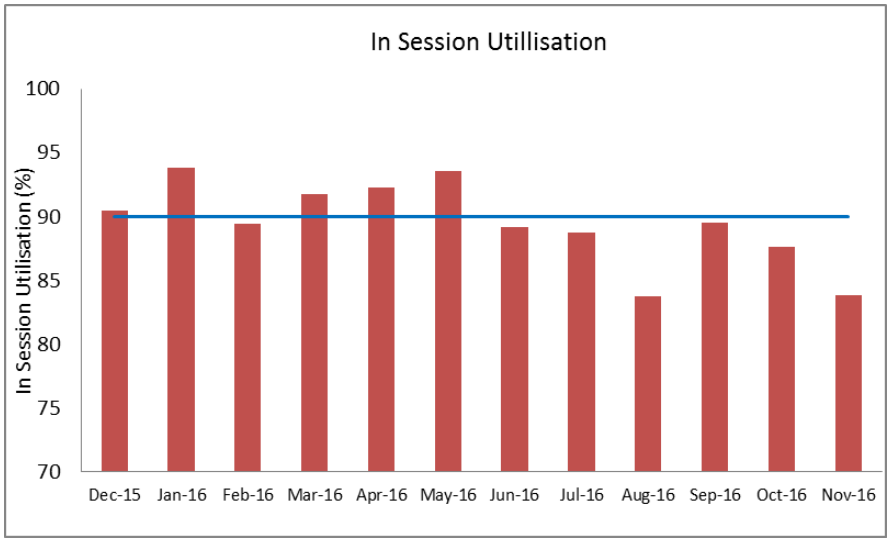
Some theatre lists are now being taken down in order that surgeons can do additional clinics, because some surgeons who are timetabled in theatres have now run out of patients. All reasonable efforts are made to recycle, including where it is deemed appropriate the use of sessions additional to job plan (paid ADHs.) Where lists are not recycled, the theatre staffing and anaesthetist are removed 1 week ahead, to reduce agency costs.

Over November, due to intensive scrutiny via 642, there has been an improvement in the recycling of sessions to above 90%; however, it should be noted that this was a month with lower surgeon leave (no school holidays) and a lower level of absence for study / professional leave.

RISKS / ISSUES

Engagement in the job planning process and delivery of timescales in Division 1. Notice required to establish buddying timetable arrangements and co-ordination of leave for surgeons evenly through the year.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained consistently above the target 85% (target adjusted as per methodology change below.) However, the previous measure (pre June) 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.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are a range of actions being undertaken to work towards improvement in theatre in session utilisation, focussing on start time, turnaround, optimal list composition and the eradication of unplanned overruns. Unfortunately, in session utilisation has dropped to below 85% in November, and with the exception of August is the worst performance in the last year. This has been due to a number of very late starts, and booking practices and last minute cancellations such that a number of lists have not been used to their maximum potential.

The implementation of the new Theatre Management System (Theatreman) now planned for February 2016 (slipped due to PAS interfacing issues) will be a further vehicle to ensure that lists are optimally booked based on the available time. Scrutiny and challenge is via the weekly 642 meeting, with instructions back through to the surgical teams to book lists to their maximum potential and to identify patients well in advance so that specific requirements can be planned for to reduce cancellations.

A new interim Head of Nursing with extensive experience of The Productive Operating Theatre is due to join the team from early January. Additionally, the Associate Medical Director Division 2 / CCIO has launched a new reporting suite that demonstrates individual theatre / consultant utilisation, and this was shared at Theatre User Group on 12th December.

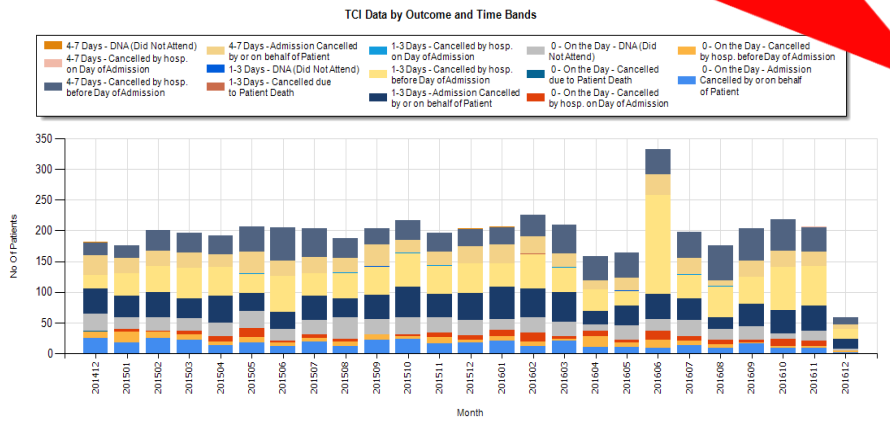
RISKS / ISSUES

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. Availability of radiographers (additional support now in place via agency.) Willingness of surgeons to fully book lists. Decentralised administrative arrangements leading to a lack of tactical control and grip. Gaps in experience in the operational management structure.

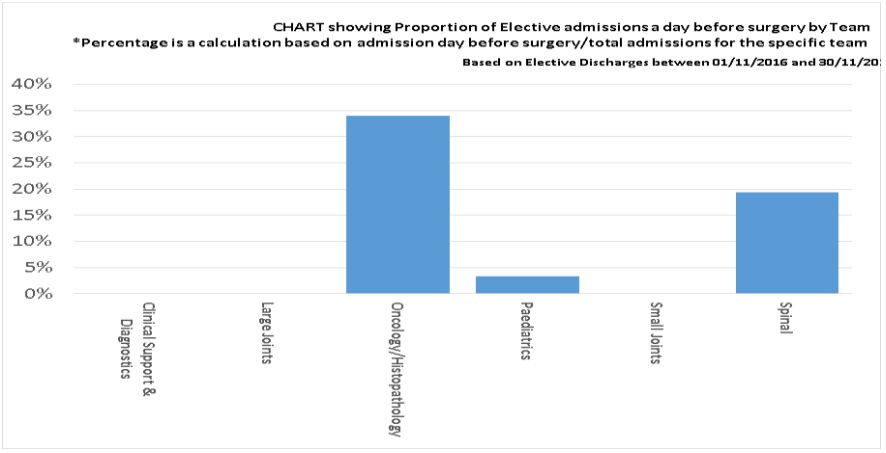
GOVERNOR QUALITY INDICATOR

11. Process & Flow efficiencies – This illustrates how [illegible]ust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

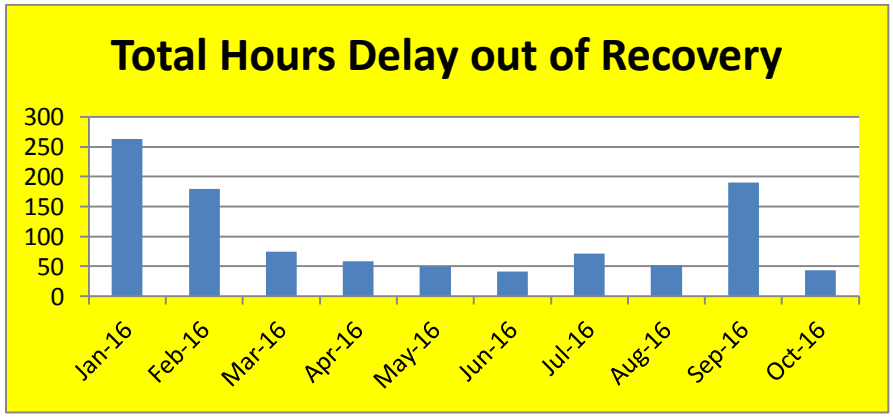
Cancellations by patient / hospital



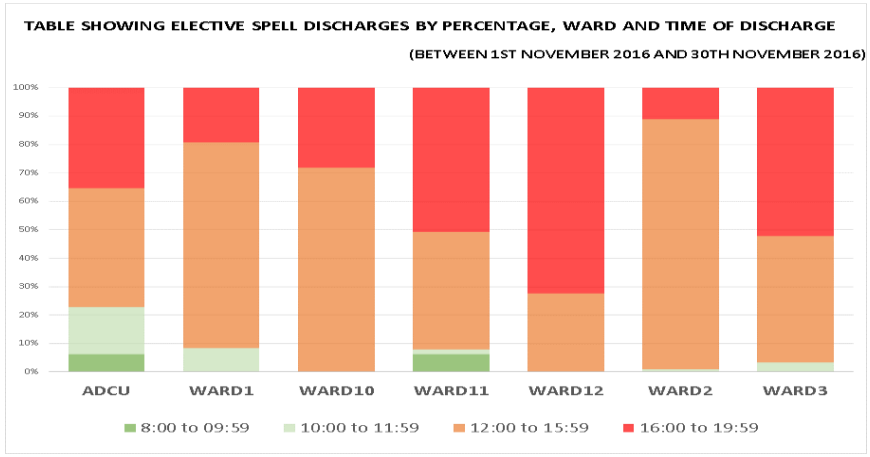
Admission the day before surgery



Delays out of recovery – TO UPDATE



Time of day patients discharged



INFORMATION

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Patients continue to be booked at very short notice, and well outside the expectation of 3 week's notice and 2 reasonable offers as per national guidance and our recently approved Access Policy. The booking of patients continues to follow a decentralised model with individual secretaries liaising with surgeons.

Short notice creates inefficiency, re-work and churn. It creates challenges at patient level (kit, HDU beds, imaging) if their requirements cannot be planned for in advance, creating delay and potential cancellation. 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.) The DGM Division 2 has led on a new SOP for cancellations and the escalation process to be followed, followed a CCG Contract Performance Notice with regard to the Trust's failure to achieve the 28 day rebook guarantee.

There continues to be great disparity with regard to waiting times between surgeons, and very limited pooling of patients for common procedures and pathways, as would be expected as part of normal business in other Trusts. 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. Good progress in transferring patients out of Recovery in a timely way has stalled in recent months because of staffing on the wards.

There have been no further breaches of the HDU / Recovery 4 hour mixed sex accommodation standard during October or November.

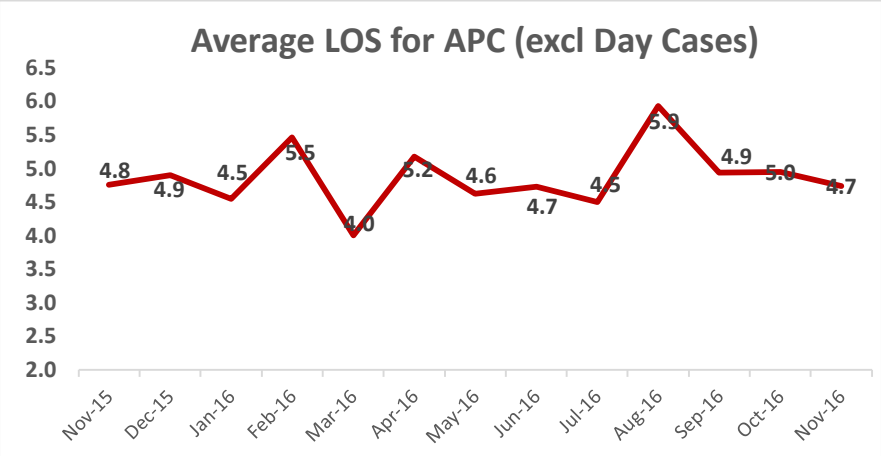
ACTIONS FOR IMPROVEMENTS / LEARNING

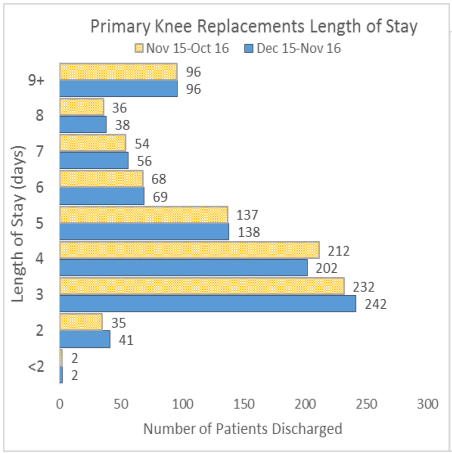
Continued work is required to ensure that all specialties have a pool of patients who are pre-op'd and available to be called in at short notice to fill cancellation slots. The concept of pooling of appropriate patients between consultants also needs to be undertaken to maximise efficiency.
Work is still required to agree criteria for admission the day before, to use beds more effectively and reduce length of stay. As activity increases in line with the Recovery Plan profile, it is important that these issues are addressed so that bed availability does not become a constraint to delivery. Pre-op improvements are also vital to increase productivity.

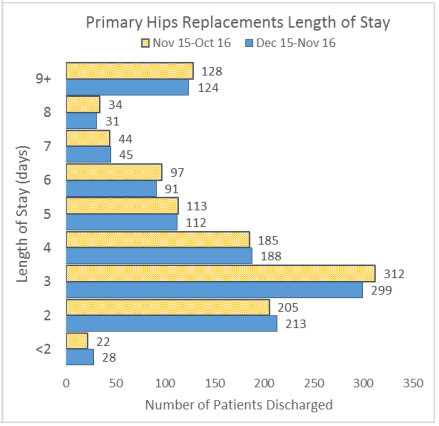
RISKS / ISSUES

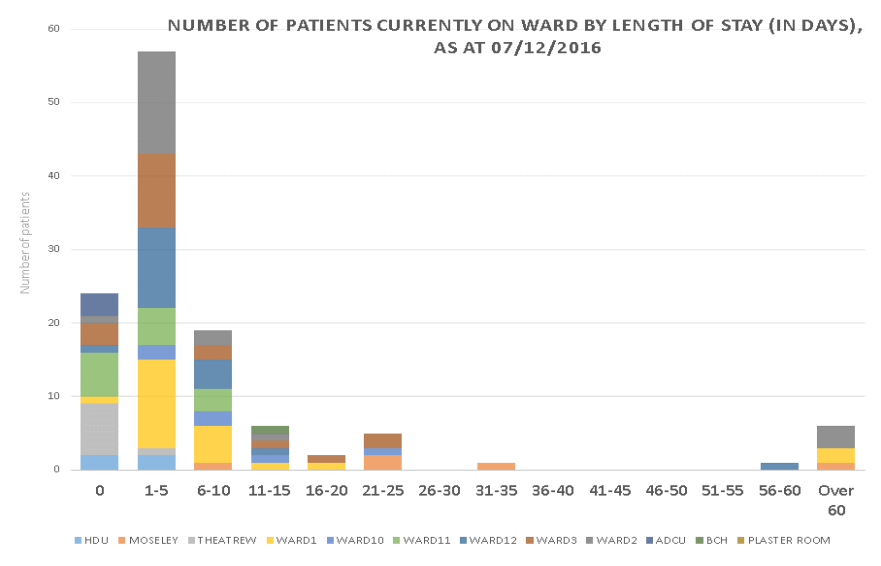
As activity increases in line with the profiled plan, it will become increasingly difficult to sustain admission before the day of surgery, and necessary to achieve a higher level of discharges before midday. There is no demonstrable progress as yet with "home before lunch", as can be seen from the graph. The increased capacity within POAC is required to ensure that sufficient numbers of patients are fit and ready for surgery. The prescribing pharmacists to support the model have been recruited and will start in post in the new year.
Given the high number of weekend lists being organised to deliver the required activity, there is a significant risk of staff burnout and fatigue, particularly given the high number of vacancies within theatres, as well as a financial risk if the number of cases and income achieved does not offset the increased costs.

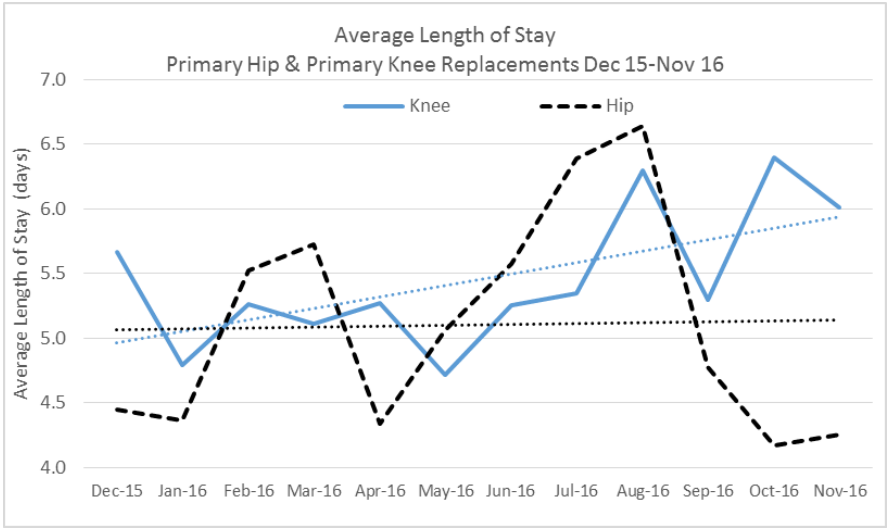
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Length of stay of for primary hips has shown early signs of improvement, and it is hoped that this links to the Rapid Recovery initiative. However, the linear trend primary knees remains upward, which is disappointing.

As at the end of November, 26 patients were being managed by the Trust's discharge nurse specialist. It is not clear whether this is good news as a result of earlier escalation by ward teams, or is a worrying sign of pressure in the system and constraints with regard to exit routes out of hospital for some of our more complex patients.

ACTIONS FOR IMPROVEMENTS / LEARNING

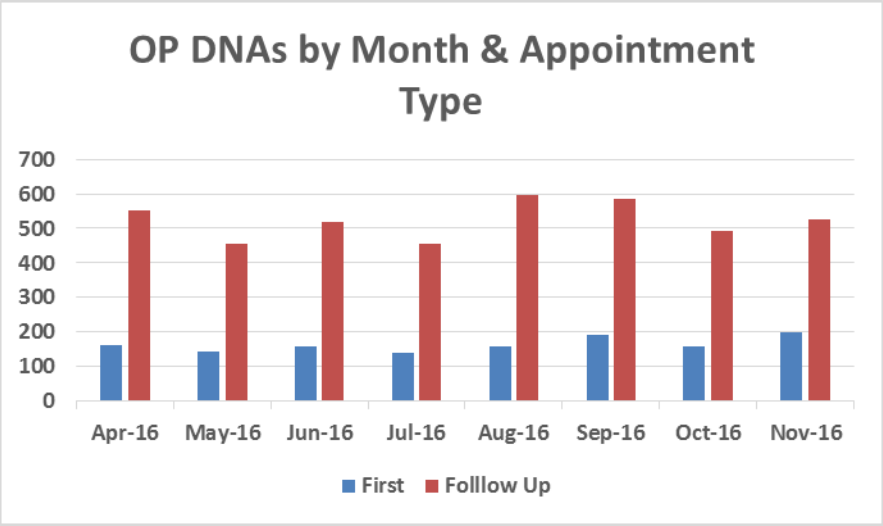
Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.

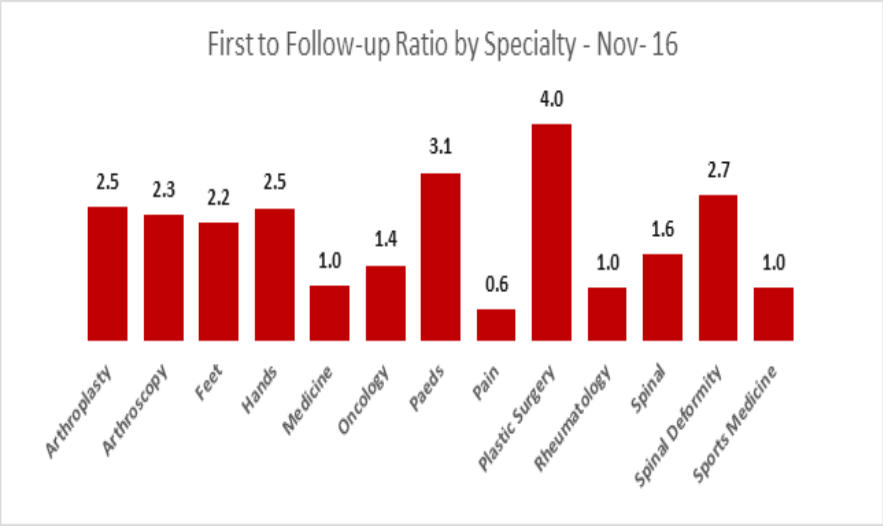
More formalised ward reviews should be part of consultant job planning discussions, which will be helpful in speeding up decision making and therefore shaving days off individual patient length of stay, or bringing discharge earlier in the day so that the bed can be recycled for incoming patients.

RISKS / ISSUES

With a defined bed stock, these changes need to happen at pace in order to deliver the level of activity required as part of the Trust's Recovery Plan.

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.

ACTIONS FOR IMPROVEMENTS / LEARNING

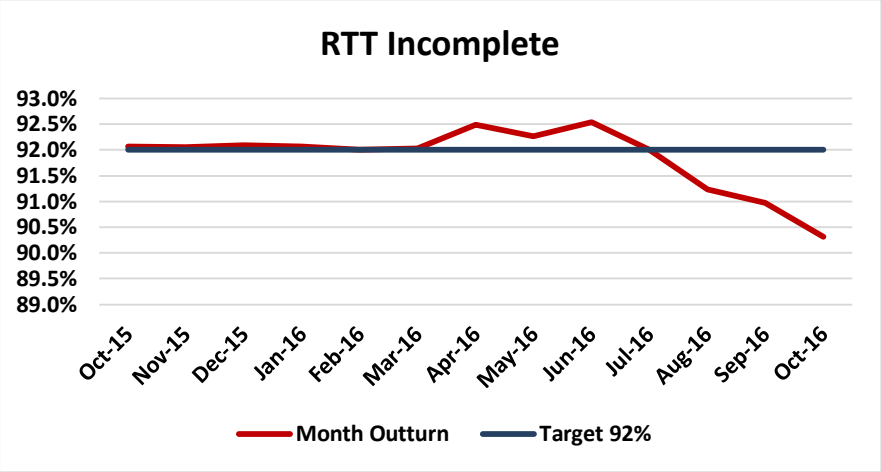
There are a range of actions as part of the CQC action plan and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

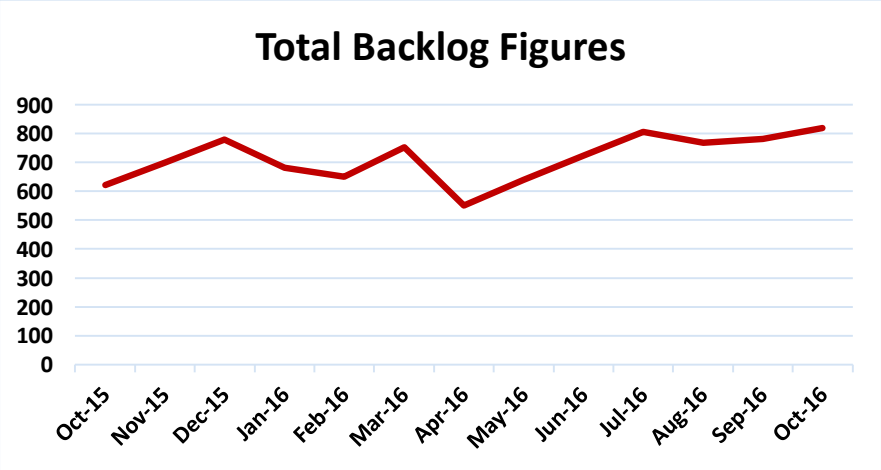
As part of the Trust's RTT recovery work, there will be a focus on outpatient pathways and any patients who are in the system awaiting a follow up appointment and have become overdue, for whom a new active RTT clock should be started in line with national guidance. Significant work is required with clinic templates to address the historic issue of "block booking" in the Oncology service, and so improve patient experience.

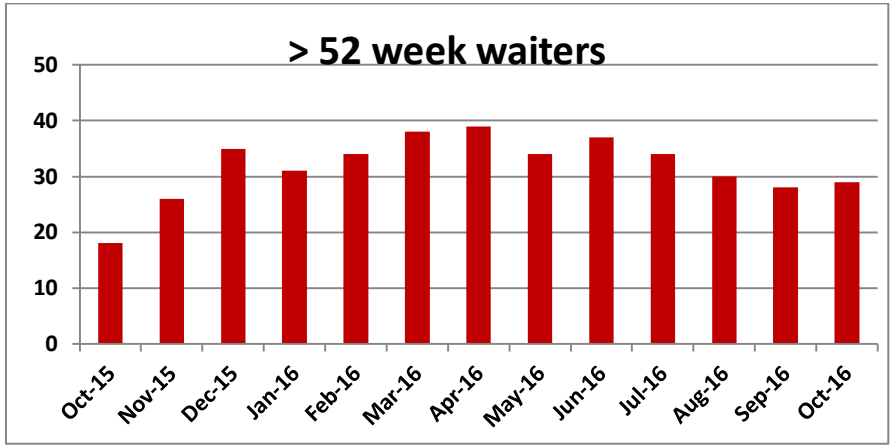
RISKS / ISSUES

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 - RTT	Target / Trajectory	Actual (October)	Actual (YTD)
52 Weeks Waiters	-	29	231
18 Weeks Incomplete	92%	90.32%	91.66%
NHSI Performance Targets - Cancer	**Target / Trajectory**	**Actual (November)**	**Actual (YTD)**
Cancer (2 week wait)	93%	100%	100%
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	98.11%
Cancer (31 days for 2nd or subsequent treatment)	94%	87.50%	95.71%
Cancer (62 days)	85%	No data	N/A

INFORMATION

RTT open pathway performance continues to be the main concern. The backlog continues to increase at a rapid rate for both admitted and non admitted pathways. The most recent externally reported performance is as follows:

- October: 90.3%
- November: likely to be no worse than 89%, but figure to be confirmed after validation. However, there are concerns around the robustness of pathway measurement.

The main issues (based on reported performance) are within arthroscopy, foot & ankle and spinal. The number of breaches within the pain service have increased due to consultant manpower, but a rectification plan is in place for this speciality.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are significant concerns with regard to data quality and the measurement of RTT waiting times. This has been escalated to NHS Improvement and other stakeholders, and was discussed at December Trust Board.

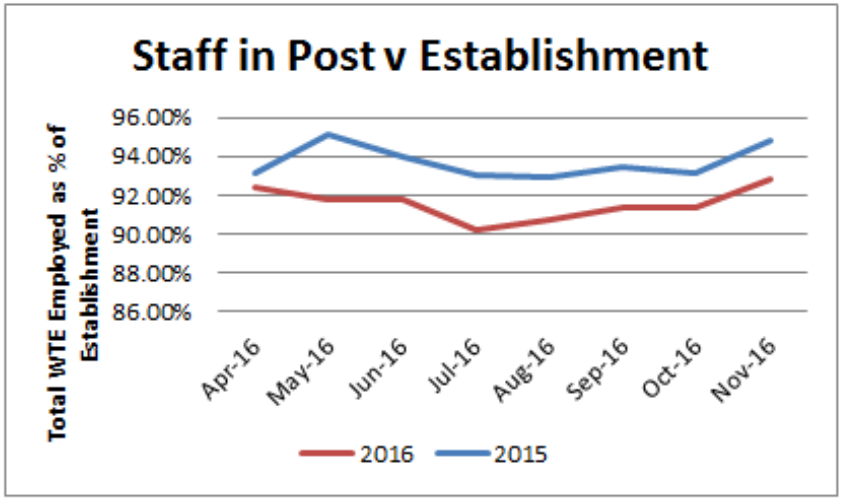
RISKS / ISSUES

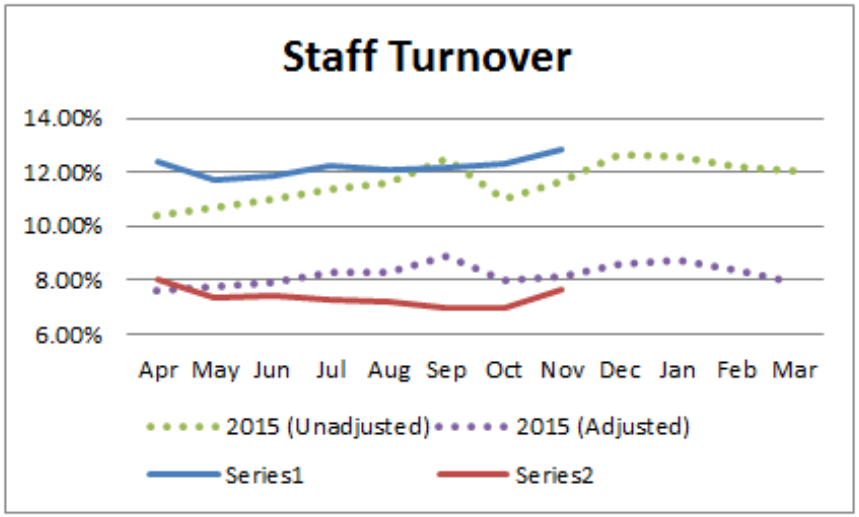
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further (end of November position to be confirmed, but likely to be 31.) Discussions continue with BCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern.

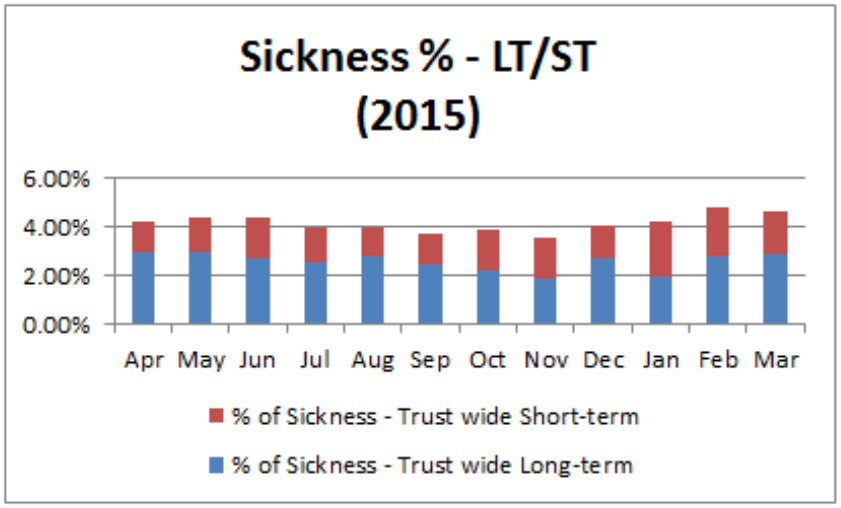
18 weeks: Significant work is underway to understand the scale of the challenge with regard to open pathways, and the extent of data quality concerns. The Trust welcomes the input and expertise of NHS Improvement in this area.

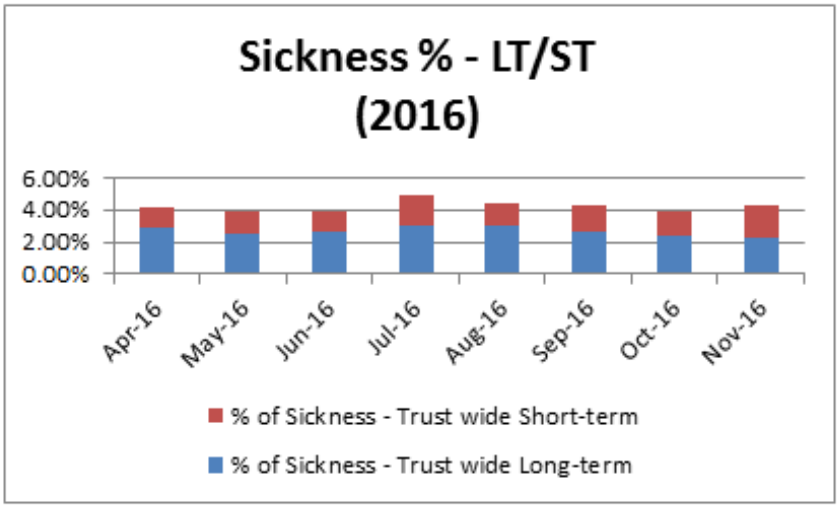
Given the concerns around RTT measurement robustness, the Divisional General Manager Division 2 is now undertaking some assurance work looking at cancer waiting times.

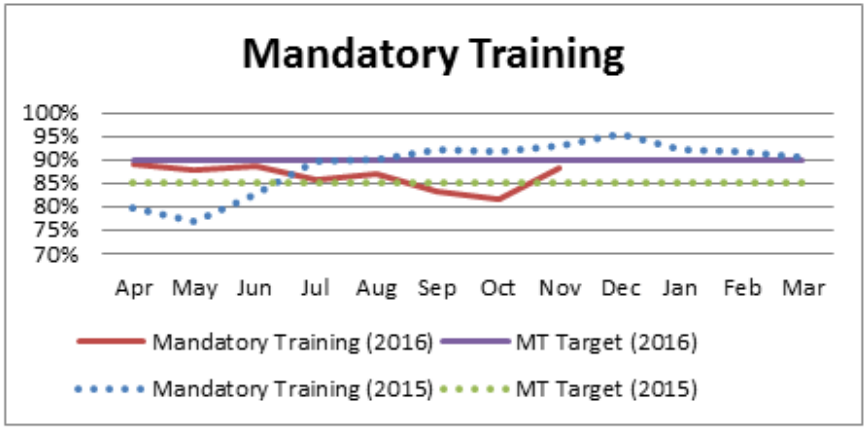
15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training.

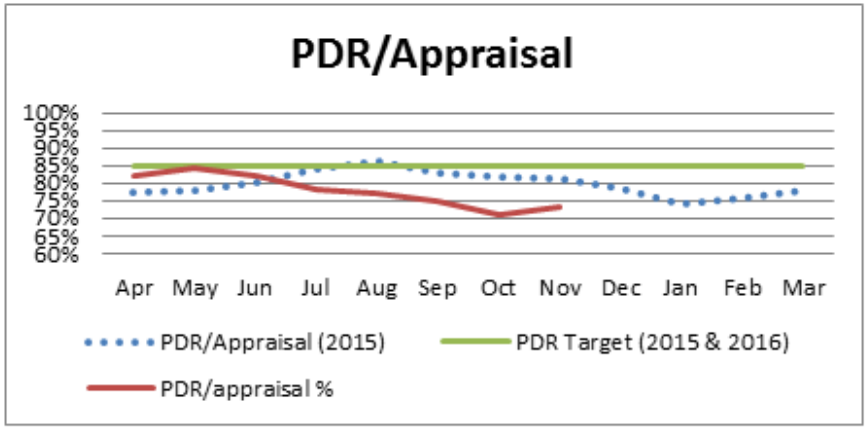












INFORMATION

The vacancy position saw a reduction in November to 7.2%. This is the 5th consecutive month where the gap has been closed and reflects good progress.

November has seen an increase in sickness absence by 0.37% versus the reported October position. Whilst progress in reducing long term sickness absence has been maintained for the 5th consecutive month, November saw an unusual amount of short term sickness which has caused the deterioration.

Mandatory training increased by a significant 7% in month. This has been achieved by provision of an additional session (increase in training capacity) together with release of appropriate staff. This is good progress.

PDR/appraisals has increased this month by 2%, so the decline of the last 5 months has stopped – but the Trust is still red and needs to improve its performance in this area.

Unadjusted turnover figure (all leavers except junior doctors in training and retire/ returners) and the adjusted turnover figure ("true leavers") were both higher than last month. Further work is being undertaken to analyse reasons for leaving to identify any causes for concern in the unadjusted figure because this is now red, but the "true leavers" remains green, despite the increase.

Turnover does tend to increase slightly in November and December at ROH but good performance in 2015 has been replaced with more typical figures in 2016, reflecting a worsening position.

ACTIONS FOR IMPROVEMENTS / LEARNING

Divisions will be asked to explain their plans for appraisal progress in their performance review meetings to improve their position.

RISKS / ISSUES

The Trust have now been issued with a compliance notice from our commissioners in relation to statutory and mandatory training and appraisal.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

November 2016

EXECUTIVE DIRECTOR:	Garry Marsh	Director of Operations, Nursing & Governance
AUTHOR:	Mustafa Ahmed	Head of Governance

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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.

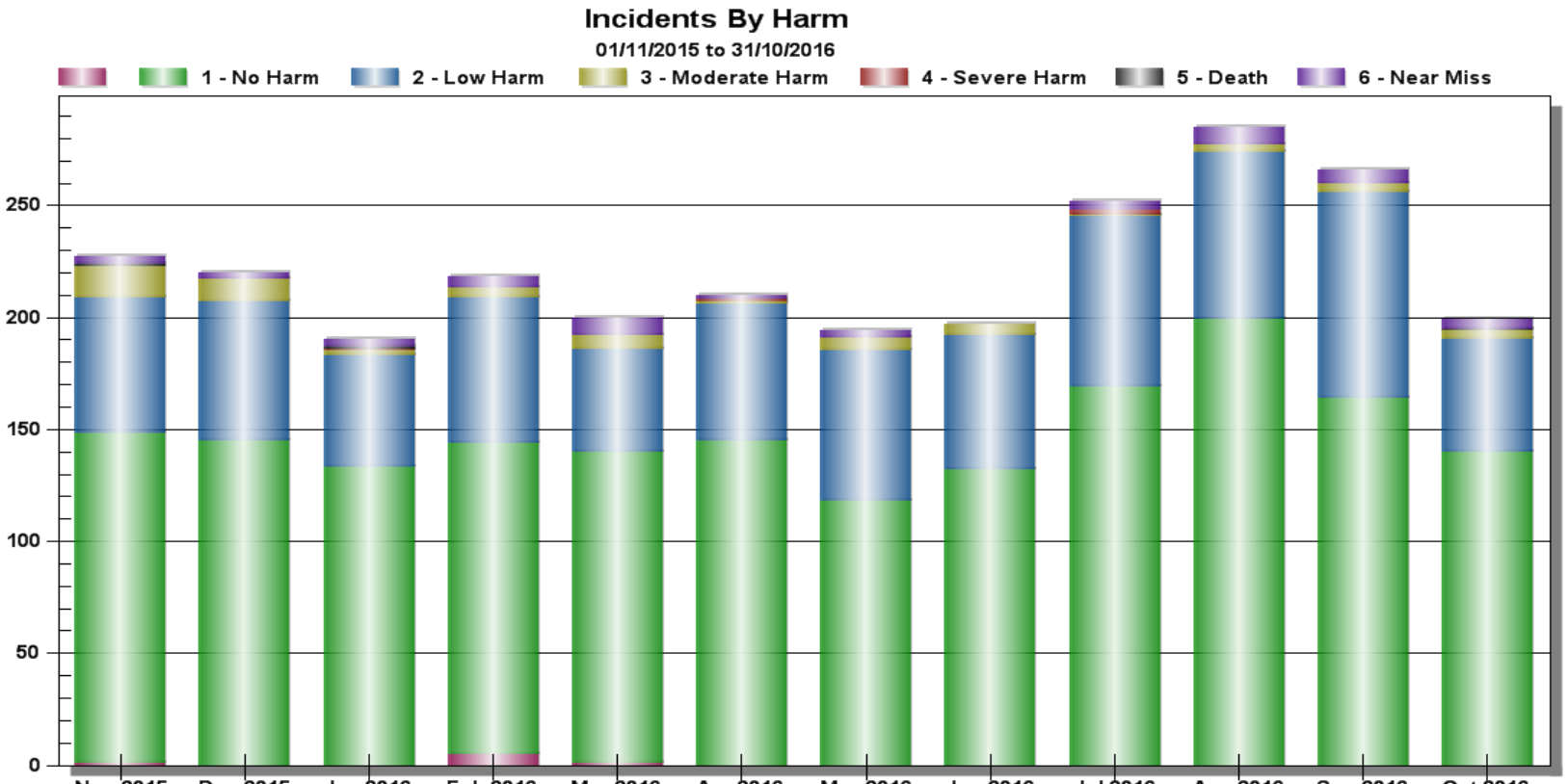
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: 0121 685 4000 (ext. 55641)

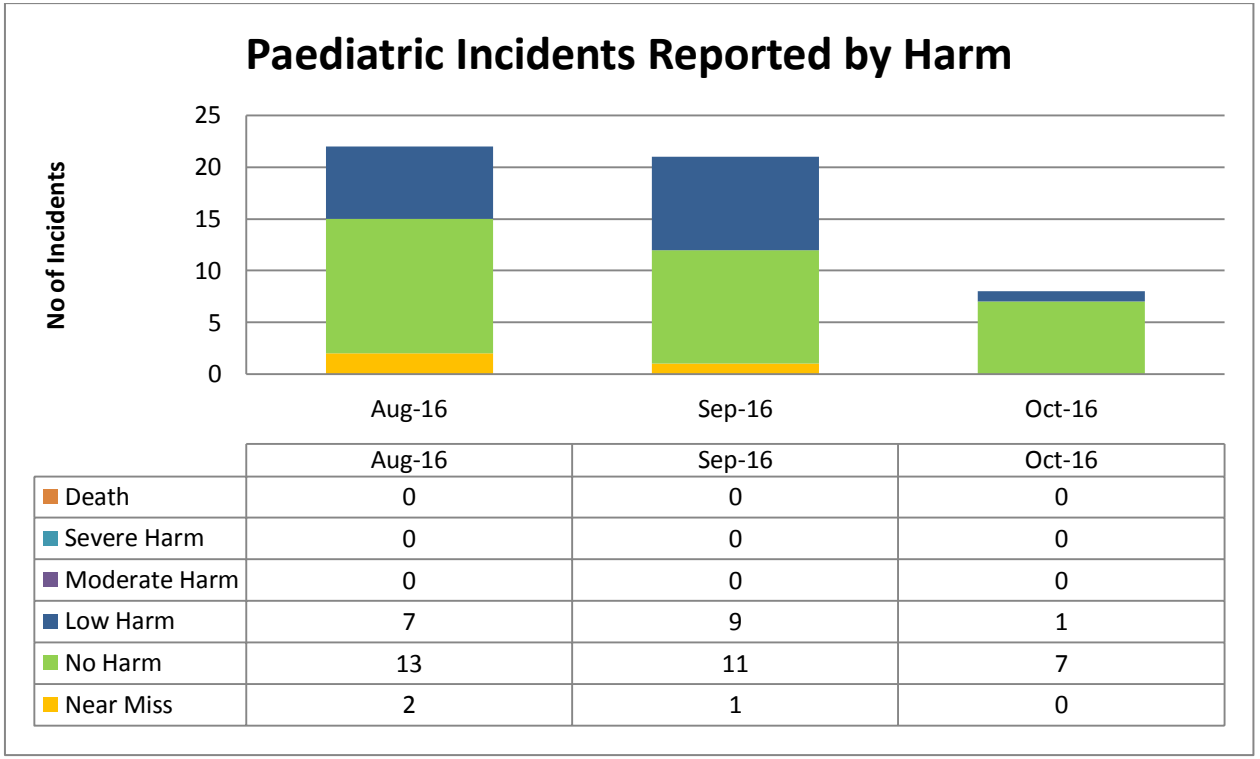
2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.



Month and Year	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016
1 - No Harm	147	145	133	139	139	145	118	132	169	199	164	140
2 - Low Harm	61	62	50	65	46	61	67	60	76	75	92	50
3 - Moderate Harm	14	10	2	4	6	1	6	5	1	3	4	4
4 - Severe Harm	0	0	1	0	0	1	0	0	2	0	0	0
5 - Death	1	0	1	0	0	0	0	0	0	0	0	1
6 - Near Miss	3	3	3	5	8	2	3	0	4	8	6	4

INFORMATION
There were 199 incidents reported in October 2016, including a death and four moderate harms.
ACTIONS FOR IMPROVEMENTS / LEARNING
Ulysses has been upgraded to provide improved services and graphics as displayed by the Incidents by Harm graph. Training has also been provided to key personnel in Governance to aid in achieving the best results from the upgrade.
RISKS / ISSUES
Incidents are not being reviewed by managers in a timely manner. Reports are being developed on Ulysses to identify these managers and the length of the delays with a view to providing them with support review their incidents accordingly.

Paediatric Incidents – This illustrates all incidents relating to Paediatric Patients that have been reported at ROH on Ulysses by members of staff during the previous 3 months (since when Ulysses was configured to capture the data). The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.

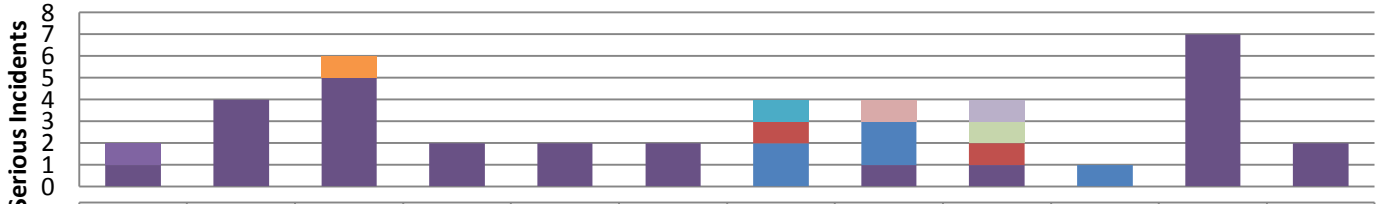


	Aug-16	Sep-16	Oct-16
Death	0	0	0
Severe Harm	0	0	0
Moderate Harm	0	0	0
Low Harm	7	9	1
No Harm	13	11	7
Near Miss	2	1	0

Eight incidents were reported in October 2016 involving Paediatric Patients. A breakdown was provided to the Children's Board in November and these were discussed in detail. The low harm incident was a Grade 1 pressure ulcer which is being investigated.

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 to October 2016



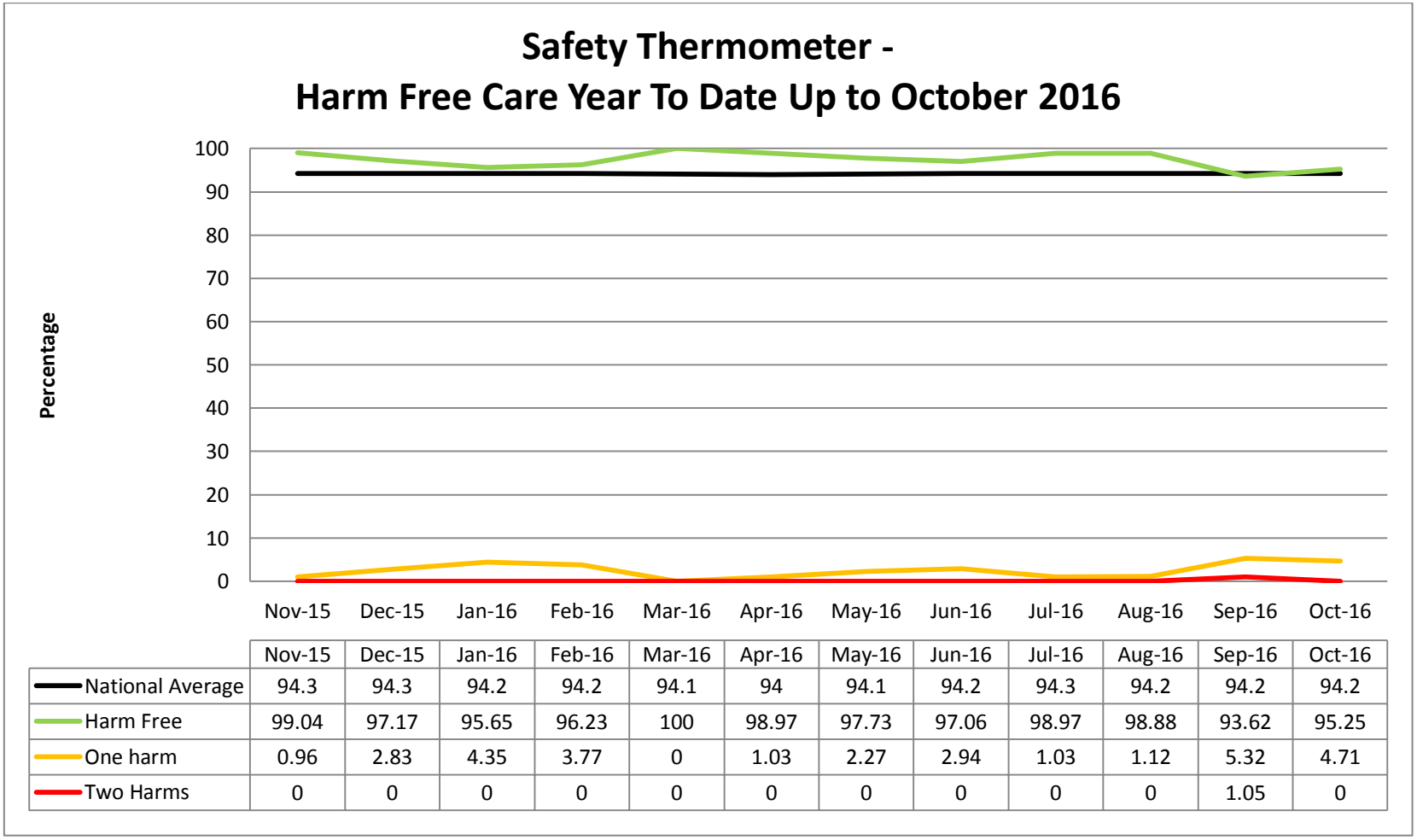
	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Wrong Site Incision									1			
Wrong Implant									1			
Suspension to services								1				
Delayed diagnosis			1									
Wrong side injection							1					
Unexpected deaths	1											
Staff conduct incidents												
Slips, trips & falls							1		1			
Pressure Ulcers							2	2		1		
Emergency transfer out of Trust												
VTE meeting SI criteria	1	4	5	2	2	2		1	1		7	2
Surgical incident meeting SI criteria												
Emergency transfer to HDU												
Failure to act on test results												

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

INFORMATION
There were two SIs declared in October 2016. These are due for submission with the Commissioners in January 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
One Serious Incident report was submitted to the Commissioners during October 2016. This was a grade 3 pressure ulcer. Lessons Learned; Although there was some very good documentation of pressure area care within the nursing documentation, detail regarding key preventative requirements e.g. off-loading were not always evident. The repositioning chart was at times inaccurately completed and the SSKIN assessment tool was not consistently completed as per expected standards. There was no documentation by medical staff regarding pressure damage either at the time of review and subsequent cutting of plaster or prior to discharge. The amount of assessment, prevention documentation relating to pressure ulcers within the Trust is significant and is currently in different booklets, this may increase the risk of sections being missed or not completed in full. All patients with any form of cast should be given written information on how to care for a cast at the earliest opportunity. This will empower them to question practice if necessary.
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.**



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
National Average	94.3	94.3	94.2	94.2	94.1	94	94.1	94.2	94.3	94.2	94.2	94.2
Harm Free	99.04	97.17	95.65	96.23	100	98.97	97.73	97.06	98.97	98.88	93.62	95.25
One harm	0.96	2.83	4.35	3.77	0	1.03	2.27	2.94	1.03	1.12	5.32	4.71
Two Harms	0	0	0	0	0	0	0	0	0	0	1.05	0

There were four harms reported during October. There were three new pressure ulcers and one fall with harm.

Children and Young Persons' Safety Thermometer

The Trust has started to submit data to the Children and Young Persons' Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. The table below illustrates the data that is recorded. The Governance Department will seek to collate National data and data from our comparable specialist Providers for the purposes of benchmarking. Further understanding of how to interpret the data is required to give meaningfulness.

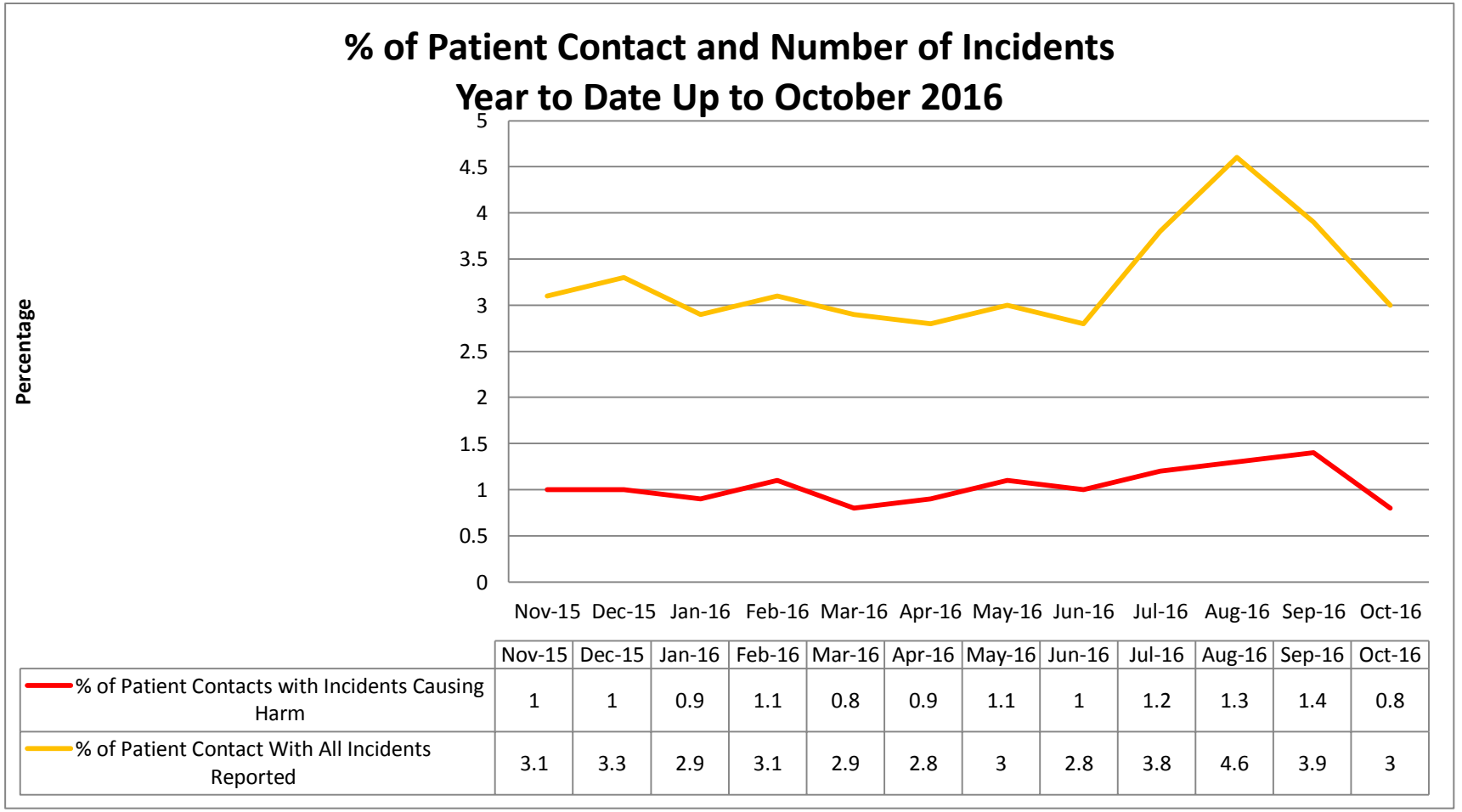
October 2016

	Local Reference	Gender	Age Group	EWS Completed	Extravasation	Patient in pain?	Pressure ulcer?	Moisture Lesion
1	1	Female	10-14 years old	Yes	No	No	No	No
2	2	Female	10-14 years old	Yes	No	No	No	No
3	3	Male	10-14 years old	Yes	No	No	No	No
4	4	Male	5-9 years old	Yes	No	No	No	No
5	5	Female	1-4 years old	Yes	No	No	No	No
6	6	Female	15-19 years old	Yes	No	No	No	No
7	7	Female	15-19 years old	Yes	No	No	No	No
8	8	Female	5-9 years old	Yes	No	Yes	No	No

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
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
Oct-16	50	4	0	1	55	201	6728

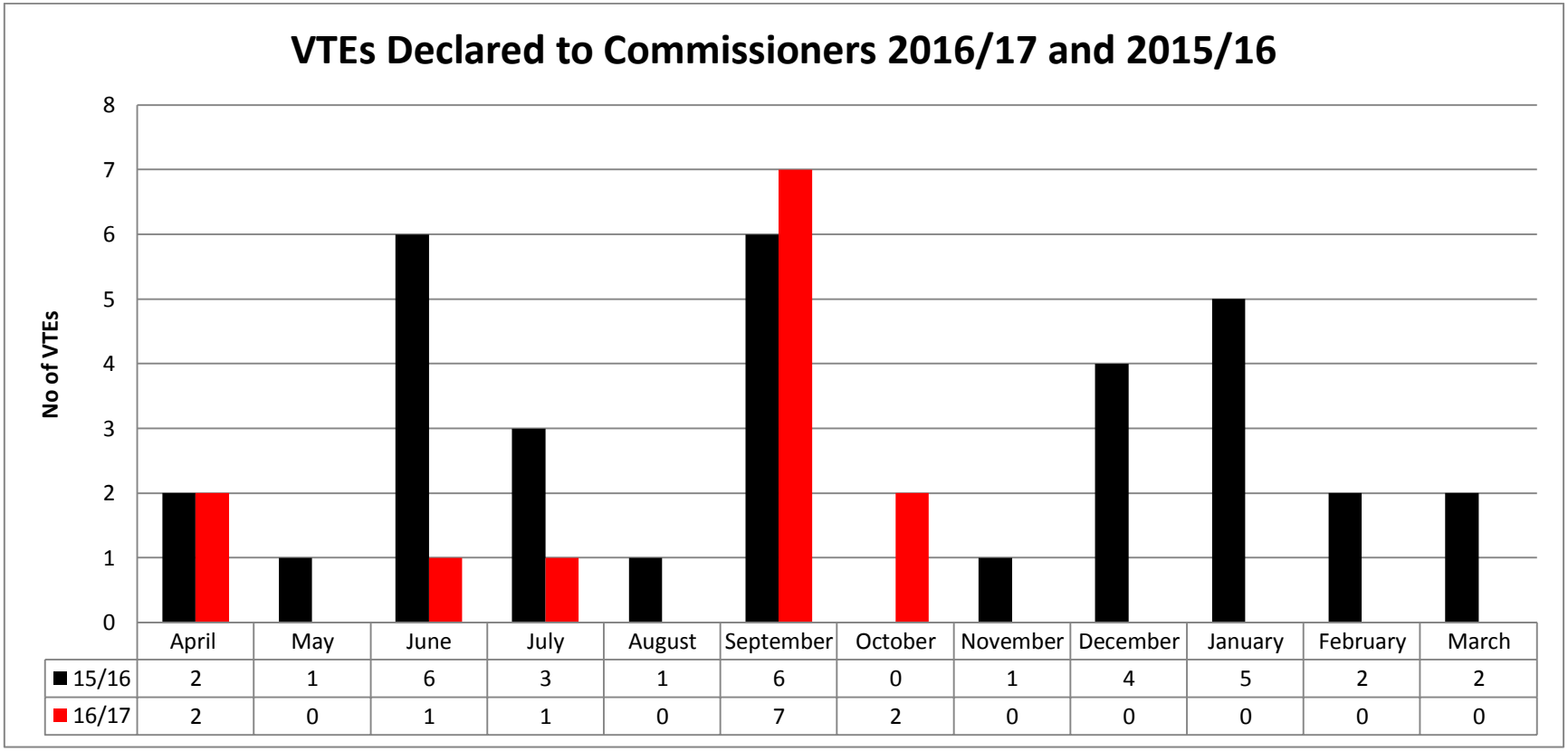
In October 2016, there were a total of 6728 patient contacts. There were 201 incidents reported which is 3 percent of the total patient contacts resulting in an incident. Of those 201 reported incidents, 55 incidents resulted in harm which is 0.8% of the total patient contact.



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
% of Patient Contacts with Incidents Causing Harm	1	1	0.9	1.1	0.8	0.9	1.1	1	1.2	1.3	1.4	0.8
% of Patient Contact With All Incidents Reported	3.1	3.3	2.9	3.1	2.9	2.8	3	2.8	3.8	4.6	3.9	3

There has been an approximate 20% reduction in the number of incidents reported this month from September 2016. 0.8% of total patient contacts resulted in an incident with harm. 3% of total patient contacts for the month resulted in an incident.

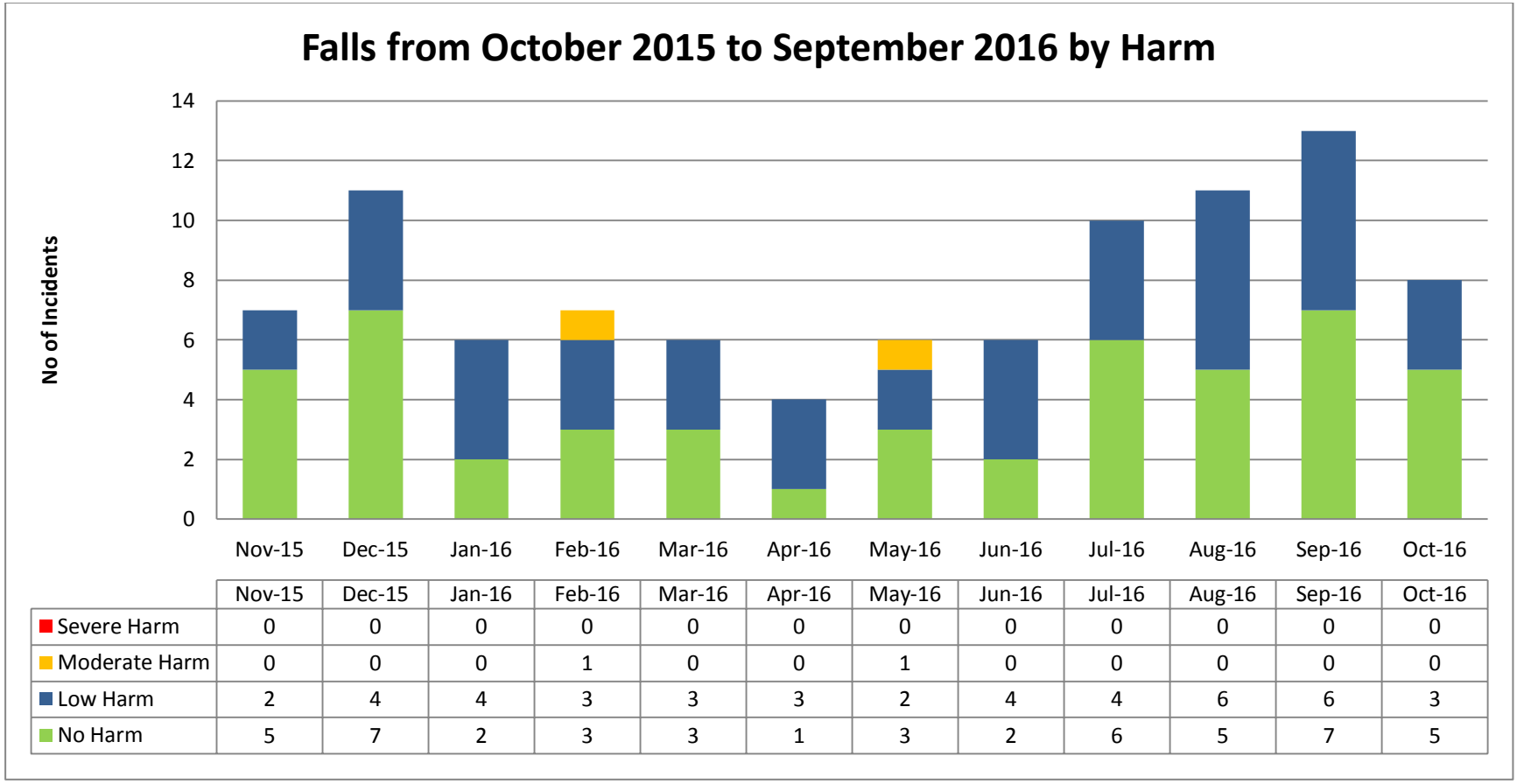
6. **VTEs - A venous thrombus is a blood clot (thrombus) that forms within a vein. Thrombosis is a term for a blood clot occurring inside a blood vessel. A common type of venous thrombosis is a deep vein thrombosis (DVT), which is a blood clot in the deep veins of the leg. If the thrombus breaks off (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).**



	April	May	June	July	August	September	October	November	December	January	February	March
15/16	2	1	6	3	1	6	0	1	4	5	2	2
16/17	2	0	1	1	0	7	2	0	0	0	0	0

INFORMATION
There were two VTEs that have been declared as SIs in October 2016. These are due for submission with the Commissioners in January 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
A questionnaire is now in use to collate patient feedback when completing post discharge VTE RCAs. 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, 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.
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.**



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	1	0	0	1	0	0	0	0	0
Low Harm	2	4	4	3	3	3	2	4	4	6	6	3
No Harm	5	7	2	3	3	1	3	2	6	5	7	5

INFORMATION

There were 8 falls incidents in October 2016;

- Four falls on Ward 1, three resulting in no harm and one resulting in low harm
- Three falls on Ward 2, one resulting in no harm and two resulting in low harm
- One fall on Ward 12 resulting in no harm

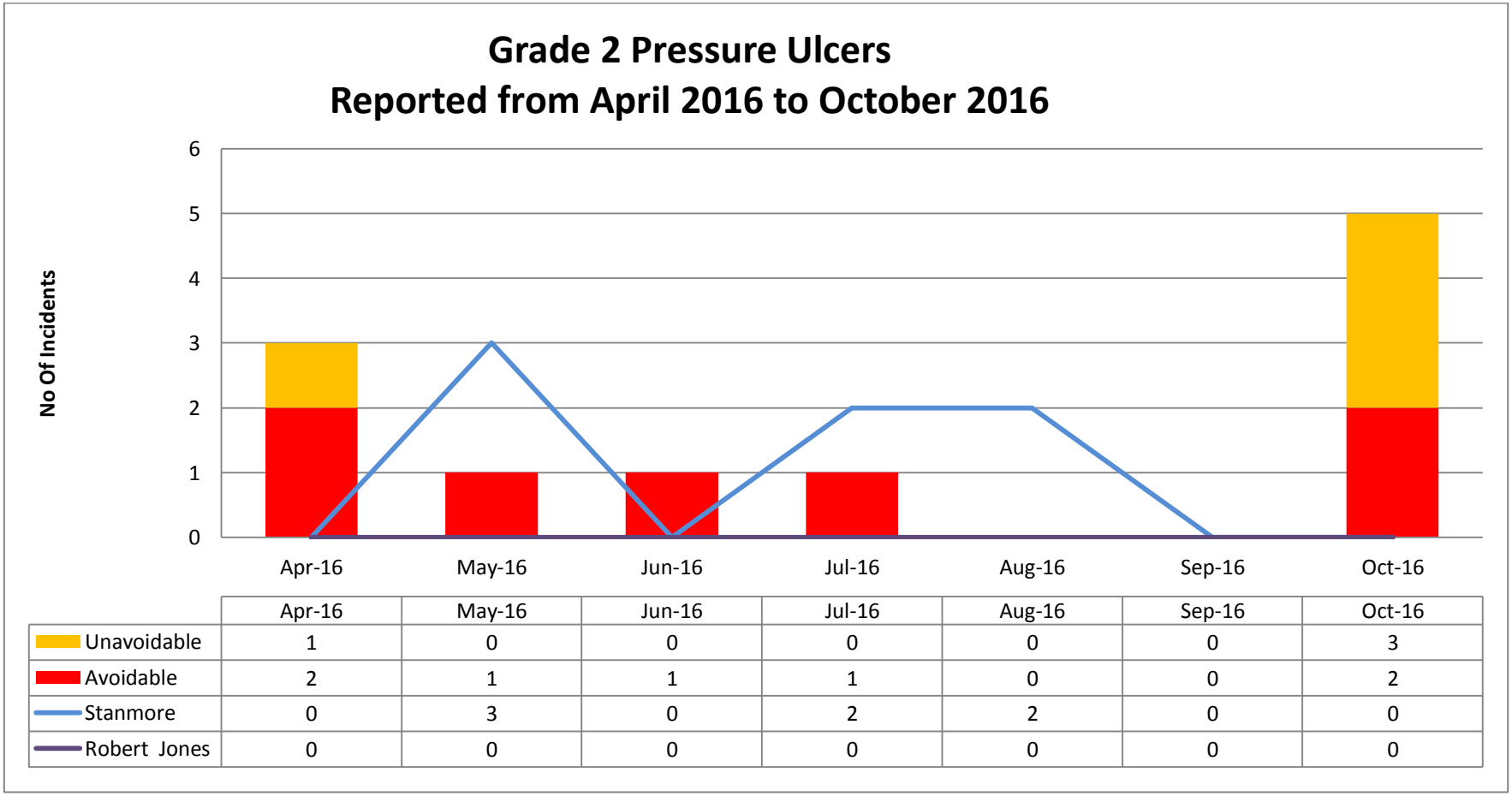
ACTIONS FOR IMPROVEMENTS / LEARNING

- 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). Training on the Hoverjack is now completed in the manual handling trainingprovided at the Trust.
- There is continued ongoing work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care. Review of this work has been extended and the aim is that this will be ready for consideration by the falls prevention and reduction committee in December 2016.
- Cross auditing will commence in November 2016.

RISKS / ISSUES

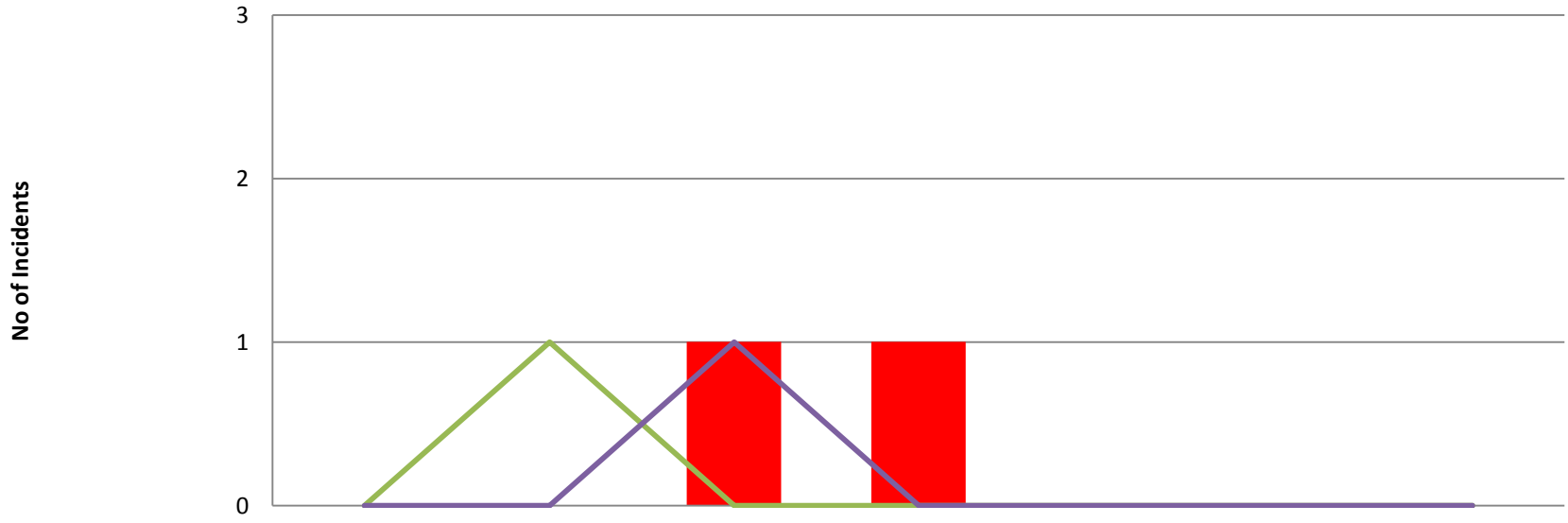
The falls agenda at the Trust requires a relaunch. Over the summer months the previous falls lead was on long term sick and the new falls lead, the Head of Nursing (Div 1), was new to post. The falls committee will be re-established and projects such as the 'Throne' project will receive new focus.

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	Oct-16
Unavoidable	1	0	0	0	0	0	3
Avoidable	2	1	1	1	0	0	2
Stanmore	0	3	0	2	2	0	0
Robert Jones	0	0	0	0	0	0	0

Grade 3 & 4 Pressure Ulcers reported April 2016 to October 2016



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Grade 4 (Avoidable)	0	0	0	0	0	0	0
Grade 3 (Avoidable)	0	0	1	1	0	0	0
Robert Jones	0	1	0	0	0	0	0
Stanmore	0	0	1	0	0	0	0

INFORMATION

There were eight grade 2 pressure ulcers reported in October 2016;

- Two were deemed avoidable.
- Three were deemed unavoidable, two in theatres and one on Ward 1. This was because all preventative measure were in place.
- Three are under investigation and are awaiting confirmation.

ROH contractual limit for Pressure Ulcers in 2016/17

- **Grade 2 Avoidable Limit is 15** - at October 2016 = 8 (avoidable)
- **Grade 3 Avoidable Limit is 0** - at October 2016 = 2
- **Grade 4 Avoidable Limit is 0** - at October 2016 = 0

ACTIONS FOR IMPROVEMENTS / LEARNING

There was an SI that was submitted to the Commissioners, approved and closed in October 2016. The lessons learnt have been detailed in the Serious Incidents section above.

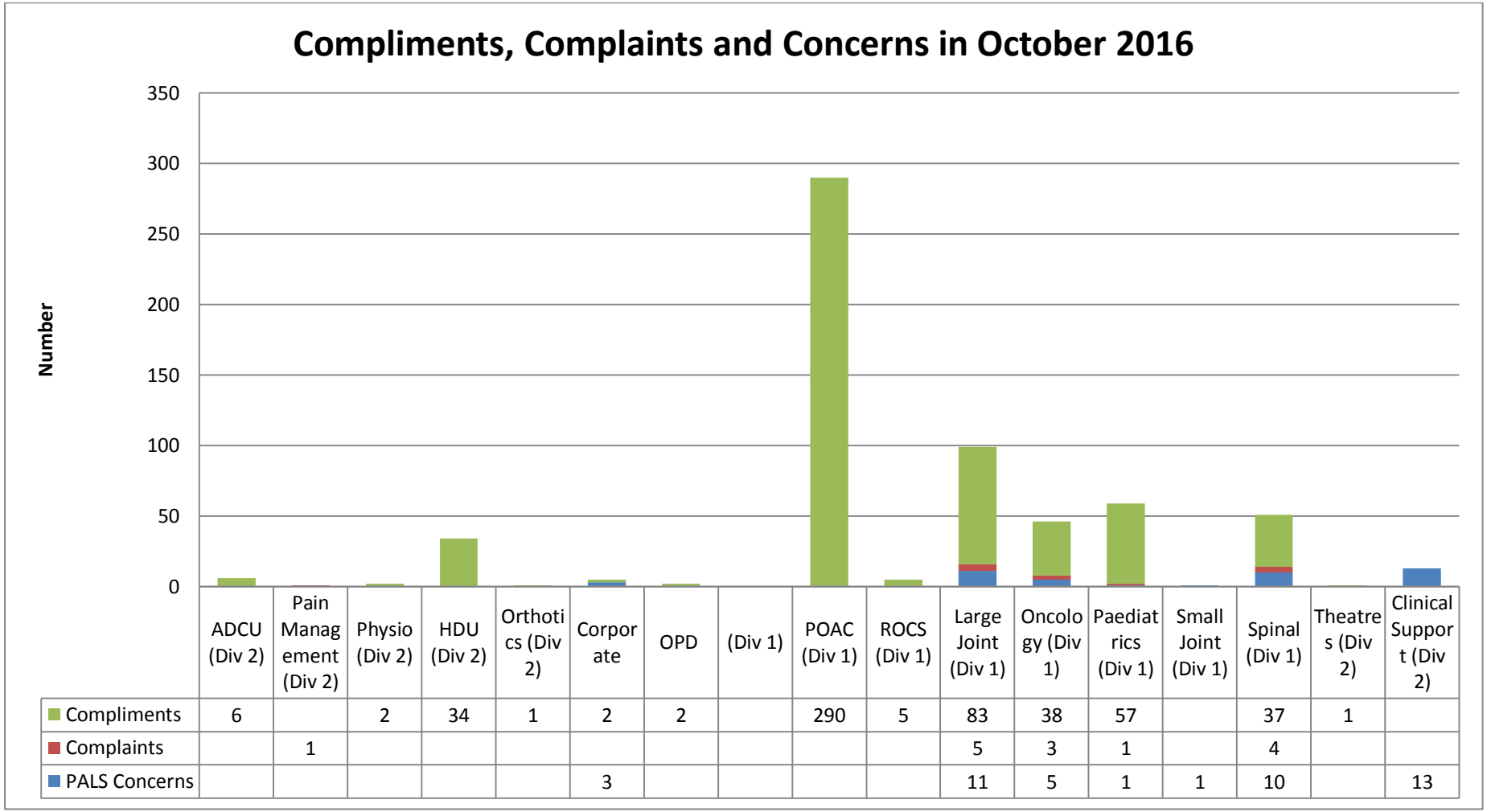
RISKS / ISSUES

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

The pressure ulcer data sources will be reviewed from the beginning of the financial year to ensure accuracy and consistency. This is due to the identification of a data quality issue.

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)	Physio (Div 2)	HDU (Div 2)	Orthotics (Div 2)	Corporate	OPD	(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)	Clinical Support (Div 2)
Compliments	6		2	34	1	2	2		290	5	83	38	57		37	1	
Complaints		1									5	3	1		4		
PALS Concerns						3					11	5	1	1	10		13

INFORMATION

There were 14 formal complaints, 44 concerns and 558 compliments received in October 2016;

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 19 complaints closed in October 2016, all of which were closed within the agreed timescales. This gives a 100% completion on time rate and meets the KPI.

- 7 were upheld
- 5 were partially upheld
- 7 were not upheld

Learning / Actions from complaints

Learning identified and actions taken as a result of complaints closed in October 2016 include;

- Approach of Junior Doctor was inappropriate and unhelpful
  Action: Professional conversation and mentoring initiated

- There is a lack of knowledge in some clinical areas with regard to provision for patients with an additional need
  Action: Training has been refreshed and presentation has been undertaken at the Senior Nurse meeting

- Communication of action being taken whilst is SIRI is in process is not always communicated to the family
  Action: Review of the SIRI process has been undertaken to ensure communication at key points

- Perception of nursing care generally continues to appear to be more negative
  Action: Review of last 6 months of complaints with regard to nursing input has begun and information will be shared at Divisional meetings and Clinical Quality Group

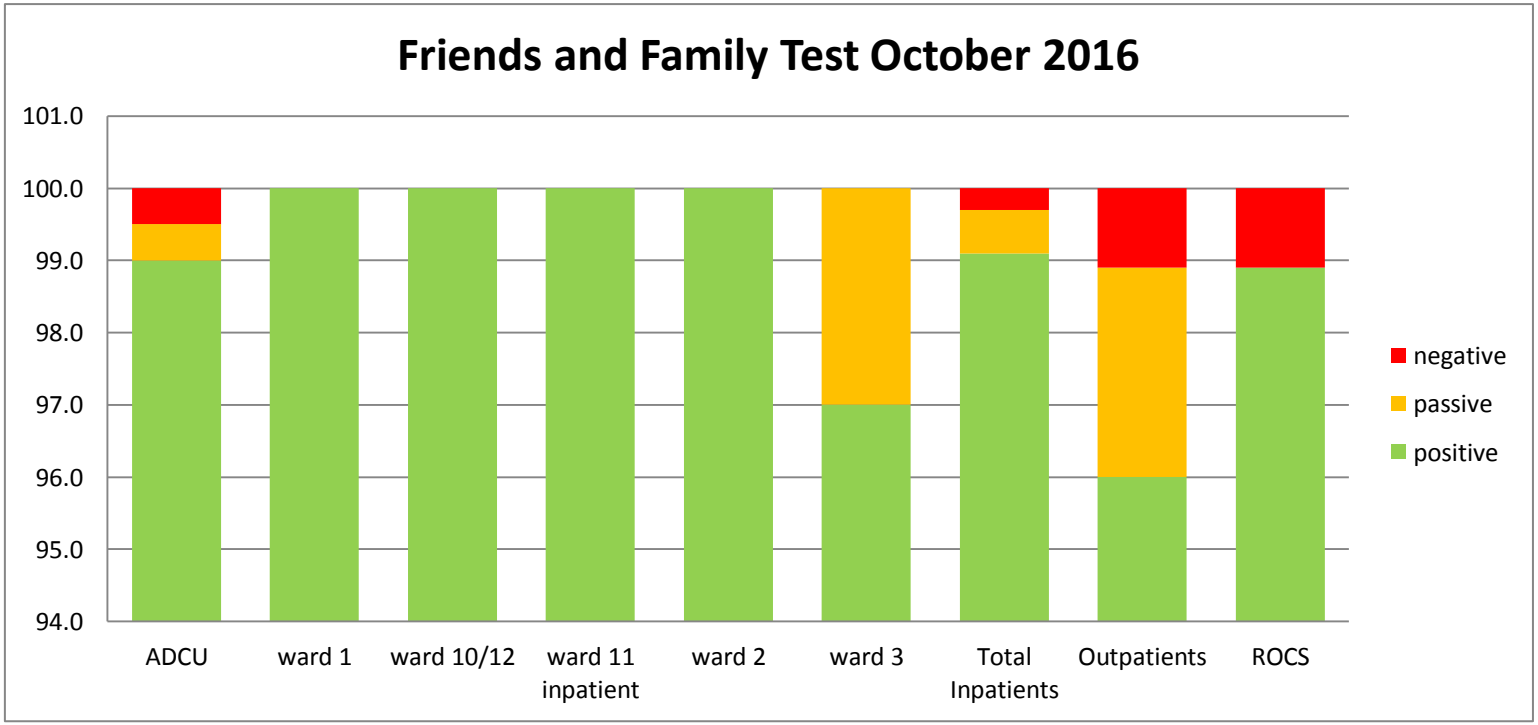
RISKS / ISSUES

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.

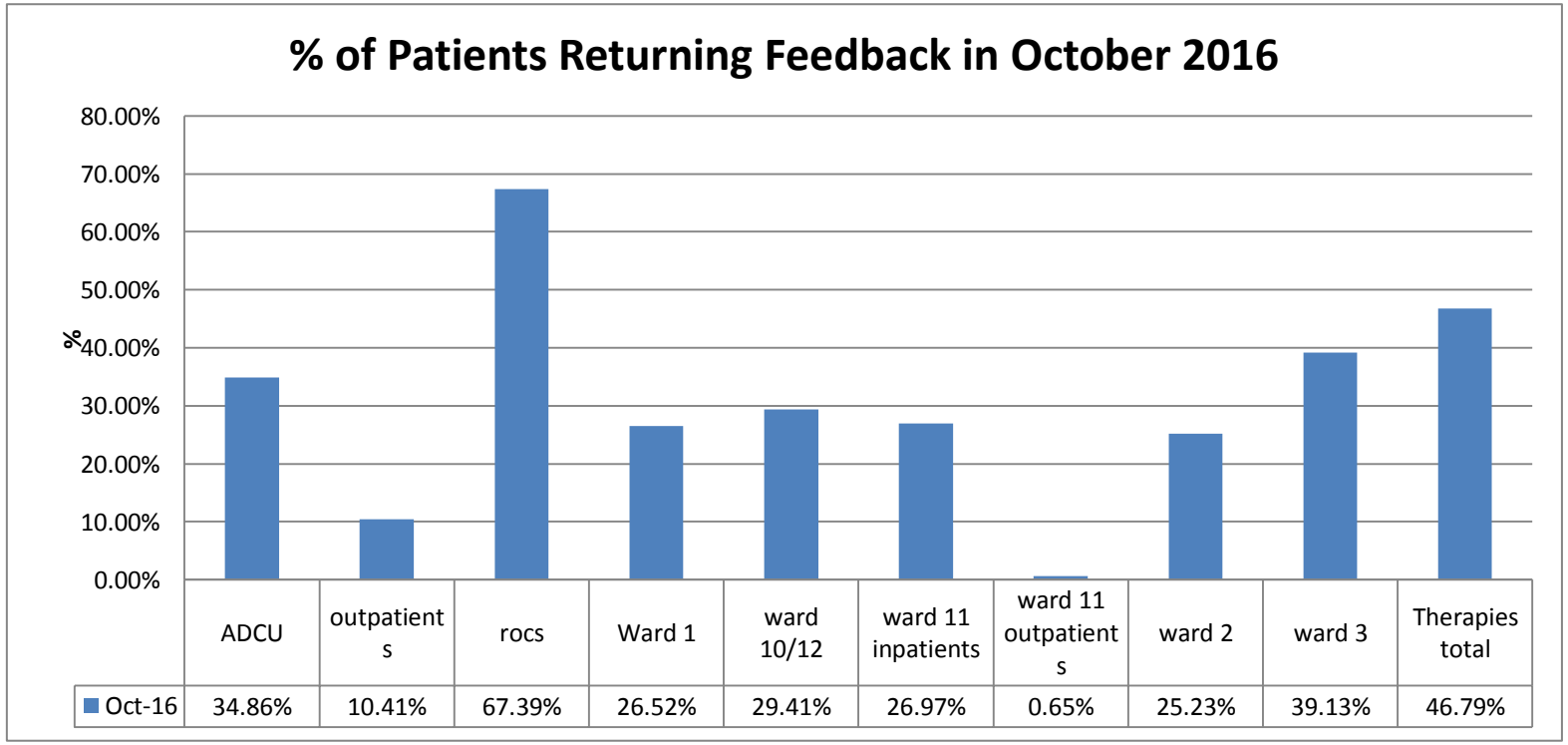
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting 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 96.91% of those who responded would promote ROH.



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.

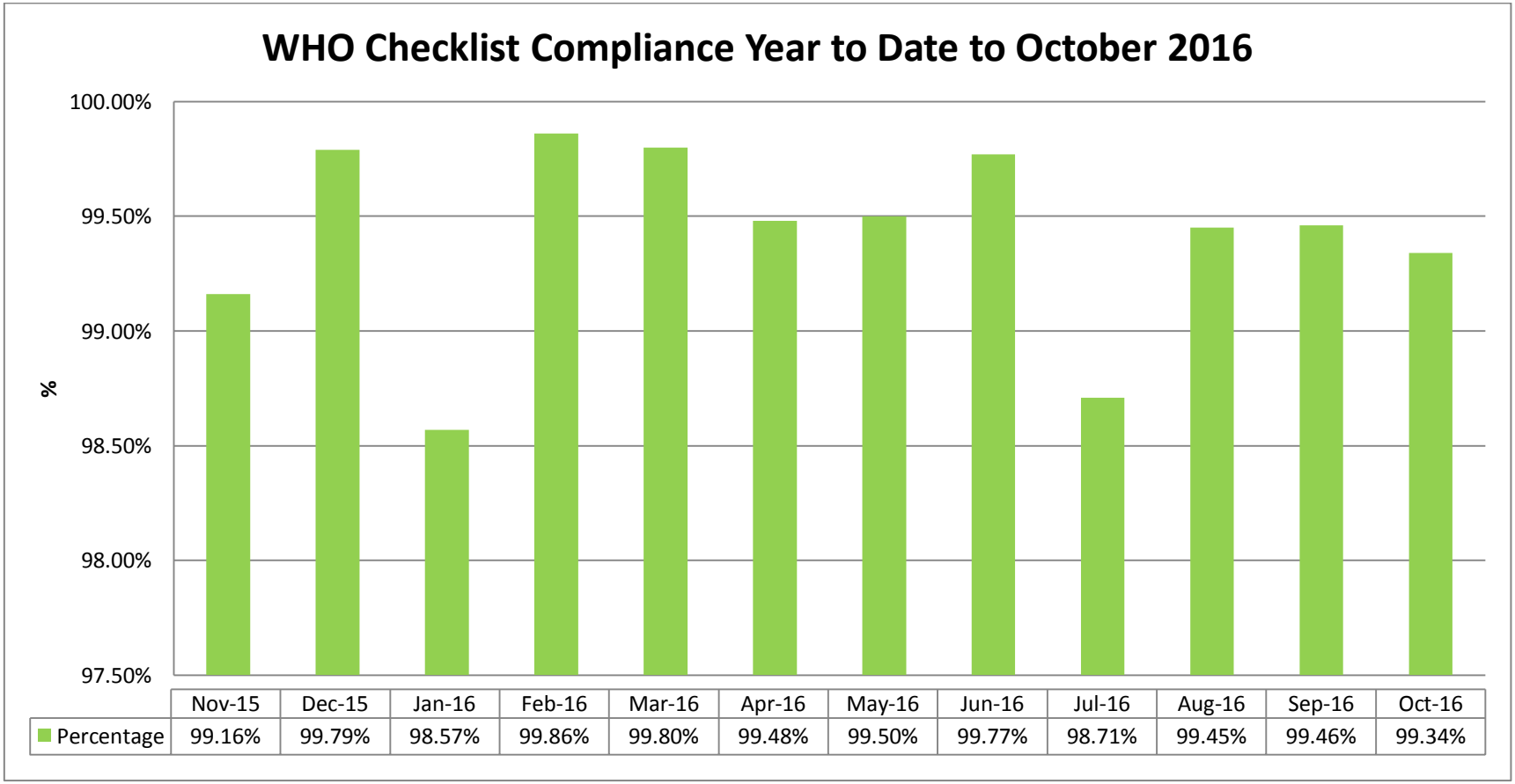
There are currently 19 open cases which have been identified as requiring statutory compliance with Duty of Candour. This is currently monitored by a Duty of Candour 'Tracker' to ensure compliance with Regulation 20.

12. Litigation

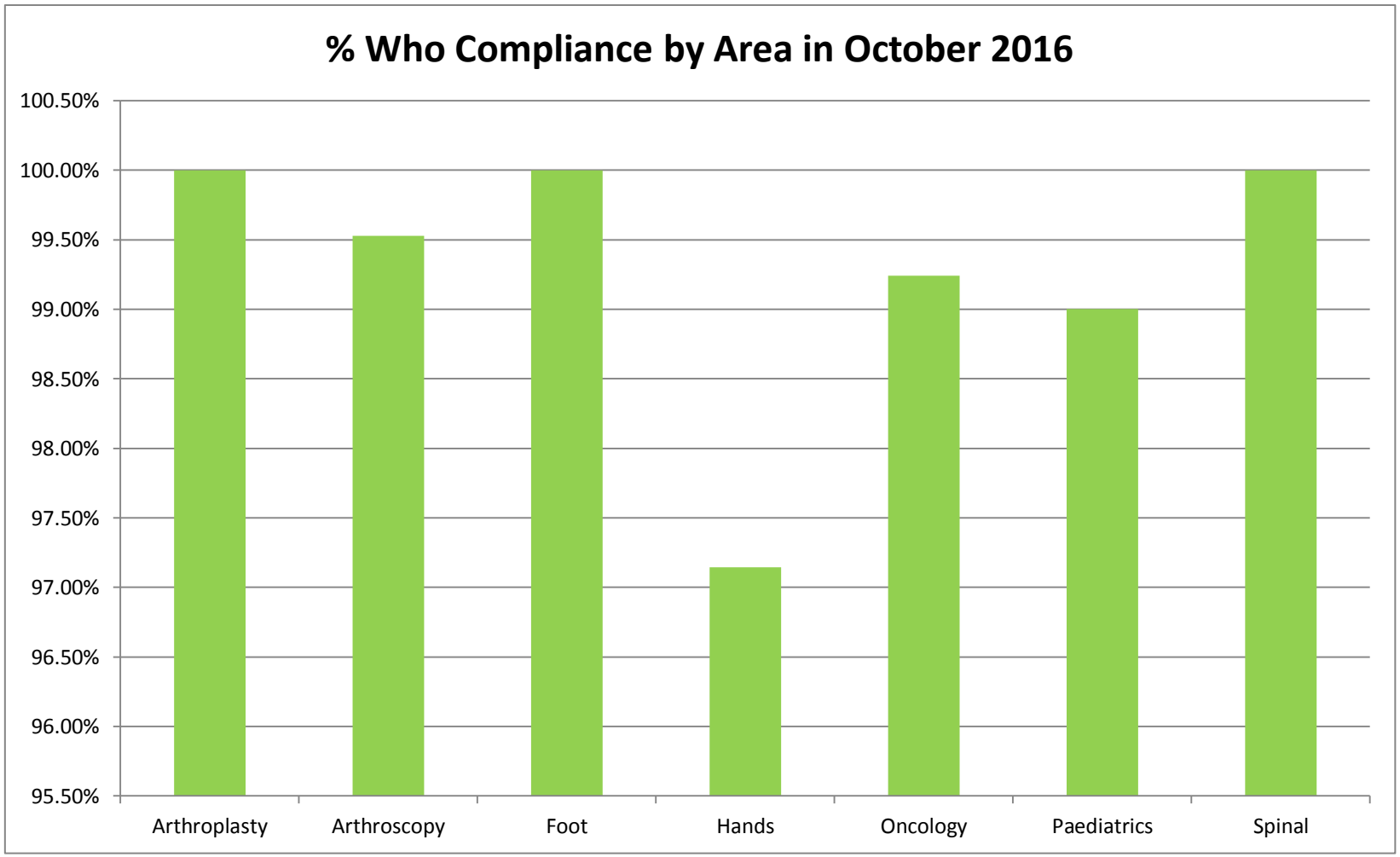
The Trust has received 1 new claim in October 2016;

Defence experts have been instructed to inform decision on liability ahead of drafting the formal Letter of Response.

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.**



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Percentage	99.16%	99.79%	98.57%	99.86%	99.80%	99.48%	99.50%	99.77%	98.71%	99.45%	99.46%	99.34%


% Who Compliance by Area in October 2016
100.50%
100.00%
99.50%
99.00%
98.50%
98.00%
97.50%
97.00%
96.50%
96.00%
95.50%
Arthroplasty
Arthroscopy
Foot
Hands
Oncology
Paediatrics
Spinal

INFORMATION

Total Cases in October 2016 = 756

Total Non-Compliance = 5

Total Compliance = **99.34% 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.
6. Audit results are also discussed as a standing agenda item at the Theatre User Group meetings

RISKS / ISSUES

Due to the Clinical Standards Lead being off sick, a detailed analysis was not available for October.

ROHGO (1/17) 008

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

SCHEDULE OF COUNCIL OF GOVERNORS, TRUST BOARD and ANNUAL MEMBERS' MEETINGS
JANUARY 2017 – JANUARY 2018

2017	January	February	March	April	May	June	July	August	September	October	November	December	January
Council of Governors **Wednesday 14.00 – 16.00** Chair: YB Secretariat: SG-L	18		15		17					Thu 5			17
Annual Members Meeting Chair: YB Secretariat: SG-L										Thu 5			

YB Yve Buckland SG-L Simon Grainger-Lloyd

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: 13 January 2017

Notice of a meeting of the Council of Governors

Notice is hereby given to all of the members of the Council of Governors of the Royal Orthopaedic Hospital NHS Foundation Trust that the following meetings of the Council of Governors will be held in the Board Room on 18 January 2017:

Meeting	**Timing**
Public section	1400h – 1600h

The business to be transacted is provided on the agenda enclosed or attached with this letter.

Signed

Dame Yve Buckland
Chairman

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 1 March 2017

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 1 March 2017 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** 1 March 2017: 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)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
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	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	Patient story – Rapid Recovery	Presentation	GM
1130h	4	Minutes of Public Board Meeting held on the 11 January 2017: *for approval*	ROHTB (1/17) 015	Chair
1135h	5	Trust Board action points: *for assurance*	ROHTB (1/17) 015 (a)	SGL
1140h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (3/17) 002 ROHTB (3/17) 002 (a)	YB/JC
		QUALITY & PATIENT SAFETY		
1155h	7	Patient Safety & Quality report: *for assurance*	ROHTB (3/17) 003	GM

FINANCE AND PERFORMANCE				
1210h	8	Finance & Performance overview: *for assurance*	ROHTB (3/17) 004	PA
GOVERNANCE, RISK AND COMPLIANCE				
1225h	9	Diversity & Inclusion update	To follow	AC
UPDATES FROM THE BOARD COMMITTEES				
1240h	10	Quality & Safety Committee & terms of reference (for approval)	ROHTB (3/17) 005 ROHTB (3/17) 006 ROHTB (3/17) 007	KS
1250h	11	Finance & Performance Committee	ROHTB (3/17) 008	TP
1255h	12	Council of Governors update	Verbal	YB
MATTERS FOR INFORMATION				
1300h	13	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 5th April 2017 at 1100h, Board Room, Trust Headquarters				

Notes

Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 11 January 2017: 1100h – 1300h

Members attending:

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair & Non Executive Director	(TP)
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:

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]

Minutes	Paper Reference
1 Apologies	**Verbal**
Apologies for absence were received from Frances Kirkham.	
2 Declarations of Interest	**Verbal**
There were no declarations of interest notified in advance.	
3 Staff story - HDU	**Presentation**
The Board welcomed Talitha Carding, HDU Matron and Jenny Ledwidge, HDU staff nurse. They presented an overview of the measures that had been taken to improve patient experience on the Trust's High Dependency Unit (HDU). The range of engagement activities and fundraising work was outlined by Ms Ledwidge. It was	

agreed that to attract c. £4k from these activities was very positive and Jenny was congratulated. The Teenage Cancer Trust had also been approached to support this work. It was suggested that the fundraising plans would further benefit from an understanding of the experience in some other children's units around the country. The link from this work to the wider fundraising activity was questioned. It was reported that the fundraising strategy was under development and work was under way to expedite this. Children's HDU formed a key part of this overall plan and was a key focus for fundraising. There was a challenge made in terms of whether a child who was using entertainment was best placed on HDU or whether these patients were more suited to a ward environment. The Director of Operations, Nursing & Clinical Governance advised that this was a matter for discussion through the Children's Board. The Chief Executive thanked the team for their work and suggested that thought should be given to linking in with the wider organisational engagement work across the Trust.	
4 Minutes of Public Board Meeting held on 2 November 2016	**ROHTB (11/16)**
The minutes of the previous meetings held on 2 November 2016 were accepted as a true and accurate record of discussions held.	
5 Trust Board action points	**ROHTB (11/16)**
The Board received and accepted the action tracker. The Associate Director of Governance & Company Secretary reported that there was some delay with those actions marked as red/amber: • Paperless Board solution – trials were underway with Content Locker. Some Executives were trialing this solution and NEDs would be engaged shortly. It was agreed that this action should be removed from the tracker until such time as reasonable progress was expected. • Quality & Safety Committee would consider how changed nursing establishments were impacting, if at all, on quality of care through consideration of the Patient Safety & Quality report	
6 Chairman's and Chief Executive's update	**ROHTB (1/17) 002** **ROHTB (1/17) 002 (a)**
The Chief Executive asked the Board to receive and accept her update. It was reported that members of the Board had attended a meeting with NHS	

Improvement (NHSI) on 20 December 2016 to discuss the Trust's revised financial recovery plan submitted on 21 November 2016. NHSI were assured by the Trust's plan, and the actions being taken to reduce the year-end deficit position. On 14 December 2016, a series of all staff briefings were held to inform staff of the Trust's recovery plan, and key schemes to drive forward the required savings. It was noted that disappointingly, the 'Recovery Day' originally scheduled for 22 January, was not going ahead given that insufficient numbers of clinical staff had volunteered to work on this day. It was noted that a meeting had been held with University Hospital Birmingham NHS FT and the Local Enterprise Partnership (LEP) around national rehabilitation centres. This was a positive collaboration and would be pursed particularly in terms of developing the functional restoration team. The Chairman advised that it had been a quiet period since the last meeting given the festivities. She reported that: • On 10 November she had spent the afternoon with Mr Grainger in theatres. • Ed Smith, Chair of NHSI had visited the Trust on the morning of Monday 14 November. • A Harrison Lecture had been held on 17 November when Prof Sir Keith Porter talked on from 'Bastion to Birmingham'. There had been good attendance from local schools. • The inaugural meeting of the STP Board had been held on 24 November • There had been a Board Development session on 7 December, which looked at team profiles but paved the way for further work later in the Board schedule to look at how the Board could better work as a Unitary body. It was important that the new Non Executives were part of this development work. • There had been a governors briefing on 13 December to discuss STP plans and the finance & performance recovery work that was underway • She had attended the funeral of Jean Rookes' funeral. Jean had died shortly before Christmas and was one of the ROH's longest serving governors. Condolences had been sent to Jean's family and in particular her husband. The process of seeking a replacement governor was underway.	
7 Patient Safety & Quality Report	**ROHTB (1/17) 003** **ROHTB (1/17) 003 (a)**

The Director of Operations, Nursing & Clinical Governance advised that the reportable Serious Incidents that were Venous Thromboembolisms (VTEs) were being investigated. Work was underway to strengthen the accountability for poor practice in this area. There had been a decrease in falls in October 2016 and the Head of Nursing was reviewing these through the oversight of the Falls Committee. There had been five pressure ulcers reported in October, however some Data Quality issues in the reporting of pressure ulcers had been detected. There was also some benchmarking work undertaken with other Orthopaedics centres. Given the low response rates, it was reported that there needed to be better focus on improving the Friends & Family Test process in future. In terms of the patient death reported, the detail and Root Cause Analysis would be presented at the January meeting of the Quality & Safety Committee. There were however, no immediate concerns.	
8 Safe Staffing Report	**ROHTB (1/17) 004** **ROHTB (1/17) 004 (a)** **ROHTB (1/17) 004 (b)**
The Board considered the usual monthly update on safe staffing which had been considered in detail by the Trust Management Committee on 23 November. It was noted that in future, the Director of Operations, Nursing & Clinical Governance would present this to Quality & Safety Committee with a biannual update to the Board. The key points of the report were: • Fill rates across ward areas showed that minimum safe staffing had been achieved. • Good progress had been made in appointing to adult nurse and healthcare support workers • Children's nurse recruitment remained a challenge • Agency use had improved, with a decline seen since September 2016 HDU recruitment was discussed, where an establishment of 6.6 Whole Time Equivalents (WTEs) would be achieved shortly. There was to be over recruitment into vacancies in recovery.	

The red ratings, were discussed, which it was reported reflected where staffing had been reduced due to bed closures. In terms of nurse vacancies, it was reported that there were 24.5 WTE vacancies, however offers had been made to cover 11.7 WTEs. A recruitment open day was planned. The nursing workforce group had continued to mature. A decrease in agency staff was noted to have been seen and was continuing largely on a downward trajectory. The nurses secured from overseas were working well.	
9 Finance & Performance overview	**ROHTB (1/17) 006** **ROHTB (1/17) 006 (a)** **ROHTB (1/17) 006 (b)**
The Board noted the key points of the Finance & Performance overview which had been discussed in detail at the last meeting of the Finance & Performance Committee. The Trust had delivered a cumulative deficit of £3,276,000 as at the end of November against a planned deficit of £1,827,000. In month, the Trust delivered a surplus of £104,000 against a planned surplus of £171,000. This represented the first monthly surplus achieved at the ROH since November 2014. The Trust was therefore £1,449,000 behind plan at the end of Month 8. Excluding the impact of the theatres closure, the Trust would be behind plan by £495,000. The Trust Executive had set up a weekly Recovery Board where progress against the action plans of the five recovery workstreams (Pre Operative Assessment Centre improvement, theatre efficiency, discharge planning, agency reduction and cost control) were monitored and challenged. The Chief Executive had also briefed the organisation on a number of key schemes that would drive improvement in the financial position for the remainder of the year and beyond. As at the end of Month 8, the Trust had recognised £1,897k of CIP savings, against a plan of £2,276k. £579k (31%) of savings to date were non-recurrent. The in-month savings recognised were £246k against a November target of £349k. November showed a significant reduction in agency spend (from £401,000 to £364,000), this being the second month in a row with agency spend reduction. This reduction was seen across nursing and corporate spend, although there was a £30k increase in locum spend. Despite the reduction, the spend remained above plan (£340,000). 18 week Referral to Treatment (RTT) open pathway performance continued to be a prominent concern. The backlog continued to increase at a rapid rate for both admitted and non admitted pathways. The main issues (based on reported performance) were within arthroscopy, foot & ankle and spinal. Significant further	

work was underway to understand the scale of the challenge with regard to 18 weeks open pathways, and the extent of data quality concerns. The Trust welcomed the input and expertise of NHS Improvement in this area. In terms of the 52 week waiting times, spinal deformity remained a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continued with Birmingham Children's Hospital to ensure that additional capacity was in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of Paediatric Intensive Care Unit beds over the winter months remained a significant concern. Given the concerns around RTT measurement robustness, the Divisional General Manager for Division 2 was undertaking some assurance work looking at cancer waiting times.	
10 Board Assurance Framework (BAF) - Quarter 3 update	**ROHTB (1/17) 008** **ROHTB (1/17) 008 (a)**
The report was received and noted, which was a quarterly update on the progress with the mitigations to address the risks that could impact on delivery of the Trust's strategic objectives Two new risks had been added: 1) declining cash reserves & impact on Going Concern status of the organisation; 2) Poor administration of 18 weeks RTT & the impact on reporting national target The BAF would go forward to be scrutinised by the Audit Committee at its next meeting. It was proposed that the Board more fully considered whether it had the right risks reflected on the BAF at a future Board Development session, a suggestion which was supported.	
11 Quality & Safety Committee	**ROHTB (1/17) 009** **ROHTB (1/17) 010**
The assurance report from the Quality & Safety Committee was received and noted. It was noted that the new Deputy Director of Nursing & Clinical Governance had been appointed.	
12 Audit Committee	**ROHTB (1/17) 011**
The assurance report from the Audit Committee was received and noted. It was noted that the recommendation tracker was to be given good focus ready	

for presentation at the next meeting. A presentation on theatre stock had provided the Committee with a good level of assurance. The Audit Committee terms of reference were presented for and gained the Board's approval.	
13 Finance & Performance Committee	**ROHTB (1/17) 012** **ROHTB (1/17) 013**
The assurance report from the Finance & Performance Committee was received and noted. It was highlighted that it was positive that data was available much more readily and was being used to drive culture change. Cancellations still remained a key issue.	
14 Revised Board & Committee meeting schedule	**ROHTB (1/17) 014** **ROHTB (1/17) 014 (a)**
The Associate Director of Governance & Company Secretary presented the proposed meeting dates for 2017/18; this saw a shift in the frequency of Board meetings from every month to alternate months, with Board Committees sitting in the vacant months. The new cycle started from April 2017. Also proposed was the establishment of a new Committee, the Major Projects and Organisational Development Committee, which would be chaired by Richard Phillips, who was to become a full NED from the end of January 2017, when Tauny Southwood and Frances Kirkham finished their term of office. The Board was asked and agreed to approve these terms of reference. A suggested membership of the Committees was considered. The Board was asked to and approved this proposal. It was suggested that Quality & Safety Committee could in the longer term be held on alternate months with a walkabout in the intervening months, however for now it should remain monthly. Clarity was sought on the February and March meetings for Finance & Performance Committee, which the Associate Director of Governance & Company Secretary agreed to provide outside of the meeting .	
15 Any other business	**Verbal**
As this was his last meeting, the Chairman wished Tauny Southwood well and presented him with a gift. In return Professor Southwood thanked the Board for its	

support during his time in office. It was reported that a Council of Governors meeting was to be held on 18 January 2016 and all NEDs were welcome to attend. Board photos were planned after the meeting.	
Details of next meeting	**Verbal**
The next meeting is planned for 1 February 2017 at 0900h in the Boardroom, Trust HQ.	

PUBLIC SESSION

Next Meeting: 1 March 2017, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

11 January 2017, Boardroom @ Trust Headquarters

Members present: Yve Buckland (YB), Tim Pile (TP), Rod Anthony (RJA), Kathryn Sallah (KS), Tauny Southwood (TS), Jo Chambers (JC), Paul Athey (PA), Garry Marsh (GM), Andrew Pearson (AP), Phil Begg (PB)

In Attendance: Richard Phillips (RP) , Anne Cholmondeley (AC)

Apologies: Frances Kirkham (FK)

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	The PAs to the Directors and some Directors have recived a demosntration of Content Locker, an electronic document management system, which has the potential to manage Board papers in a paperlite way. Suggested names of NEDs to trial the system have been provided and contact will be made in due course.	
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	~~05/12/2016~~ 01/02/2017	Action also raised by Quality and safety Committee and will be reported back in ~~December~~ February (there was no meeting of the Quality & Safety Committee in December to discuss this issue)	
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 provided on the agenda of the January 2017 meeting, which reflects a number of risks around sustainability	

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:	**1 March 2017**

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:

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 March 2017

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 11 January 2017.

2 RECOVERY DAYS

2.1 The decision was made to cancel the first of the planned 'Recovery Days' in January 2017 because more time was needed to establish a protocol and secure sign up to undertake additional lists. The first Recovery Day therefore was held on Sunday 5th February, with three of our consultant surgeons (supported by their anaesthetist & theatre teams) operating on this day. The next Recovery Day is due to be held on 26 February 2017.

3 OPERATIONAL IMPROVEMENTS

3.1 It is anticipated that the Trust will achieve its Rapid Recovery CQUIN for 2016/17 which is an excellent achievement. Over 50 patients have been treated as 'rapid recovery' patients, enabling them to return home within 24-48 hours of their operation. The intention is to expand this programme from large joints across other specialties in 2017/18.

3.2 Our new Theatre scheduling software 'Theatreman' is due to go live across the Trust on 6 March 2017. Training is underway, and this presents the Trust with the opportunity to be more productive, reducing variation and removing inefficiencies.

4 MENTAL HEALTH CONCORDAT

4.1 The Trust has submitted a letter of intention to support the newly established West Midlands Mental Health Concordat, demonstrating the commitment of key organisations to support the key principles of improving the mental health and wellbeing of people across the region. Further detail is provided at Appendix A & B.

5 STAFF RECOGNITION

5.1 The Trust's Staff Awards were held on 3 February 2017 at Rowheath Pavillion in Bournville. In total, 11 awards were presented including 'Developing People Award',

'Patient Safety Award' and the 'Lifetime Achievement Award'. Feedback from the event has been very positive, and it was a great start to our bicentenary year.

5.2 Our Associate Medical Director, Mr Matthew Revell, has been shortlisted for the 'Inclusive Leader Award' at the West Midlands Leadership Academy Recognition Awards for 2016/17. The ceremony will take place on 28 February 2017.

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:

- With the Chairman, welcomed a delegation from the Health Ministry in Thailand
- Partnership meeting with Chair and CEO of Robert Jones & Agnus Hunt Orthopaedic Hospital NHS Foundation Trust
- Attended Leadership Transformation Theme Group meeting
- West Midlands CEO Provider meetings (January & February)
- ROH hosted Paediatric Spinal Deformity meeting with NHS England (specialised commissioners), NHS Improvement and Birmingham Children's Hospital to discuss the demand and capacity challenges which are resulting in long waiting times for patients with complex needs
- STP Board meeting
- Presented an award at Health Education England West Midlands NHS Apprenticeship Recognition Awards 2017
- Interview with the Health Service Journal about the work of the National Orthopaedic Alliance vanguard

7 UPDATE FROM TRUST MANAGEMENT COMMITTEE

7.1 Since the last meeting of the Board on 11 January 2017, the Trust Management Committee (TMC) was held on 25 January 2017.

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

- An agreement was reached with NHS England Specialised Commissioners on 20 January 2017 on tariff for some of our more complex procedures
- New Paediatric HDU will be fully operational from 30 January 2017, and the official opening ceremony planned for 28 February 2017
- A nurse recruitment open day is planned for 4 March 2017, with a particular focus on paediatric nurse recruitment
- A Procurement Programme Group will be set up by the end of Q4 to oversee procurement savings plans & associated actions for delivery
- The Trust has approved a preferred supplier to undertake network improvements across the site, enabling future IT development to take place. This work has commenced in February and is expected to finish in August/September 2017
- The Trust has received a Contract Performance Notice (CPN) for mandatory training compliance. Learning & Development are working closely with the operational

divisions to ensure that teams are up to date with their training requirements. TMC agreed that managers have a significant role to play to ensure that their teams attend mandatory training, and there was a commitment from managers to improve the positon

- TMC noted that the Trust is unlikely to achieve 100% payment for the flu vaccination CQUIN
- It was noted that the Q3 milestone for Rapid Recovery had been achieved

7.3 The following policies were recommended to be approved by the CEO:

- Consent to Examination or Treatment policy
- Clinical Audit & Service Evaluation policy
- Medicines Management policy

7.4 As part of moving to the new structure from 1 April 2017, a review of meetings has taken place in an effort to streamline and reduce duplication. As a result, the Trust Management Committee has been formally disbanded, and replaced by a new Operational Management Board (OMB) which will meet monthly. It has been recognised that there is some duplication of reporting across the Trust's existing meeting structure, and a need for a collective forum to discuss operational and divisional performance. OMB will be chaired by the Executive Director of Patient Services and the first meeting will be held on 22 March 2017. Policy and business case approval will now report through the Executive Team meeting on a monthly basis.

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
24 January 2017

Appendix A

Sarah Norman, Chief Executive
Council House, Priory Road, Dudley, West Midlands DY1 1HF
www.dudley.gov.uk
Email: sarah.norman@dudley.gov.uk

Our ref: SN/SR/kj Direct line: 01384 815201 Date: 13.1.17

Dear Colleague,

Re: -Mental Health Commission Concordat sign up by key stakeholders.

Further to my letter dated 6th January 2017. I have been in discussion with a number of stakeholders this week in relation to the wording of the Concordat and the proposal for organisations to sign up to the Action Plan.

I have spent considerable time over the last few days with a number of key partners developing a refreshed wording for the concordat and I now believe that we have an approach which will be acceptable to you and your organisation (I have highlighted the amended final sentence in red below).

I am conscious that there has been a nervousness over the delivery and sign up to the principles without seeing the detail in the developing plan and the potential funding requirements.

Firstly, let me confirm for a number of our larger projects we are currently in discussion with Department Of Work and Health seeking significant financial contributions. We are confident in our bids and we will receive confirmation later this month.

At local level please let me also assure you that for each of the projects that have already been identified, a plan will be designed and implemented with stakeholders and any requirement for additional funding or resources will be brought through the West Midlands Wellbeing Board Governance framework and then onward to the wider West Midlands Combined Authority Board where all stakeholders will have the opportunity to contribute to the final joint decisions.

The following Concordat for Action statement demonstrates the commitment of key organisations from across the West Midlands to the key principles of improving the mental health and wellbeing of people within our region:

> *"We will work together to improve mental health and wellbeing, to reduce the burden of mental ill health across the West Midlands. We will work to improve people's lives and to encourage healthy communities.*
>
> *We will ensure services meet the needs of people with mental ill health and are provided with empathy and compassion. We will involve people who have experienced mental ill health and their carers at the earliest opportunity in decisions about services.*
>
> *We will work together to develop and deliver the actions agreed across the West Midlands Combined Authority area"*

Sarah Norman, Chief Executive
Council House, Priory Road, Dudley, West Midlands DY1 1HF
www.dudley.gov.uk
Email: sarah.norman@dudley.gov.uk

I am seeking your support as part of the process to enable me to create a list of signatories to the Concordat and where possible, a copy of your organisational logos, so that I can work with The West Midlands Combined Authority Comms team.

Please may I have you intention to support via email to the following address: - s.russell@west-midlands.pnn.police.uk

The deadline for the notification of the signatories is close of play on Monday 23rd January 2017 to provide sufficient time for the list to be added to the final document.

If there are any questions please do not hesitate to contact me

Yours sincerely,

Sean Russell
Implementation Director
West Midlands Mental Health Commission

Appendix B

JC/GS/17012301

23 January 2017

Sean Russell
Implementation Director
West Midlands Mental Health Commission
Dudley Metropolitan Borough Council
Council House
Priority Road
Dudley
West Midlands DY1 1HF

Dear Sean

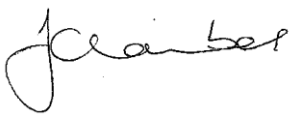
Mental Health Commission Concordat sign up by Key Stakeholders

Thank you for your letter dated 13 January 2017.

I am writing to confirm that the Royal Orthopaedic Hospital NHS Foundation Trust would like to sign up to this Concordat. As requested, I attach a copy of our Trust logo.

Please do not hesitate to contact me if you require any further information.

Yours sincerely



Jo Chambers
Chief Executive Officer

Enc

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

February 2017

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INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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.

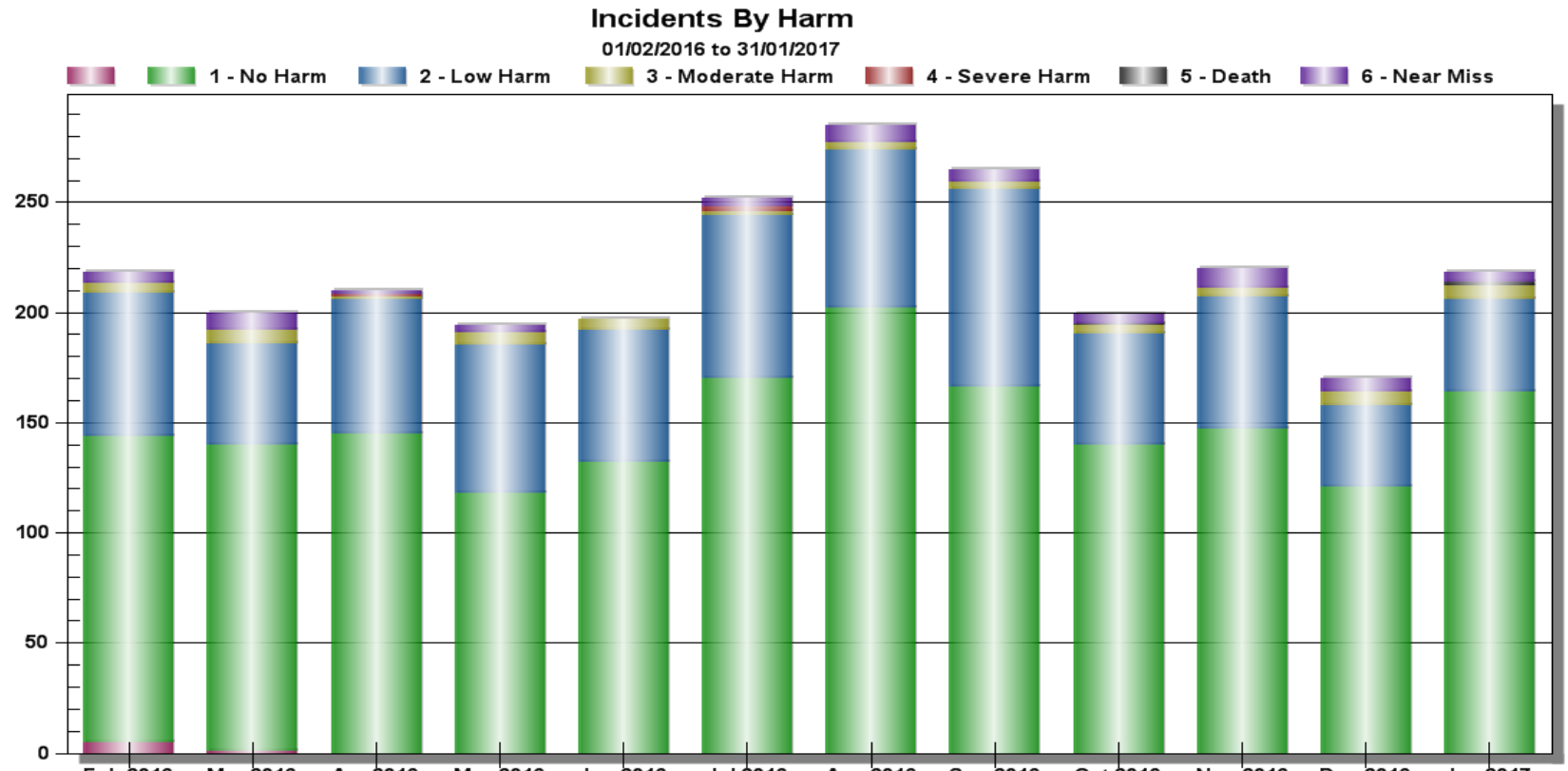
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: 0121 685 4000 (ext. 55641)

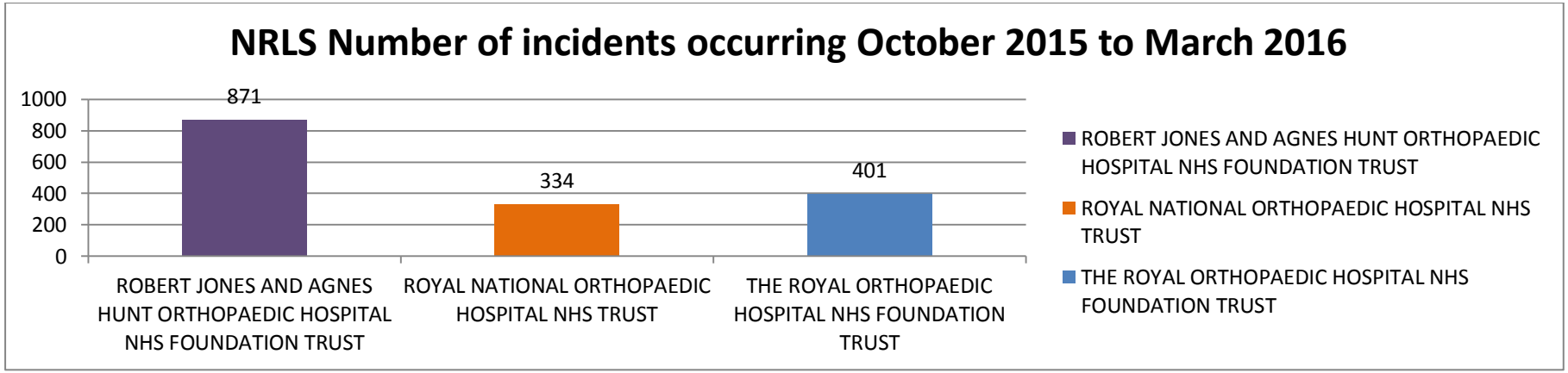
2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.

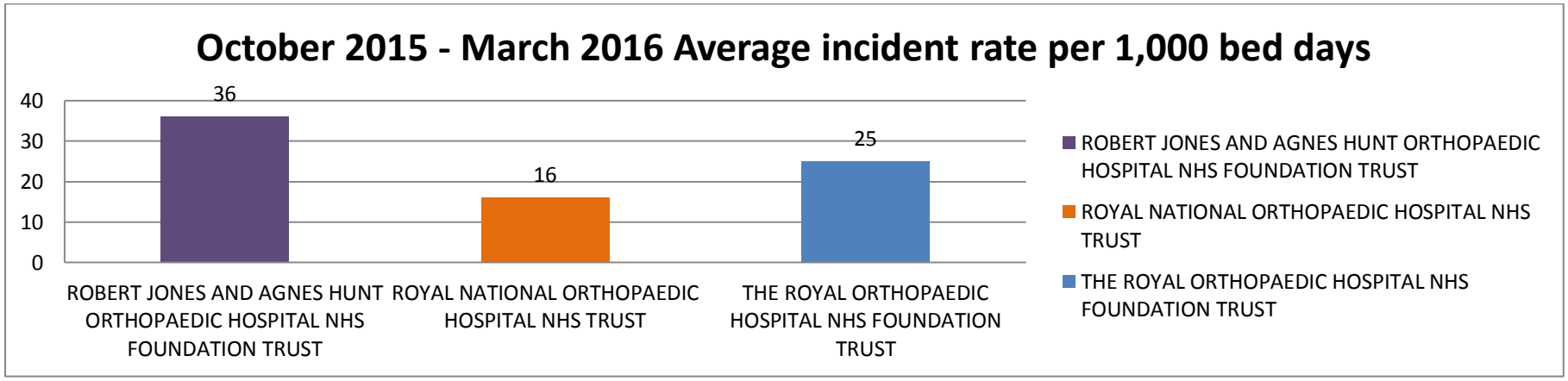


Month and Year	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017
	5	1	0	0	0	0	0	0	0	0	0	0
1 - No Harm	139	139	145	118	132	170	202	166	140	147	121	164
2 - Low Harm	65	46	61	67	60	74	72	90	50	60	37	42
3 - Moderate Harm	4	6	1	6	5	2	3	3	4	4	6	6
4 - Severe Harm	0	0	1	0	0	2	0	0	0	0	0	0
5 - Death	0	0	0	0	0	0	0	0	1	0	0	2
6 - Near Miss	5	8	2	3	0	4	8	6	4	9	6	4

National Reporting and Learning System (NRLS): Every six months NHS improvement publishes national statistics of the organisation patient safety incident reports. This is data for NHS providers on the breakdown of patient safety incidents they have reported to the NRLS.

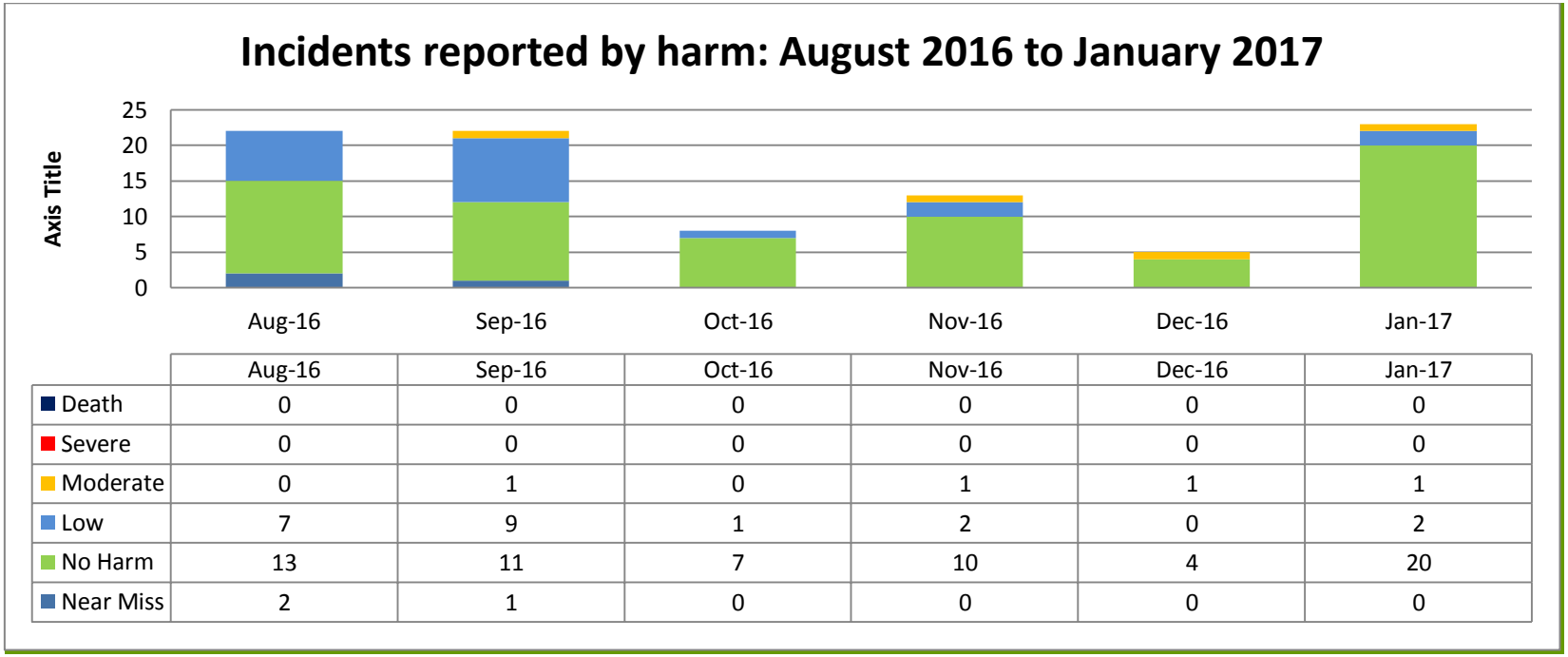
The Data is based on incidents that occurred in England and Wales from 1 October 2015 to 31 March 2016 and were submitted to the National Reporting and Learning System (NRLS) by the 31 May 2016. This is a comparison to other Orthopaedic Trusts.





INFORMATION
There were 218 incidents reported in January 2017; There were six moderate harms and two deaths.
ACTIONS FOR IMPROVEMENTS / LEARNING
The new quality indicators/dashboards will be used for the first time in March 2017. This will include information on incidents and harm. The Quality report now contains data on NRLS national reporting and benchmarking against other Trusts.
RISKS / ISSUES
Incidents are not being reviewed by managers in a timely manner. Reports have been developed on Ulysses to identify these managers and the length of the delays with a view to providing them with support review their incidents accordingly. The first report was sent out in January 2017. Division 2 are undertaking an exercise to ensure that all incidents in the last 12 months have been closed off with appropriate actions. The same process is planned for the other divisions.

Paediatric Incidents – This illustrates all incidents relating to Paediatric Patients that have been reported at ROH on Ulysses by members of staff during the previous 5 months (since when Ulysses was configured to capture the data). The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.



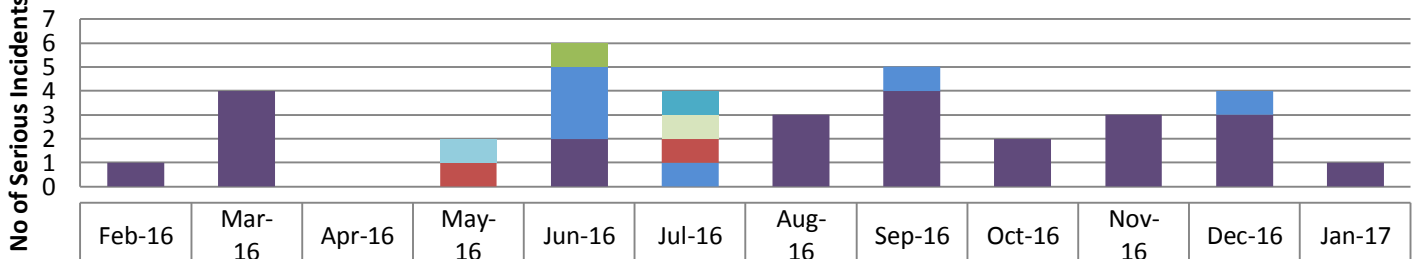
	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Death	0	0	0	0	0	0
Severe	0	0	0	0	0	0
Moderate	0	1	0	1	1	1
Low	7	9	1	2	0	2
No Harm	13	11	7	10	4	20
Near Miss	2	1	0	0	0	0

23 incidents were reported in January 2017 involving Paediatric Patients. A breakdown was provided to the Children's Board in February and these were discussed in detail.

2 Paediatric Incidents that were reported in the Children's quality report resulted in Moderate harm – One of these has since been reviewed and downgraded.

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.**

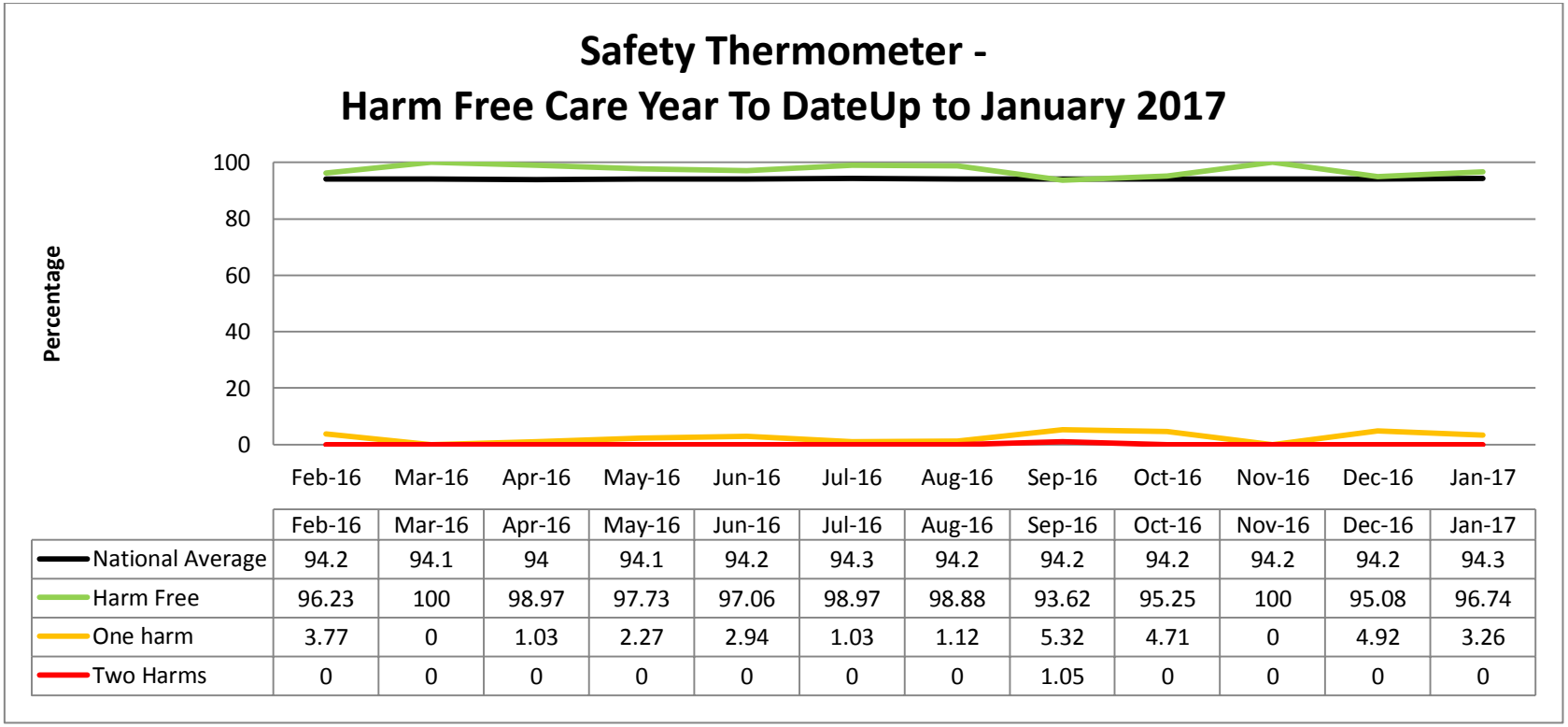
Serious Incidents Declared Year to Date to January 2017



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Staff conduct incidents												
Emergency transfer out of Trust												
Surgical incident meeting SI criteria												
Emergency transfer to HDU												
Failure to act on test results												
Wrong Site Incision						1						
Wrong Implant						1						
Suspension to services					1							
Delayed diagnosis												
Wrong side injection				1								
Unexpected deaths												
Slips, trips & falls				1		1						
Pressure Ulcers				0	3	1		1			1	
VTE meeting SI criteria	1	4	0	0	2	0	3	4	2	3	3	1

INFORMATION
There was one SI declared in January 2017. This is due for submission with the Commissioners April 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
Two Serious Incident reports were submitted to the Commissioners during January 2017. These were both VTEs.
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.**



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
National Average	94.2	94.1	94	94.1	94.2	94.3	94.2	94.2	94.2	94.2	94.2	94.3
Harm Free	96.23	100	98.97	97.73	97.06	98.97	98.88	93.62	95.25	100	95.08	96.74
One harm	3.77	0	1.03	2.27	2.94	1.03	1.12	5.32	4.71	0	4.92	3.26
Two Harms	0	0	0	0	0	0	0	1.05	0	0	0	0

There were three harms reported during January 2017. There was 2 new pressure ulcers and one old pressure ulcer.

Children and Young Persons' Safety Thermometer

The Trust has started to submit data to the Children and Young Persons' Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. The table below illustrates the data that is recorded. The Governance Department will seek to collate National data and data from our comparable specialist Providers for the purposes of benchmarking. A meeting has been arranged for 21st February 2017 to discuss the further understanding of how to interpret the data to give meaningfulness.

January 2017

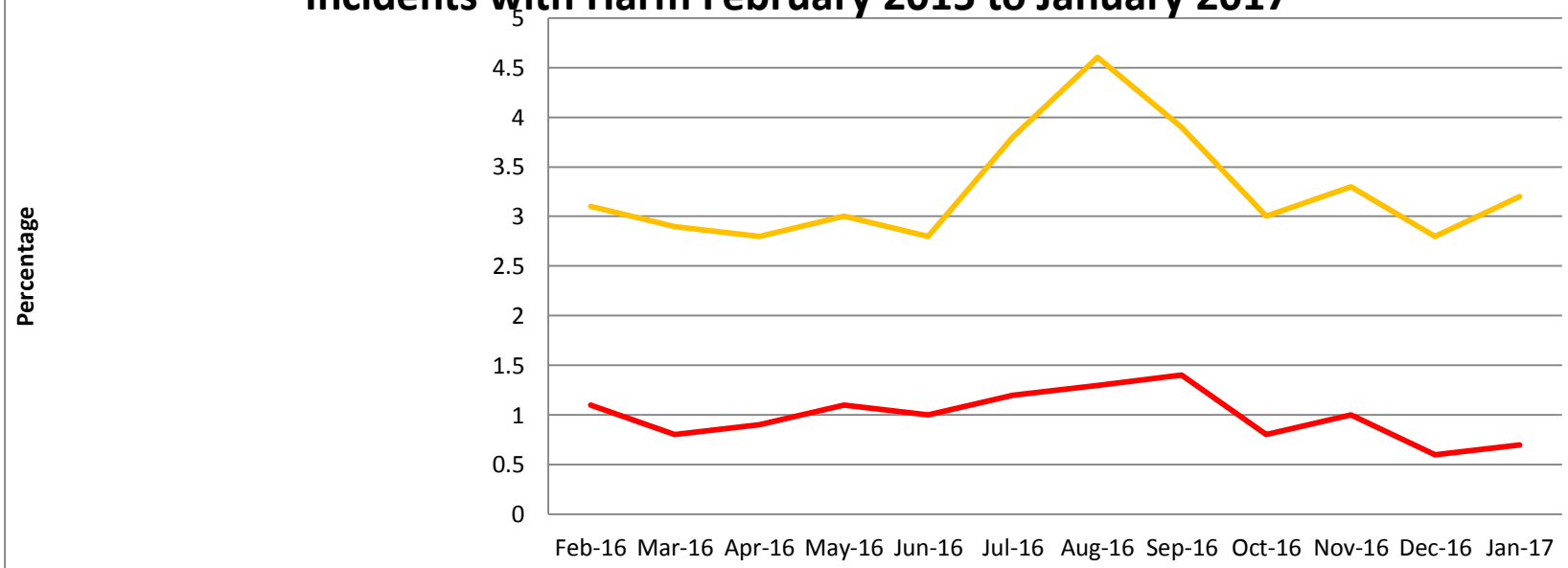
	Local Reference	Gender	Age Group	EWS Completed	Extravasation	Patient in pain?	Pressure ulcer?	Moisture Lesion
1	1	Male	5-9 years old	Yes	No	No	No	No
2	2	Male	10-14 years old	Yes	No	No	No	No
3	3	Female	15-19 years old	Yes	No	No	No	No
4	4	Female	10-14 years old	Yes	No Device	No	No	No
5	5	Female	15-19 years old	Yes	No Device	No	No	No
6	6	Female	10-14 years old	Yes	No	No	No	No
7	7	Male	10-14 years old	Yes	No	No	No	No
8	8	Male	15-19 years old	No	No Device	No	No	No
9	9	Female	10-14 years old	Yes	No Device	No	No	No
10	10	Female	5-9 years old	Yes	No	No	No	No
11	11	Male	10-14 years old	Yes	No	Yes	No	No
12	12	Male	15-19 years old	Yes	No	No	No	No
13	13	Male	15-19 years old	Yes	No	No	No	No

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 January 2017 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
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
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794

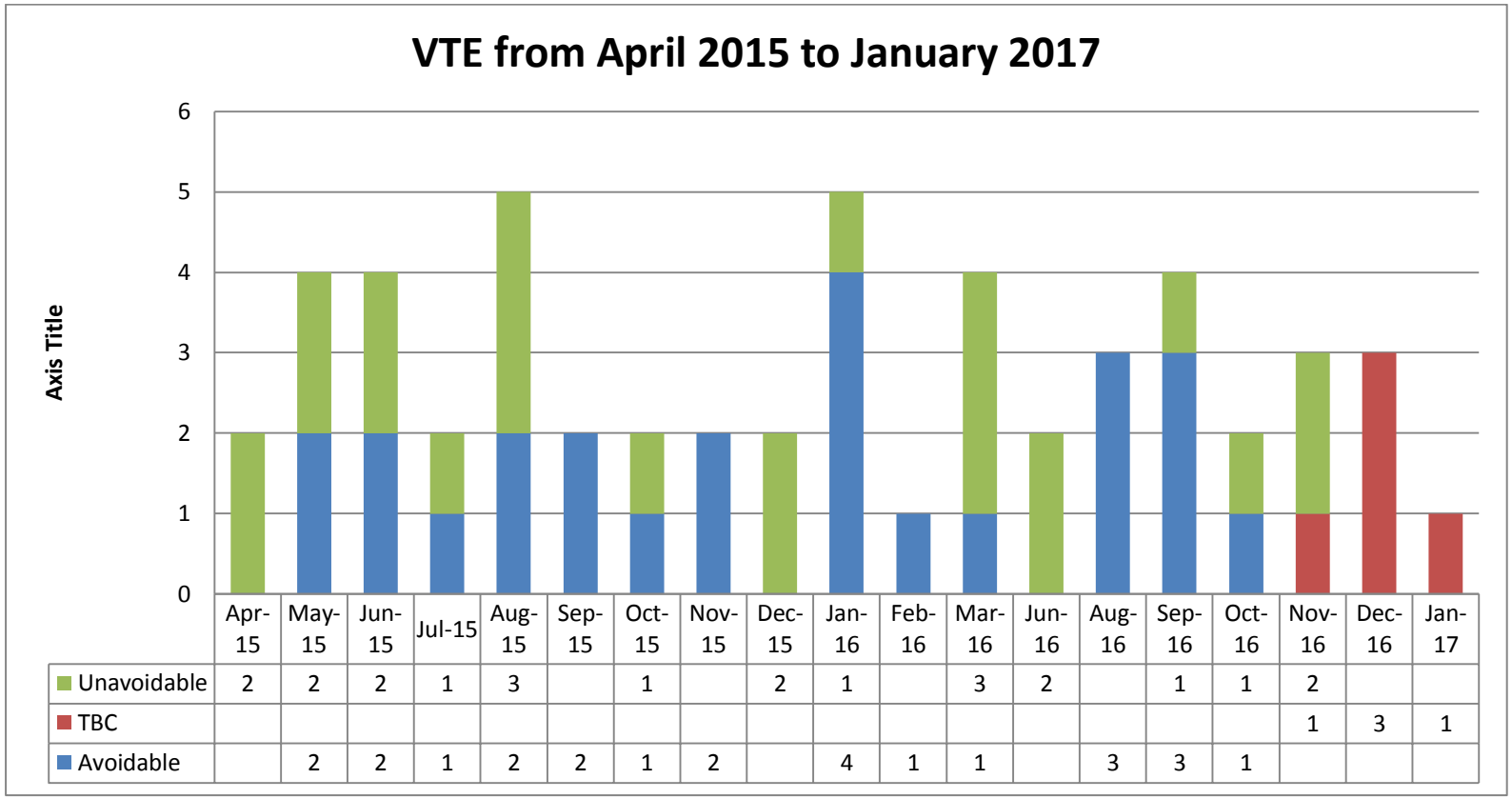
In January 2017, there were a total of 6794 patient contacts. There were 218 incidents reported which is 3 percent of the total patient contacts resulting in an incident. Of those 218 reported incidents, 50 incidents resulted in harm which is 0.7% of the total patient contact.

% of Patient Contact Compared to Number of Incidents and Incidents with Harm February 2015 to January 2017



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
% of Patient Contacts with Incidents Causing Harm	1.1	0.8	0.9	1.1	1	1.2	1.3	1.4	0.8	1	0.6	0.7
% of Patient Contact With All Incidents Reported	3.1	2.9	2.8	3	2.8	3.8	4.6	3.9	3	3.3	2.8	3.2

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).**



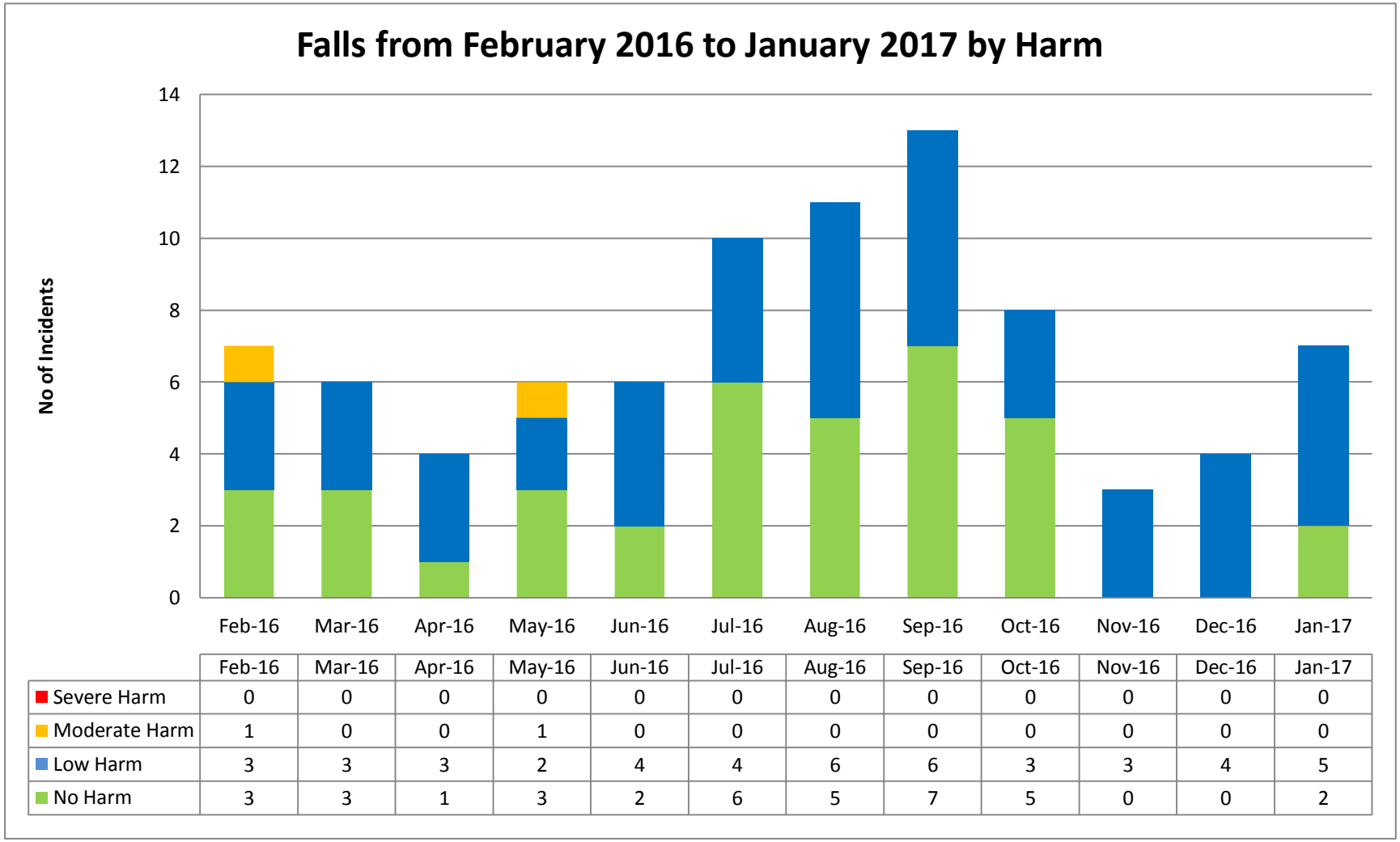
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Jun-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Unavoidable	2	2	2	1	3		1		2	1		3	2		1	1	2		
TBC																	1	3	1
Avoidable		2	2	1	2	2	1	2		4	1	1		3	3	1			

14

Year to date total		Avoidable
15/16	35	18
16/17	18	7

INFORMATION
There was one VTE declared as an SI in January 2017; This is due for submission with the Commissioners in April 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
All commissioner KPIs /audits have been completed and continue to be consistently achieved Medicines link roles have been updated to formalise responsibilities in relation to VTE as this will meet Exemplar Site requirements. Post discharge Hospital acquired VTE patient questionnaire is now built into Ulysses for completion (opposed to being a separate paper version). The Governance team have improved the VTE graph above by highlighting VTEs that are unavoidable or avoidable.
RISKS / ISSUES
Need to ensure VTE action plans are completed on Ulysses to enable appropriate completion and monitoring. On-going key issue identified from RCA's is non-completion of 24 hour risk assessments by Medical staff. This will be a mandatory field once PICS implemented. Shared learning continues. The VTE guidelines are currently under review, it is anticipated they will come to February CQG for approval. This is overdue as had been put on hold to enable the processes required as part of the CQUIN to be agreed.

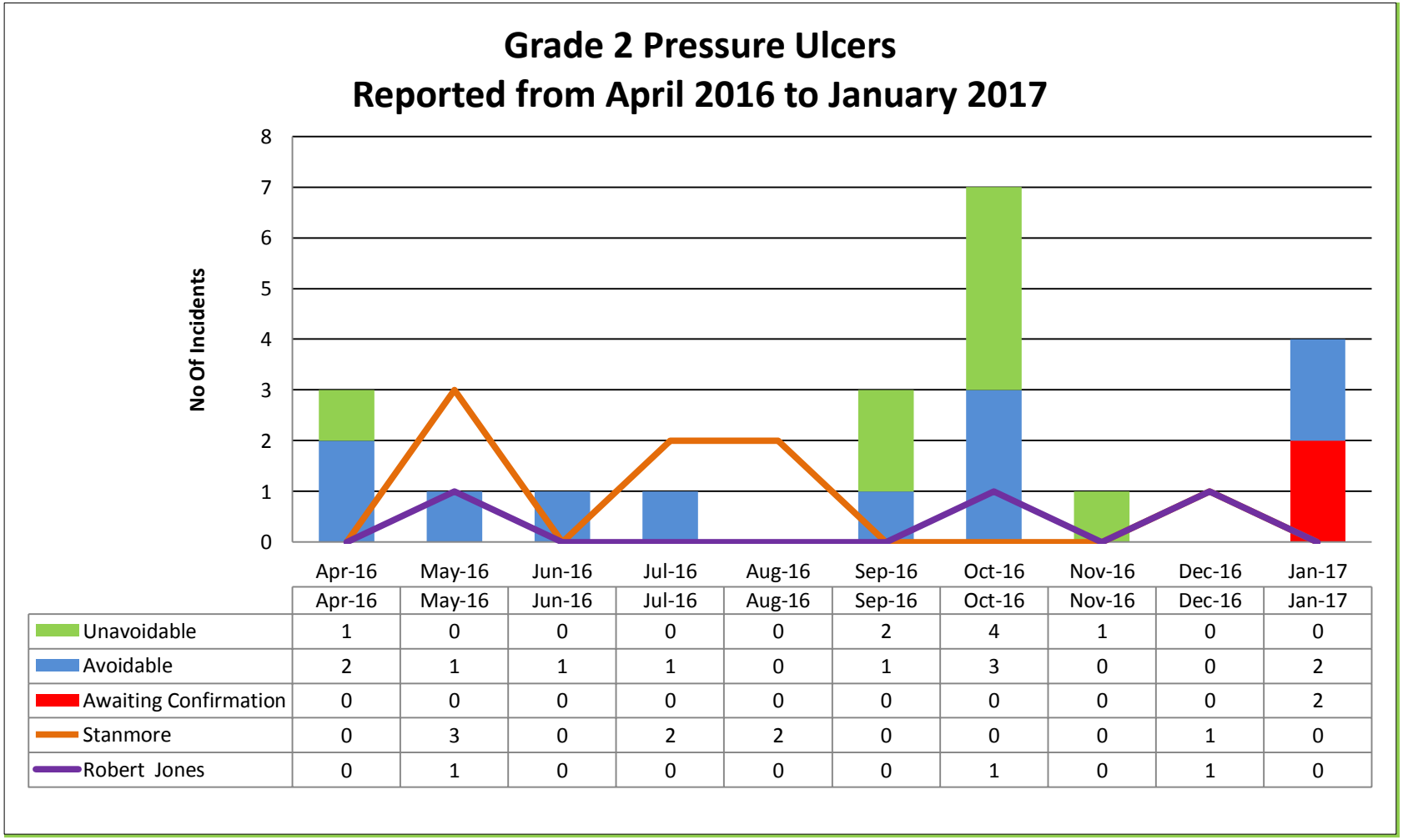
7. **Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident.**



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	1	0	0	1	0	0	0	0	0	0	0	0
Low Harm	3	3	3	2	4	4	6	6	3	3	4	5
No Harm	3	3	1	3	2	6	5	7	5	0	0	2

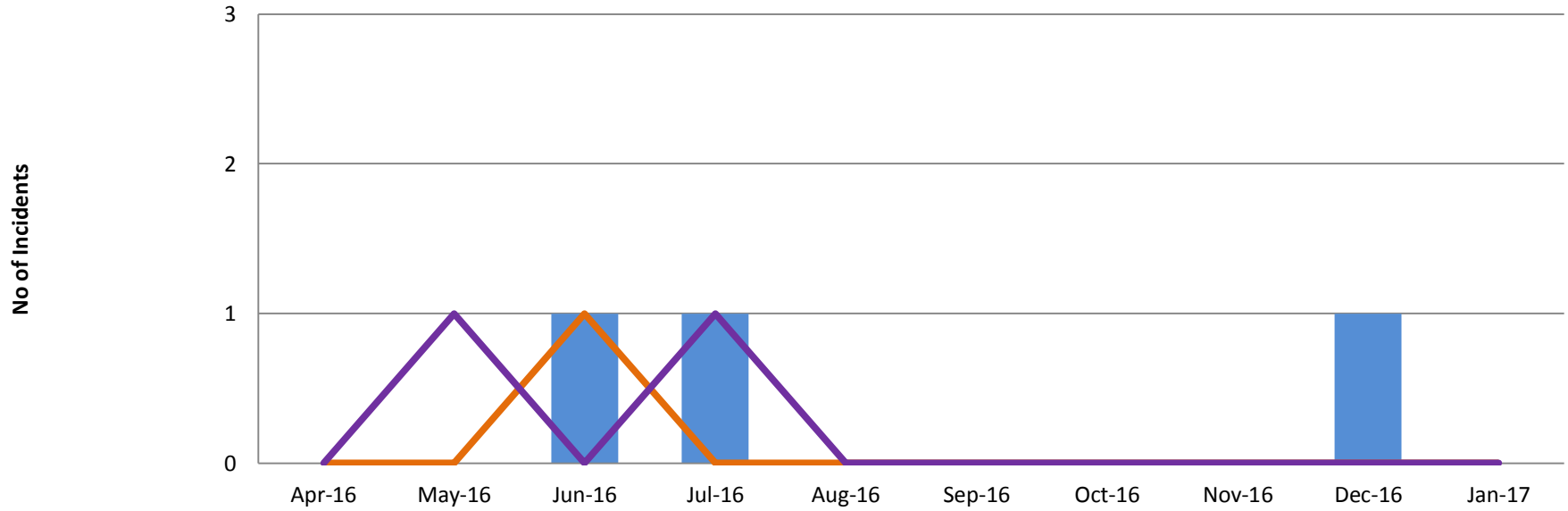
INFORMATION
There were 7 falls incidents in January 2017
ACTIONS FOR IMPROVEMENTS / LEARNING
• The Falls Working Group (FWG) meetings recommenced in December 2016 and are scheduled bi-monthly after the January 2017 meeting. • Through the Falls Working Group the work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller is in progress. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care. • An update regarding the Throne Project is still being sought from therapies. This is being addressed through the Falls Working Group meetings Trend analysis identified that patients fall in the bathroom/toilet. • Falls information boards are to be standardised across all ward areas, with the information being agreed at the FWG meeting in March 2017. 'Walking stick' visual information to be produced on a monthly basis for all ward areas for cascading of information regarding the number of falls per ward, per month to all staff. • To note: annual bed rail audit is due in April 2017.
RISKS / ISSUES
None

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	Oct-16	Nov-16	Dec-16	Jan-17
Unavoidable	1	0	0	0	0	2	4	1	0	0
Avoidable	2	1	1	1	0	1	3	0	0	2
Awaiting Confirmation	0	0	0	0	0	0	0	0	0	2
Stanmore	0	3	0	2	2	0	0	0	1	0
Robert Jones	0	1	0	0	0	0	1	0	1	0

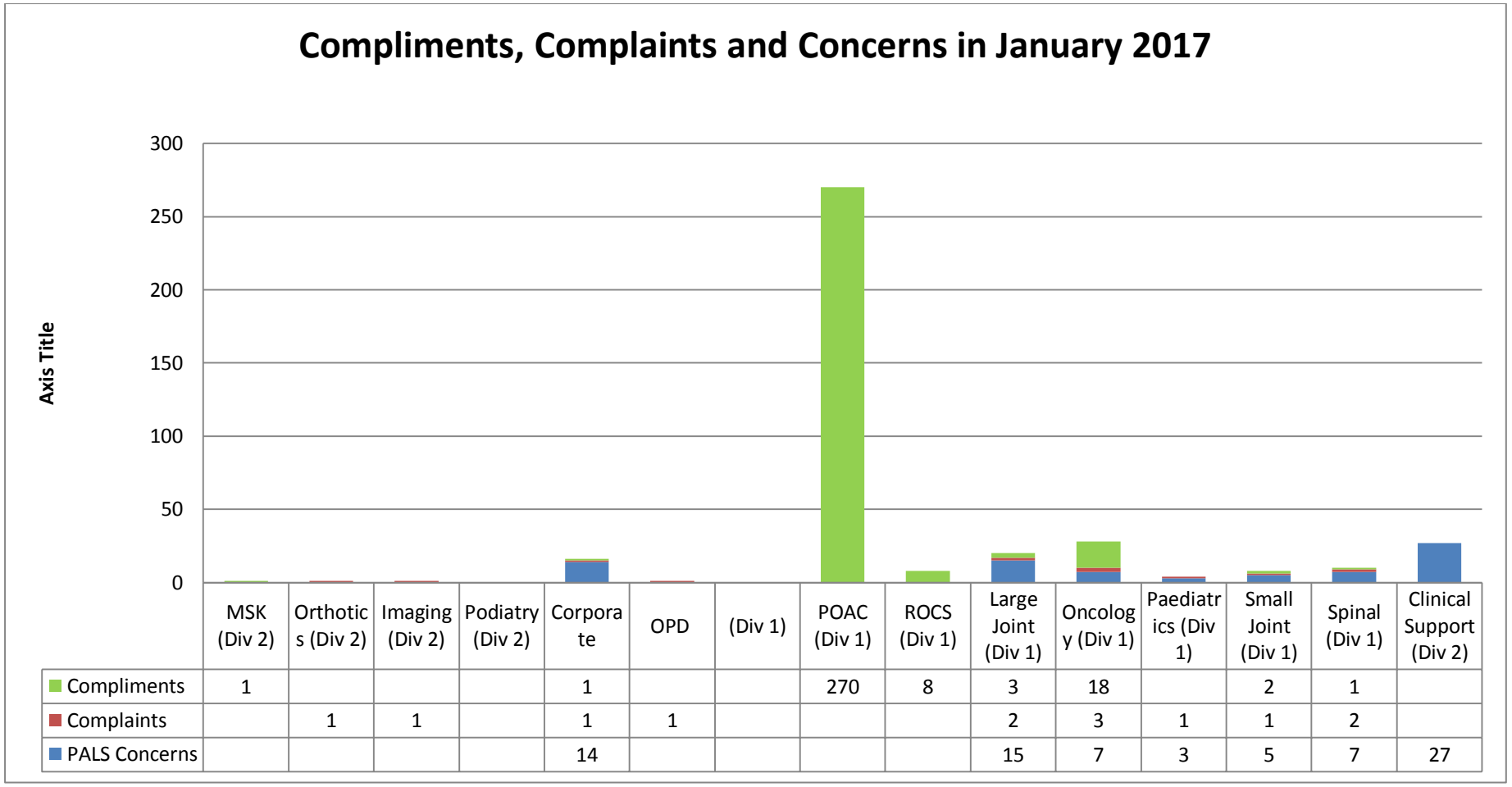
Grade 3 & 4 Pressure Ulcers reported April 2016 to January 2017



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0
Grade 3 (Avoidable)	0	0	1	1	0	0	0	0	1	0
Stanmore	0	0	1	0	0	0	0	0	0	0
Robert Jones	0	1	0	1	0	0	0	0	0	0

INFORMATION
There have been 6 reported grade 2 incidents for January. Two were present on admission from referring Trusts and 4 were hospital acquired 2 of which have been deemed avoidable and two are currently awaiting investigation. Of the one incident outstanding from October this has now been deemed avoidable and is included in the numbers. In total, from 1st April 2016 the Trust has reported the following: **11 avoidable Grade 2 pressure Ulcers** against a limit (target) of 15. (One Grade 2 Pressure Ulcer currently awaiting RCA to establish avoid ability and are therefore not included in these figures) **3 avoidable Grade 3 pressure Ulcers** against a limit of 0. **0 avoidable Grade 4 pressure Ulcers** were reported against a limit of 0.
ACTIONS FOR IMPROVEMENTS / LEARNING
Charitable funds investment to be requested to improve the patient chairs – new chairs will need to meet IPC and TV requirements (built in pressure relieving properties). New bid to be submitted ahead of February meeting to include subsequent liaisons.
RISKS / ISSUES
None

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.**



	MSK (Div 2)	Orthotics (Div 2)	Imaging (Div 2)	Podiatry (Div 2)	Corporate	OPD	(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)	Clinical Support (Div 2)
Compliments	1				1			270	8	3	18		2	1	
Complaints		1	1		1	1				2	3	1	1	2	
PALS Concerns					14					15	7	3	5	7	27

INFORMATION

There were 304 compliments recorded in January 2017
Compliments are helpful ways of letting staff know when they are getting it right. They can be given directly to an individual, team or department, or you can share them with the Patient Experience Team via the telephone, email, and letter. The data collected by the Trust does not include verbal compliments.

The PALS department handled 273 contacts during January 2017 of which 78 were classified as concerns.

There were 13 formal complaints made in January 2017, bringing the total to 145 for the year in total. All were initially risk rated as amber or yellow. This is an increase on the same period last year (10 complaints received in January 2016).

Of the 13 complaints closed in January 2017:

- 4 were upheld
- 7 were partially upheld
- 2 were not upheld

The subjects of this month's complaints were:
Initially Risk Rated Amber:

- Discharge too soon with no aids provided (Div 1, Oncology)
- Fitting and ordering of shoes (Div 2, Orthotics)
- Delays for spinal surgery (Div 1, Spinal)
- Attitude of Staff Member (Div 2, Imaging)
- Delays to follow up appointments (Div 1, Spinal)
- Infection following hip replacement (Div 1, Large Joints)
- Management of allergic reaction (Div 1, Large Joints)
- Failure to notice sufficient healing to progress treatment (Div 1, Paeds)
- OPD apt changes and pt not notified; (Div 1, Oncology)
- Lack of provision of hearing loop (Div 1, OPD)

Initially Risk Rated Yellow:

- Received appointment but not a patient (Corporate)
- Delays to injection in foot (Div 1, Small Joint)
- Approach of secretary (Div 1, Oncology)

ACTIONS FOR IMPROVEMENTS / LEARNING

Learning identified and actions taken as a result of complaints closed in January 2016 include:

- There continues to be issues with long waits in the spinal deformity for children.
  Action: Hospital is contacting MPs to advise of issue. Regular meetings between ROH, BCH and NHS England have begun to attempt to find new solutions.

- Attitude of a member of staff was abrupt and unhelpful, approach not consistent with Trust Values
  Action: Professional conversation undertaken.

- Process of admitting into ADCU not always followed correctly
  Action: Staff have received reminder of processes to be followed.

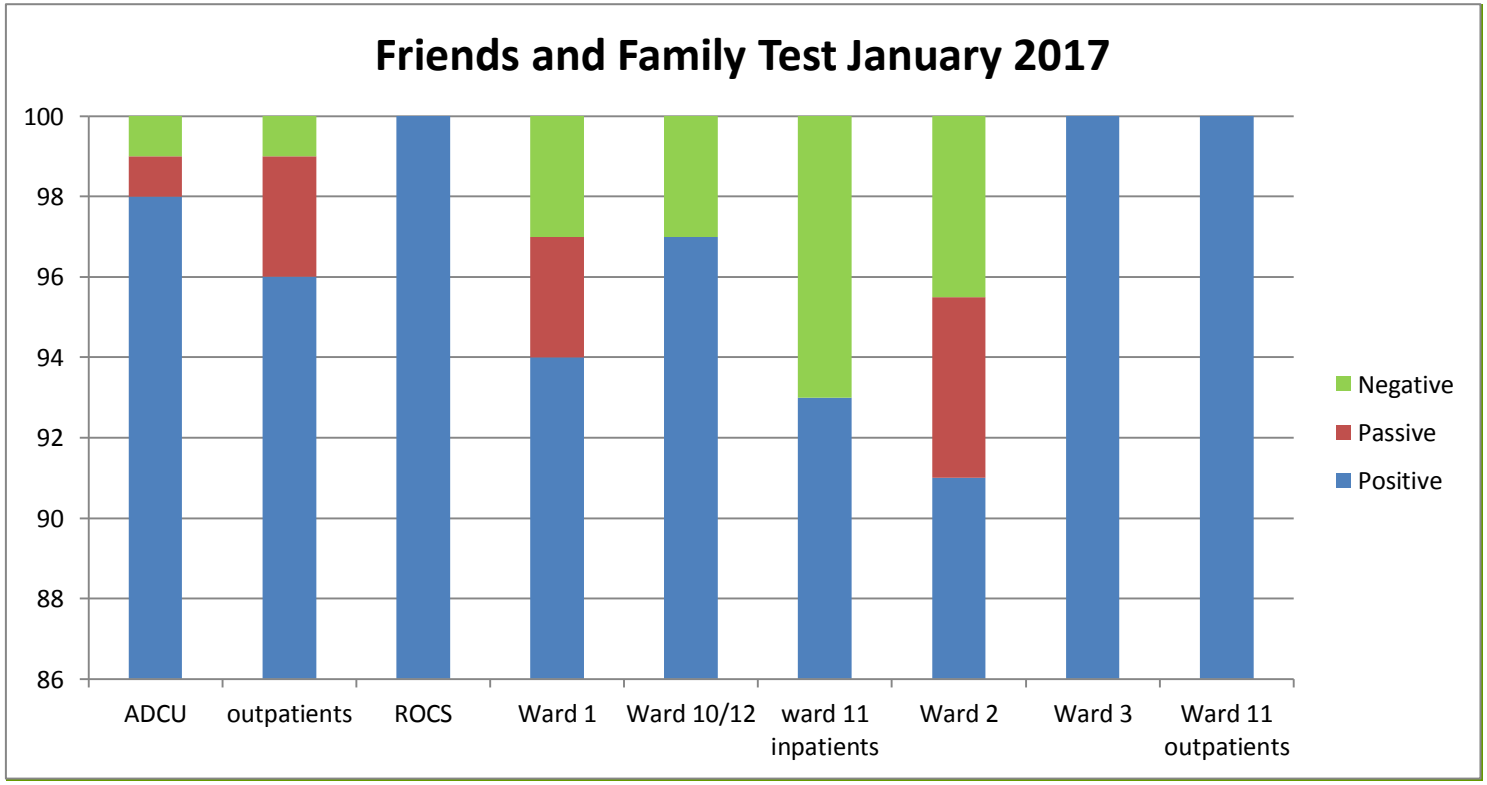
RISKS / ISSUES

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.

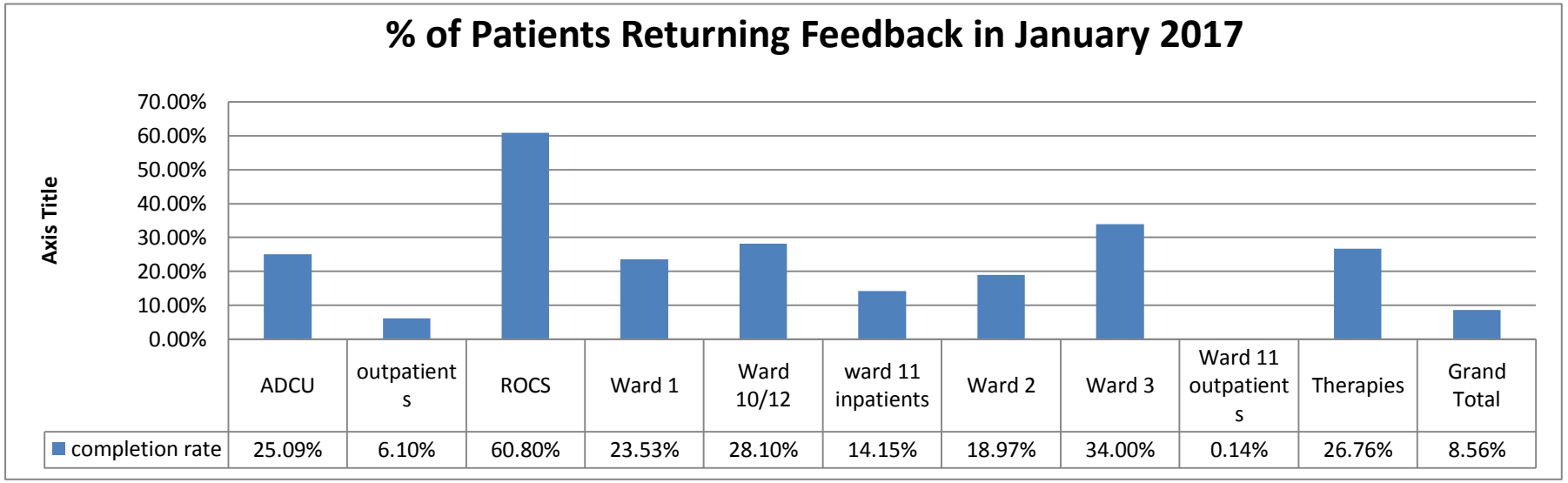
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting 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 January 2017 are 97% of those who responded would promote ROH.



	ADCU	outpatients	ROCS	Ward 1	Ward 10/12	ward 11 inpatients	Ward 2	Ward 3	Ward 11 outpatients	Therapies	Grand Total
completion rate	25.09%	6.10%	60.80%	23.53%	28.10%	14.15%	18.97%	34.00%	0.14%	26.76%	8.56%

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.

There is no national target response set however, as a Trust we are aiming to achieve 35% response rate across all areas in Q1 17/18. This would enable the Trust to gain a richer understanding of the service provision from our patient's perspective.

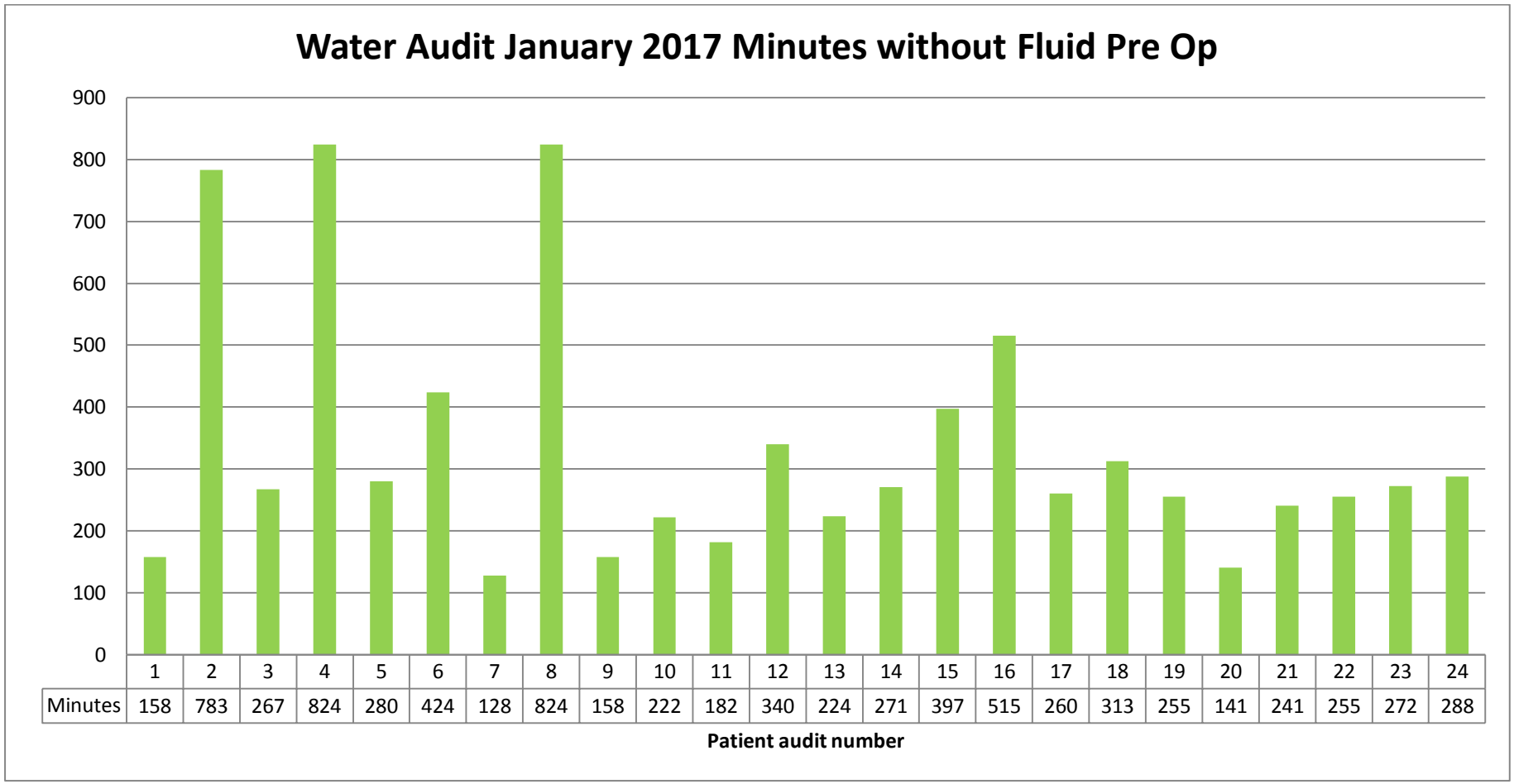
11. Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 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. All DOC is compliant.

12. Litigation

The Trust has received 0 new claims in January 2017;

13. Water audit January 2017; The snap shot audit of 24 patients was carried out on ADCU over seven days. Patients were selected randomly from different theatre and CT lists, with a mix of day case and in patient procedures. These snap shot audits are carried out every other month, therefore the next audit will be carried out in March 2017



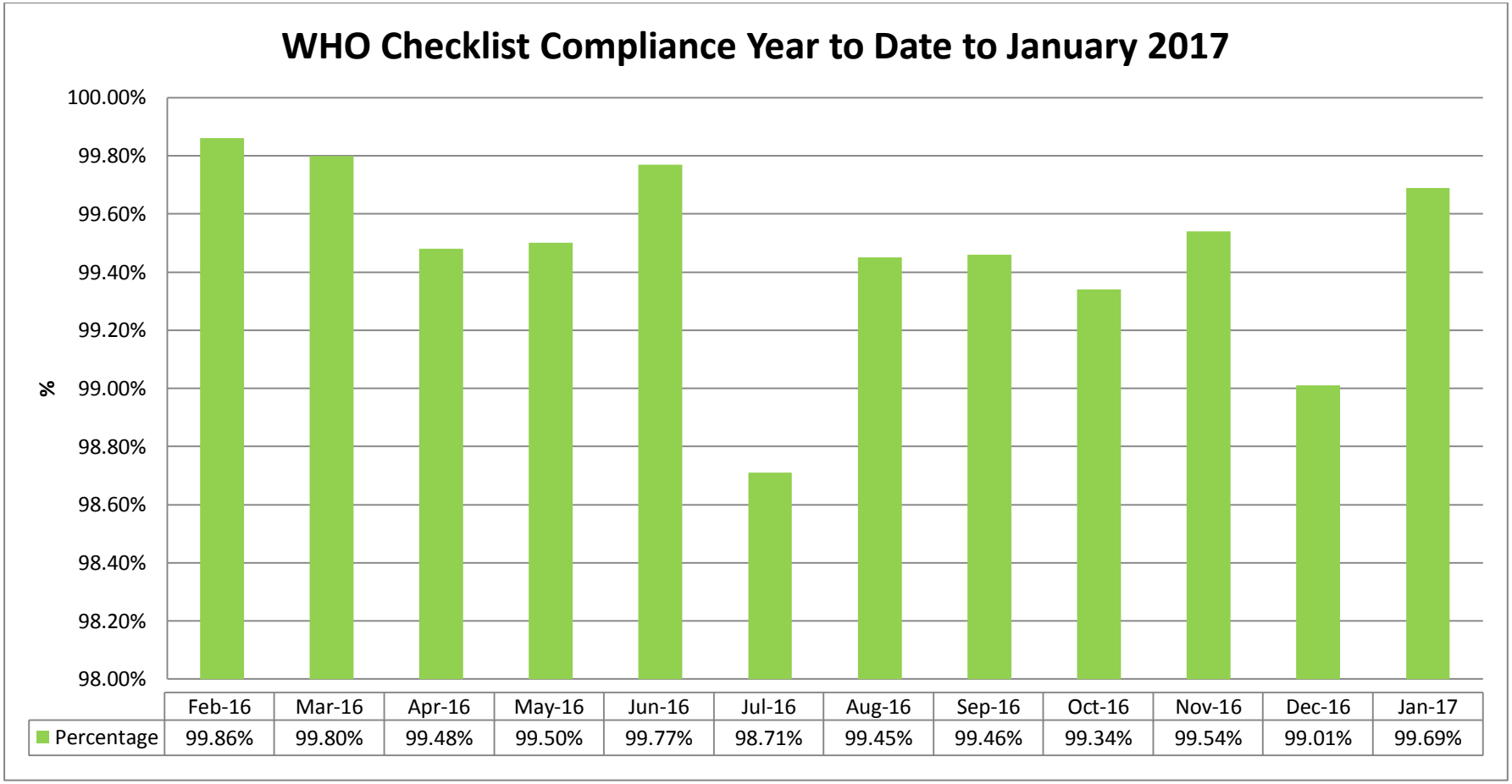
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Minutes	158	783	267	824	280	424	128	824	158	222	182	340	224	271	397	515	260	313	255	141	241	255	272	288

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

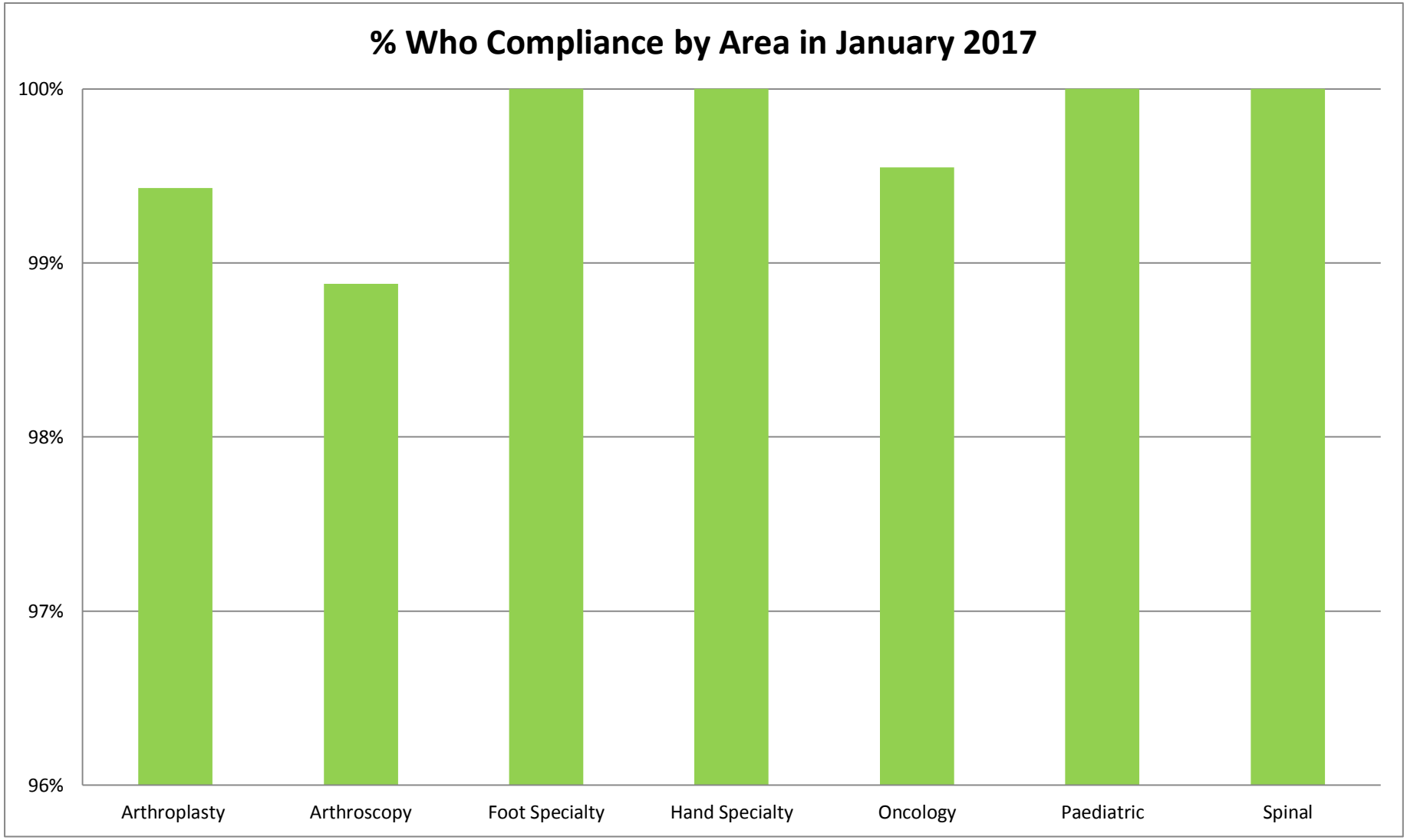
First choice for orthopaedic care

INFORMATION
The Average length of time without drinking pre operatively was 5hrs 30mins. The last snap shot audit that was carried out in November and the average time was 4hrs 30 mins. However, had all of the patients followed the advice given to them in relation to drinking water pre operatively the average length of time would have been 3 hours 50 mins.
ACTIONS FOR IMPROVEMENTS / LEARNING
The results show an increase in the time patients went without water. This is in part due to 4 patients going through the CT department where communication can be less than ideal and changes to list order can mean patients are not allowed water. It was highlighted that better communication from CT/ list lock down is needed. A meeting is February 2017 is due to address this issue further.
RISKS / ISSUES
Better communication from CT/list lock down is needed.

14. 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 perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Percentage	99.86%	99.80%	99.48%	99.50%	99.77%	98.71%	99.45%	99.46%	99.34%	99.54%	99.01%	99.69%


% Who Compliance by Area in January 2017
100%
99%
98%
97%
96%
Arthroplasty
Arthroscopy
Foot Specialty
Hand Specialty
Oncology
Paediatric
Spinal

30

INFORMATION

January 2017
Total Cases = 766
Total Non -Compliance = 5

Total Compliance == **99.69 % 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.
6. Audit results are also discussed as a standing agenda item at the Theatre User Group meetings

RISKS / ISSUES

All non-compliance was due to Consultants not completing the sign/time out section.

Finance and Performance Report

FEBRUARY 2017

CONTENTS

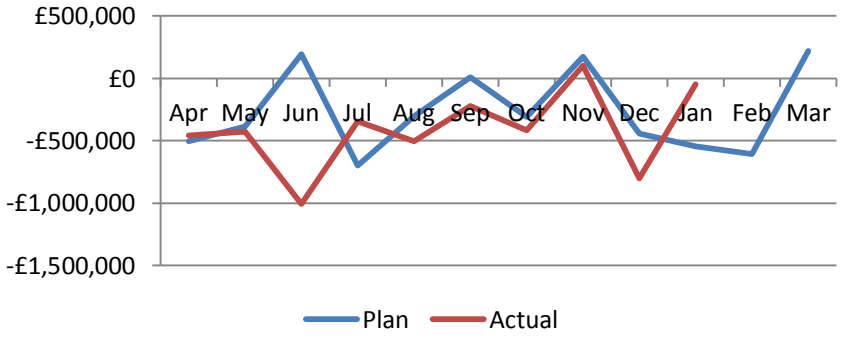
INTRODUCTION

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.

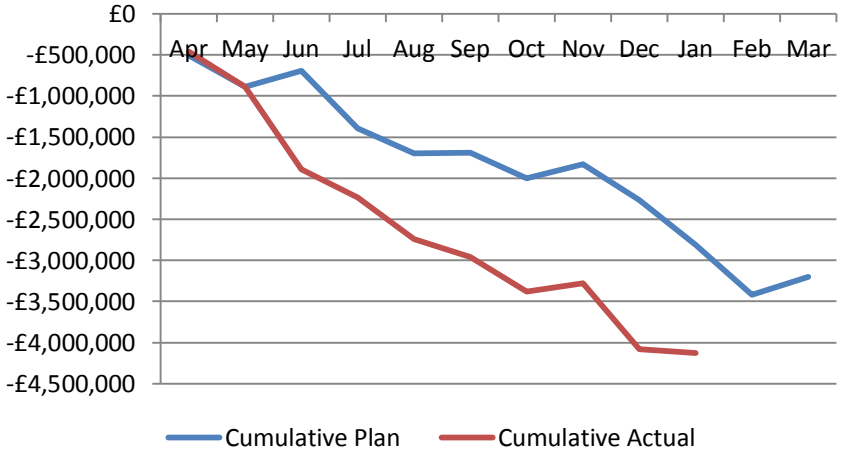
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Monthly Surplus/Deficit Actual vs Plan

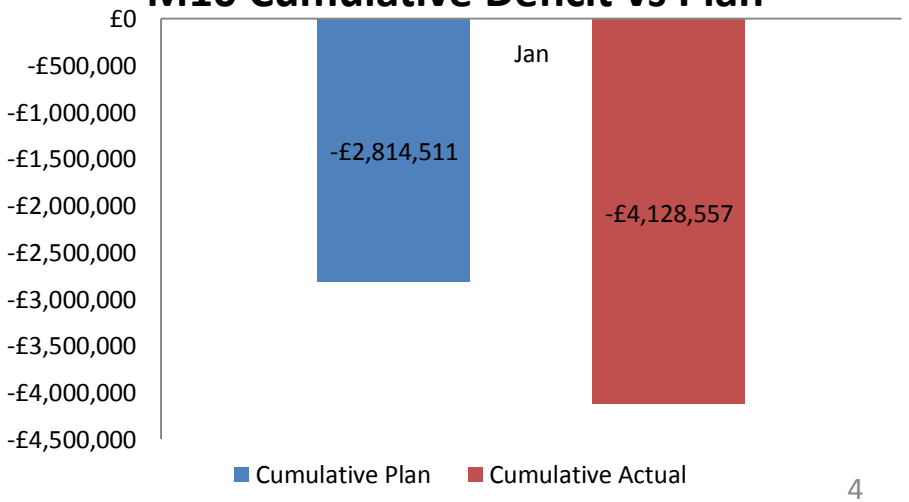


NHSI Use of Resources Rating (UOR)		
	Plan	Actual
Capital Service Cover	4	4
Liquidity	2	3
I&E Margin	4	4
I&E Margin – Variance against plan	N/A	4
Agency metric	1	2
Overall UOR	N/A	3

Cumulative Deficit vs Plan



M10 Cumulative Deficit vs Plan



INFORMATION

The Trust has delivered a cumulative deficit of £4,128,000 as at the end of January against an original planned deficit of £2,815,000. In month, the Trust delivered a deficit of £49,000 against a planned deficit of £544,000.

The Trust is therefore £1,313000 behind original plan at the end of M10. Excluding the impact of the theatres closure in June (£954,000), the Trust would be behind original plan by £359,000. Further detail on the key drivers of the financial position is provided in the income and expenditure sections below, and information about the Trust's performance against the recovery plan is included within the Recovery Plan paper.

As at the end of Month 10, the Trust has recognised £2,528,000 of CIP savings, against a plan of £2,971,000. £1,017,000 (40%) of savings to date are non-recurrent. The in-month savings recognised were £355,000 against a target of £350,000.

With regards to the Trust's Use of Resources Risk Rating (UOR), the deficit position results in the Trust achieving ratings of 4 for Capital Service Cover, I&E Margin metrics and I&E Margin Metrics against plan. In addition, the Trust's liquidity position is rated as a 3, a deterioration against previous month. 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 metric. The overall Trust score has been capped to a 3.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Trust Executive have a weekly Recovery Board where progress against the action plans of the five recovery workstreams (POAC, theatre efficiency, discharge planning, agency reduction and cost control) is monitored and challenged. Schemes such as MARS and a series of recovery sessions are being implemented to improve the position.

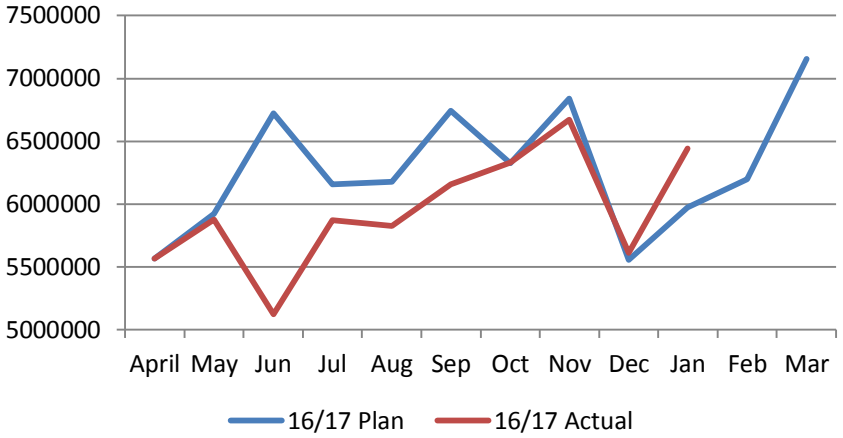
RISKS / ISSUES

The activity targets for the coming months will be challenging, and will result in pressure on theatres and wards in addition to the Trust's support services to ensure that patient flow runs smoothly with no excess capacity in the system.

Buy-in and progress against the schemes set out in the workstream action plans, and by the Chief Executive, will be vital in achieving improvement in the Trust's financial position and its long-term sustainability. The operational team are reviewing mitigations for the contribution generated through the planned recovery days if these are unable to be delivered.

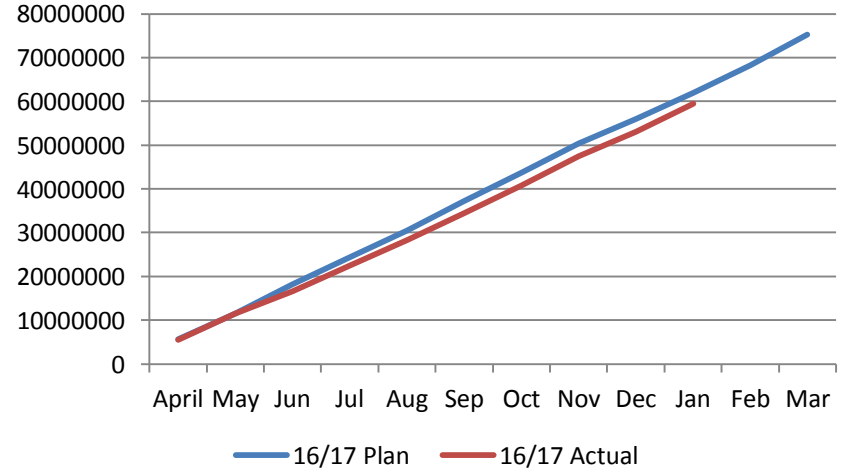
2. Income – This illustrates the total income generated by the Trust in 2016/17, including the split of income by category

Monthly NHS Clinical Income vs Plan 1617



NHS Clinical Income – January 2017			
	Plan	Actual	Variance
Inpatients	2,998	3,136	138
Excess Bed Days	66	140	74
Total Inpatients	3,064	3,276	212
Day Cases	704	835	131
Outpatients	677	720	43
Critical Care	220	186	-34
Therapies	228	201	-27
Pass-through income	201	123	-78
Other variable income	376	516	140
Block income	507	507	0
TOTAL	5,977	6,364	387

Cumulative NHS Clinical Income vs Plan 1617



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INFORMATION

NHS Clinical income over-performed by 8.48% in January having also over-performed by 2.38% in December. Although admitted patient care performance was above plan financially, activity was slightly below plan. The overperformance has therefore been driven by a particularly rich case mix, especially within spinal. January does have increased levels of activity compared with December but this is expected due to the holiday period. This results in an increased in partially completed spells income compared to prior month.

Outpatients slightly overperformed in month, although year to date there is a underperformance in income. This is driven largely by an underperformance in outpatient procedures that 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

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.

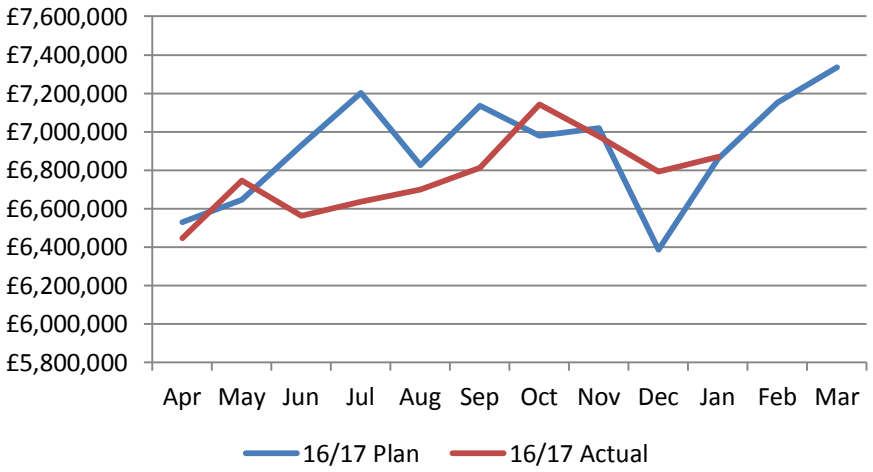
Trust to run recovery days or other methods to improve activity throughout the remainder of the year to attempt to claw back lost income due to the theatre closure in June 16.

RISKS / ISSUES

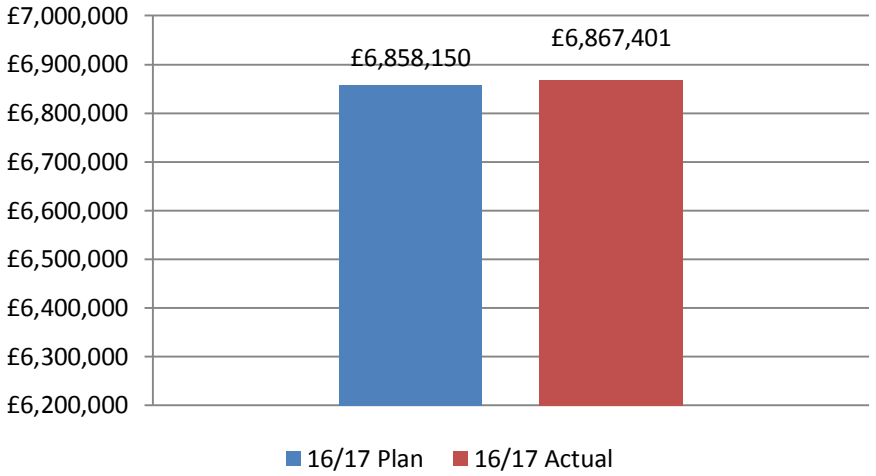
The closure of all theatres for 1 week from 6th June 2016 will have a significant effect on both June's income position, but also on the ability of the Trust to clawback that activity in later months of the year when stretch targets are already in place. The Operations team are developing a plan for how this can be achieved.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2016/17, compared to historic trends

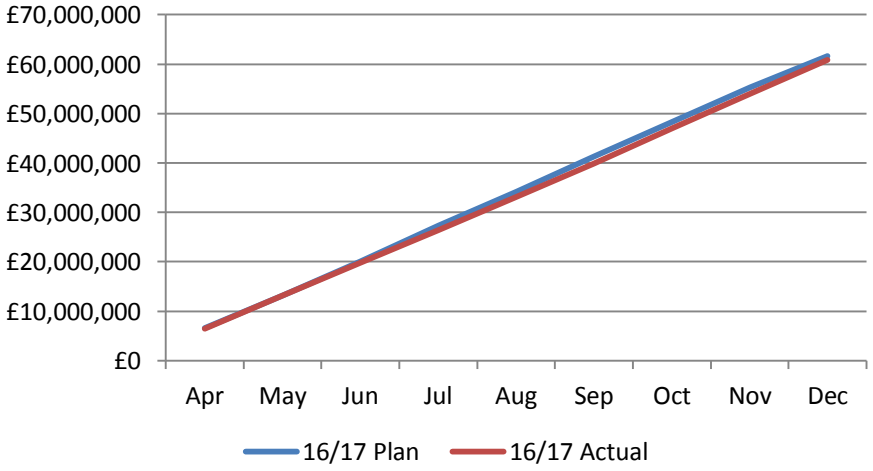
1617 Monthly Expenditure vs Plan



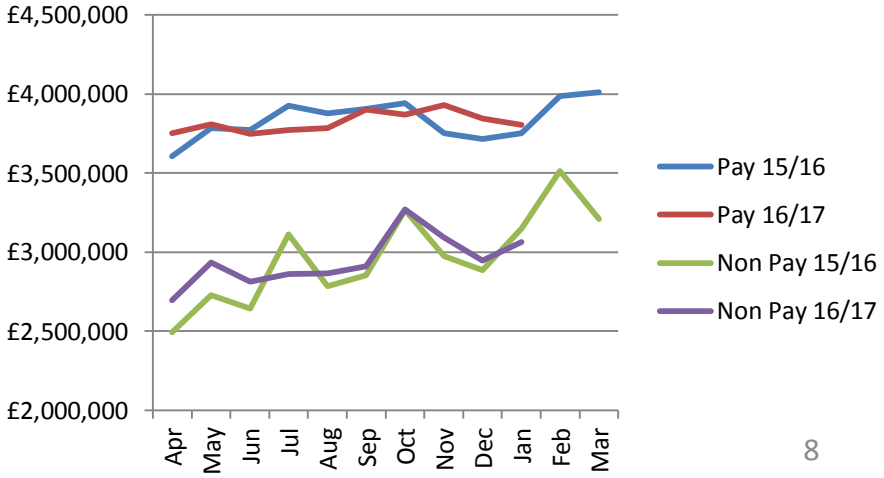
16/17 M10 Expenditure vs Plan



Cumulative Expenditure vs Plan 1617



16/17 vs 15/16 Pay & Non Pay Spends



INFORMATION

Expenditure levels remain below the plan set as the start of the year. For the year to date, expenditure levels are £840,000 below plan.

Pay spend is largely consistent with plan in month. Non pay spend is significantly above plan in month, although spend was lower than the 2015/16 January equivalent. The in-month spend is also being bolstered by c.£100k of costs which had previously been expensed which have now been recognised within capital.

Non pay costs have been driven by higher than expected prosthesis and general theatre costs due to higher activity. The non-pay spend is supported by the higher than average casemix as described in the income section above.

ACTIONS FOR IMPROVEMENTS / LEARNING

Costs will continue to be scrutinised and minimised. One of the 5 recovery workstreams is cost control, with actions being tracked through the Recovery Board on a weekly basis.

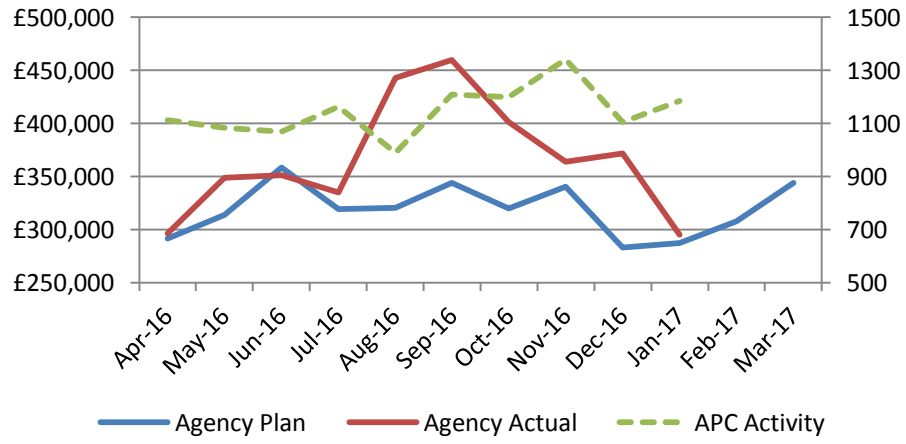
RISKS / ISSUES

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 have moved all prosthesis stock into a new controlled location 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. EDC Gold has also gone live in month with the first line being piloted onto the system.

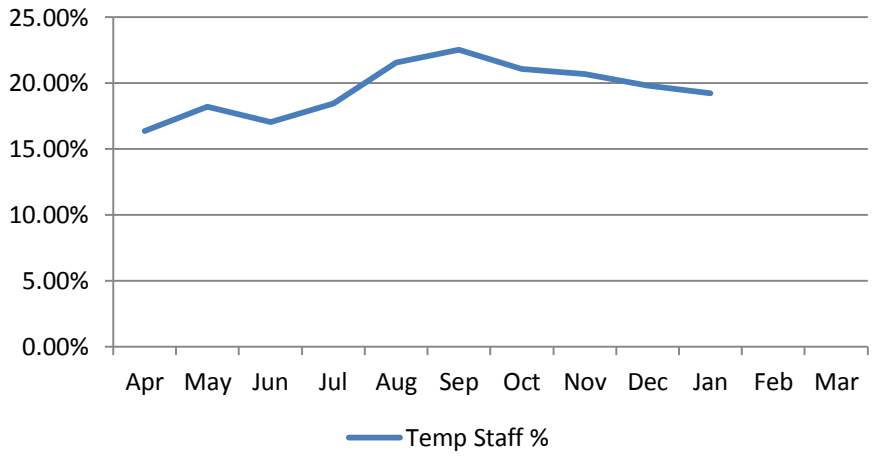
A stock count was performed at Month 9, with the count details being analysed over the coming weeks.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2016/17, and performance against the NHSI agency requirements

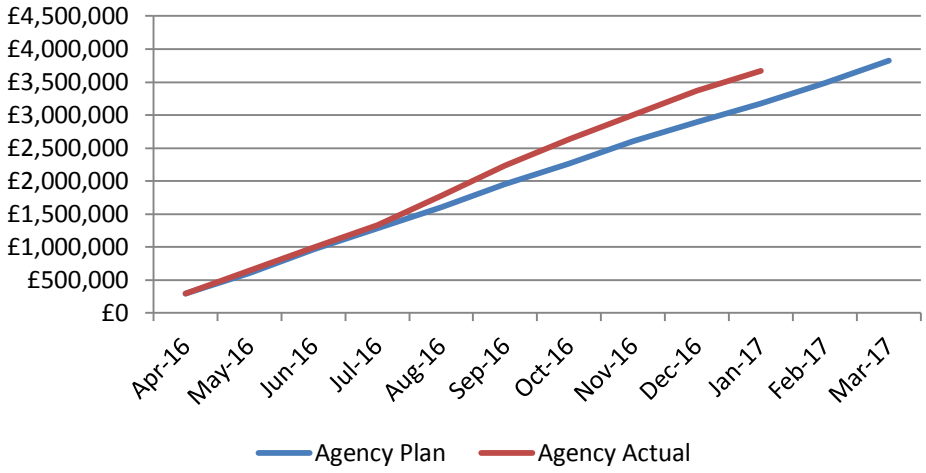
Total Monthly Agency Spend vs Plan



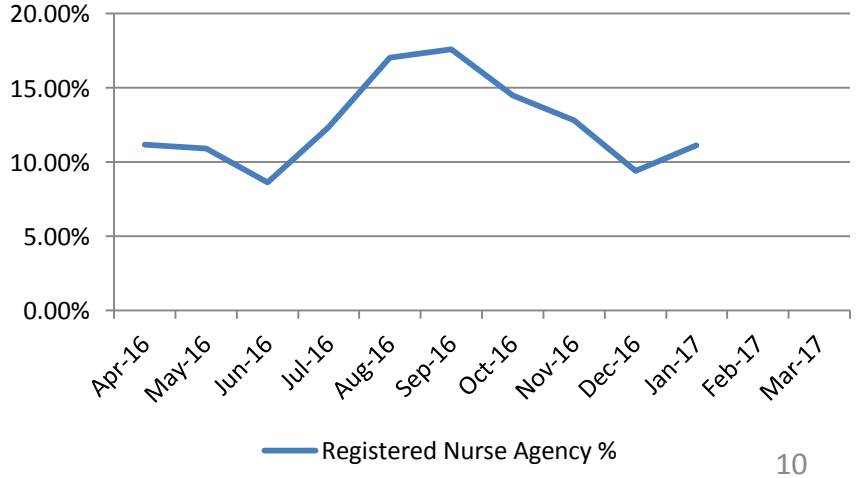
Temp Staff %



Total Cumulative Agency Spend vs Plan



Registered Nurse Agency %



INFORMATION

January showed a decrease in agency spend (from £372,000 to £295,000) despite the increase in activity in January compared to December. Some of this reduction is likely to be lower annual leave. Both medical and other agency spend has dropped significantly, but nursing agency has increased. A significant driver of the reduction in medical agency spend is a £40,000 credit note received regarding a dispute over locum doctor rates.

ACTIONS FOR IMPROVEMENTS / LEARNING

One of the 5 recovery workstreams is reduction in agency spend, and as such a detailed action plan is being reported against on a weekly basis to Recovery Board. This is in addition to the agency group run by the DOWOD and DOONCG. Ongoing actions to reduce agency spend include workforce redesign, e.g. the POAC workforce model, in addition to reviewing the outputs of Healthroster.

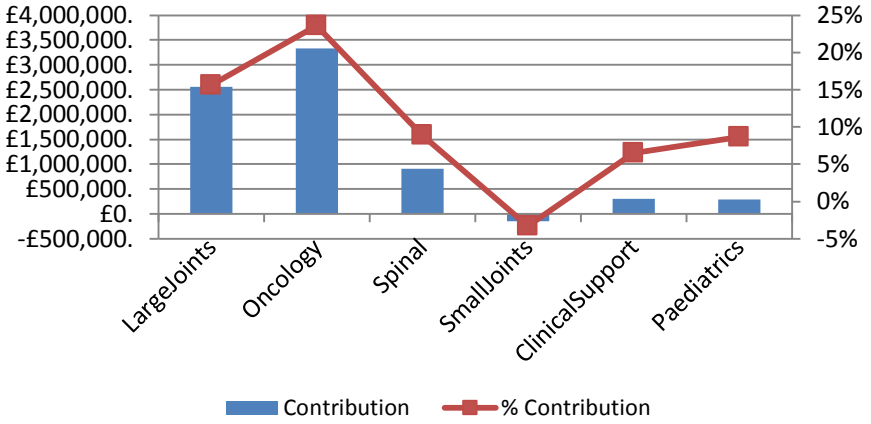
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios.

RISKS / ISSUES

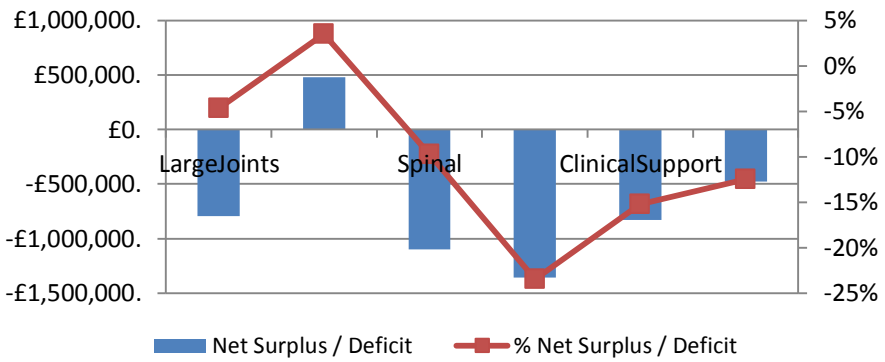
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is now being built into the Single Oversight Framework from Q3. An overspend against the trajectory will therefore have a direct impact on our regulator ratings.

5. Service Line Reporting – This represents the profitability of service units, in terms of both consultant and HRG groupings

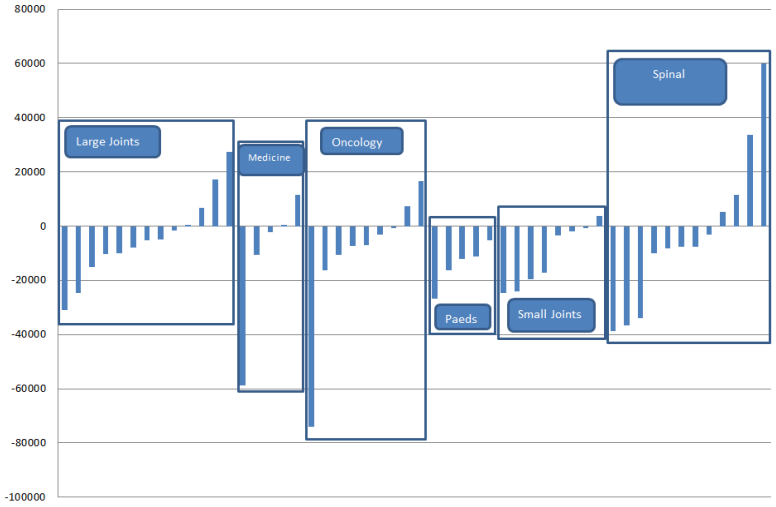
Total Contribution by Service Cumulative to M09



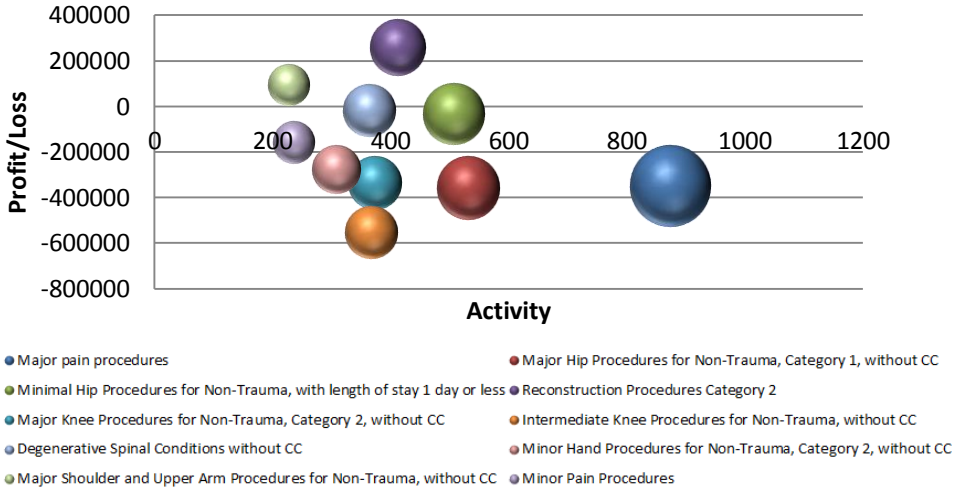
Net Surplus/Deficit by Service Cumulative to M09



Consultant Net Profit/Loss Dec 2016



Top 10 HRG by Volume April - Dec 2016-17



INFORMATION

The graphs above, and the associated narrative, relate to year to date to M9.

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 December 2016. Small Joints is the only service to have provided a negative contribution of -£147K. 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 apart from Oncology are then running at a net loss.

Currently services are being reviewed in terms of session planning for certain operation types to improve theatre utilisation and patient throughput.

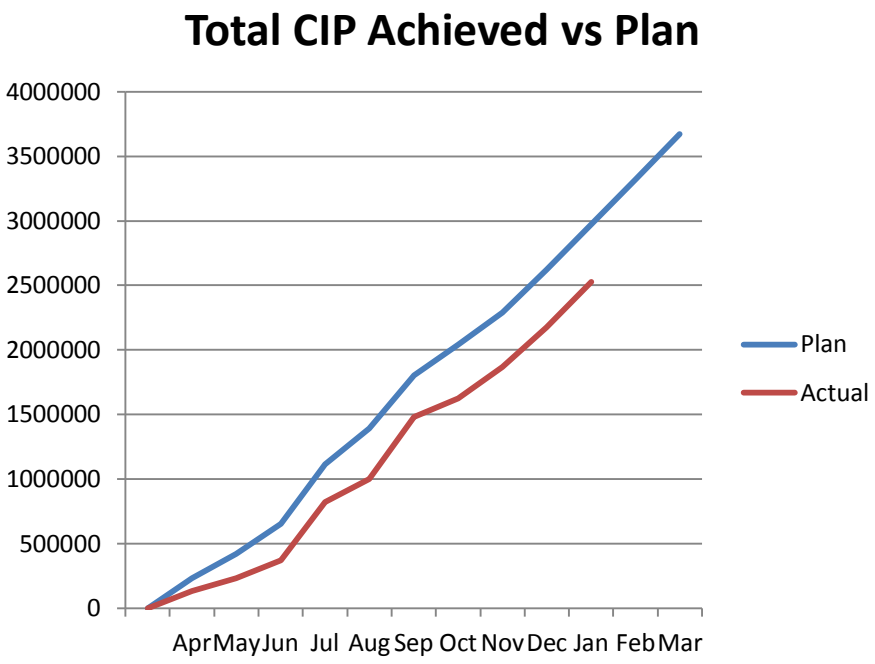
The Trust's most common HRG performed is are major pain procedures, followed by major hip procedures without complications and minimal hip procedures although our data would suggest that the most profitable procedures for the Trust are largely reconstructions. There is work ongoing to improve the allocation of costs to these codes, particularly with regards to prosthesis which may alter our understanding of the Trust's most profitable procedures.

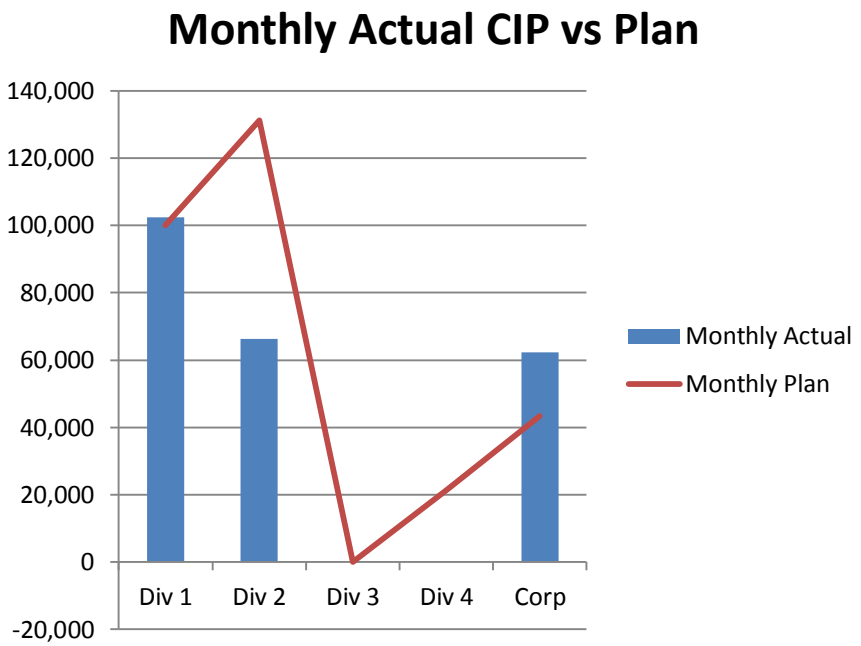
ACTIONS FOR IMPROVEMENTS / LEARNING

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. The costing team have been meeting with each individual firm over the past couple of months to identify areas for costing improvement and to identify any potential areas of income underrecognition. Paediatrics is the only remaining service left to meet.

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 10, the Trust has recognised £2,528,000 of CIP savings, against a plan of £2,971,000. £1,017,000 (40%) of savings to date are non-recurrent. The in-month savings recognised were £355,000 against a target of £350,000. A significant proportion of the CIPs relate to non-recurrent vacancy savings.

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:
Negotiations are ongoing with implant suppliers to achieve best value for money, in addition to consultants changing their implant usage in a number of areas.
Review of the operational and executive structure is being finalised.

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.

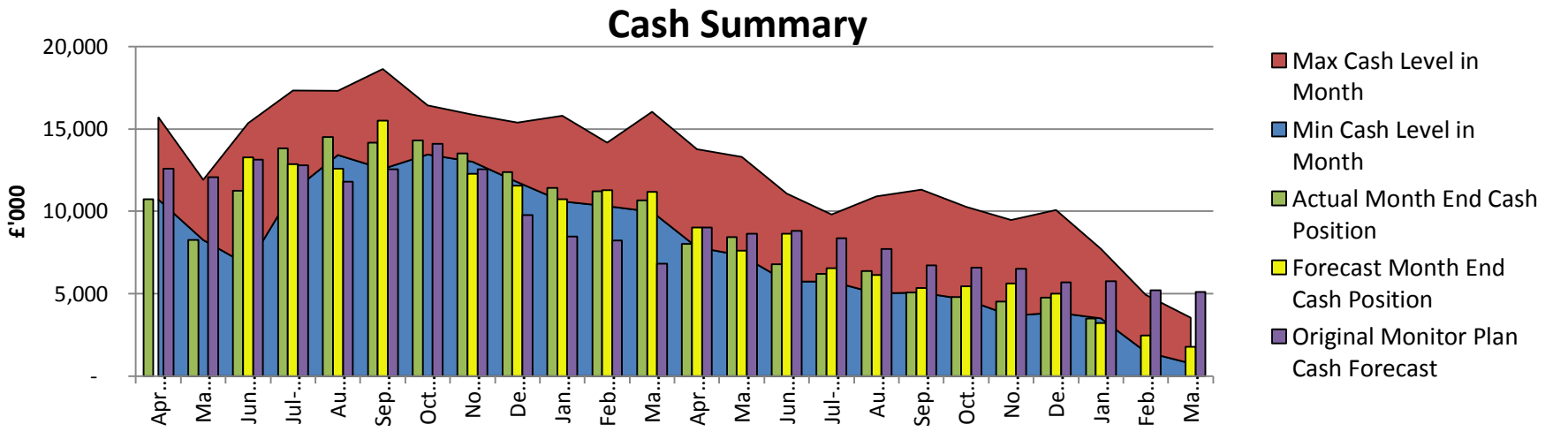
ACTIONS FOR IMPROVEMENTS / LEARNING

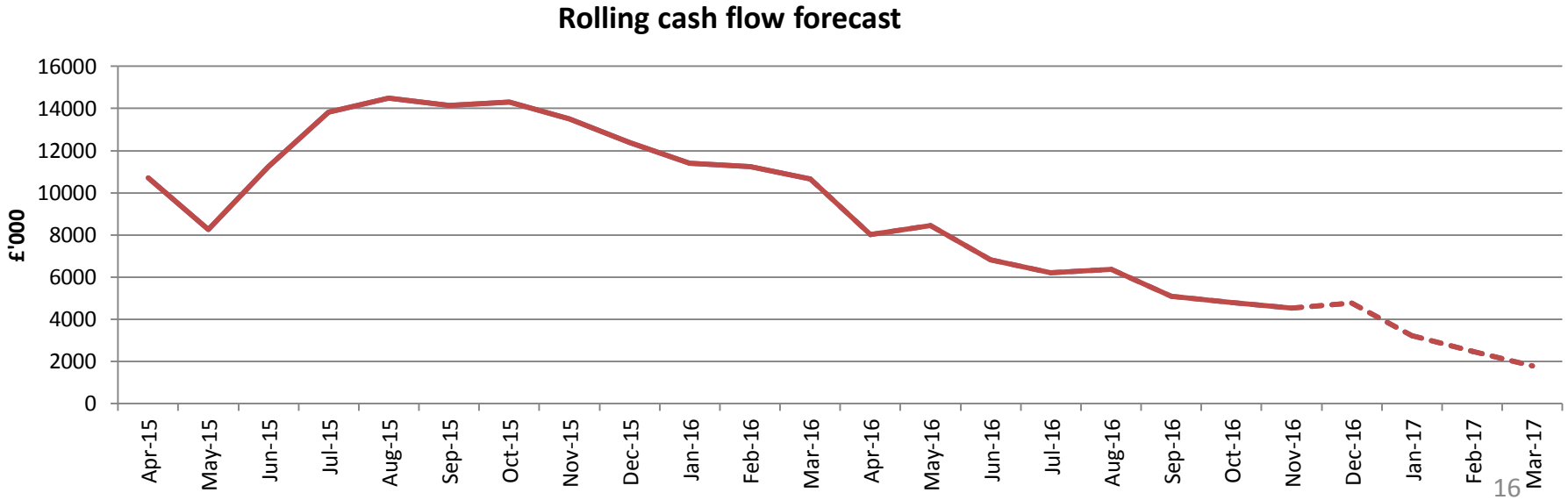
There are still unrecognised CIP balances which need to be identified, particularly in Division 1 and 2.

RISKS / ISSUES

The CIP target of £3.67m represents a significant challenge to the Trust. It is vital that we remain on target despite increased pressures on costs as the Trust increases its activity in the remaining months of 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 £2.2m lower than planned levels at the end of January 2016. The reduction on previous month is due to underperformance payments having been made in January for the Month 1-4 activity (which included the June theatres closure). The Trust is forecasting an end of year cash balance of circa £1.5m, which relies upon the delivery of our revised deficit plan and the control of capital spend within the budget that has been set.

Due to the reduction in cash, liquidity levels within the Use of Resources Rating have dropped to a 3, with cash likely to dip below £nil early in 2017/18.

ACTIONS FOR IMPROVEMENTS / LEARNING

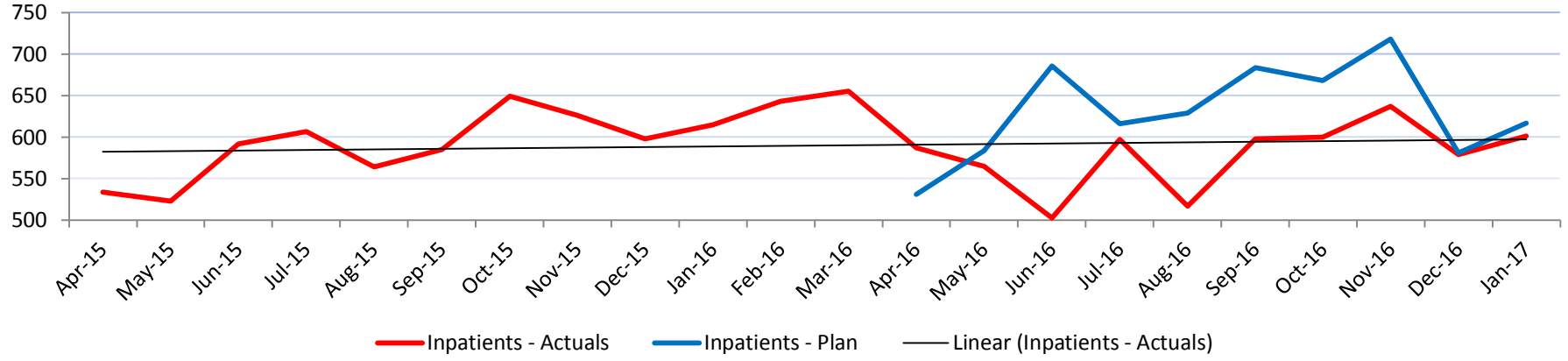
The Director of Finance is reviewing options for the receipt of a cash loan to support the running of the hospital in the new year. The DDOF and Head of Financial Accounting are reviewing cash management controls to ensure they are robust, and are beginning to set up arrangements to allow monthly applications of cash from the Department of Health to be actioned.

RISKS / ISSUES

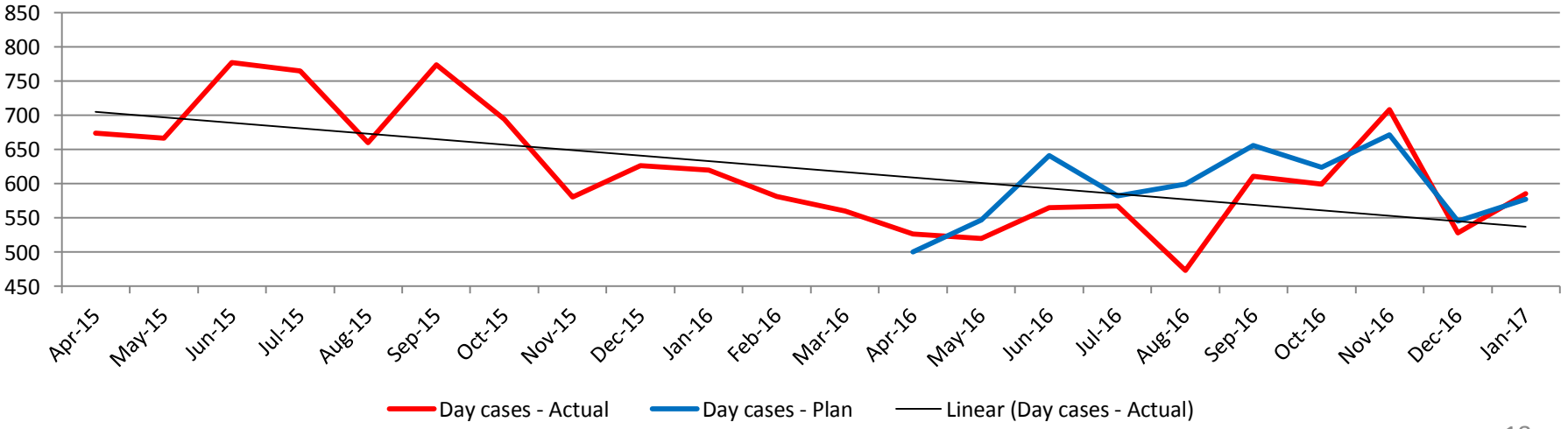
Given the in-month fluctuation of the cash position, which can potentially hit levels £1m-£2m below month end figures before mandate payments are received, it is vital that financial projections are met to ensure that cash can be comfortably managed within safe tolerances.

8. Activity: Admitted Patient Care – This illustrates the number of inpatient and day case discharges in the month, and year to date

Inpatients – Activity against original plan



Day Cases – Activity against original plan



INFORMATION

Activity improved in January as would be expected after the Christmas break. Day case activity overperformed against the original Trust activity plan, with elective activity slightly below. Performance against the recovery activity plan is discussed within the recovery paper.

ACTIONS FOR IMPROVEMENTS / LEARNING

3 of the 5 recovery workstreams relate to increasing activity, through increasing POAC capacity, increasing theatre efficiency and making discharge more efficient. These workstreams are being monitored against their detailed action plans and KPIs on a weekly basis through Recovery Board.

Some of the actions taken include the continue work in the "6,4,2" meeting 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.

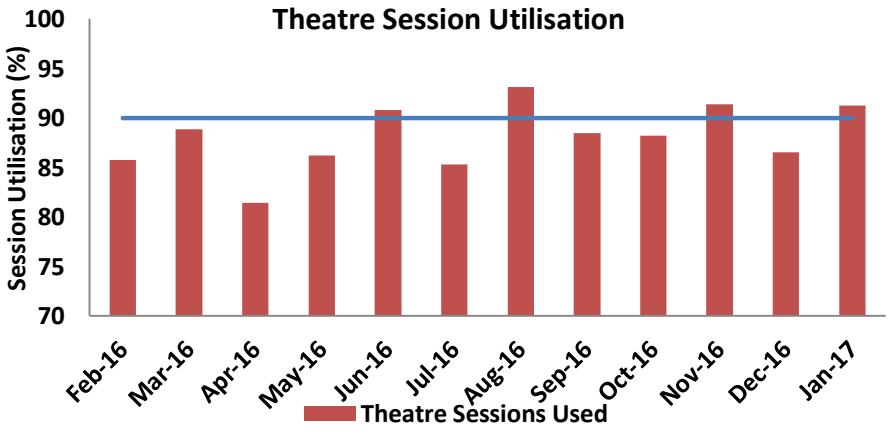
Significant engagement work is underway across the Trust to appreciate the scale of the challenge that is now facing the Trust to deliver the activity and associated income each week, in order to deliver the Trust's agreed financial control total. The planned recovery days to deliver some additional activity are being reviewed as to their deliverability and contingency plans being reviewed.

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.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are potentially available (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we aim to use at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis. The January utilisation improved back to November levels.

ACTIONS FOR IMPROVEMENTS / LEARNING

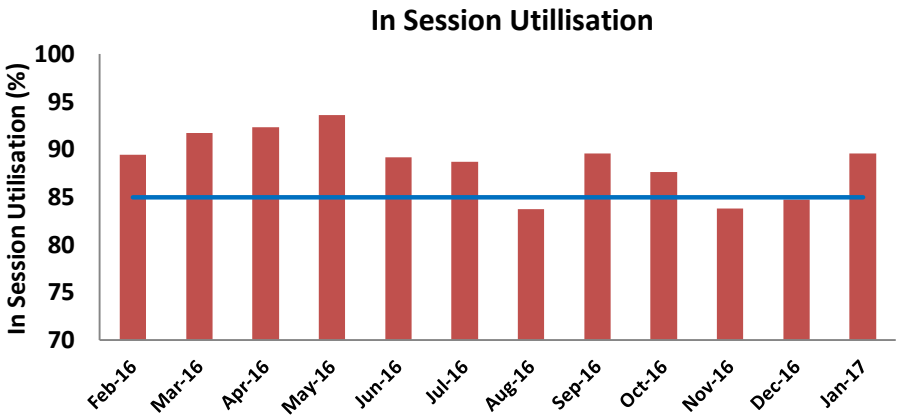
Due to annual leave / study leave, we typically plan that surgeons cover a 42 week year. Timetables are currently based on a 52 week year. Discussions take place proactively as part of the "6,4,2" process to ensure that other surgeons pick up lists that would otherwise be fallow. Job planning is building in buddy arrangements and prospective cover, as well as identifying a need for recruitment to specialities where there are vacancies or that are under pressure from an activity / RTT / 52 week perspective. Improvements have been made to the communications to surgeons of the availability of fallow lists, enabling more effective utilisation. There are now additional 3 session days in the schedule to facilitate the 2 x scoliosis cases on a list for spinal deformity. Looking ahead, following February Half term week, (20-24 February), there are minimal fallow sessions in the following 4 weeks.

Some theatre lists are now being released by individual surgeons (and offered to be reutilised by other surgeons) to do additional clinics, because some surgeons who are timetabled in theatres have very short waiting lists. All reasonable efforts are made to recycle, including where it is deemed appropriate the use of sessions additional to job plan (paid ADHs.) Where lists are not recycled, the theatre staffing and anaesthetist are removed 1 week ahead, to reduce agency costs.

RISKS / ISSUES

Job planning is now completed for over 50% of surgeons, with Oncology completed, Spinal and Arthroplasty nearly completed and other specialties progressing well. Notice is required to establish buddying timetable arrangements (Consultant of the Week) and co-ordination of leave evenly through the year, although there will always be times e.g. school holidays where it is not possible to utilise every available session.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained above the target 85% in the majority of months. However, the previous measure (pre June) 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. Performance in January exceeded plan, and there is continued effort to ensure that this continues throughout the future months.

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. This will be led by the Head of Nursing, Division 2, working on The Productive Operating Theatre principles.

The implementation of the new Theatre Management System (Theatreman) has been rescheduled for 6th March 2017 (This has been slipped several times due to PAS interfacing issues). The prescriptive nature of this software will be a further aid to ensure that lists are optimally booked based on the available time. Scrutiny and challenge is via the weekly 6-4-2 meeting, with instructions back through to the surgical teams to book lists to their maximum potential and to identify patients well in advance so that specific requirements can be planned for to reduce cancellations.

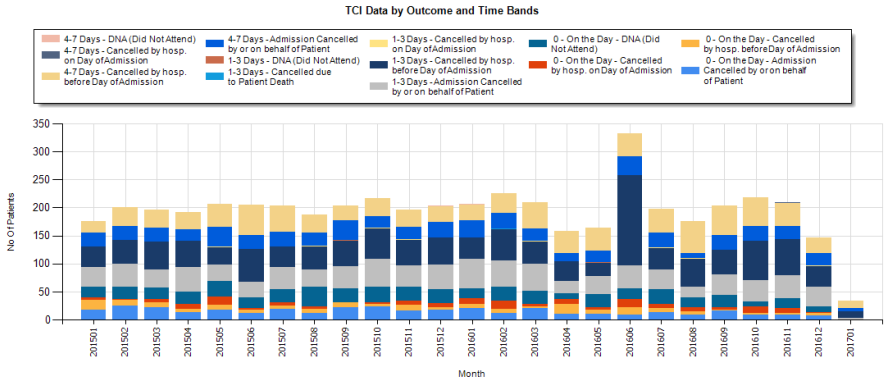
A detailed analysis of all theatre activity during the week commencing 9th January 2017 has identified further improvement opportunities, for example, the time patients are called for surgery, variations in anaesthetic practice and differing practices of listing patients, as well as how individual firms operate. Work on trajectories in the Hands, Feet and Arthroscopy specialties has also brought to the fore some opportunities for greater efficiency and the possibility of moving some cases out of the theatre environment.

RISKS / ISSUES

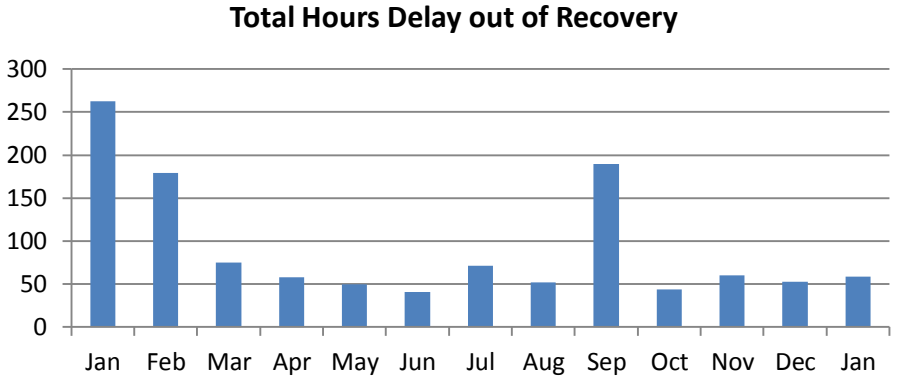
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (e.g. experience in spinal scrub) to ensure the best possible use of available operating time. Availability of radiographers (additional support now in place via agency.) Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit. Gaps in the operational structure, although recruitment is underway.

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

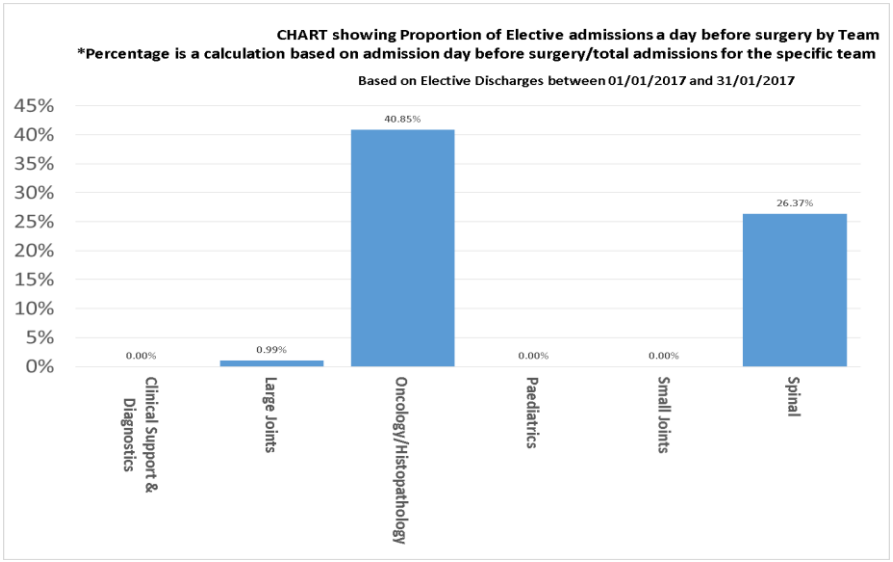
Cancellations by patient / hospital



Delays out of recovery

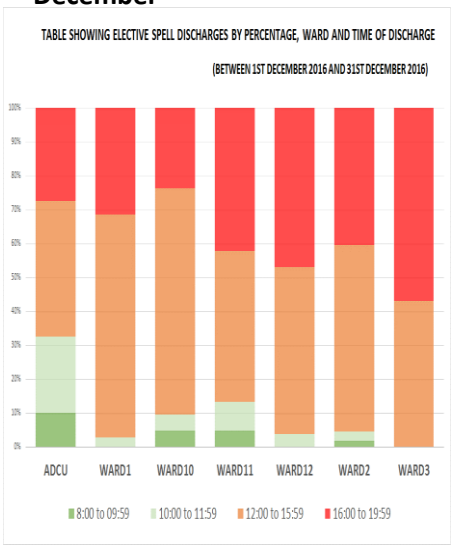


Admission the day before surgery

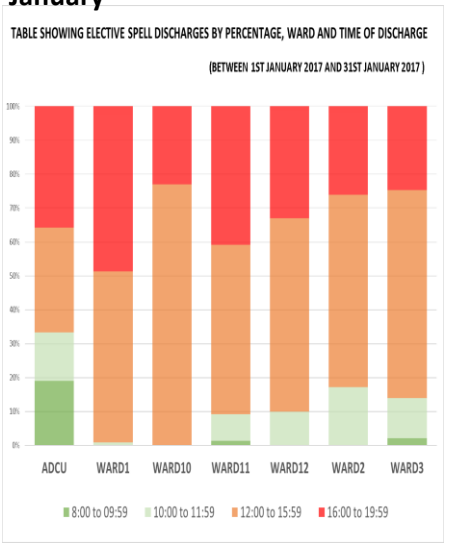


Time of day patients discharged

December



January



INFORMATION

Active management of the Patient Tracking List (PTL) , the establishment of a separate Oncology PTL weekly meeting to track the booking of individual patients, and a separate large joints PTL weekly meeting to track patients is creating a new momentum , with lists being booked several weeks ahead where previously they were being booked only days ahead.

Work on the trajectories for hands, feet and arthroscopy is identifying opportunities for streamlining referrals, reviewing the use of an operating theatre for cases being undertaken (rather than an OPD setting) and the rebalancing of waiting lists across firms. The implications of these are being worked through with Clinical Service leads and Clinical Service Managers.

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Some of the replacement patients are then booked at short notice. We are working towards booking with 3 week's notice and 2 reasonable offers as per national guidance and our Access Policy.

Now that there are Clinical Service Leads and Clinical Service Managers for each specialty, and regular team meetings, some longstanding issues relating to disparity of waiting lists across consultants, variations in theatre productivity and listing protocols are being addressed and resolved.

Forensic analysis of cancellations continues, with a focussed analysis by the anaesthetic lead and nursing lead for POAC of the majority cause of cancellations on the day of surgery, namely those who are medically unfit, to ascertain what process changes can be made in POAC or to the 72 hour phone call to reduce this.

Progress in transferring patients out of Recovery in a timely way, which had stalled in September, has improved and stabilised. However, it is of note that this standard is maintained by Recovery staff escorting the patients back to wards due to ward staffing levels, which may have an adverse impact on theatre utilisation and presents further infection control / red line concerns.

ACTIONS FOR IMPROVEMENTS / LEARNING

Now that the longstanding vacancies in Medical secretaries, admin support and operational management have been filled, there is now the capacity for transacting the forward booking of patients for both preoperative assessment and surgery. Typing backlogs are being cleared and will be up to date by the end of March 2017.

This will create a pool of patients available to be called forward earlier at short notice to fill cancellation slots.

Work is still required to agree criteria for admission the day before, to use beds more effectively and reduce length of stay. Bed availability has not been a constraint to delivery.

Pre-operative assessment improvements have been delivered, so that there are now 32 slots available each day.

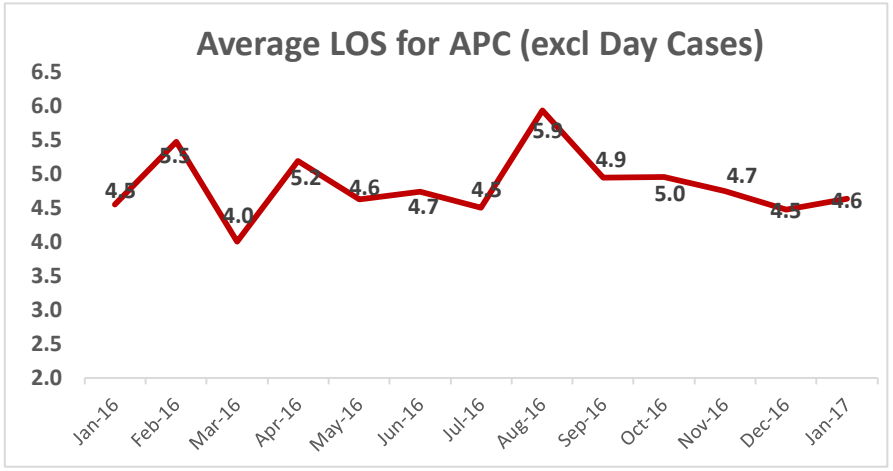
A daily update review by operational management of forward bookings has been established and the 642 and daily huddle is being trialled.

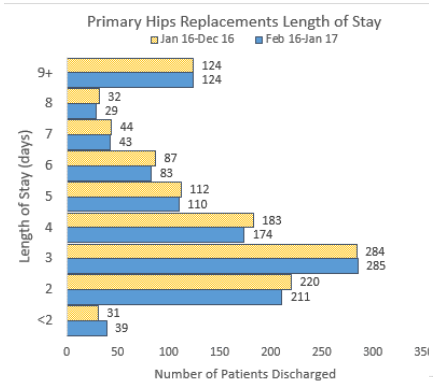
RISKS / ISSUES

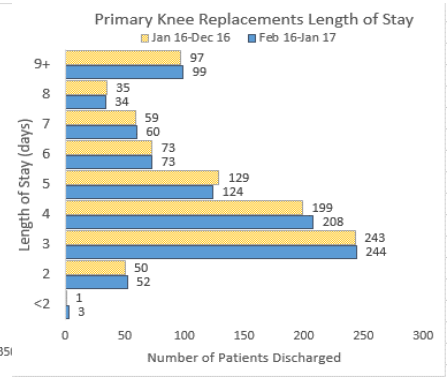
Continued focus with all staff involved to ensure that the operating lists are booked in advance, with sufficient caseloads, together with daily tracking.

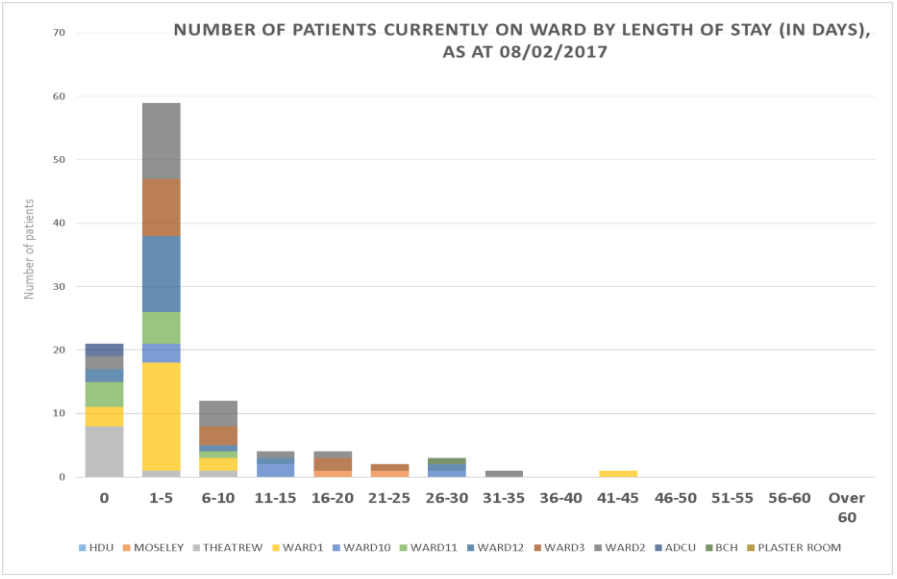
It is curently not possible to identify if the time of day patients are discharged is an accurate reflection of reality, or whether data is being entered onto the system in a delayed manner, making discharges look later in the day.

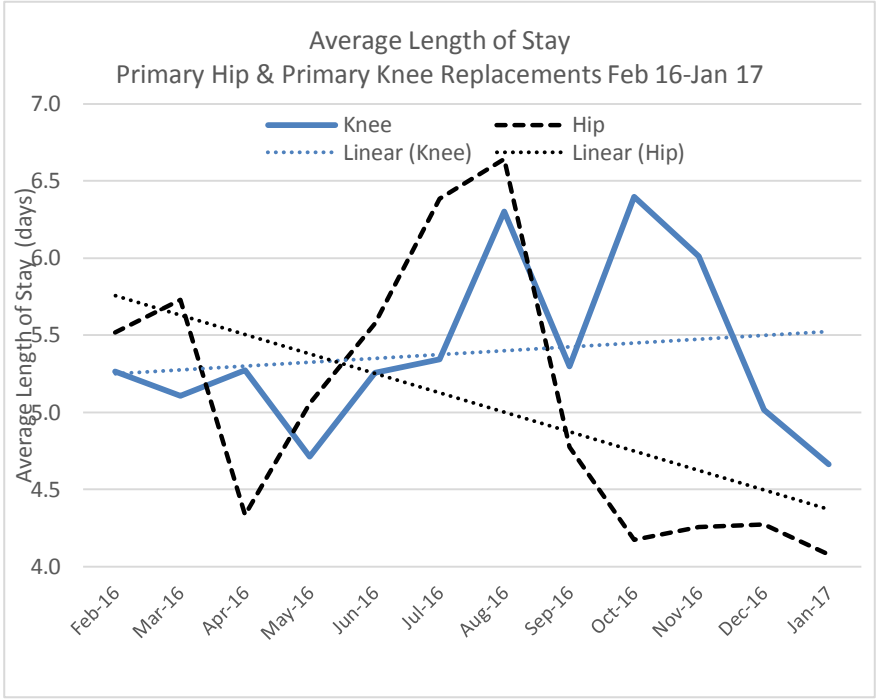
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Length of stay of for primary hips has shown early signs of improvement, and with the extra focus on Estimated Discharge Date and the Rapid Recovery initiative. However, the linear trend for primary knees remains upward, which is disappointing. 'The Home for Lunch' information campaign has been formally launched to staff and patients during Mid February and this will help to reduce length of stay with the expectation setting with staff and patients about when a patient can leave the hospital, and the marshalling of resources to ensure that this occurs as early as possible in the day. This clearly sets out to all concerned that we expect that more than 80% of patients due for discharge that day will leave hospital or be off the ward and in the discharge lounge before midday.

ACTIONS FOR IMPROVEMENTS / LEARNING

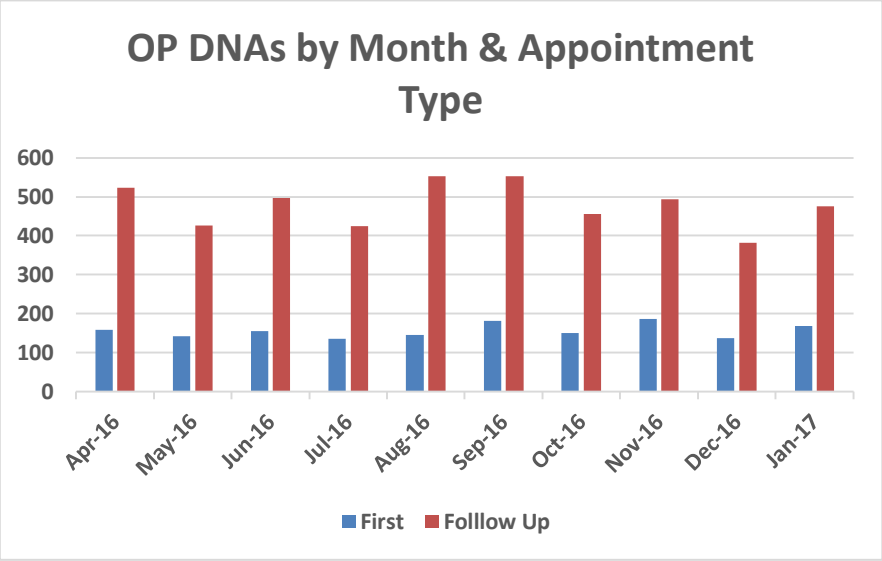
Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.

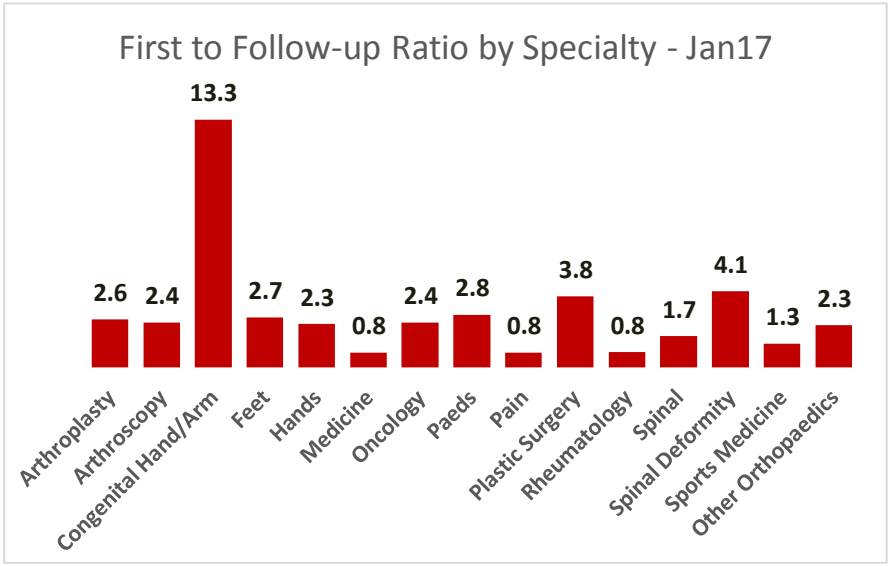
Daily senior reviews are being formalised as part of job planning, and the rising adherence to recording the Expected Date of Discharge (EDD) (now over 90%) is helping all involved in that patient's care to manage their length of stay more effectively.

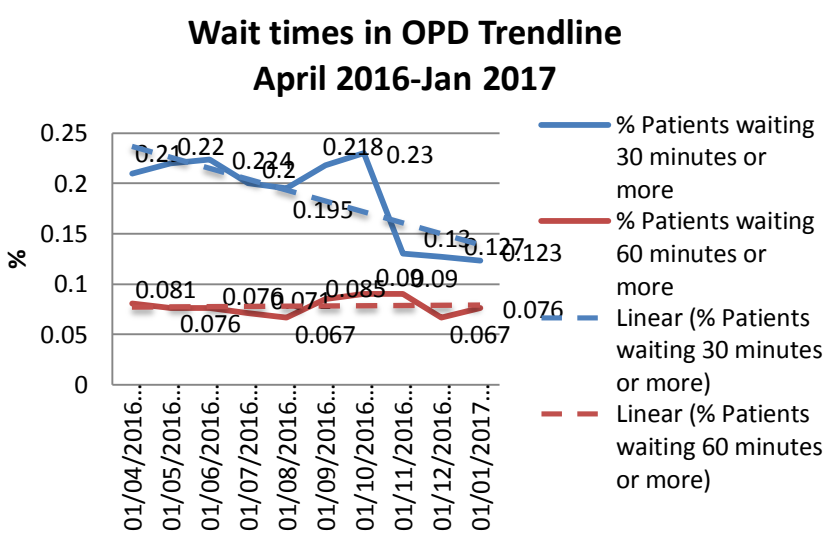
RISKS / ISSUES

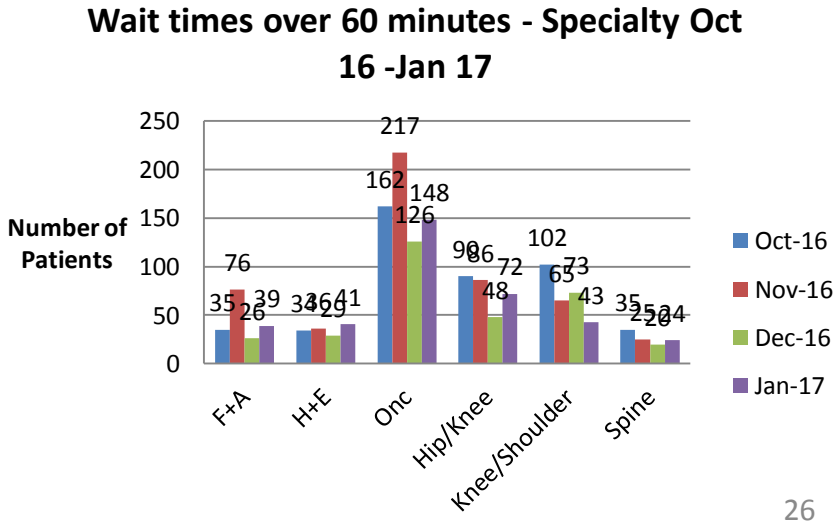
Using individual consultant information, Operational management teams and Clinical Service Leads are reviewing outlying clinical practice to help ensure that all patients are able to go home as soon as possible after their surgery.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients









INFORMATION

Outpatient DNAs remain stubbornly high. The first to follow up ratios at consultant level remain variable, relating to individual clinical practice. Discussions around booking rules and proactively overbooking are being discussed with Clinical Service Leads to ensure that productivity is maximised and as many patients as possible can be seen as soon as possible.

The work undertaken in February to understand the trajectories for Hands, Feet and Arthroscopy will be rolled out across all specialties- initial results are showing very low conversion rates from first OPD appointment to surgery, and also from second OPD appointment to surgery for some specialties.

ACTIONS FOR IMPROVEMENTS / LEARNING

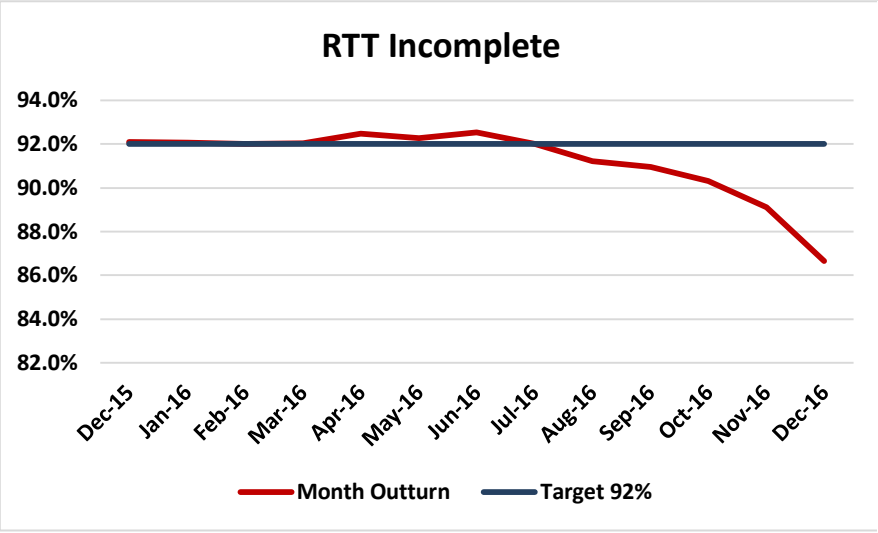
There are a range of actions as part of the CQC action plan and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

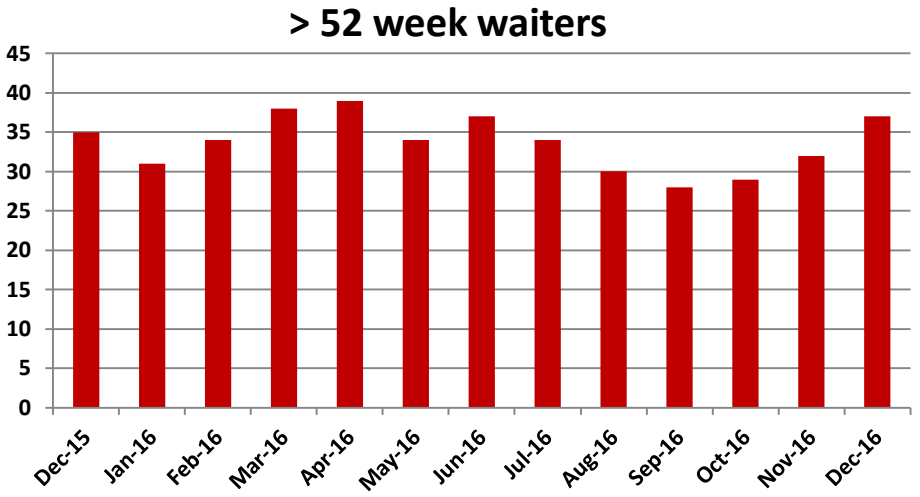
As part of the Trust's RTT recovery work, there will be a focus on out patient pathways and any patients who are in the system awaiting a follow up appointment and have become overdue, for whom a new active RTT clock should be started in line with national guidance. However, if it is found that there is a follow up appointment capacity problem, then this could worsen new to review ratios in the short term. This is being reinforced through RTT training and the clinical service managers working closely with consultants and medical secretaries to ensure that the Trust access policy is being adhered to by all involved.

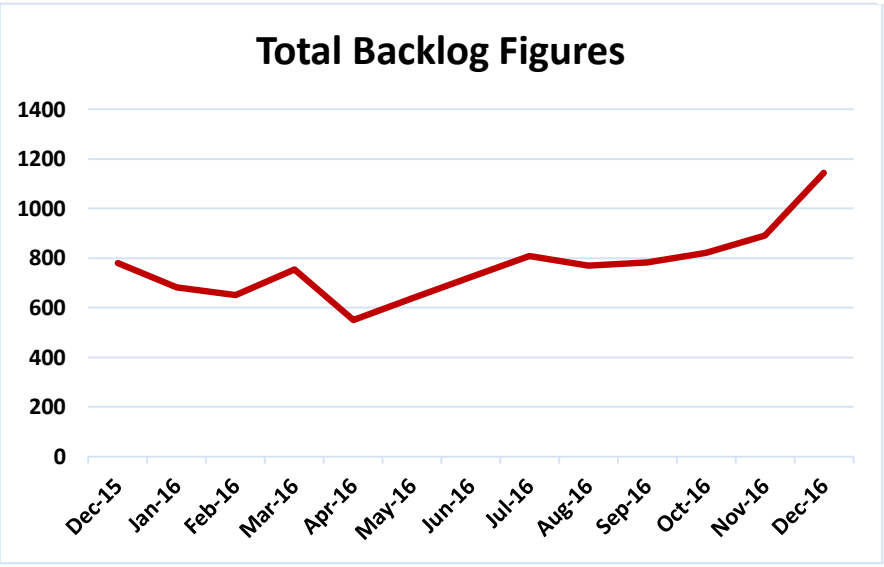
RISKS / ISSUES

Further work is underway on the production of meaningful reports from the In Touch system and the sharing of this information across specialties.

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets - RTT	Target / Trajectory	Actual (Dec16)	Actual (YTD)
52 Weeks Waiters	-	37	300
18 Weeks Incomplete	92%	86.65%	90.78%
NHSI Performance Targets - Cancer	Target / Trajectory	Actual (Jan17)	Actual (YTD)
Cancer (2 week wait)	93%	100%	100%
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	98.65%
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	96.67%
Cancer (62 days)	85%	71.43%	93.62%

INFORMATION

RTT open pathway performance continues to be the main concern. The backlog continues to increase at a rapid rate for both admitted and non admitted pathways.

The current position is 85%, compared to the unvalidated position for December of 86.27%, which was significantly below the November performance of 89.12%, continuing an established pattern of month on month deterioration. This is a mixture of addressing data quality issues as they are identified as part of the ongoing validation work associated with the 100,000 open pathways, and also pathways through to surgery that are not 18 week compliant for a significant number of surgeons in the majority of specialities.

As at 13th Feb 2017 there are a total of 1,410 patients at 18 weeks or over on the waiting list (admitted / non admitted) which is 40 patients higher than last week; this is 16% of the total waiting list. At each milestone the number of patients at 18 weeks and over has risen since last week. Whilst these figures include both dated and undated patients, the number of patients dated 14 weeks and above is not sufficient to improve the Trust's position.

A retrospective review of waiting list / pathway status has indicated to achieve 92% the Trust's backlog will need to be circa 550 with total pathways around the 7,500 mark. January's performance against the 18 week 92% unfinished target is currently being validated. With a backlog of 1285, the team need to stop 658 clocks to achieve 92%.

The main issues (based on reported performance) are within arthroscopy, foot & ankle and spinal. The number of breaches within the pain service have increased due to consultant manpower, but a rectification plan is in place for this speciality. Rectification plans are being developed and will be completed shortly for the other specialties.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are significant concerns with regard to data quality and the measurement of RTT waiting times. This includes inappropriate clock stops in the Oncology service following biopsy, and the monitoring of services that are not consultant led but are delivered within an 18 week pathway (Therapies) that therefore improve the position. This has been escalated to NHS Improvement. It is likely that the true position, when the reporting anomalies are resolved, will be significantly worse that the current level of performance being reported.

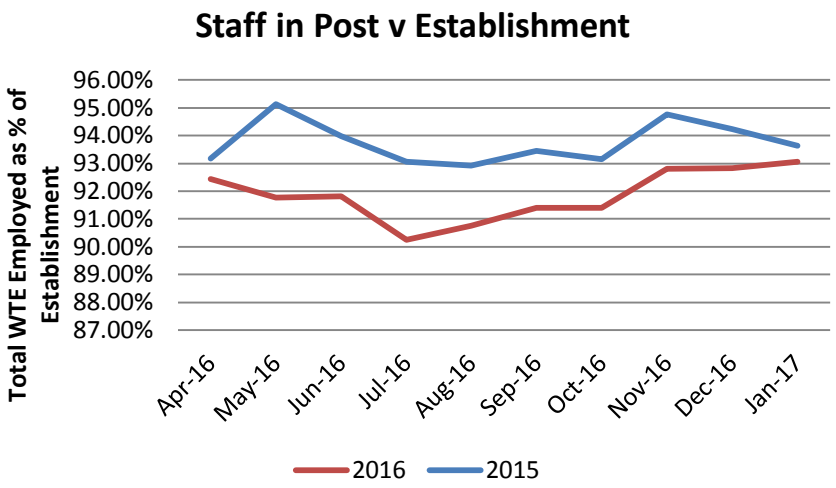
RISKS / ISSUES

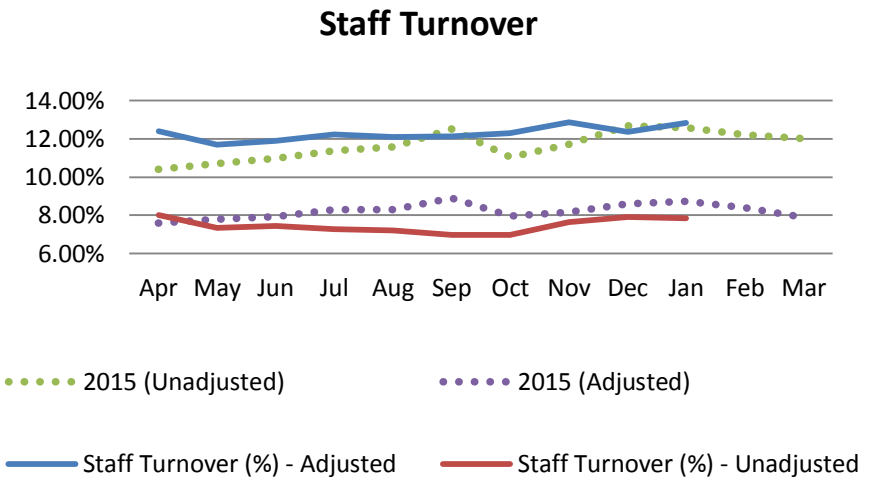
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern.

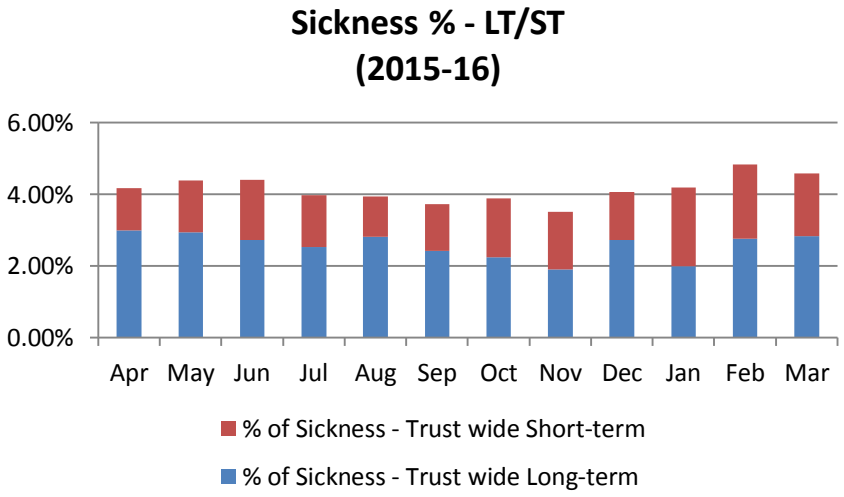
18 weeks: Significant work continues to understand the scale of the challenge with regard to open pathways, and the extent of data quality concerns. The Trust welcomes the input and expertise of NHS Improvement in this area.

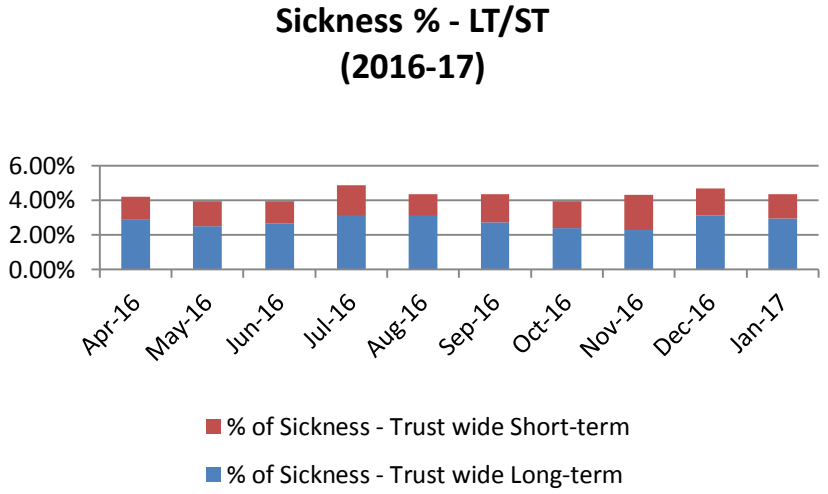
A review is under way with regard to the robustness of cancer waiting times reporting, given the concerns with data quality around the other access targets.

15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

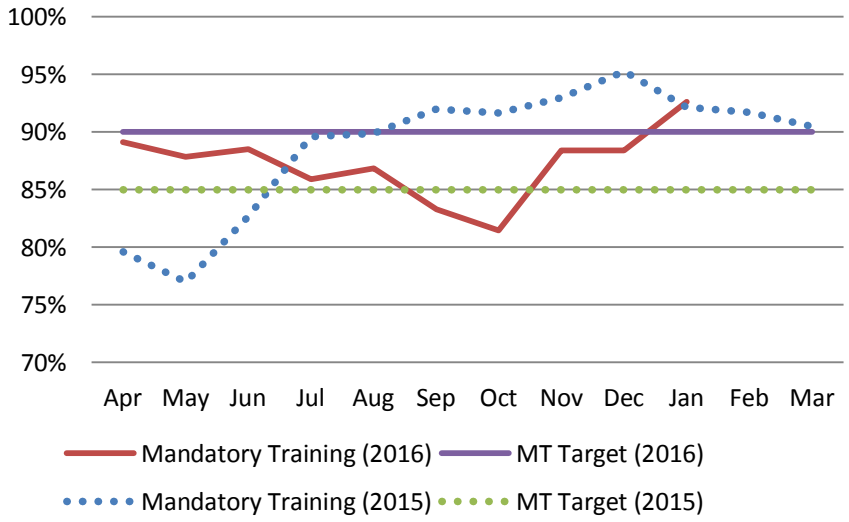




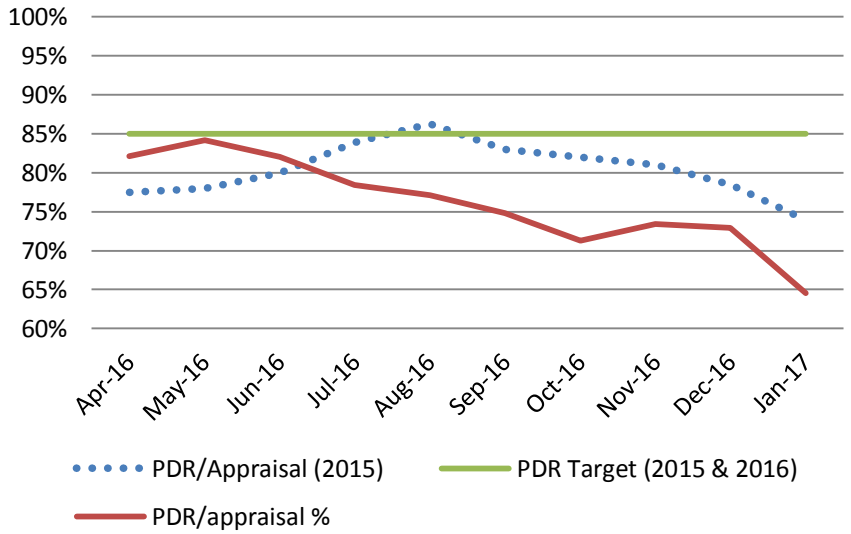




Mandatory Training



PDR/Appraisal



INFORMATION

January 2017 in general terms was a better month for workforce performance than December 2016.

The vacancy position, in terms of staff employed, moved above 93% for the first time in 9 months and turned "green", reflecting continued steady upward progress in recruitment since July.

Sickness absence saw a decrease in both short and long term absence in January (4.34%) versus December's position (4.67%), which is encouraging.

There should be progress to report in the underlying 12 month figure in February (current 12 month average as at end January stands at 4.52%) if we can maintain or improve our current position: February does tend to feature consistently in the top 3 worst months for sickness absence, so there is an opportunity for improvement next month.

The Trust's Mandatory training position increased in January to 92% and was "green" for the first time since March 2016. It is unfortunate that on 23 January 2017 the Trust received a contract performance notice from our commissioners on this issue - although the progress is encouraging to report externally. Maintaining performance now becomes the challenge.

PDR/appraisals have decreased this month to their lowest level since September 2013 as a result of operational efforts to achieve the recovery plan: this will be an area of focus in coming months.

The turnover figures this month were unremarkable: both are within typical ranges of the last 12 months.

ACTIONS FOR IMPROVEMENTS / LEARNING

The importance of remaining compliant in mandatory training was reinforced at Divisional performance reviews In January, discussed at Trust Management Committee in January and has also been core briefed in February.

The appraisal position has been discussed at Divisional Boards in February and trajectories will be re-examined in April: other current operational recovery plan priorities make significant immediate progress unlikely, however.

RISKS / ISSUES

The Trust is under a contract performance notice from our commissioners in relation to statutory and mandatory training currently as above.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	25 January 2017
Guests	Sarah Mimmack, Infection Control Lead Evelyn O'Kane, Safeguarding Lead
Presentations received	Board & Committee reporting
Major agenda items discussed	• Upward report from Clinical Quality Committee • Upward report from the Safeguarding Committee • Upward report from the Infection Control Committee • Upward report from the Clinical Audit & Effectiveness Committee • Quality & Patient Safety report • Accountable Officer for Controlled Drugs report • Lessons learned update • Consent update • Safe staffing report • CQC action plan – progress update
Matters presented for information or noting	Discussed under matters arising: • ***WHO checklist champion in theatres*** – this was reported to be Mr Matthew Revell, Associate Medical Director for Division 2. It was agreed that he would be invited to attend the next meeting to describe the WHO checklist process and the measures taken to ensure adhere to this. • ***Injectable materials incident*** – it was reported that following concerns raised at the last meeting, as part of the report back from the Chair of the Drugs & Therapeutics Committee, there had been a review of the incident and it had been identified that there had been no inappropriate injections performed. A plan to comply with the relevant Central Alert System (CAS) requirement by September 2017 was in place. • ***Communication with families on a spinal deformity pathway*** – a letter had been drafted which the Committee would see at its next meeting.
Matters of concern, gaps in assurance or key risks to escalate to the Board	• There had been an increase in the number of complaints, although it was suggested that this could be related to increased awareness about how to complain. • Following a recent visit by the Clinical Commissioning Group (CCG), it had been noted that there were deficiencies in the formal assessment of patients against

	the Mental Capacity Act, therefore there had been some focussed pieces of work underway and amendments to the Mandatory Training suite to include training on the Mental Capacity Act. There was improved compliance with training, although further work was needed to increase the uptake on training further, possibly through the use of e-learning. • As part of the upward report from the Infection Control Committee, it was noted that the CQUIN around 'flu vaccinations had not been fully met. The overall vaccination rates were improved on previous years however. • The Committee was advised that the reporting of cleanliness was due to change shortly, with a move to reporting externally against the 'Cleaning for Credits' system. • The effectiveness of the theatre cleaning programme was discussed, where it was asserted by the Head of Infection Control that there may be some inefficiency in the current theatre cleaning programme where theatres were cleaned on a sectional basis, rather than a total clean as had been the case when the theatres were closed in June 2016. The Committee challenged this view as being largely speculative. The cleaning regime was noted to be largely dictated by the current theatre environment, a risk that was flagged on the Corporate Risk Register. • The need for a programme of replacement bins needed to be arranged as soon as possible • An external review of infection control systems and processes was to be undertaken. • Further work was planned to review Patient Outcomes, including comparions to peer organisations and other benchmarking information • Some deviation from the VTE protocol was outlined in terms of th 24 hour reassessment. It was noted that individuals needed to be held to account where this had occurred. The Chair of the VTE Committee would be asked to attend the next meeting of the Quality & Safety Committee. • A number of vulnerabilities with the operational and corporate governance arrangements of the committees reporting up to the Quality & Safety Committee were outlined, included lack of central storage of papers and the variation of administrative support. The operation of the Drugs & Therapeutics Committee was noted to be of particular concern, although processes were reported to have strengthened recently through improved administration and the development of terms of reference

	for the Committee.
Positive assurances and highlights of note for the Board	• The management of the complaints function would fall under the remit of the Governance Team in future. • The upward report from the Clinical Audit & Effectiveness Committee reported that the backlog of NICE guidance had now been cleared and Clinical Service Leads were now reviewing guidance as it was published. There had been good improvement in this area and recommendations from the recent internal audit had been addressed. • It was noted that there were pockets of the organisation where staff were reluctant to report incidents and work was underway to encourage people to report incidents more routinely and with more confidence • An internal audit of Controlled Drugs had been undertaken and had provided 'Reasonable Assurance'; all recommendations had been addressed. • Within the report from the Accountable Officer for Controlled Drugs, it was reported that during the period, there had been a number of errors made by dispensers, which was a concern for the Committee. • Good progress was being made with developing plans to identify and share lessons learned. Work was underway to develop granular information for various clinical areas to provide a better understanding of key trends on incidents, complaints, claims and risks. An e-bulletin had also been created to share lessons and the use of Ulysses functionality would be improved. • The Committee reviewed the revised Consent policy, which had been updated in line with revised national guidance
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Prof Begg would be asked to identify the plans to ensure that the upward reporting to the Quality & Safety Committee from the Research & Development Committee resumed • Mr Matthew Revell to be invited to the next meeting bto discuss the WHO checklist process • The letter to patients on the spinal deformity pathway is to be reviewed at the next meeting • Minutes of the Clinical Quality Group are to be considered in future alongside the upward assurance report • The tissue viability lead should be invited to the meeting of the Quality & Safety Committee in April 2017 • An update on the reporting processes and operation of the Quality committees is to be reported back at the next meeting • The Head of Communications is to be invited to the March meeting of the Quality & Safety Committee to discuss the plans to improve Friends & Family Test response rates • Alex Gilder, Deputy Director of Finance, to be invited to the

	next Quality & Safety Committee meeting to discuss the Quality Impact Assessment process for Cost Improvement schemes
Decisions made	• None specifically, although it was agreed that discussions at the Committee in future needed to focus more clearly on the assurances that were needed.

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

For the meeting of the Trust Board scheduled for 1 March 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	22 February 2017
Guests	Dr Bill Rea – Chair of the Drugs & Therapeutics Committee Dr Tony Sutherland – Chair of the VTE Committee Mr Matthew Revell – Associate Medical Director, Division 2 Mrs Alex Gilder – Deputy Director of Finance
Presentations received	None
Major agenda items discussed	• Upward report from the Drugs and Therapeutics Committee • Upward report from Clinical Quality Committee • VTE update • WHO checklist compliance • Quality & Patient Safety report • Quality Account priorities • CIP assessment process • Divisional governance update
Matters presented for information or noting	• Update on Research & Development
Matters of concern, gaps in assurance or key risks to escalate to the Board	• As part of the upward report from the Clinical Quality Group, it was reported that the Group's risk register needed to be reviewed and refreshed • The Committee was made aware of a red risk around fire escape plans for theatres – although the process for evacuating theatres was clear, there was no documented process in place. This was being addressed through the Health & Safety Committee • Concerns were expressed about the robustness of the operation of the Health & Safety Committee, particularly its connectivity to the 'front line' • A risk around the monitoring of drug fridge temperatures was discussed and a business case had been developed to address this • There was a significant discussion around the practice to reassess patients VTE prophylaxis 24 hours after a procedure, given that practice at the ROH was more appropriate for a large mixed take acute Trust, rather than a specialist elective organisation. The risks associated with a delay in administering prophylaxis were discussed, particularly as nurses were not currently able to authorise

	this. The Committee was advised that there was evidence of poor completion of documentation associated with VTE assessments, a matter it agreed should be addressed as a priority. It was agreed that some peer based learning would be useful to improve the VTE process at ROH • As part of the consideration of the Quality & Patient Safety report, it was noted that response rates to Friends and Family Test remained low; the Head of Communications would attend the next meeting to outline plans to address this • Although there had been good work in the Admission and Day Case Unit to move to a position closer to the national guidance on pre-operative starvation & fluid intake, it was noted that more work was required in inpatient areas to prevent patients having to go without food and water for an excessively long time prior to surgery • The Committee received a presentation on the current process for undertaking Quality Impact Assessments (QIAs) on Cost Improvement Programme schemes. At present the process was not robust and sign off of QIAs by relevant senior members of staff was not occurring as it should. An update would be presented at the next meeting. • Example minutes from the divisional governance boards were revised and it was noted that the quality of these needed to be improved to reflect more fully the key issues discussed at these meetings. • The Committee was updated with the detail of a recent Controlled Drugs incident.
Positive assurances and highlights of note for the Board	• The Committee reviewed the proposed letters to families with patients on the spinal deformity waiting list and provided feedback to be incorporated into the final version • The issue previously discussed about the accessibility of drugs charts by clinicans was reported to have been addressed through drugs charts now being located at the end of patients' beds • As part of the upward report from the Drugs & Therapeutics Committee, it was reported that there were risks around the current arrangements to store chlorohexidine; risk assessments were currently being undertaken by Health & Safety, Pharmacy and the Fire Officer – there needed to be a balance between sufficient stock being kept on site and excessive amounts which could pose a fire risk • There were encouraging results from the recent round of drug storage audits on wards • Although there were a number of issues discussed as part of the VTE update, it was noted that as a percentage of patients seen by the ROH, the level of VTEs reported was

	low overall • The Committee received a useful update from Mr Revell regarding compliance with the WHO checklist and the process that was in place to enforce this practice. It was noted that a new theatre system would come on line in early March which would make the process more rigourous. The need to move away from a 'tick box' culture to one where the practice encouraged more reflection and planning was noted to be needed. Wilful non-compliance in future might result in HR procedures being invoked. • Incident levels were reported to have returned to typical levels. • The Quality Account priorities for 2017/18 would be presented at the next meeting
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• An update on consent for use of human tissue as part of research trials to be presented as part of a future report by the Director of Strategy & Transformation • Professor Begg be invited to join the Committee to present an update on the Knowledge Hub development at the April meeting • It was agreed that the Director of Operatios, Nursing & Clinical Governance would work with Operations colleagues to understand the definiftion of a 'one stop' clinic in relation to Outpatients
Decisions made	• The Committee approved the revised terms of reference for the Drugs & Therapeutics Committee

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

For the meeting of the Trust Board scheduled for 1 March 2017

The Royal Orthopaedic Hospital NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Quality & Safety Committee
Terms of reference
Revised February 2017,

Deleted: December
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1 Constitution

The Constitution of the Trust provides that the committees and sub-committees established by the Board of Directors are:

(i) Remuneration Committee;
(ii) Nominations Committee;
(iiii) Quality & Safety Committee; and
(iv) Audit Committee
(v) Major Projects & OD Committee
(iv) Finance & Performance Committee

The Constitution states that "Quality & Safety Committee" means a committee whose functions are concerned with the arrangements for scrutiny and monitoring and improving the quality of healthcare for which the Trust has responsibility.

2 Delegated Authority

The Committee has the following delegated authority:
2.1.1 The authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee;
2.1.2 The authority to establish Sub-committees. The Committee shall determine the membership and terms of reference of those Sub-committees.
2.1.3 The authority to establish Advisory Groups including forums. The Committee shall determine the membership and terms of reference of those Advisory Groups including forums.

3 Accountability

The Trust Board

4 Reporting Line

The Trust Board

5 Objective

Oversight and scrutiny of all aspects of quality, patient safety, clinical outcomes, effectiveness and experience

To assure the board that robust systems, clinical policies and processes are in place to enable the Trust to:

5.1.1 Fulfil its statutory duty to act with a view to securing continuous improvement in the quality of services provided to individuals; and,

5.1.2 Identify and effectively manage any quality or clinical risks associated with performing statutory and non-statutory functions

6 Duties

The Committee will deliver its Objectives by seeking assurance across the following areas:

6.1 **Contract management and Commissioning**

6.1.1 The committee will oversee, by appropriate monitoring of actions taken by responsible officers the provision of evidence of trust performance in line with contractual requirements commissioners.

6.2 **Leadership for quality**

6.2.1 Provide oversight to maintain a focus on quality by the Trust's leadership provide assurance to the Board regarding the adequacy of skills to lead efforts across the organisation to drive continuous quality improvement.

6.2.2 The committee will review the trust's quality reports and approve the annual Quality Account for inclusion in the Annual Report

6.3 **Regulatory Assurance** – Monitor and CQC (review of guidance, CQC outcome assurance report,)

6.3.1 The committee will oversee, by appropriate monitoring of actions taken by responsible officers, compliance with standards set by the Care Quality Commission and, insofar as they relate to clinical matters, those set by NHS Improvement.

6.3.2The Committee will seek assurance that there are robust systems and processes in place for monitoring and assuring the quality of services and for driving continuous quality improvement.

6.4 **Clinical Audit of outcomes and effectiveness**

6.4.1 The committee will oversee the annual programme of clinical audit – this will include surgical audit, anaesthetic audit, histopathology audit, radiology audit, participation in national audits and locally determined audits

6.5 **Other**

6.5.1 The committee will assure the Board that the Trust's research activity

Deleted: (from Quality Committee, Quality Governance Framework)

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Deleted: quarterly governance declaration

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complies with necessary regulations and supports the Trust's strategy (reports from the Knowledge Hub)
6.5.2 The committee will assure the board that the Trust's medical and clinical education meets the required standards.

6.6 **Risk management**
6.6.1 The committee will regularly review clinical risk - in particular, Board Assurance Framework clinical risks, Corporate Risk Register and those risks owned by executive committees providing assurance to the Quality & Safety Committee.
6.7 The committee will review reports from other committees as outlined below:
6.7.1. Committee reports at agreed intervals from drugs and therapeutics, infection control, safeguarding children and adults groups, Children's Board and Clinical Quality Group
6.8 The committee will consider feedback from the Trust's patient groups and from peer reviews.
6.9 As part of the Quality & Patient Safety report, the committee will receive updates on cases which are dealt with by the NHSLA or any successor body and will seek to monitor lessons learnt.

Deleted: Research and Development Committee

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7 Permanency

The Committee is permanent

8 Membership

The Committee membership will comprise no fewer than three Non Executive Directors and the Chair of the Committee will be a non Executive holding a clinical background.
The Vice Chair of the Committee will be a Non Executive with a clinical background and will take on the Chair's duties in their capacity as chairman of the Quality & Safety Committee if the Chair is absent for any reason.

Executive members
Medical Director
Chief Executive
Director of Operations, Nursing and Clinical Governance
Director of Operations

9 Quorum

At least 2 NEDs and one from Medical Director or Director of Operations, Nursing and Clinical Governance

10 Secretariat
Associate Director of Governance & Company Secretary

11 In attendance, by invitation

Deputy Director of Nursing & Clinical Governance
Governance Manager
Others relevant to the agenda of the meeting such as chairs of advisory groups and Clinical Directors and successor roles
A representative from the Council of Governors may attend in a non-participative, observatory capacity

12 Internal Executive Lead
Director of Operations, Nursing and Clinical Governance

13 Frequency of meetings
At least 8 meetings per annum

14 Work programme
The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document which steers the agenda for the committee. Progress should be updated for each meeting via rolling action notes
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15 Review of terms of reference
This should be undertaken annually.

Date of adoption **1 March 2017**
Date of next review **February 2018**

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Deleted: January
Deleted: 7

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	17 January 2017
Guests	None
Presentations received and discussed	Update on Job Planning
Major agenda items discussed	• Stock Rationalisation • Finance & Performance Overview – Month 09 • Financial recovery: workstream update
Matters presented for information or noting	• Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• Those previously involved in job planning no longer worked in the Trust. Nicky Lloyd was clear on dates for sign off and good progress had been made in gaining sign off of Oncology job descriptions but support from GMs was needed to achieve a successful job planning outcome. • Non pay was overspent including the element associated with BCH. • The value of additional spend on Radiographers in theatres needed to be understood. • In terms of SLR, the top ten volume procedures were not necessarily the most profitable. Major pain was loss making. • It was anticipated CIP would be behind plan at year end. • Cash was declining. Discussions with NHS Improvement had been held to secure support for cash in future years. • Activity dropped in December, together with theatre utilisation; in session utilisation was less than the 85% target. • There remained a significant level of cancellations (key reason medically unfit patients on the day of surgery). There was a discrepancy on the view of the fitness of patients for surgery between Pre-Op anaesthetists and anaesthetists in theatre on the day of surgery that needed to be addressed by agreeing a set of protocols. • Outpatient DNAs remained high. • For RTT arthroscopy and foot and ankle were key challenges. Pooling of some waiting lists was being

	explored. There continued to be data quality issues and the link with RTT performance needed to be established. The popularity of key surgeons was influencing the 18 week RTT performance. • Appraisal rates were below par. • Mandatory training was being challenged across the board and non-essential clinical update days had been cancelled to release time for staff to undertake training. • Day cases needed to improve together with a better understanding of Oncology. • POAC - recruitment of Physician Associates was a key risk. There was no confidence on 'walk ins' from Outpatients. DNA rates needed to be added into the POAC forward look. • The 6-4-2 processes needed to be more efficient. • The patient information element of discharge planning had been delayed. LOS and occurrences of patients staying beyond their EDD were being reviewed. • A formal delay to the EPMA project was needed, which the Committee approved. • The 22 January 'Recovery Day' had been stood down but the recovery day concept should be maintained as a key part of the Trust's recovery plan. • The Trust was negotiating some aspects of the 2017/18 & 18/19 contracts which related to the new orthopaedic tariff.
Positive assurances and highlights of note for the Board	• There was now more appropriate use of some implants already in use. • The operational plan for 2017/18 and 2018/19 had been submitted. • A major stocktake session had been held. • There was some good clinical engagement on ensuring costs procedures were as accurate as possible. • In December there had been a slight over performance against the financial plan overall, although the Trust was slightly below plan on inpatient income. • Nursing agency spend had reduced. • Oncologists had agreed that a different clerking model be put in place to prevent admission on day prior to surgery. • Average length of stay had reduced and appeared to be sustainable. • A set of KPIs was being developed for Theatre workstream productivity & list planning. New consultants would assist with delivering this work. A new Head of Nursing in theatres was in place. • Additional agency spend controls were being added and there had been some success in theatres with agency staff transferring onto the bank.

	• The MARS scheme had closed. Buy back of annual leave from some key groups of staff was planned. • Some surgeons were coming forward and were being encouraged to be advocates of the 'Recovery Day concept'.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The Director of Operations, Nursing & Clinical Governance to investigate the basis for which the Trust was charged for spinal cord monitoring in the event a procedure was cancelled. • AG to share a summary of the performance pack with the Council of Governors at its next meeting • GM to update the Committee on the use of text messaging functionality for managing Outpatient appointments • PA to review the staff turnover graph for accuracy. • PA to arrange for DNA rates to be added to the forward look for POAC bookings
Decisions made	• The Committee agreed to formally delay the ePMA project.

Mr Tim Pile
VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 1 March 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Friday 10 March 2017

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 15th March 2017 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 1415h.

Questions for the Council of Governors should be received by the Associate Director of Governance & Company Secretary no later than 24hrs prior to the meeting by post or e-mail to Associate Director of Governance & Company Secretary, Simon Grainger-Lloyd, Trust Headquarters or via email s.grainger-lloyd@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** 15 March 2017: 1400h – 1600h

TIME	ITEM	TITLE	PAPER REF	LEAD
1400h	1#	Chairman and Non Executive reappointment & remuneration	ROHGO (3/17) 002 ROHGO (3/17) 002 (a)	AL/ SGL
1415h	2	Apologies and welcome	Verbal	Chair
1417h	3	Declarations of interest	Verbal	ALL
1420h	4	Minutes of previous meetings on 18 January 2017	ROHGO (1/17) 008	Chair
1425h	5	Update on actions arising from previous meetings	Verbal	SGL
1430h	6	Chief Executive's update	ROHGO (3/17) 003 ROHGO (3/17) 003 (a)	GM
1445h	7	STP update	Verbal	YB
1500h	8	Quality Account – Governor-selcted indicator	ROHGO (3/17) 004 ROHGO (3/17) 004 (a) ROHGO (3/17) 004 (b)	JW
1510h	9	CQC regulation – training session	Presentation	BT
1535h	10	Quality & Safety Committee update	ROHGO (3/17) 005 ROHGO (3/17) 006	KS
1545h	11	Operations update	Verbal	GM
1555h	12	Governor updates	Verbal	ALL
1600h	13	For information: • Finance & Performance report • Quality & Patient Safety report	ROHGO (1/17) 007 ROHGO (1/17) 008	
	Date of next meeting: Wednesday 17 May 2017 @ 1400h – 1600h in Trust Headquarters			

1# Item to be taken in private and without the Chairman and Non Executives present

MINUTES

Council of Governors - Version 0.3

Venue Boardroom, Trust Headquarters **Date** 18 January 2017 @ 1400h

Members present

Yve Buckland	Chairman	YB
Alan Last	Lead Governor	AL
Rob Talboys	Public Governor	RT
Brian Toner	Public Governor	BT
Marion Betteridge	Public Governor	MB
Anthony Thomas	Public Governor	AT
Carol Cullimore	Public Governor	CC
Petro Nicolaides	Public Governor	PN
Changese Khan	Appointed Governor	CK
Karen Hughes	Staff Governor	KH
Lynda Hindley	Staff Governor	LH
Mel Grainger	Staff Governor	MG
Alex Gilder	Staff Governor	AG

In attendance

Tim Pile	Vice Chair and Non Executive Director	TP	
Kathryn Sallah	Non Executive Director	KS	
Paul Athey	Director of Finance	PA	
Garry Marsh	Director of Operations, Nursing and Clinical Governance	GM	[Part]
Stella Noon	Chair of the Patient & Carers' Forum	SN	

Minutes	**Paper Ref**
1 Apologies and welcome	
The Council received apologies from Sue Arnott and Paul Sabapathy. Jo Chambers was also not present, however Paul Athey attended in her place. It was reported that Jean Rookes had sadly died recently. Her husband Dr Peter Rookes had been invited to join the meeting at the end to address the Council. All governors introduced themselves. Cllr Khan advised that he was the MP for Selly Oak and was attending in his capacity as a stakeholder representative for Birmingham City	

Council.	
2 Declarations of interest	
There were none.	
3 Minutes of the previous meeting on 14 September 2016	**ROHGO (10/15) 006**
The minutes of the meeting held on 14 September were accepted as a true and accurate record of discussions held.	
RESOLVED: The Council of Governors approved the minutes of the meeting held on 14 September 2016	
4 Update on actions arising from previous meetings	**Verbal**
The Associate Director of Governance & Company Secretary reported that there were two outstanding actions but these would be addressed at this meeting: • Garry Marsh, Director of Operations, Nursing & Clinical Governance would join the Council later on the agenda to present the new divisional management structure • Governor quality indicator had been highlighted more clearly in the Finance & Performance report as requested	
5 Non Executive recruitment - recommendation to appoint	**ROHGO (1/17) 002** **ROHGO (1/17) 002a**
The Council considered a proposal to appoint Professor David Gourevitch as a clinical Non Executive, replacing Professor Tauny Southwood whose term of office would conclude on 31 January 2017. A robust selection and recruitment process, organised internally, was noted to have been followed. The Chairman reported that Rod Anthony's first term of office would conclude in May and asked the Council for its approval to appoint Rod for a second term. This was agreed, however, in accordance with due process, the justification for this would also be discussed by the Nominations and Remuneration Committee (Council of Governors) at its next meeting.	
6 Chief Executive's update	**ROHGO (1/17) 003** **ROHGO (1/17) 003 (a)**
The report was taken for receipt and noting.	
7 STP Update	**Verbal**
The Chairman reported that the Birmingham and Solihull (BSol) Sustainability and Transformation Plan (STP) had not been well accepted at a national level and this	

needed to be refreshed in the light of feedback received. The nature of this feedback was consistent with that in relation to other STPs. As part of the refresh, Orthopaedics would be introduced into the plan more fully. The project cost for the STP for which the ROH would be liable was £40k for Year 1 but a proposal had been agreed that this should be on a fair cost basis thereafter. A Memorandum of Understanding had been developed, which set out the collaborative arrangements and would be shared with Council of Governors when this was no longer in draft format. The future leadership of the STP was under discussion at present. The Chairman was asked whether the feedback from ROH was taken seriously. She advised that this was the case and the concerns raised at the STP Board and events had been accepted.	
8 NHS Finances - training session	**Presentation**
The Governors were reminded by the Chairman that their role was to hold the Non Executives to account and that it was the intention of this item to assist them in fulfilling this duty. Alex Gilder, Staff Governor and Deputy Director of Finance, presented an overview of NHS Finances and the plan for the year. The Council was interested in the detail of payments for clinical negligence claims. It was noted that there was a pressure in relation to claims associated with orthopaedics and maternity particularly which were areas of growth. There was no spike in claims received by the Trust however; advice was taken from the Trust's solicitors in terms of whether liability should be admitted on each and every claim. The reasons for the downtime in theatres were discussed which concerned potential impairment the air filtration arrangements which presented a quality & safety issue and therefore the decision had been taken to cease operating until the position was better understood and there had been some deep cleaning. The overall financial impact was a £1.2m hit on income, although this had been offset to some degree by not spending on implants that would otherwise have been used during the period. It was noted that each theatre session brought in several thousand pounds of income. The measures to prevent the reoccurrence of a theatre closure were discussed; it was noted that Quality & Safety Committee had reviewed this and were satisfied that measures had been put into place to prevent this again, as far as reasonable practicable, with there having been good work to understand the reasons for the issue and the use of experts to provide advice & learning. Theatre utilisation was discussed, the target for which was noted to be c. 85%, a target which allowed a degree of downtime. This was not currently being met however and needed to be addressed as this had the potential to positively impact on	

the performance overall. It was noted that the forecast outturn for agency spend was lower for this year, due mainly to the use of a lower number of agency nursing staff. Medical locum spend remained static. The Council was advised that there had been a requirement to address nurse staffing ratios in line with recommendations arising from the Mid Staffordshire NHS Trust review and therefore a cap for spend had been applied by the regulators. In terms of the Pre-Operative assessment (POAC) processes, the validity of the blood results was noted to be time limited, which could result in patients having to visit more than once to provide a blood sample before their operation. This would be addressed through the recovery workstream that reviewed the pre-operative function. It was noted that there needed to be a pool of patients who could fill vacant theatre slots at short notice. The new workforce model in POAC was discussed which included Advanced Nurse Practitioners, prescribing pharmacists, Physician Associates and increased presence by anaesthetists. The model was planned to reduce costs significantly and increase the number of assessment slots available. It was reported that there was good consultant engagement with coding to ensure that the charging mechanisms were as robust as possible. Tim Pile advised that the sharing of data was helping to create a changed behaviour. Spinal, Oncology & large joints were the firms that were delivering the most significant income. In terms of the overall financial position, the Council was advised that there had been a failure to invest in technology and infrastructure in the past which was the reason for the higher cash position in previous years. Regarding future challenges, the adequate reimbursement for work undertaken through tariff was a key concern. Cash support may also be needed in the next year from regulators.	
9 Finance & Performance Committee update, including financial and activity recovery	**ROHGO (1/17) 004**
Tim Pile reported that in terms of recent months, was that there was now a plan in place to address the activity and financial position, with clear objectives and workstreams which provided a good amount of focus. Some of the work was enabling, such as improvement in the IT infrastructure. The benefit of the improvements was noted to include the delivery of good experience for patients. The Council was advised that patient stories received by the Board suggested that processes let our patients down; these took a long time to change. November was a good month financially, but the 'step up' in the recovery plan was noted to start in January 2017. Activity was the touchstone for the work; demand was not an issue. It was noted that the levels of the 'step up' requirements had been	

delivered previously.

There was improvement in the engagement around implant rationalisation, which would create savings of significance. The governance of recovery was also noted to be strong through weekly recovery board and Finance & Performance Committee.

Cancellations were reported to remain extremely high and to eliminate these would help considerably with meeting the recovery plan. Did Not Attends (DNAs) were also problematic. It was agreed that the hospital needed to sharpen its processes to avoid cancellations. The use of text technology was noted to be used elsewhere and it was suggested that ROH should exploit this.

There was confidence that Cost Improvement Programme (CIP) would be achieved, although this was behind plan are present. This was noted to be ahead of the average that was expected of the NHS overall.

The recovery plan was reported to have been submitted to NHS Improvement who had supported this and expressed confidence that this could be achieved.

Kathryn Sallah noted that the processes impacted on quality of care and highlighted that there were measures planned to ensure people on long waiting lists were kept up to date.

It was noted that there had been previous assurance that an action plan was in place and a question was asked of the Non Executives whether there was certainty that a plan was in place and was being delivered with clarity. Tim Pile assured the Council that this was the case and that people would be held to account for its delivery. It was reiterated that the plan included a 'step up' in January and activity needed to be ramped up to levels previously achieved. It was suggested that staff morale may have been lower than desired but staff engagement was better, with individuals having taken ownership for the delivery of the various pieces of work. Given that the recovery plan was a change programme, there was an expectation that this would take some time to deliver. Previously there had been significant churn in the levels below the Board and there had not been medical engagement, exacerbated by the division between Operations and Clinical Services; these had now been brought together.

The Director of Finance advised that although he was cautious, he was confident that the programme was working to deliver the improvement needed, as evidenced by the greater number of weeks where a high number of patients were treated compared to the first part of the year. The spread of the work was questioned and it was noted that a cohort of consultants were undertaking higher levels of work than their colleagues, therefore there was a need for these cases to be spread more evenly for a sustainable model. This was being achieved through better engagement, although this would not provide a quick fix. In November, £1m more income had been secured, with a fairly stable cost base. Processes need to change however, to ensure that a baseline level was being worked to and cancellations were avoided. There were some

risks going forward and there was little headroom to achieve the end of year forecast. It was noted that the recovery trajectory was an improvement on the initial £5.8m revised figure first presented to the NHS Improvement. The Director of Finance was asked whether the plan was overly ambitious; he noted that although it was challenging, the impact of the theatre closure had been taken into account and on this basis, it was possible to achieve the plan. The length of the recovery plan was discussed and it was highlighted that there was sufficient capacity in theatre sessions to deliver levels achieved in November, but systems needed to be improved to allow people to work as they should. The plan was noted to be long term and there was no intention to rely on individuals; it needed to be a collaborative effort. The changes needed to ensure that the start of the financial year was strong. Management and peer challenge was also needed to ensure that people were performing adequately. Clinical Service Leads would assist with this, together with the job planning work. In terms of Recovery Days, it was reported that there was willingness from some consultants to work additional hours at weekends and gift their time to assist with the recovery plans. There had however, been overall a mixed response and therefore the first of these Recovery Days had been cancelled. There was still some empty theatre time during the week which could be utilised better which might assist and surgeons offering to operate in this time might help. It was noted that this would contribute to but not solve the recovery plan. It was suggested that it would be good to keep these Recovery Days as a protected time as it served to demonstrate that there was good clinical engagement with the work. Selling the downtime theatre space to other organisations was noted to have been explored with Birmingham Children's Hospital (BCH), although there were planning considerations and the Trust could not operate a model that was fully flexible. It was suggested that the workforce plan to support the work needed to be articulated which included consideration of staff retention, recruitment and reward. It was noted that this had last been discussed at Board-level in October but further consideration would be given to this by the Trust Board.	
10 Operations update including divisional management structures and plans	**Verbal**
The Director of Operations, Nursing & Clinical Governance joined the meeting and reported that there had been some changes to the operations structure, with more due to come. It was reported that the previous model had included too few active managers, with those roles in post being too high level. There were also few staff who could act up in the event that someone left and therefore there was an over-reliance on the interim staff. Additionally, there was felt to be an inequity between the operational and nursing structures and all clinical leadership roles had been vacant, a position which had created a distance between the medical director and the service leads. Going forward, there would be one individual as a Divisional General Manager, Nicky Lloyd, who was working in the Trust on a fixed term basis. She had also been a finance director and had worked on turnaround matters, so was well placed in this	

position for the interim. In Division 1, three Clinical Service Leads would be in post. To support these individuals, two service managers had been put in place. Some work had been undertaken to offset the cost of these posts. In Division 2, Matthew Payne would remain the Clinical Service Lead for theatres, who was supported by other heads of department. Nicky Lloyd would also oversee this division with Matt Revell as the Associate Medical Director. In the nursing structure, a new Deputy Director of Nursing had been appointed who would join the Trust full time from 1 February 2017. She would join from Sandwell and West Birmingham Hospital NHS Trust and had a critical care background. Heads of Nursing were also in post, with Sue Smith occupying this position for Division 1. A Head of Nursing for Division 2 needed to be recruited but this was being filled by an interim at present for a six month period. The matron structure was outlined. Alison Wharram had started as a Paediatric matron and was strengthening relationships with BCH. The Outpatients matron post had been reintroduced and was under the guidance of Evelyn O'Kane together with her safeguarding responsibilities. All adult inpatient areas were under the oversight of Stacey Keegan. Clinical leadership positions were now all occupied and a Paediatric Associate Medical Director had been put in place. The Division 1 Associate Medical Director had also been appointed, with a background in governance and was a knee surgeon. The recruitment of Clinical Service Leads was a challenge in Division 2 with some further recruitment still planned. Planning for retirements was discussed. It was recognised that this was a challenge in spinal services and in certain nurse segments, where these staff could retire from 55. It was reported that some good appointments had been made into spinal services. Oncology surgeons were also a success.	
11 Quality & Safety Committee update	**ROHGO (1/17) 005**
Mrs Sallah guided the Council through the key points of her previous Board briefing on the work of the Quality & Safety Committee. The detail of the Patient Safety Walkabouts was discussed and it was noted that governors could be involved. The implementation of national NICE guidance was also discussed. Much effort was being directed into ensuring that the families of children on the spinal waiting list were kept up to date. There was an understanding that there was national guidance about treating children with diabetes and the Committee would seek assurance that this was implemented. It was requested that there be better information be provided on complaints in future. This was currently reviewed by the Quality Committee. It was agreed that the	

Council needed an annual update on complaints and patient stories. Given that the changes to the structure had been made, Kathryn Sallah was asked whether there was sufficient attention given the Quality & Safety given the broader remit of the Director of Operations, Nursing & Clinical Governance. She confirmed that this had been a risk that she had raised, as there was potential for inadequate challenge between the Operations and Nursing functions. Given the recruitment of a new Deputy Director of Nursing, she was confident that there would be sufficient focus on nursing matters while Garry Marsh's focus would be largely on Operations.	
ACTION: **SGL to arrange for the Council of Governors to receive the annual complaints report and an annual report on patient stories**	
12 Update from the Patient & Carers' Forum	**Verbal**
Stella Noon joined the meeting and explained the purpose of the Patient & Carers' Council which met monthly. It was noted that the terms of reference were reviewed annually. The new Deputy Director of Nursing was to take an active role in the forum. The information issued to patients was reviewed, including that which related to infection control, bone infection and Paediatrics. There had been difficulty in administrative support for the Forum, however this had been addressed by the Associate Director of Governance & Company Secretary. Lisa Kealey was thanked for her previous support. The Forum received updates from some groups, including from the dementia group. Future meetings would be attended by members from the Knowledge Hub and Physiotherapy. Good progress had been made on the Patient Handbook including the inclusion of an updated map. The experience of some patients who were trying to find the Orthotics department was outlined; volunteers helped with wayfinding. The Forum was now represented at the Clinical Quality Group. The absence of Jean Rookes was missed; a replacement would be canvassed. The Chairman thanked Stella Noon for her update.	
13 Governor updates including governor elections	**Verbal**
It was noted that following the sad death of Jean Rookes, the previous election results would be revisited to identify a new public governor.	
14 Matters for Information	**ROHGO (1/17) 006**

	ROHGO (1/17) 007 **ROHGO (1/17) 008**
Dr Peter Rookes joined the meeting who addressed the Council and thanked it for its support and condolences over the death of his wife.	
15 Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 15 March 2017 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:	**15 March 2017**

EXECUTIVE SUMMARY:

This report provides an update to the Council of Governors on the national context and key local activities not covered elsewhere on the agenda.

REPORT RECOMMENDATION:

The Council of Governors 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 1 March 2017

FOR INFORMATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Council of Governors on 15 March 2017

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 during January and February 2017.

2 RECOVERY DAYS

2.1 The decision was made to cancel the first of the planned 'Recovery Days' in January 2017 because more time was needed to establish a protocol and secure sign up to undertake additional lists. The first Recovery Day therefore was held on Sunday 5th February, with three of our consultant surgeons (supported by their anaesthetist & theatre teams) operating on this day. A Recovery Day was also held on 26 February 2017.

3 OPERATIONAL IMPROVEMENTS

3.1 It is anticipated that the Trust will achieve its Rapid Recovery CQUIN for 2016/17 which is an excellent achievement. Over 50 patients have been treated as 'rapid recovery' patients, enabling them to return home within 24-48 hours of their operation. The intention is to expand this programme from large joints across other specialties in 2017/18.

3.2 Our new Theatre scheduling software 'Theatreman' was due to go live across the Trust on 6 March 2017. Training is underway, and this presents the Trust with the opportunity to be more productive, reducing variation and removing inefficiencies.

4 MENTAL HEALTH CONCORDAT

4.1 The Trust has submitted a letter of intention to support the newly established West Midlands Mental Health Concordat, demonstrating the commitment of key organisations to support the key principles of improving the mental health and wellbeing of people across the region. Further detail is provided at Appendix A & B.

5 STAFF RECOGNITION

5.1 The Trust's Staff Awards were held on 3 February 2017 at Rowheath Pavillion in Bournville. In total, 11 awards were presented including 'Developing People Award',

'Patient Safety Award' and the 'Lifetime Achievement Award'. Feedback from the event has been very positive, and it was a great start to our bicentenary year.

5.2 Our Associate Medical Director, Mr Matthew Revell, has been shortlisted for the 'Inclusive Leader Award' at the West Midlands Leadership Academy Recognition Awards for 2016/17. The ceremony took place on 28 February 2017.

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:

- With the Chairman, welcomed a delegation from the Health Ministry in Thailand
- Partnership meeting with Chair and CEO of Robert Jones & Agnus Hunt Orthopaedic Hospital NHS Foundation Trust
- Attended Leadership Transformation Theme Group meeting
- West Midlands CEO Provider meetings (January & February)
- ROH hosted Paediatric Spinal Deformity meeting with NHS England (specialised commissioners), NHS Improvement and Birmingham Children's Hospital to discuss the demand and capacity challenges which are resulting in long waiting times for patients with complex needs
- STP Board meeting
- Presented an award at Health Education England West Midlands NHS Apprenticeship Recognition Awards 2017
- Interview with the Health Service Journal about the work of the National Orthopaedic Alliance vanguard

7 UPDATE FROM TRUST MANAGEMENT COMMITTEE

7.1 The Trust Management Committee (TMC) was held on 25 January 2017.

7.2 TMC considered the following items to be of note:

- An agreement was reached with NHS England Specialised Commissioners on 20 January 2017 on tariff for some of our more complex procedures
- New Paediatric HDU would be fully operational from 30 January 2017, and the official opening ceremony was planned for 28 February 2017
- A nurse recruitment open day was to be held on 4 March 2017, with a particular focus on paediatric nurse recruitment
- A Procurement Programme Group will be set up by the end of Q4 to oversee procurement savings plans & associated actions for delivery
- The Trust has approved a preferred supplier to undertake network improvements across the site, enabling future IT development to take place. This work has commenced in February and is expected to finish in August/September 2017
- The Trust has received a Contract Performance Notice (CPN) for mandatory training compliance. Learning & Development are working closely with the operational divisions to ensure that teams are up to date with their training requirements. TMC

agreed that managers have a significant role to play to ensure that their teams attend mandatory training, and there was a commitment from managers to improve the positon

- TMC noted that the Trust is unlikely to achieve 100% payment for the flu vaccination CQUIN
- It was noted that the Q3 milestone for Rapid Recovery had been achieved

7.3 The following policies were recommended to be approved by the CEO:

- Consent to Examination or Treatment policy
- Clinical Audit & Service Evaluation policy
- Medicines Management policy

7.4 As part of moving to the new structure from 1 April 2017, a review of meetings has taken place in an effort to streamline and reduce duplication. As a result, the Trust Management Committee has been formally disbanded, and replaced by a new Operational Management Board (OMB) which will meet monthly. It has been recognised that there is some duplication of reporting across the Trust's existing meeting structure, and a need for a collective forum to discuss operational and divisional performance. OMB will be chaired by the Executive Director of Patient Services and the first meeting will be held on 22 March 2017. Policy and business case approval will now report through the Executive Team meeting on a monthly basis.

8 RECOMMENDATION(S)

8.1 The Council of Governors is asked to discuss the contents of the report, and

8.2 Note the contents of the report.

Jo Chambers
Chief Executive
24 January 2017

Appendix A

Sarah Norman, Chief Executive
Council House, Priory Road, Dudley, West Midlands DY1 1HF
www.dudley.gov.uk
Email: sarah.norman@dudley.gov.uk

Our ref: SN/SR/kj Direct line: 01384 815201 Date: 13.1.17

Dear Colleague,

Re: -Mental Health Commission Concordat sign up by key stakeholders.

Further to my letter dated 6th January 2017. I have been in discussion with a number of stakeholders this week in relation to the wording of the Concordat and the proposal for organisations to sign up to the Action Plan.

I have spent considerable time over the last few days with a number of key partners developing a refreshed wording for the concordat and I now believe that we have an approach which will be acceptable to you and your organisation (I have highlighted the amended final sentence in red below).

I am conscious that there has been a nervousness over the delivery and sign up to the principles without seeing the detail in the developing plan and the potential funding requirements.

Firstly, let me confirm for a number of our larger projects we are currently in discussion with Department Of Work and Health seeking significant financial contributions. We are confident in our bids and we will receive confirmation later this month.

At local level please let me also assure you that for each of the projects that have already been identified, a plan will be designed and implemented with stakeholders and any requirement for additional funding or resources will be brought through the West Midlands Wellbeing Board Governance framework and then onward to the wider West Midlands Combined Authority Board where all stakeholders will have the opportunity to contribute to the final joint decisions.

The following Concordat for Action statement demonstrates the commitment of key organisations from across the West Midlands to the key principles of improving the mental health and wellbeing of people within our region:

> *"We will work together to improve mental health and wellbeing, to reduce the burden of mental ill health across the West Midlands. We will work to improve people's lives and to encourage healthy communities.*
>
> *We will ensure services meet the needs of people with mental ill health and are provided with empathy and compassion. We will involve people who have experienced mental ill health and their carers at the earliest opportunity in decisions about services.*
>
> *We will work together to develop and deliver the actions agreed across the West Midlands Combined Authority area"*

Sarah Norman, Chief Executive
Council House, Priory Road, Dudley, West Midlands DY1 1HF
www.dudley.gov.uk
Email: sarah.norman@dudley.gov.uk

I am seeking your support as part of the process to enable me to create a list of signatories to the Concordat and where possible, a copy of your organisational logos, so that I can work with The West Midlands Combined Authority Comms team.

Please may I have you intention to support via email to the following address: - s.russell@west-midlands.pnn.police.uk

The deadline for the notification of the signatories is close of play on Monday 23rd January 2017 to provide sufficient time for the list to be added to the final document.

If there are any questions please do not hesitate to contact me

Yours sincerely,

Sean Russell
Implementation Director
West Midlands Mental Health Commission

Appendix B

JC/GS/17012301

23 January 2017

Sean Russell
Implementation Director
West Midlands Mental Health Commission
Dudley Metropolitan Borough Council
Council House
Priority Road
Dudley
West Midlands DY1 1HF

Dear Sean

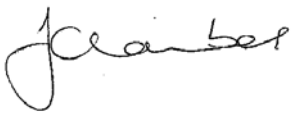
Mental Health Commission Concordat sign up by Key Stakeholders

Thank you for your letter dated 13 January 2017.

I am writing to confirm that the Royal Orthopaedic Hospital NHS Foundation Trust would like to sign up to this Concordat. As requested, I attach a copy of our Trust logo.

Please do not hesitate to contact me if you require any further information.

Yours sincerely



Jo Chambers
Chief Executive Officer

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The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Quality Account 2016/17 & priorities for 2017/18**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Wakeman, Deputy Director of Nursing & Clinical Governance**
AUTHOR:	**Jo Wakeman, Deputy Director of Nursing & Clinical Governance**
DATE OF MEETING:	**15 March 2017**

EXECUTIVE SUMMARY:

The Trust has a statutory duty to produce an annual Quality Account. Quality Accounts are reports to the public on the healthcare services a healthcare provider delivers and reflect the three domains of quality: patient safety, clinical effectiveness and patient experience.

NHS Improvement requires that an overview of the quality of care offered by the NHS foundation trust based on performance in 2016/17 against indicators selected by the board in consultation with stakeholders, with an explanation of the underlying reason(s) for selection. The indicator set selected must include:

- at least 3 indicators for patient safety;
- at least 3 indicators for clinical effectiveness; and
- at least 3 indicators for patient experience.

The "long list" of 20 potential priorities is presented in this report and has been developed during February 2017 from a range of sources.

It is a mandatory requirement that the Council of Governors selects one of the Quality Account measures**.**

REPORT RECOMMENDATION:

The Council of Governors is asked to:

- Note the timeline for the publication of the Trust 2017/18 Quality Account
- Consider the list of Quality Account priorities detailed above and come to an agreement as to the measure which shall be nominated as the key priority from the perspective of the Council of Governors

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

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

The quality priorities align to a number of the Trust's objectives and address some of the risks detailed on the corporate risk register.
PREVIOUS CONSIDERATION:
Quality & Safety Committee on 22 February and Audit Committee on 3 March 2017.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Quality Account 2017/18 – Timetable and Process

Report to Council of Governors –15th March 2017

1.0 Introduction

The Trust has a statutory duty to produce an annual Quality Account. Quality Accounts are reports to the public on the healthcare services a healthcare provider delivers and reflect the three domains of quality: patient safety, clinical effectiveness and patient experience. Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services and look forward, explaining the Trust priorities for quality improvement over the coming year. Quality Accounts must be published electronically on the NHS Choices website by the end of June 2016.

2.0 Developing the Quality Account

A Quality Account must include:

- A statement from the Board summarising the quality of NHS services provided;
- Priorities for quality improvement for the coming financial year;
- A series of statements from the Board set out in regulations;
- A review of the quality of services within the domains of quality: patient safety, clinical effectiveness and patient experience; and
- Any statements from the Trust commissioners, Healthwatch organisations and Overview and Scrutiny Committee (OSC).

In addition NHS England has requested that the 2017/18 Quality Account makes reference to the following:

- How the Trust is implementing the Duty of Candour;
- The most recent NHS Staff Survey results for indicators KF19 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF27 (percentage believing that trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard.
- The Trust CQC ratings grid, alongside how we plan to address any areas that require improvement or are inadequate, and by when that improvement is expected.

Lead commissioners, Healthwatch organisations and the Overview and Scrutiny Committee must be offered the opportunity to comment on the report ahead of publication.

2.1 Timetable

Table 1 below outlines the timetable for publication of the Quality Account in 2017/18, some steps of which have already been completed.

Table 1

Date	Action
22th February 2018	Presentation of process and timetable for preparation of quality Accounts to QSC.
15TH March 2017	Share priorities with Council of Governors
27TH March 2017	Circulation of Draft Quality Account to Trust Executives
29 th March 2017	Review of draft Quality Account by QSC
31st March 2017	Circulation to External Stakeholders
5th April 2017	Ratification of agreed priorities at Trust Board
24th April 2017	Submission of unaudited Quality account to Audit committee
26th April 2017	Approval of Unaudited Quality Account by QSC
28th April 2017	Quality Account submitted for external audit
1 st May 2017	Circulation of unaudited Quality account to Trust Board and Audit Committee for consideration.
17th May 2017	Circulation of unaudited Quality account to Council of Governors for consideration
30th May 2017	Audit Committee to consider the Quality Account and recommend submission to NHS Improvement
30th May 2017	Trust Board to approve Quality Account for submission to Monitor.
30th June 2017	Latest date by which Quality Accounts to be uploaded to NHS Choices.

3.0 Developing 2017/18 Improvement Priorities

As an annual report, it is expected that the Trust shows continuity between reports as time progresses; reflecting and reporting on progress against priorities and future actions. The Trust's progress against the 2016/17 priorities was discussed with the Quality and Safety Committee in February 2017. The 2016/17 priorities were based on feedback received from a number of sources including the local Clinical Commissioning Group (CCG), findings of incident investigations, findings from the National In Patient Survey, Friends and Family test and patient feedback. The priorities have been monitored through the Clinical Quality Group with updates presented to the Quality and Safety Committee

To date those consulted have acknowledged the progress made against last year's priorities (Appendix 1) and indicated support that the Trust show continuity of priorities in 2017/18. It is therefore recommended that 2017/18 Quality Account priorities be built on those identified during 2016/17.

3.1 NHS Improvement Requirements

NHS Improvement requires that an overview of the quality of care offered by the NHS foundation trust based on performance in 2016/17 against indicators selected by the board in consultation with stakeholders, with an explanation of the underlying reason(s) for selection. The indicator set selected must include:

- at least 3 indicators for patient safety;
- at least 3 indicators for clinical effectiveness; and
- at least 3 indicators for patient experience.

3.2 The Long List

The "long list" of 20 potential priorities has been developed during February 2017 from a range of sources including:

- Clinical Quality Report performance (areas of underachievement)
- Clinical Quality Group (areas of focus for coming year)
- Trust Management Committee (proposals for inclusion reflecting local key issues)
- Quality and Safety Committee (feedback on areas of focus)
- Corporate Objectives 2016/17
- Patient Feedback including national in patient survey and Friends and Family Test
- CQC report 2015
- Contract Performance Meeting (areas of focus)
- Findings from incident investigations.

In order to reduce the long list to the required number (9), it is proposed that the following groups will be formally consulted:

- Staff Survey (through Survey Monkey in February 2017)
- Healthwatch Birmingham (formal letter)
- Birmingham Cross City CCG (formal letter)
- Councils of Governors
- Patient and Carers Forum
- Trust Management Committee
- Clinical Quality Group
- Quality and Safety Committee

3.3 List of Measures

Detailed below is a proposed long list of measures:

Patient safety

- Reduce number of incidences of consent on day (based on patient feedback)
- Medical wards rounds to be supported by the wider MDT (based on CQC recommendations)
- Reduce the number of avoidable pressure ulcers (based on incident data, patient feedback)
- Reduce the number of avoidable VTE events (based on incident data, CCG feedback)
- Reduce the number of avoidable falls (based on incident data)
- Reduce avoidable mortality (based on national requirements and local incident data)

- RTT – Nicky Lloyd
- Spinal Cancer – To work in collaboration with BCH to develop a sustainable pathway.
- Aim for 35% of all discharges to be before midday.
- Reduce the number of drug incidences.
- To develop a standardised repository of patient notes that is used by all disciplines of staff that promotes individualised, patient centred documentation.

Clinical effectiveness

- PROMS- improvement on baseline scores (based on PROMS findings 2015)
- Ensure that learning identified from serious incidents and complaints are embedded in practice (based on staff feedback, feedback from Quality and safety Committee)
- Implement the EPMA system across the Trust (based on Corporate priorities, Trust Management Committee)
- Ensure that all clinical and corporate policies are in date and have an appropriate audit plan (based on feedback from clinical staff, Clinical Quality Group and Quality and Safety Committee)

Patient experience

- Develop a strategy for learning disability
- Reduction in waiting times in clinic (based on feedback from CQC (report) and patient surveys
- Reduction in cancellation on day of surgery (based on patient feedback)
- Deliver the commitments outlined in the second year of the Dementia Strategy (improvement in carer's experience) (based on patient feedback)
- Improve FFT response rates aiming for 35% in all areas' I want great care'.
- Reduction in PALS complaints by 20% by introducing 'time to talk' across all clinical areas.

It is a mandatory requirement that the Council of Governors selects one of the Quality Account measures.

4.0 <u>Conclusion and Recommendation</u>

The Council of Governors is asked to:

- Note the timeline for the publication of the Trust 2017/18 Quality Account
- Consider the list of Quality Account priorities detailed above and come to an agreement as to the measure which shall be nominated as the key priority from the perspective of the Council of Governors

Jo Wakeman
Deputy Director of Nursing and Clinical Governance
February 2017

Appendix 1: Quality Priorities 2016/17

Reducing the number of incidents of consent on the day.
Reducing the number of avoidable pressure sores.
Reducing the number of avoidable VTEs.
Ensuring that learning identified from serious incidents and complaints are embedded in practice
Reducing cancellations on the day of surgery (Governors Priority)
Delivering the commitments outlined in the first year of the Dementia Strategy
Improving patient reported experience of pain
To reduce the length of time patients wait in outpatients clinics to less than 60 minutes

	Delivered
	Partially Delivered
	Inconsistent Delivery

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Preparing For Quality Account 2017/18

Jo Wakeman

Deputy Director of Nursing and Clinical Governance

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

What is required?

- Statutory requirement
- Must reflect the three domains of Quality- safety, effectiveness and experience.
- Must look back and look forward
- Should be consulted on widely
- Submission to NHS Improvement by June 2017
- Publication on NHS Choices website by 30th June 2017

Progress on 2016/17 Quality Priorities

Reducing the number of incidents of consent on the day.
Reducing the number of avoidable pressure sores.
Reducing the number of avoidable VTEs.
Ensuring that learning identified from serious incidents and complaints are embedded in practice
Reducing cancellations on the day of surgery (Governors Priority)
Delivering the commitments outlined in the first year of the Dementia Strategy
Improving patient reported experience of pain
To reduce the length of time patients wait in outpatients clinics to less than 60 minutes

Timetable

Date	Action
22th February 2018	Presentation of process and timetable for preparation of quality Accounts to QSC.
15TH March 2017	Share priorities with Council of Governors
27TH March 2017	Circulation of Draft Quality Account to Trust Executives
29 th March 2017	Review of draft Quality Account by QSC
31st March 2017	Circulation to External Stakeholders
5thApril 2017	Ratification of agreed priorities at Trust Board
24th April 2017	Submission of unaudited Quality account to Audit committee
26th April 2017	Approval of Unaudited Quality Account by QSC
28th April 2017	Quality Account submitted for external audit
1 st May 2017	Circulation of unaudited Quality account to Trust Board and Audit Committee for consideration.
17th May 2017	Circulation of unaudited Quality account to Council of Governors for consideration
30th May 2017	Audit Committee to consider the Quality Account and recommend submission to NHS Improvement
30th May 2017	Trust Board to approve Quality Account for submission to NHS Improvement
30th June 2017	Latest date by which Quality Accounts to be uploaded to NHS Choices.

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

NHSI Requirements

- NHSI requires that the indicators for 2017/18 are based on performance in 2016/17 and are developed in consultation with stakeholders.
- The indicator set must include three for each domain, one of which must be chosen by the Council of Governors.

Areas to be included within the Quality Accounts include updates on the following areas:

- How we have implemented the Duty of Candour.
- Patient Safety improvement plan (Sign up to Safety Campaign)
- Recent NHS staff survey results (indicators KF26 and KF21)
- CQC rating grid- to includes plans for improvement based on findings.

Developing the Long List

- Clinical Quality Report performance (areas of underachievement)
- Clinical Quality Group (areas of focus for coming year)
- Trust Management Committee (proposals for inclusion reflecting local key issues)
- Quality and Safety Committee (feedback on areas of focus)
- Corporate Objectives 2016/17
- Patient Feedback including national in patient survey and Friends and Family Test
- CQC report 2015
- Contract Performance Meeting (areas of focus)
- Findings from incident investigations.

Patient Experience

- Develop a strategy for learning disability.
- Reduction in waiting times in clinic (based on feedback from CQC (report) and patient surveys.
- Reduction in cancellation on day of surgery (based on patient feedback).
- Deliver the commitments outlined in the second year of the Dementia Strategy (improvement in carer's experience) (based on patient feedback).
- Improve FFT response rates aiming for 35% in all areas through' I want great care'.
- Reduction in PALS complaints by 20% by introducing 'time to talk' across all clinical areas.

Patient Safety

- Reduce number of incidences of consent on day (based on patient feedback)
- Medical wards rounds to be supported by the wider MDT (based on CQC recommendations)
- Reduce the number of avoidable pressure ulcers (based on incident data, patient feedback)
- Reduce the number of avoidable VTE events (based on incident data, CCG feedback)
- Reduce the number of avoidable falls (based on incident data)
- Reduce avoidable mortality (based on national requirements and local incident data)
- RTT – Nicky Lloyd
- Spinal Cancer – To work in collaboration with BCH to develop a sustainable pathway.
- Aim for 35% of all discharges to be before midday.
- Reduce the number of drug incidences.
- To develop a standardised repository of patient notes that is used by all disciplines of staff that promotes individualised, patient centred documentation.

Clinical Effectiveness

- PROMS- improvement on baseline scores (based on PROMS findings 2015)
- Ensure that learning identified from serious incidents and complaints are embedded in practice (based on staff feedback, feedback from Quality and safety Committee)
- Implement the EPMA system across the Trust (based on Corporate priorities, Trust Management Committee)
- Ensure that all clinical and corporate policies are in date and have an appropriate audit plan (based on feedback from clinical staff, Clinical Quality Group and Quality and Safety Committee)

What am I asking for?

- Note the timeline for publication of the account.
- As the Council of Governors you are required to identify one area for improvement as part of the quality accounts for 2017/18.
- Contribute to the development of the shortlist by emailing or contacting Jo Wakeman on 55539 or email jo.wakeman@nhs.net

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	25 January 2017
Guests	Sarah Mimmack, Infection Control Lead Evelyn O'Kane, Safeguarding Lead
Presentations received	Board & Committee reporting
Major agenda items discussed	• Upward report from Clinical Quality Committee • Upward report from the Safeguarding Committee • Upward report from the Infection Control Committee • Upward report from the Clinical Audit & Effectiveness Committee • Quality & Patient Safety report • Accountable Officer for Controlled Drugs report • Lessons learned update • Consent update • Safe staffing report • CQC action plan – progress update
Matters presented for information or noting	Discussed under matters arising: • ***WHO checklist champion in theatres*** – this was reported to be Mr Matthew Revell, Associate Medical Director for Division 2. It was agreed that he would be invited to attend the next meeting to describe the WHO checklist process and the measures taken to ensure adhere to this. • ***Injectable materials incident*** – it was reported that following concerns raised at the last meeting, as part of the report back from the Chair of the Drugs & Therapeutics Committee, there had been a review of the incident and it had been identified that there had been no inappropriate injections performed. A plan to comply with the relevant Central Alert System (CAS) requirement by September 2017 was in place. • ***Communication with families on a spinal deformity pathway*** – a letter had been drafted which the Committee would see at its next meeting.
Matters of concern, gaps in assurance or key risks to escalate to the Board	• There had been an increase in the number of complaints, although it was suggested that this could be related to increased awareness about how to complain. • Following a recent visit by the Clinical Commissioning Group (CCG), it had been noted that there were deficiencies in the formal assessment of patients against

	the Mental Capacity Act, therefore there had been some focussed pieces of work underway and amendments to the Mandatory Training suite to include training on the Mental Capacity Act. There was improved compliance with training, although further work was needed to increase the uptake on training further, possibly through the use of e-learning. • As part of the upward report from the Infection Control Committee, it was noted that the CQUIN around 'flu vaccinations had not been fully met. The overall vaccination rates were improved on previous years however. • The Committee was advised that the reporting of cleanliness was due to change shortly, with a move to reporting externally against the 'Cleaning for Credits' system. • The effectiveness of the theatre cleaning programme was discussed, where it was asserted by the Head of Infection Control that there may be some inefficiency in the current theatre cleaning programme where theatres were cleaned on a sectional basis, rather than a total clean as had been the case when the theatres were closed in June 2016. The Committee challenged this view as being largely speculative. The cleaning regime was noted to be largely dictated by the current theatre environment, a risk that was flagged on the Corporate Risk Register. • The need for a programme of replacement bins needed to be arranged as soon as possible • An external review of infection control systems and processes was to be undertaken. • Further work was planned to review Patient Outcomes, including comparions to peer organisations and other benchmarking information • Some deviation from the VTE protocol was outlined in terms of th 24 hour reassessment. It was noted that individuals needed to be held to account where this had occurred. The Chair of the VTE Committee would be asked to attend the next meeting of the Quality & Safety Committee. • A number of vulnerabilities with the operational and corporate governance arrangements of the committees reporting up to the Quality & Safety Committee were outlined, included lack of central storage of papers and the variation of administrative support. The operation of the Drugs & Therapeutics Committee was noted to be of particular concern, although processes were reported to have strengthened recently through improved administration and the development of terms of reference

	for the Committee.
Positive assurances and highlights of note for the Board	• The management of the complaints function would fall under the remit of the Governance Team in future. • The upward report from the Clinical Audit & Effectiveness Committee reported that the backlog of NICE guidance had now been cleared and Clinical Service Leads were now reviewing guidance as it was published. There had been good improvement in this area and recommendations from the recent internal audit had been addressed. • It was noted that there were pockets of the organisation where staff were reluctant to report incidents and work was underway to encourage people to report incidents more routinely and with more confidence • An internal audit of Controlled Drugs had been undertaken and had provided 'Reasonable Assurance'; all recommendations had been addressed. • Within the report from the Accountable Officer for Controlled Drugs, it was reported that during the period, there had been a number of errors made by dispensers, which was a concern for the Committee. • Good progress was being made with developing plans to identify and share lessons learned. Work was underway to develop granular information for various clinical areas to provide a better understanding of key trends on incidents, complaints, claims and risks. An e-bulletin had also been created to share lessons and the use of Ulysses functionality would be improved. • The Committee reviewed the revised Consent policy, which had been updated in line with revised national guidance
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Prof Begg would be asked to identify the plans to ensure that the upward reporting to the Quality & Safety Committee from the Research & Development Committee resumed • Mr Matthew Revell to be invited to the next meeting bto discuss the WHO checklist process • The letter to patients on the spinal deformity pathway is to be reviewed at the next meeting • Minutes of the Clinical Quality Group are to be considered in future alongside the upward assurance report • The tissue viability lead should be invited to the meeting of the Quality & Safety Committee in April 2017 • An update on the reporting processes and operation of the Quality committees is to be reported back at the next meeting • The Head of Communications is to be invited to the March meeting of the Quality & Safety Committee to discuss the plans to improve Friends & Family Test response rates • Alex Gilder, Deputy Director of Finance, to be invited to the

	next Quality & Safety Committee meeting to discuss the Quality Impact Assessment process for Cost Improvement schemes
Decisions made	• None specifically, although it was agreed that discussions at the Committee in future needed to focus more clearly on the assurances that were needed.

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

For the meeting of the Council of Governors scheduled for 15 March 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	22 February 2017
Guests	Dr Bill Rea – Chair of the Drugs & Therapeutics Committee Dr Tony Sutherland – Chair of the VTE Committee Mr Matthew Revell – Associate Medical Director, Division 2 Mrs Alex Gilder – Deputy Director of Finance
Presentations received	None
Major agenda items discussed	• Upward report from the Drugs and Therapeutics Committee • Upward report from Clinical Quality Committee • VTE update • WHO checklist compliance • Quality & Patient Safety report • Quality Account priorities • CIP assessment process • Divisional governance update
Matters presented for information or noting	• Update on Research & Development
Matters of concern, gaps in assurance or key risks to escalate to the Board	• As part of the upward report from the Clinical Quality Group, it was reported that the Group's risk register needed to be reviewed and refreshed • The Committee was made aware of a red risk around fire escape plans for theatres – although the process for evacuating theatres was clear, there was no documented process in place. This was being addressed through the Health & Safety Committee • Concerns were expressed about the robustness of the operation of the Health & Safety Committee, particularly its connectivity to the 'front line' • A risk around the monitoring of drug fridge temperatures was discussed and a business case had been developed to address this • There was a significant discussion around the practice to reassess patients VTE prophylaxis 24 hours after a procedure, given that practice at the ROH was more appropriate for a large mixed take acute Trust, rather than a specialist elective organisation. The risks associated with a delay in administering prophylaxis were discussed, particularly as nurses were not currently able to authorise

	this. The Committee was advised that there was evidence of poor completion of documentation associated with VTE assessments, a matter it agreed should be addressed as a priority. It was agreed that some peer based learning would be useful to improve the VTE process at ROH • As part of the consideration of the Quality & Patient Safety report, it was noted that response rates to Friends and Family Test remained low; the Head of Communications would attend the next meeting to outline plans to address this • Although there had been good work in the Admission and Day Case Unit to move to a position closer to the national guidance on pre-operative starvation & fluid intake, it was noted that more work was required in inpatient areas to prevent patients having to go without food and water for an excessively long time prior to surgery • The Committee received a presentation on the current process for undertaking Quality Impact Assessments (QIAs) on Cost Improvement Programme schemes. At present the process was not robust and sign off of QIAs by relevant senior members of staff was not occurring as it should. An update would be presented at the next meeting. • Example minutes from the divisional governance boards were revised and it was noted that the quality of these needed to be improved to reflect more fully the key issues discussed at these meetings. • The Committee was updated with the detail of a recent Controlled Drugs incident.
Positive assurances and highlights of note for the Board	• The Committee reviewed the proposed letters to families with patients on the spinal deformity waiting list and provided feedback to be incorporated into the final version • The issue previously discussed about the accessibility of drugs charts by clinicans was reported to have been addressed through drugs charts now being located at the end of patients' beds • As part of the upward report from the Drugs & Therapeutics Committee, it was reported that there were risks around the current arrangements to store chlorohexidine; risk assessments were currently being undertaken by Health & Safety, Pharmacy and the Fire Officer – there needed to be a balance between sufficient stock being kept on site and excessive amounts which could pose a fire risk • There were encouraging results from the recent round of drug storage audits on wards • Although there were a number of issues discussed as part of the VTE update, it was noted that as a percentage of patients seen by the ROH, the level of VTEs reported was

	low overall • The Committee received a useful update from Mr Revell regarding compliance with the WHO checklist and the process that was in place to enforce this practice. It was noted that a new theatre system would come on line in early March which would make the process more rigourous. The need to move away from a 'tick box' culture to one where the practice encouraged more reflection and planning was noted to be needed. Wilful non-compliance in future might result in HR procedures being invoked. • Incident levels were reported to have returned to typical levels. • The Quality Account priorities for 2017/18 would be presented at the next meeting
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• An update on consent for use of human tissue as part of research trials to be presented as part of a future report by the Director of Strategy & Transformation • Professor Begg be invited to join the Committee to present an update on the Knowledge Hub development at the April meeting • It was agreed that the Director of Operatios, Nursing & Clinical Governance would work with Operations colleagues to understand the definiftion of a 'one stop' clinic in relation to Outpatients
Decisions made	• The Committee approved the revised terms of reference for the Drugs & Therapeutics Committee

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

For the meeting of the Council of Governors scheduled for 15 March 2017

Finance and Performance Report

FEBRUARY 2017

CONTENTS

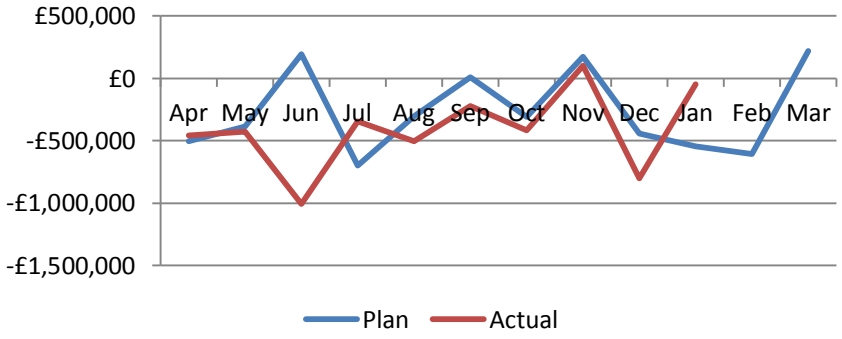
INTRODUCTION

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.

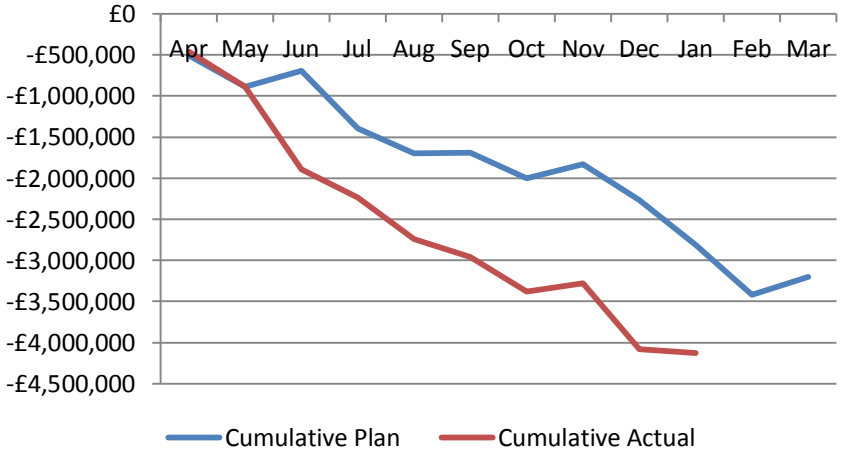
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Monthly Surplus/Deficit Actual vs Plan

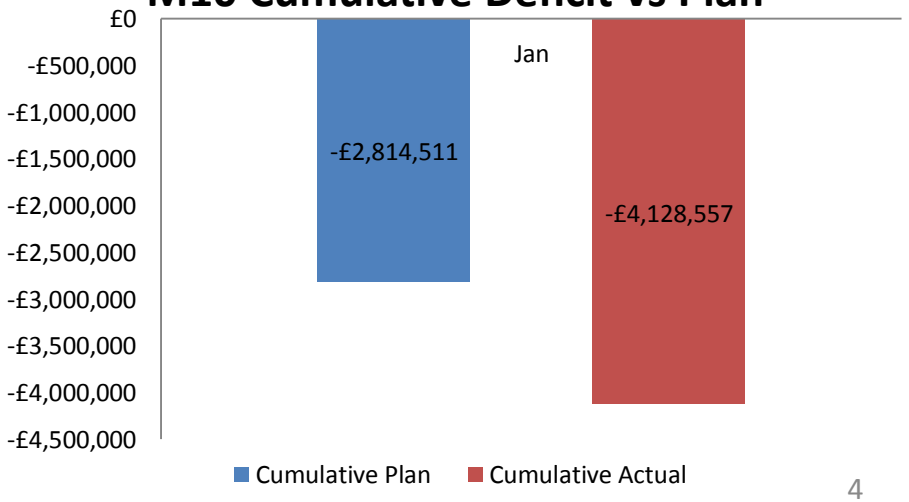


NHSI Use of Resources Rating (UOR)		
	Plan	Actual
Capital Service Cover	4	4
Liquidity	2	3
I&E Margin	4	4
I&E Margin – Variance against plan	N/A	4
Agency metric	1	2
Overall UOR	N/A	3

Cumulative Deficit vs Plan



M10 Cumulative Deficit vs Plan



INFORMATION

The Trust has delivered a cumulative deficit of £4,128,000 as at the end of January against an original planned deficit of £2,815,000. In month, the Trust delivered a deficit of £49,000 against a planned deficit of £544,000.

The Trust is therefore £1,313000 behind original plan at the end of M10. Excluding the impact of the theatres closure in June (£954,000), the Trust would be behind original plan by £359,000. Further detail on the key drivers of the financial position is provided in the income and expenditure sections below, and information about the Trust's performance against the recovery plan is included within the Recovery Plan paper.

As at the end of Month 10, the Trust has recognised £2,528,000 of CIP savings, against a plan of £2,971,000. £1,017,000 (40%) of savings to date are non-recurrent. The in-month savings recognised were £355,000 against a target of £350,000.

With regards to the Trust's Use of Resources Risk Rating (UOR), the deficit position results in the Trust achieving ratings of 4 for Capital Service Cover, I&E Margin metrics and I&E Margin Metrics against plan. In addition, the Trust's liquidity position is rated as a 3, a deterioration against previous month. 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 metric. The overall Trust score has been capped to a 3.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Trust Executive have a weekly Recovery Board where progress against the action plans of the five recovery workstreams (POAC, theatre efficiency, discharge planning, agency reduction and cost control) is monitored and challenged. Schemes such as MARS and a series of recovery sessions are being implemented to improve the position.

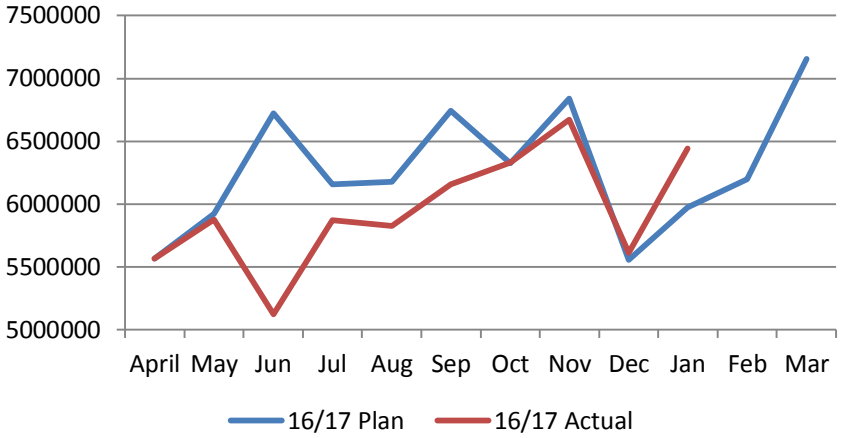
RISKS / ISSUES

The activity targets for the coming months will be challenging, and will result in pressure on theatres and wards in addition to the Trust's support services to ensure that patient flow runs smoothly with no excess capacity in the system.

Buy-in and progress against the schemes set out in the workstream action plans, and by the Chief Executive, will be vital in achieving improvement in the Trust's financial position and its long-term sustainability. The operational team are reviewing mitigations for the contribution generated through the planned recovery days if these are unable to be delivered.

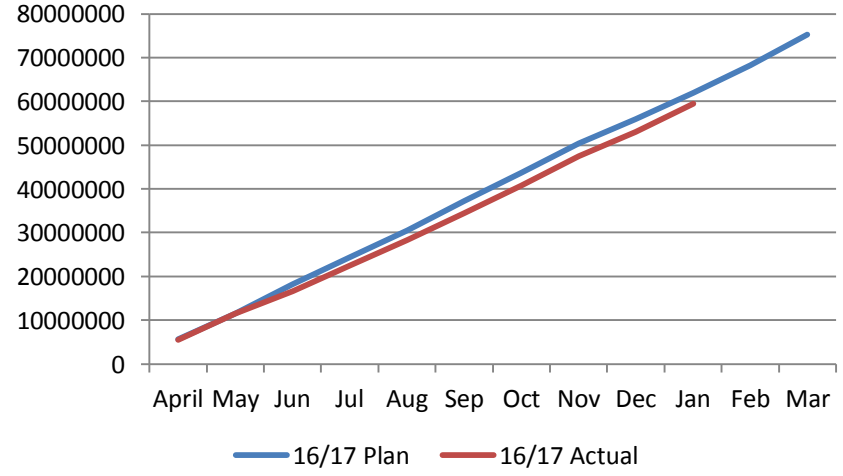
2. Income – This illustrates the total income generated by the Trust in 2016/17, including the split of income by category

Monthly NHS Clinical Income vs Plan 1617



NHS Clinical Income – January 2017			
	Plan	Actual	Variance
Inpatients	2,998	3,136	138
Excess Bed Days	66	140	74
Total Inpatients	3,064	3,276	212
Day Cases	704	835	131
Outpatients	677	720	43
Critical Care	220	186	-34
Therapies	228	201	-27
Pass-through income	201	123	-78
Other variable income	376	516	140
Block income	507	507	0
TOTAL	5,977	6,364	387

Cumulative NHS Clinical Income vs Plan 1617



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INFORMATION

NHS Clinical income over-performed by 8.48% in January having also over-performed by 2.38% in December. Although admitted patient care performance was above plan financially, activity was slightly below plan. The overperformance has therefore been driven by a particularly rich case mix, especially within spinal. January does have increased levels of activity compared with December but this is expected due to the holiday period. This results in an increased in partially completed spells income compared to prior month.

Outpatients slightly overperformed in month, although year to date there is a underperformance in income. This is driven largely by an underperformance in outpatient procedures that 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

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.

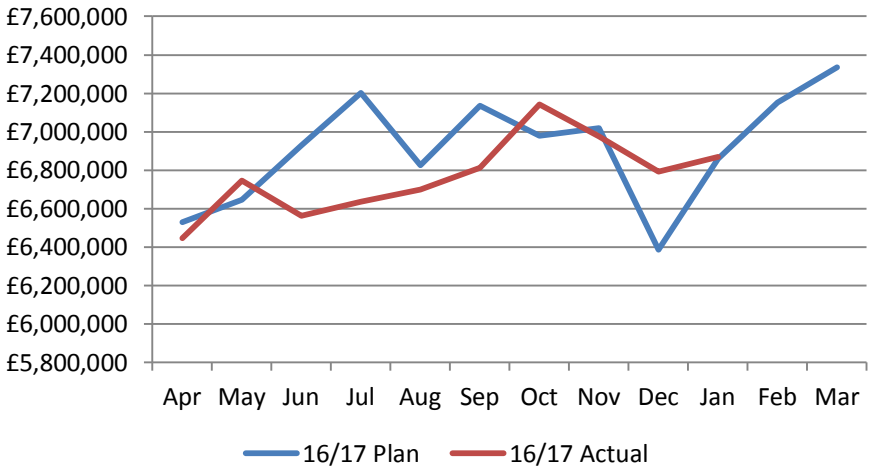
Trust to run recovery days or other methods to improve activity throughout the remainder of the year to attempt to claw back lost income due to the theatre closure in June 16.

RISKS / ISSUES

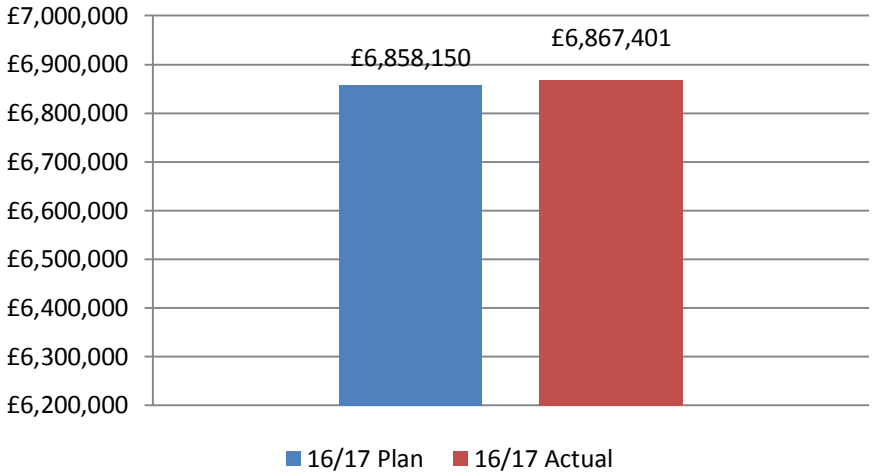
The closure of all theatres for 1 week from 6th June 2016 will have a significant effect on both June's income position, but also on the ability of the Trust to clawback that activity in later months of the year when stretch targets are already in place. The Operations team are developing a plan for how this can be achieved.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2016/17, compared to historic trends

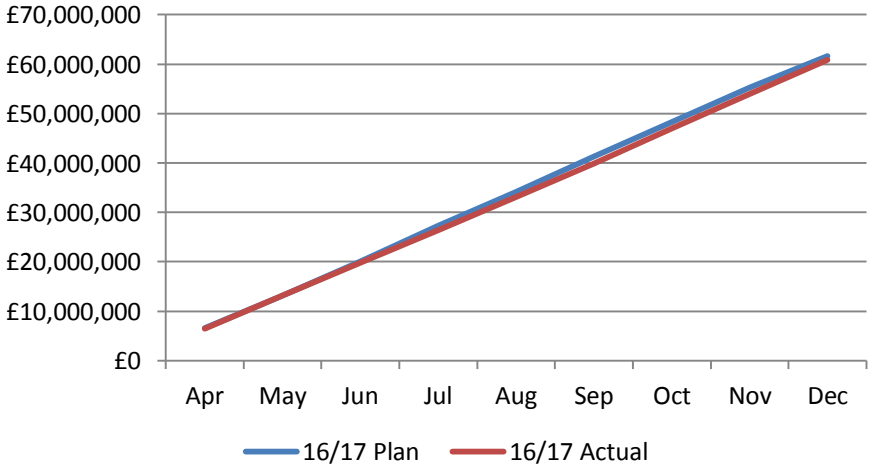
1617 Monthly Expenditure vs Plan



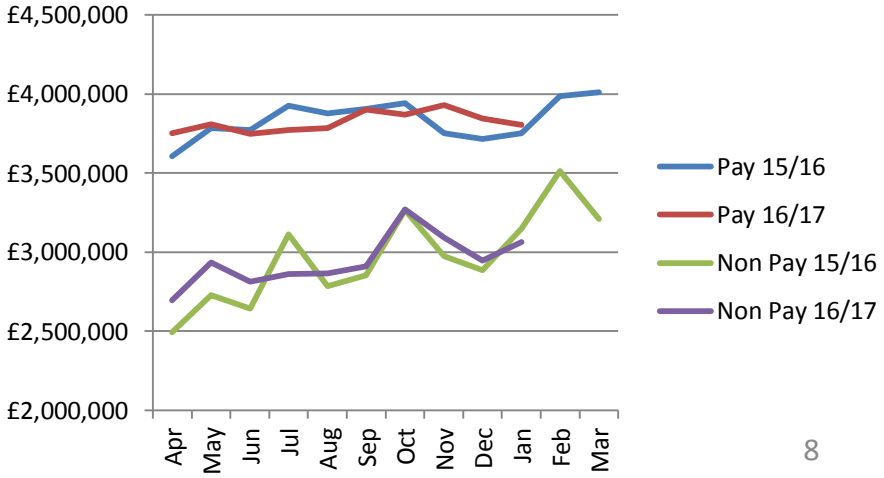
16/17 M10 Expenditure vs Plan



Cumulative Expenditure vs Plan 1617



16/17 vs 15/16 Pay & Non Pay Spends



INFORMATION

Expenditure levels remain below the plan set as the start of the year. For the year to date, expenditure levels are £840,000 below plan.

Pay spend is largely consistent with plan in month. Non pay spend is significantly above plan in month, although spend was lower than the 2015/16 January equivalent. The in-month spend is also being bolstered by c.£100k of costs which had previously been expensed which have now been recognised within capital.

Non pay costs have been driven by higher than expected prosthesis and general theatre costs due to higher activity. The non-pay spend is supported by the higher than average casemix as described in the income section above.

ACTIONS FOR IMPROVEMENTS / LEARNING

Costs will continue to be scrutinised and minimised. One of the 5 recovery workstreams is cost control, with actions being tracked through the Recovery Board on a weekly basis.

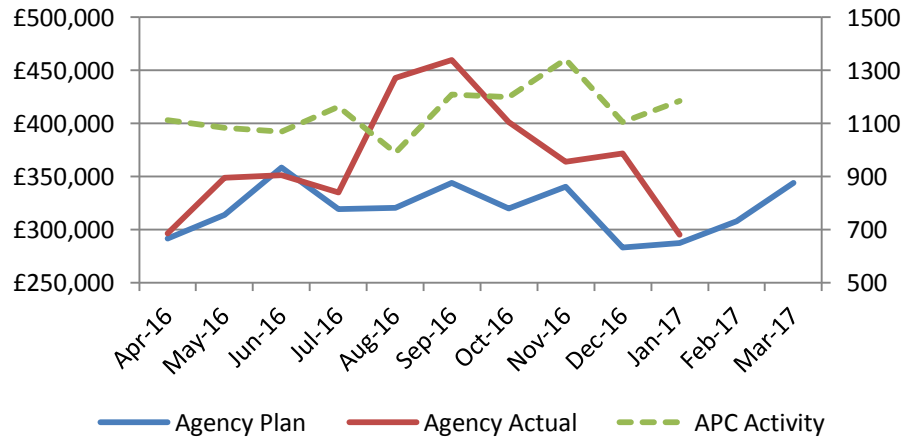
RISKS / ISSUES

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 have moved all prosthesis stock into a new controlled location 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. EDC Gold has also gone live in month with the first line being piloted onto the system.

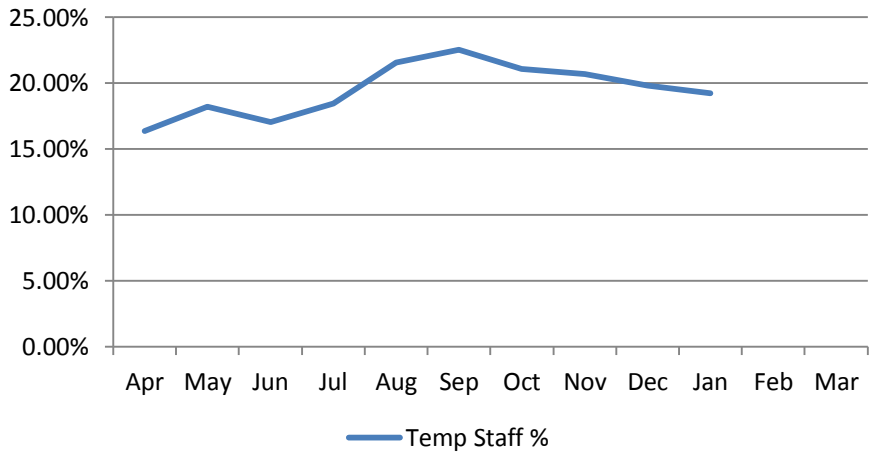
A stock count was performed at Month 9, with the count details being analysed over the coming weeks.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2016/17, and performance against the NHSI agency requirements

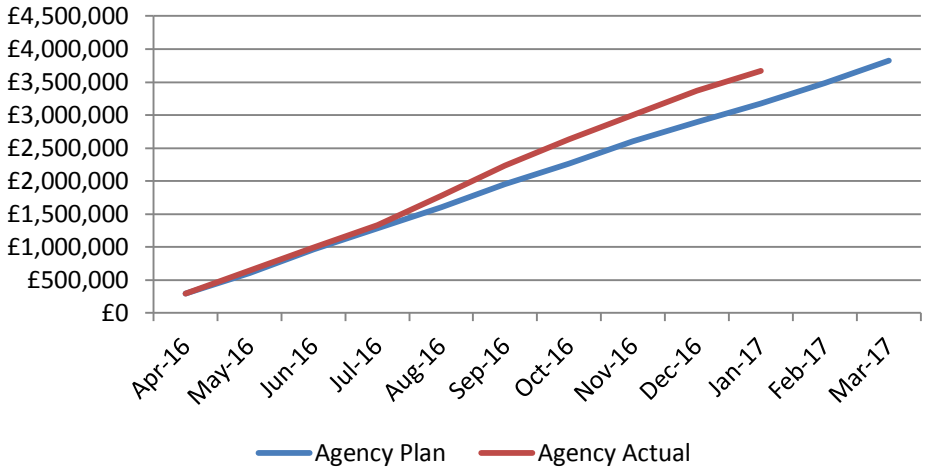
Total Monthly Agency Spend vs Plan



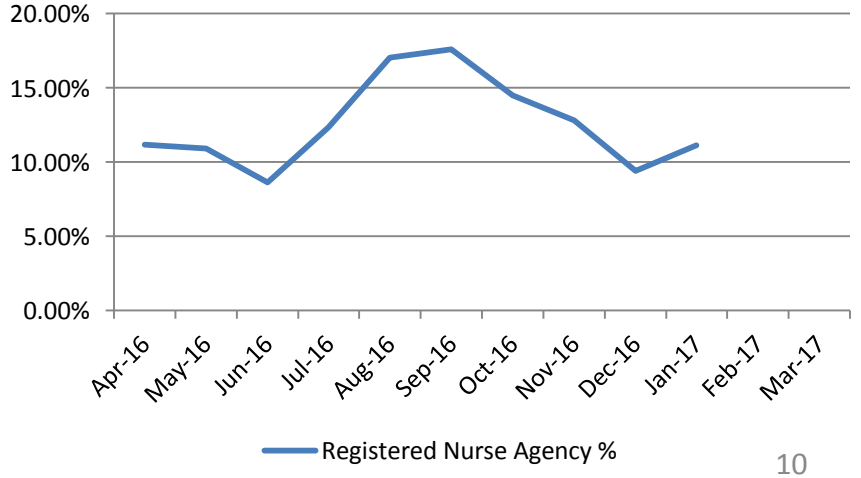
Temp Staff %



Total Cumulative Agency Spend vs Plan



Registered Nurse Agency %



INFORMATION

January showed a decrease in agency spend (from £372,000 to £295,000) despite the increase in activity in January compared to December. Some of this reduction is likely to be lower annual leave. Both medical and other agency spend has dropped significantly, but nursing agency has increased. A significant driver of the reduction in medical agency spend is a £40,000 credit note received regarding a dispute over locum doctor rates.

ACTIONS FOR IMPROVEMENTS / LEARNING

One of the 5 recovery workstreams is reduction in agency spend, and as such a detailed action plan is being reported against on a weekly basis to Recovery Board. This is in addition to the agency group run by the DOWOD and DOONCG. Ongoing actions to reduce agency spend include workforce redesign, e.g. the POAC workforce model, in addition to reviewing the outputs of Healthroster.

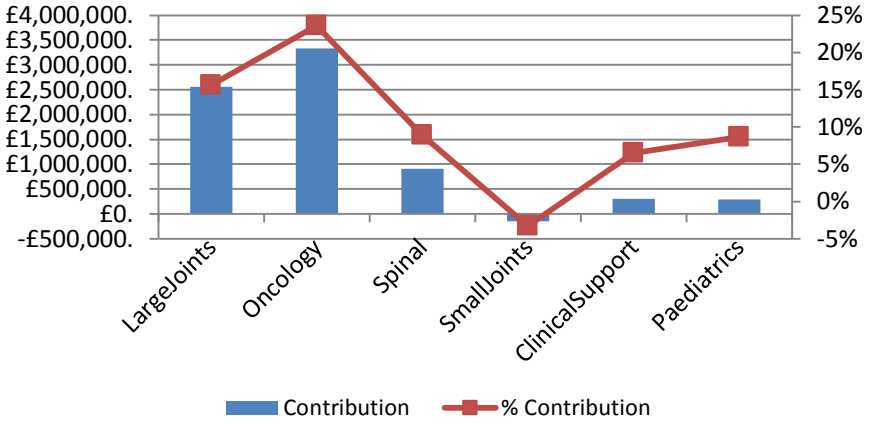
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios.

RISKS / ISSUES

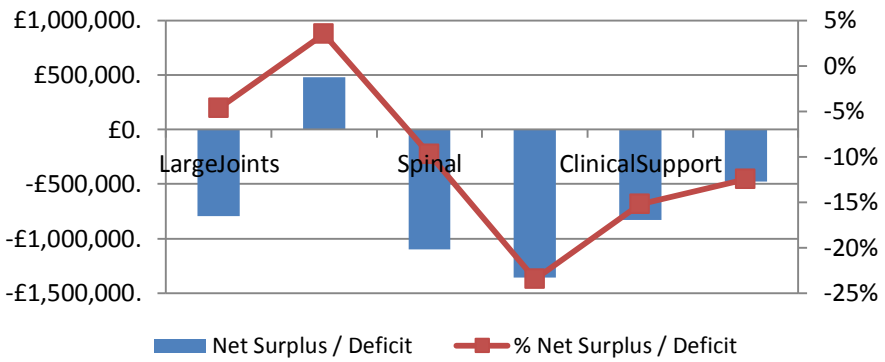
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is now being built into the Single Oversight Framework from Q3. An overspend against the trajectory will therefore have a direct impact on our regulator ratings.

5. Service Line Reporting – This represents the profitability of service units, in terms of both consultant and HRG groupings

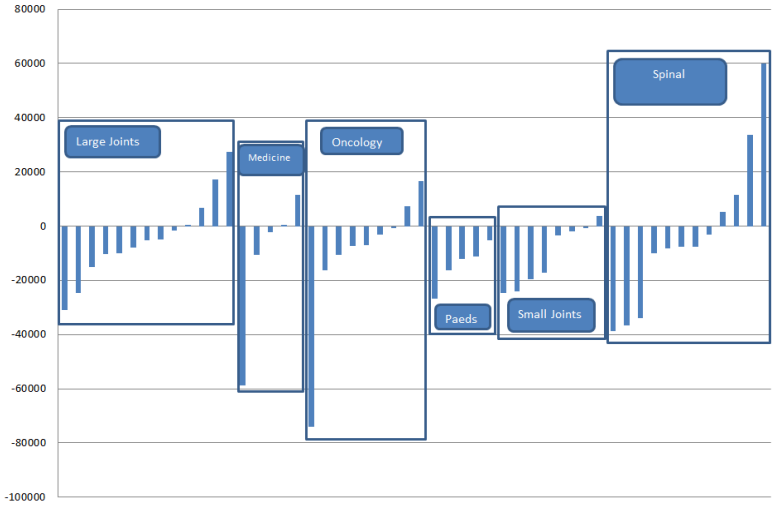
Total Contribution by Service Cumulative to M09



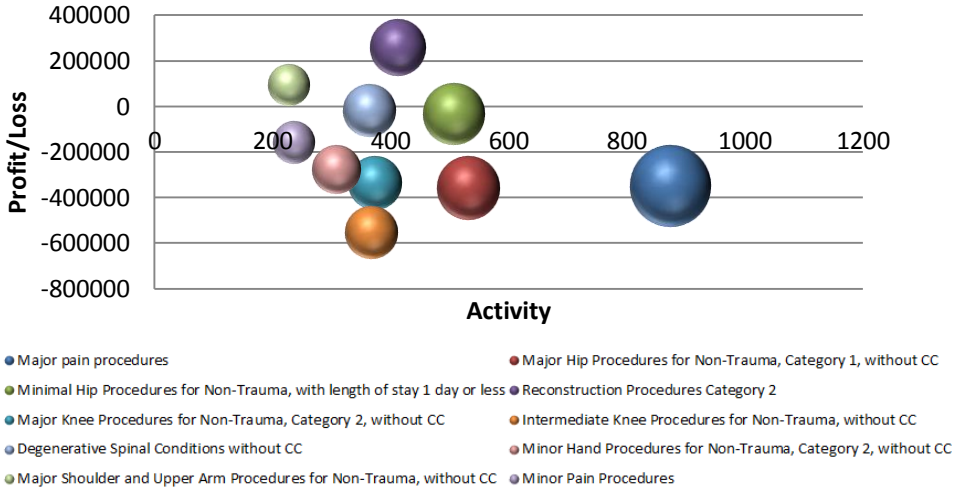
Net Surplus/Deficit by Service Cumulative to M09



Consultant Net Profit/Loss Dec 2016



Top 10 HRG by Volume April - Dec 2016-17



INFORMATION

The graphs above, and the associated narrative, relate to year to date to M9.

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 December 2016. Small Joints is the only service to have provided a negative contribution of -£147K. 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 apart from Oncology are then running at a net loss.

Currently services are being reviewed in terms of session planning for certain operation types to improve theatre utilisation and patient throughput.

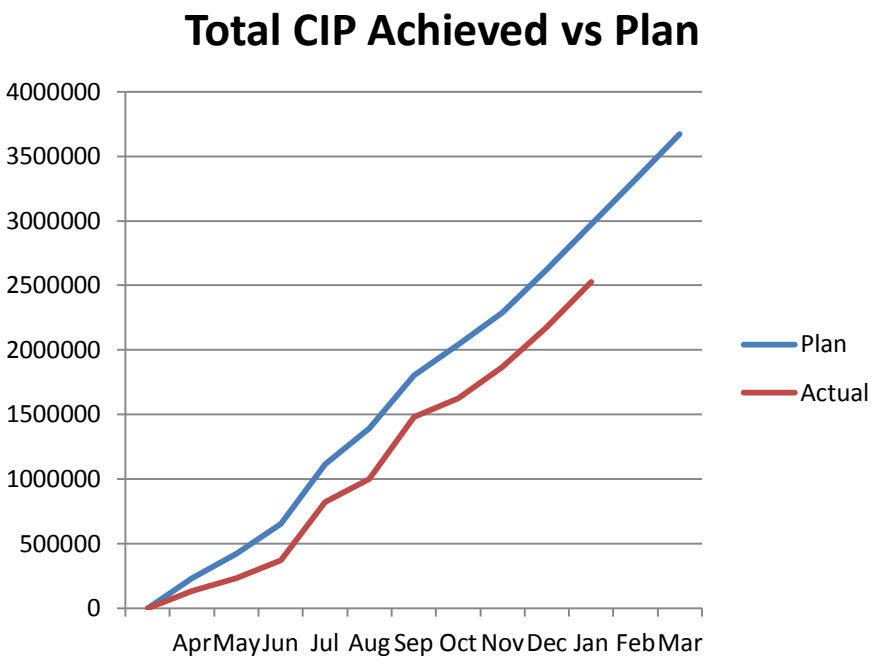
The Trust's most common HRG performed is are major pain procedures, followed by major hip procedures without complications and minimal hip procedures although our data would suggest that the most profitable procedures for the Trust are largely reconstructions. There is work ongoing to improve the allocation of costs to these codes, particularly with regards to prosthesis which may alter our understanding of the Trust's most profitable procedures.

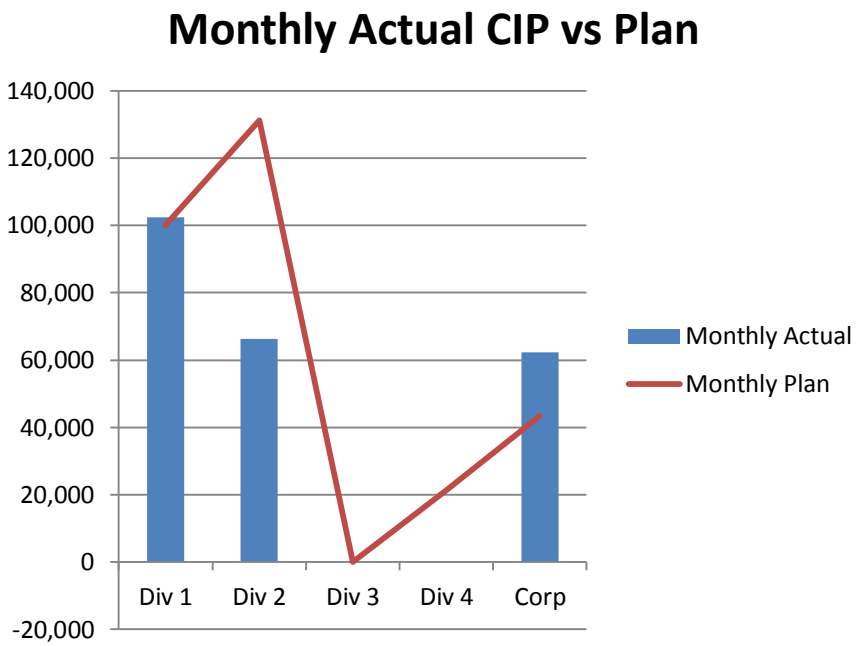
ACTIONS FOR IMPROVEMENTS / LEARNING

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. The costing team have been meeting with each individual firm over the past couple of months to identify areas for costing improvement and to identify any potential areas of income underrecognition. Paediatrics is the only remaining service left to meet.

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 10, the Trust has recognised £2,528,000 of CIP savings, against a plan of £2,971,000. £1,017,000 (40%) of savings to date are non-recurrent. The in-month savings recognised were £355,000 against a target of £350,000. A significant proportion of the CIPs relate to non-recurrent vacancy savings.

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:
Negotiations are ongoing with implant suppliers to achieve best value for money, in addition to consultants changing their implant usage in a number of areas.
Review of the operational and executive structure is being finalised.

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.

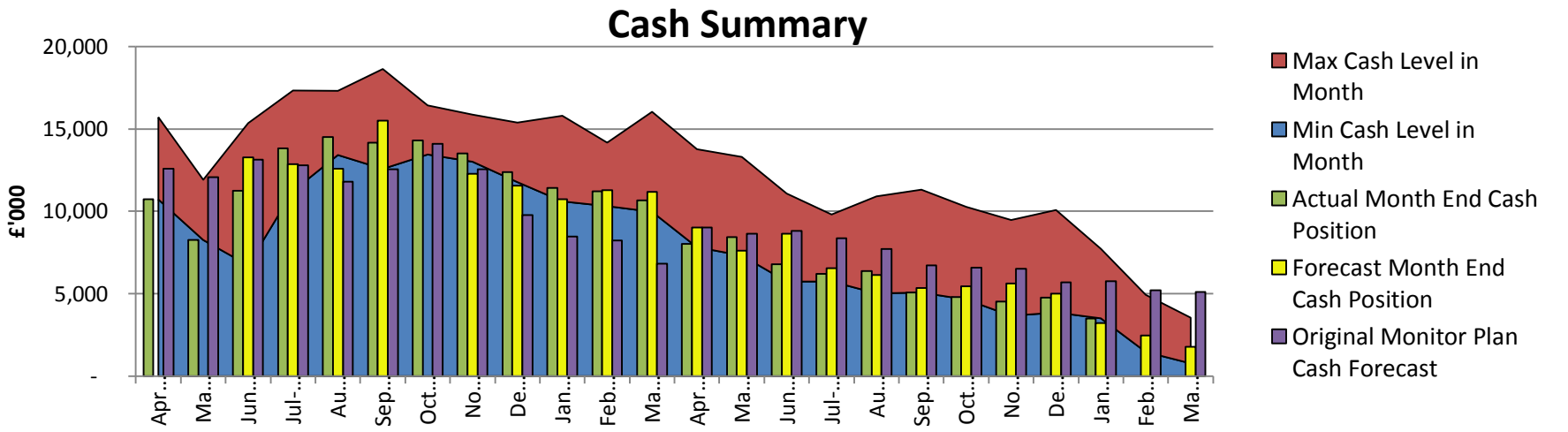
ACTIONS FOR IMPROVEMENTS / LEARNING

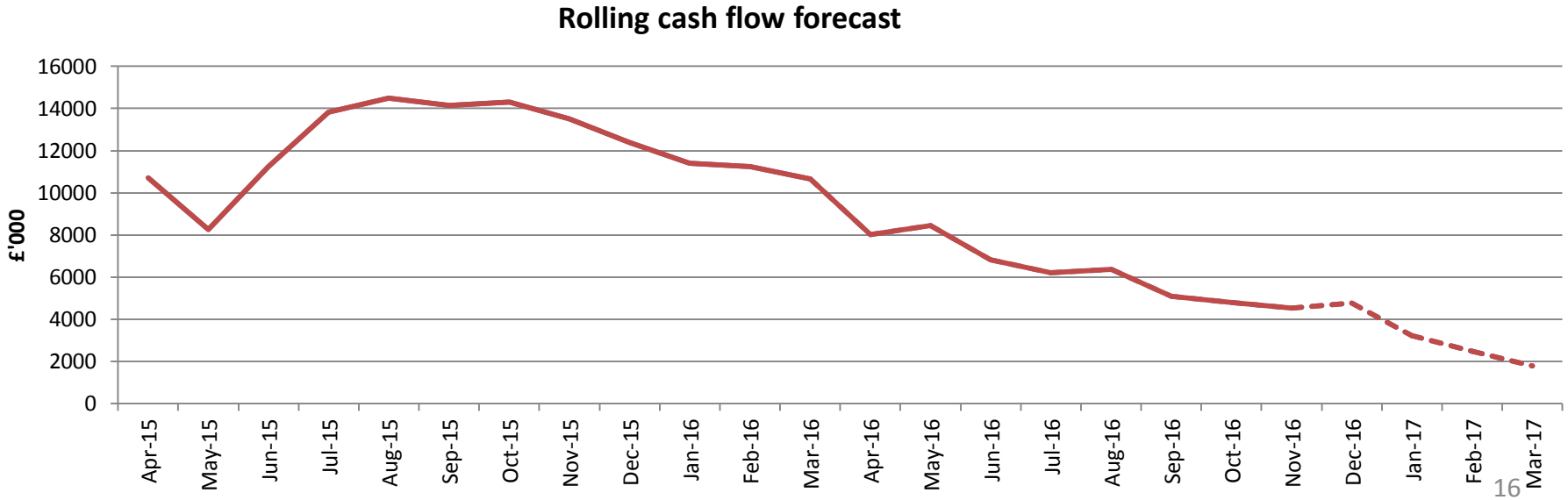
There are still unrecognised CIP balances which need to be identified, particularly in Division 1 and 2.

RISKS / ISSUES

The CIP target of £3.67m represents a significant challenge to the Trust. It is vital that we remain on target despite increased pressures on costs as the Trust increases its activity in the remaining months of 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 £2.2m lower than planned levels at the end of January 2016. The reduction on previous month is due to underperformance payments having been made in January for the Month 1-4 activity (which included the June theatres closure). The Trust is forecasting an end of year cash balance of circa £1.5m, which relies upon the delivery of our revised deficit plan and the control of capital spend within the budget that has been set.

Due to the reduction in cash, liquidity levels within the Use of Resources Rating have dropped to a 3, with cash likely to dip below £nil early in 2017/18.

ACTIONS FOR IMPROVEMENTS / LEARNING

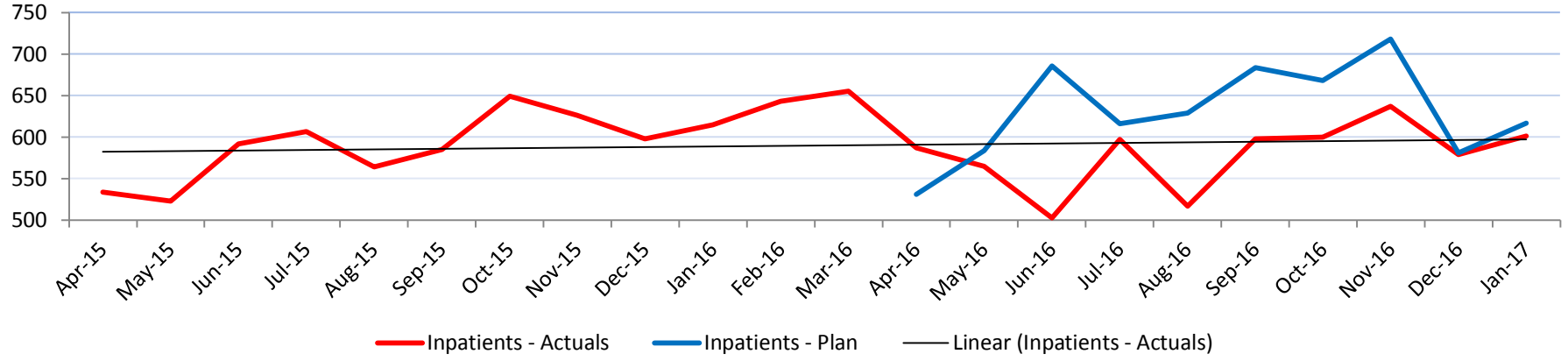
The Director of Finance is reviewing options for the receipt of a cash loan to support the running of the hospital in the new year. The DDOF and Head of Financial Accounting are reviewing cash management controls to ensure they are robust, and are beginning to set up arrangements to allow monthly applications of cash from the Department of Health to be actioned.

RISKS / ISSUES

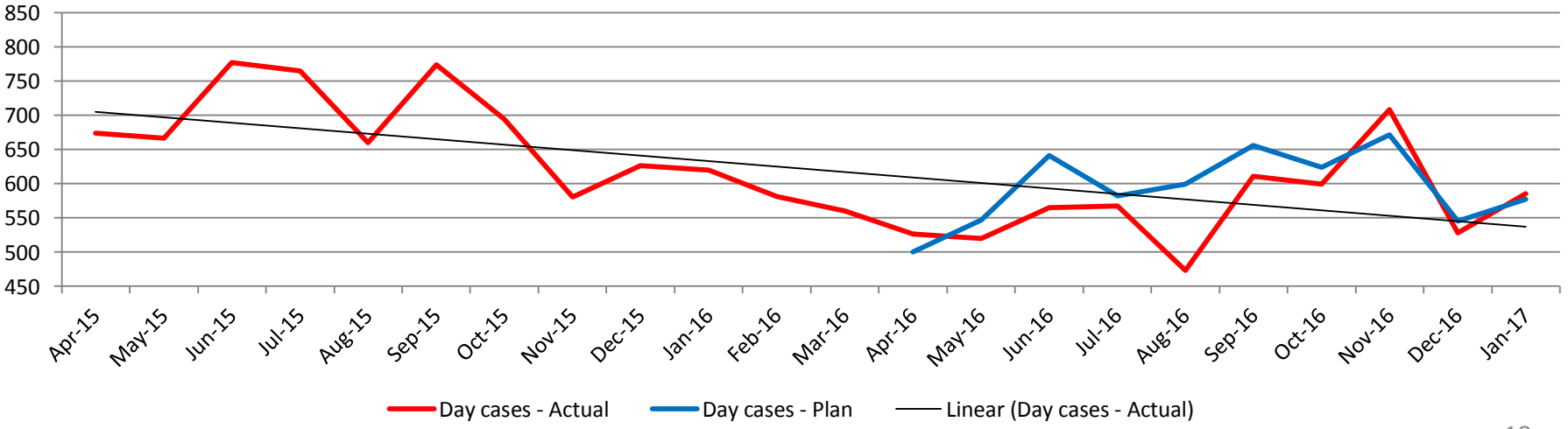
Given the in-month fluctuation of the cash position, which can potentially hit levels £1m-£2m below month end figures before mandate payments are received, it is vital that financial projections are met to ensure that cash can be comfortably managed within safe tolerances.

8. Activity: Admitted Patient Care – This illustrates the number of inpatient and day case discharges in the month, and year to date

Inpatients – Activity against original plan



Day Cases – Activity against original plan



INFORMATION

Activity improved in January as would be expected after the Christmas break. Day case activity overperformed against the original Trust activity plan, with elective activity slightly below. Performance against the recovery activity plan is discussed within the recovery paper.

ACTIONS FOR IMPROVEMENTS / LEARNING

3 of the 5 recovery workstreams relate to increasing activity, through increasing POAC capacity, increasing theatre efficiency and making discharge more efficient. These workstreams are being monitored against their detailed action plans and KPIs on a weekly basis through Recovery Board.

Some of the actions taken include the continue work in the "6,4,2" meeting 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.

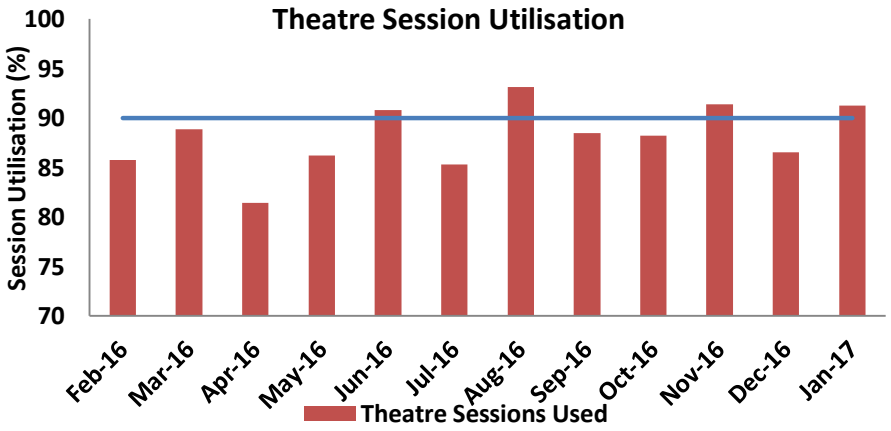
Significant engagement work is underway across the Trust to appreciate the scale of the challenge that is now facing the Trust to deliver the activity and associated income each week, in order to deliver the Trust's agreed financial control total. The planned recovery days to deliver some additional activity are being reviewed as to their deliverability and contingency plans being reviewed.

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.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are potentially available (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we aim to use at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis. The January utilisation improved back to November levels.

ACTIONS FOR IMPROVEMENTS / LEARNING

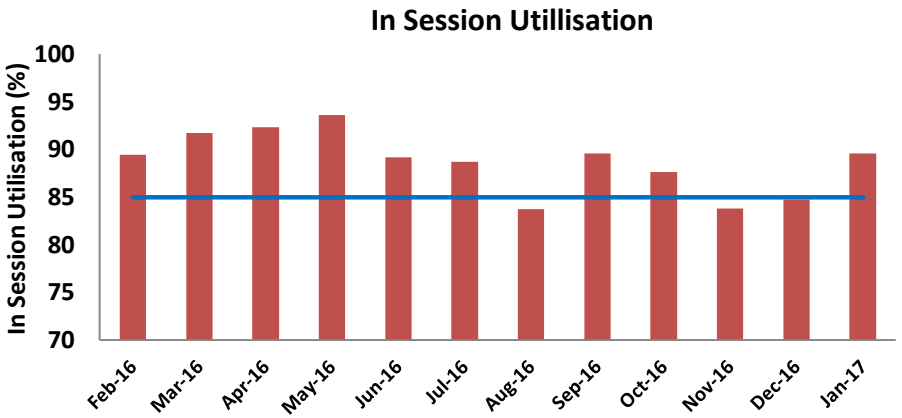
Due to annual leave / study leave, we typically plan that surgeons cover a 42 week year. Timetables are currently based on a 52 week year. Discussions take place proactively as part of the "6,4,2" process to ensure that other surgeons pick up lists that would otherwise be fallow. Job planning is building in buddy arrangements and prospective cover, as well as identifying a need for recruitment to specialities where there are vacancies or that are under pressure from an activity / RTT / 52 week perspective. Improvements have been made to the communications to surgeons of the availability of fallow lists, enabling more effective utilisation. There are now additional 3 session days in the schedule to facilitate the 2 x scoliosis cases on a list for spinal deformity. Looking ahead, following February Half term week, (20-24 February), there are minimal fallow sessions in the following 4 weeks.

Some theatre lists are now being released by individual surgeons (and offered to be reutilised by other surgeons) to do additional clinics, because some surgeons who are timetabled in theatres have very short waiting lists. All reasonable efforts are made to recycle, including where it is deemed appropriate the use of sessions additional to job plan (paid ADHs.) Where lists are not recycled, the theatre staffing and anaesthetist are removed 1 week ahead, to reduce agency costs.

RISKS / ISSUES

Job planning is now completed for over 50% of surgeons, with Oncology completed, Spinal and Arthroplasty nearly completed and other specialties progressing well. Notice is required to establish buddying timetable arrangements (Consultant of the Week) and co-ordination of leave evenly through the year, although there will always be times e.g. school holidays where it is not possible to utilise every available session.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained above the target 85% in the majority of months. However, the previous measure (pre June) 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. Performance in January exceeded plan, and there is continued effort to ensure that this continues throughout the future months.

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. This will be led by the Head of Nursing, Division 2, working on The Productive Operating Theatre principles.

The implementation of the new Theatre Management System (Theatreman) has been rescheduled for 6th March 2017 (This has been slipped several times due to PAS interfacing issues). The prescriptive nature of this software will be a further aid to ensure that lists are optimally booked based on the available time. Scrutiny and challenge is via the weekly 6-4-2 meeting, with instructions back through to the surgical teams to book lists to their maximum potential and to identify patients well in advance so that specific requirements can be planned for to reduce cancellations.

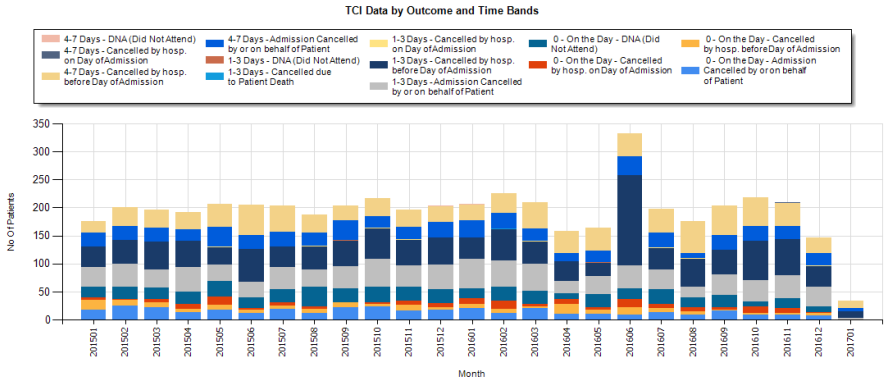
A detailed analysis of all theatre activity during the week commencing 9th January 2017 has identified further improvement opportunities, for example, the time patients are called for surgery, variations in anaesthetic practice and differing practices of listing patients, as well as how individual firms operate. Work on trajectories in the Hands, Feet and Arthroscopy specialties has also brought to the fore some opportunities for greater efficiency and the possibility of moving some cases out of the theatre environment.

RISKS / ISSUES

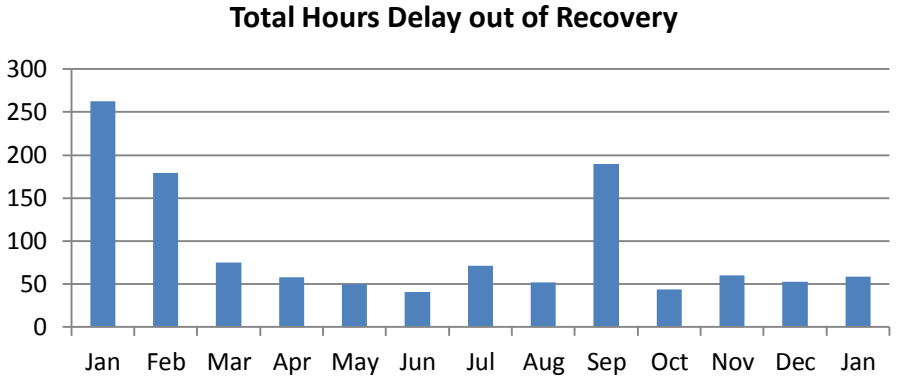
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (e.g. experience in spinal scrub) to ensure the best possible use of available operating time. Availability of radiographers (additional support now in place via agency.) Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit. Gaps in the operational structure, although recruitment is underway.

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

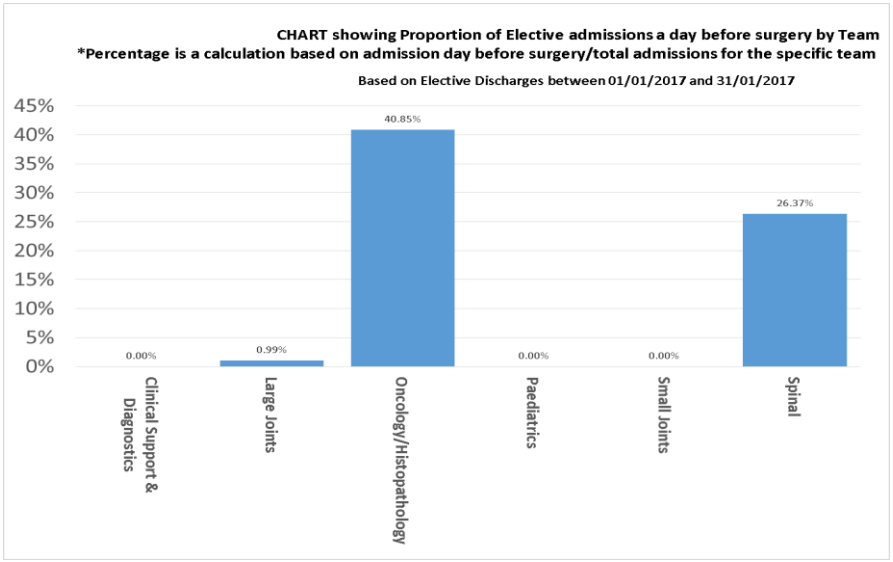
Cancellations by patient / hospital



Delays out of recovery

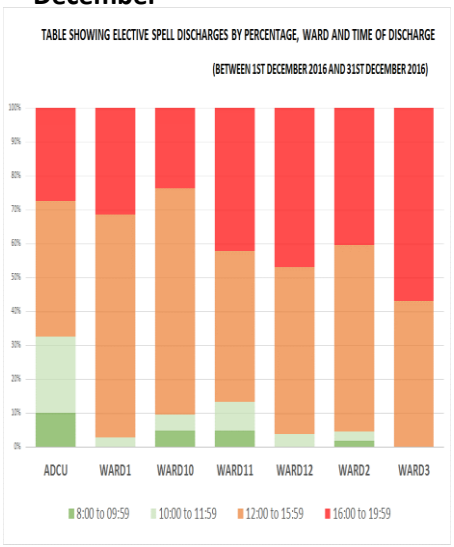


Admission the day before surgery

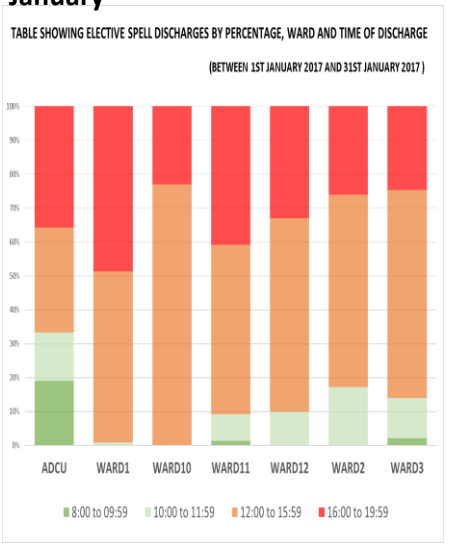


Time of day patients discharged

December



January



INFORMATION

Active management of the Patient Tracking List (PTL) , the establishment of a separate Oncology PTL weekly meeting to track the booking of individual patients, and a separate large joints PTL weekly meeting to track patients is creating a new momentum , with lists being booked several weeks ahead where previously they were being booked only days ahead.

Work on the trajectories for hands, feet and arthroscopy is identifying opportunities for streamlining referrals, reviewing the use of an operating theatre for cases being undertaken (rather than an OPD setting) and the rebalancing of waiting lists across firms. The implications of these are being worked through with Clinical Service leads and Clinical Service Managers.

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Some of the replacement patients are then booked at short notice. We are working towards booking with 3 week's notice and 2 reasonable offers as per national guidance and our Access Policy.

Now that there are Clinical Service Leads and Clinical Service Managers for each specialty, and regular team meetings, some longstanding issues relating to disparity of waiting lists across consultants, variations in theatre productivity and listing protocols are being addressed and resolved.

Forensic analysis of cancellations continues, with a focussed analysis by the anaesthetic lead and nursing lead for POAC of the majority cause of cancellations on the day of surgery, namely those who are medically unfit, to ascertain what process changes can be made in POAC or to the 72 hour phone call to reduce this.

Progress in transferring patients out of Recovery in a timely way, which had stalled in September, has improved and stabilised. However, it is of note that this standard is maintained by Recovery staff escorting the patients back to wards due to ward staffing levels, which may have an adverse impact on theatre utilisation and presents further infection control / red line concerns.

ACTIONS FOR IMPROVEMENTS / LEARNING

Now that the longstanding vacancies in Medical secretaries, admin support and operational management have been filled, there is now the capacity for transacting the forward booking of patients for both preoperative assessment and surgery. Typing backlogs are being cleared and will be up to date by the end of March 2017.

This will create a pool of patients available to be called forward earlier at short notice to fill cancellation slots.

Work is still required to agree criteria for admission the day before, to use beds more effectively and reduce length of stay. Bed availability has not been a constraint to delivery.

Pre-operative assessment improvements have been delivered, so that there are now 32 slots available each day.

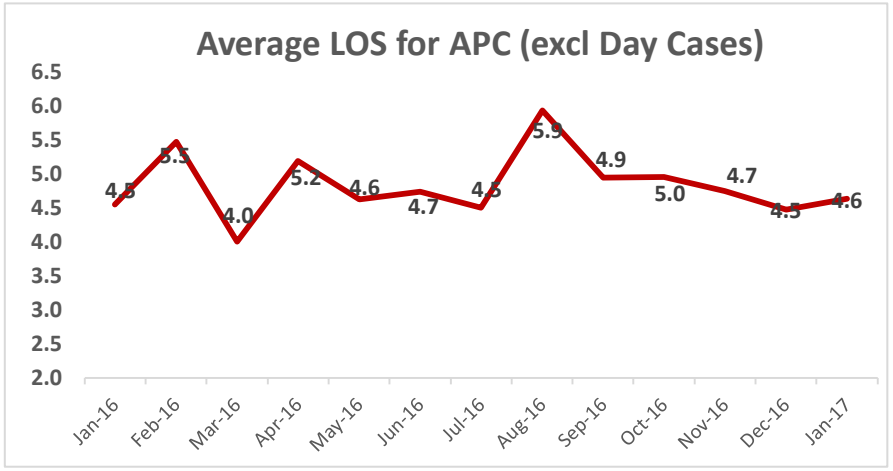
A daily update review by operational management of forward bookings has been established and the 642 and daily huddle is being trialled.

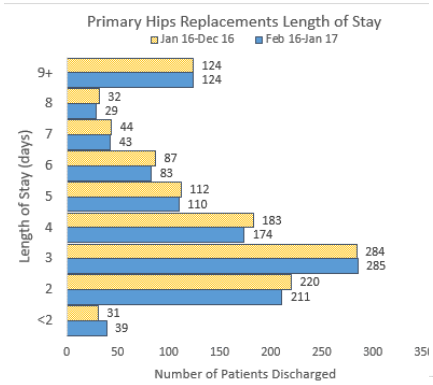
RISKS / ISSUES

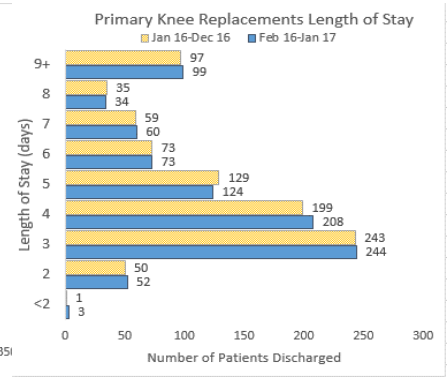
Continued focus with all staff involved to ensure that the operating lists are booked in advance, with sufficient caseloads, together with daily tracking.

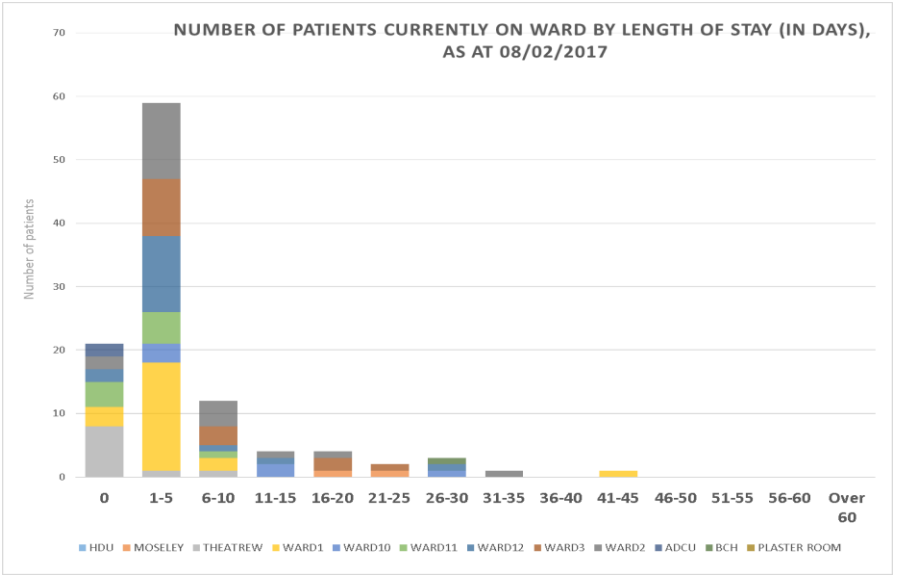
It is curently not possible to identify if the time of day patients are discharged is an accurate reflection of reality, or whether data is being entered onto the system in a delayed manner, making discharges look later in the day.

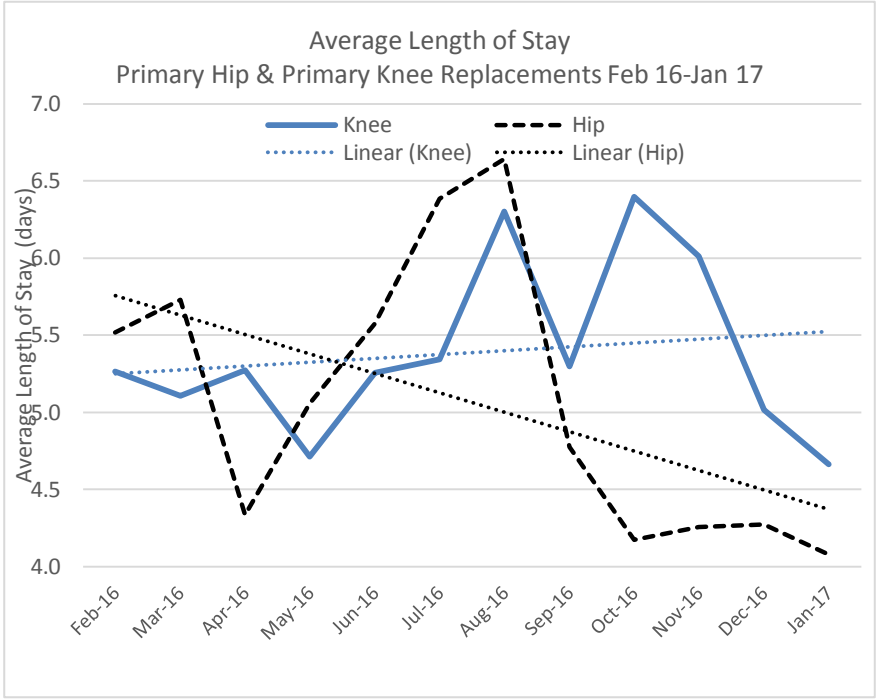
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Length of stay of for primary hips has shown early signs of improvement, and with the extra focus on Estimated Discharge Date and the Rapid Recovery initiative. However, the linear trend for primary knees remains upward, which is disappointing. 'The Home for Lunch' information campaign has been formally launched to staff and patients during Mid February and this will help to reduce length of stay with the expectation setting with staff and patients about when a patient can leave the hospital, and the marshalling of resources to ensure that this occurs as early as possible in the day. This clearly sets out to all concerned that we expect that more than 80% of patients due for discharge that day will leave hospital or be off the ward and in the discharge lounge before midday.

ACTIONS FOR IMPROVEMENTS / LEARNING

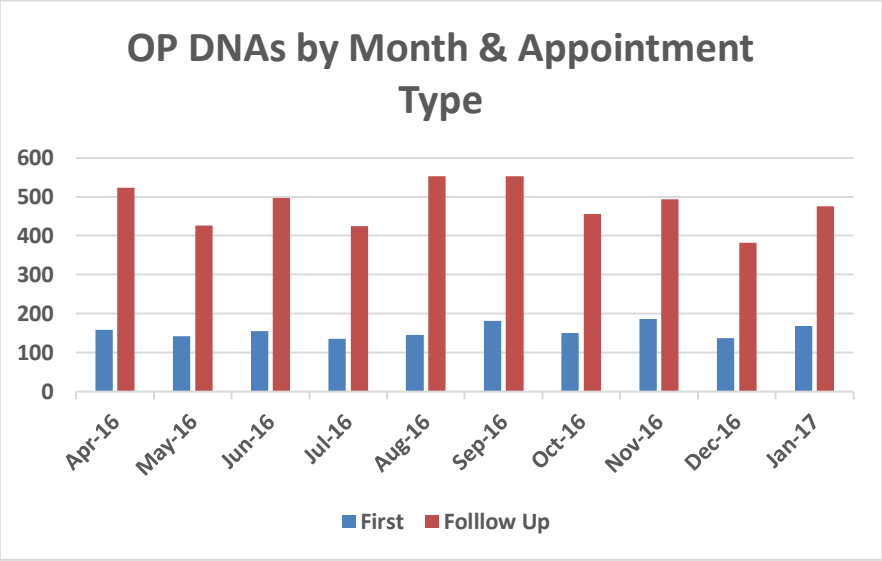
Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.

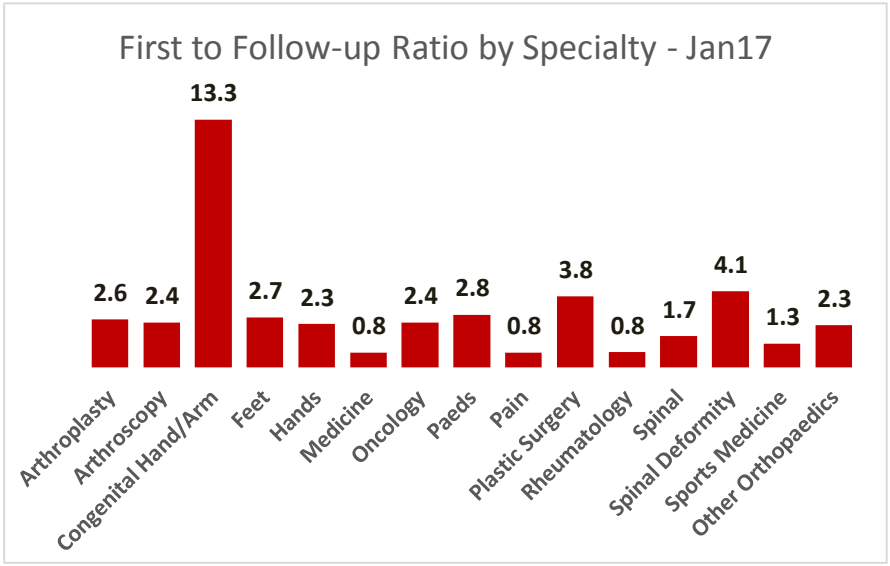
Daily senior reviews are being formalised as part of job planning, and the rising adherence to recording the Expected Date of Discharge (EDD) (now over 90%) is helping all involved in that patient's care to manage their length of stay more effectively.

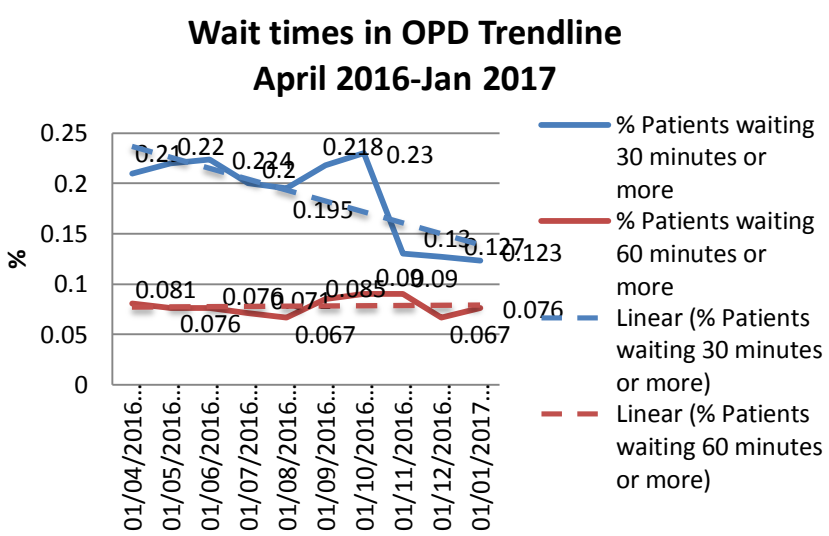
RISKS / ISSUES

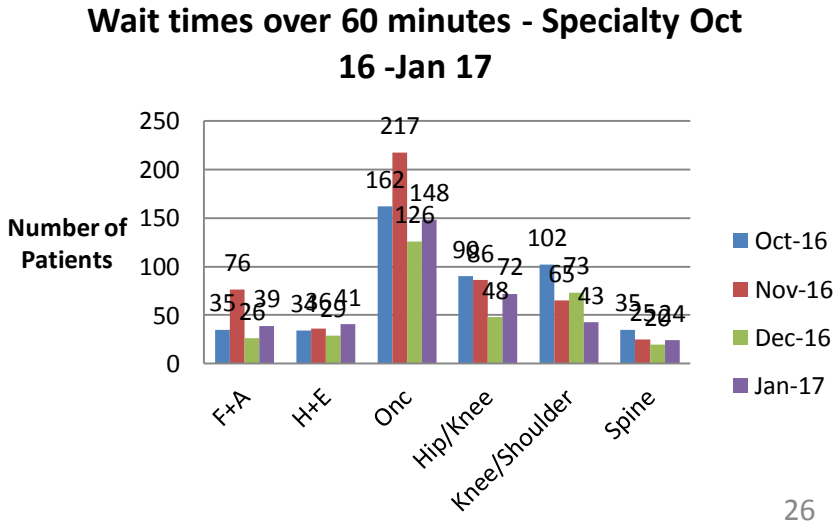
Using individual consultant information, Operational management teams and Clinical Service Leads are reviewing outlying clinical practice to help ensure that all patients are able to go home as soon as possible after their surgery.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients









INFORMATION

Outpatient DNAs remain stubbornly high. The first to follow up ratios at consultant level remain variable, relating to individual clinical practice. Discussions around booking rules and proactively overbooking are being discussed with Clinical Service Leads to ensure that productivity is maximised and as many patients as possible can be seen as soon as possible.

The work undertaken in February to understand the trajectories for Hands, Feet and Arthroscopy will be rolled out across all specialties- initial results are showing very low conversion rates from first OPD appointment to surgery, and also from second OPD appointment to surgery for some specialties.

ACTIONS FOR IMPROVEMENTS / LEARNING

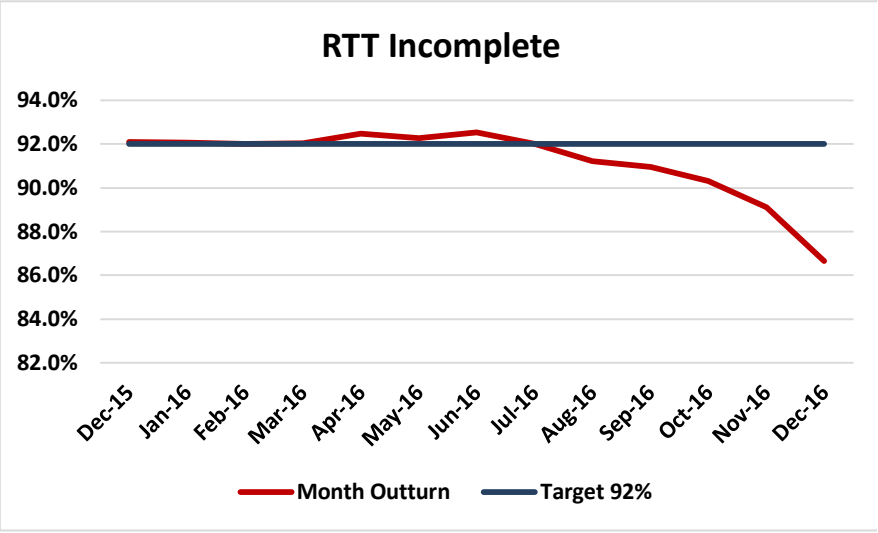
There are a range of actions as part of the CQC action plan and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

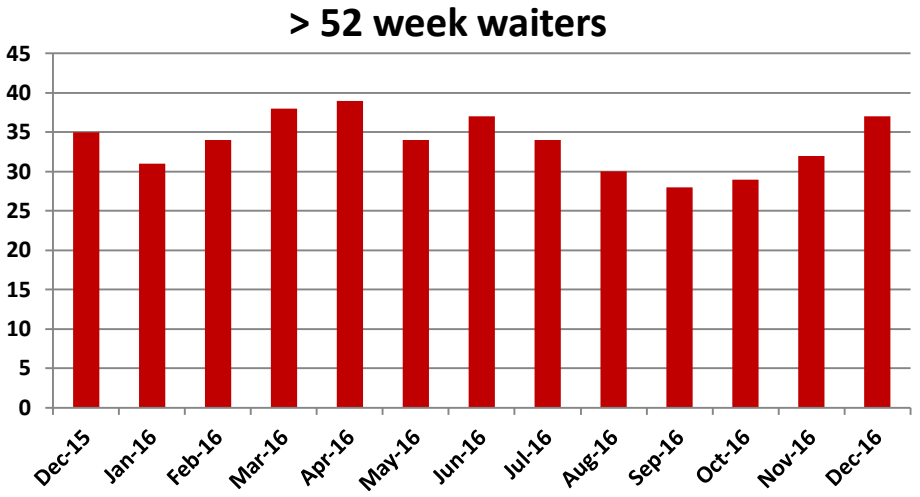
As part of the Trust's RTT recovery work, there will be a focus on out patient pathways and any patients who are in the system awaiting a follow up appointment and have become overdue, for whom a new active RTT clock should be started in line with national guidance. However, if it is found that there is a follow up appointment capacity problem, then this could worsen new to review ratios in the short term. This is being reinforced through RTT training and the clinical service managers working closely with consultants and medical secretaries to ensure that the Trust access policy is being adhered to by all involved.

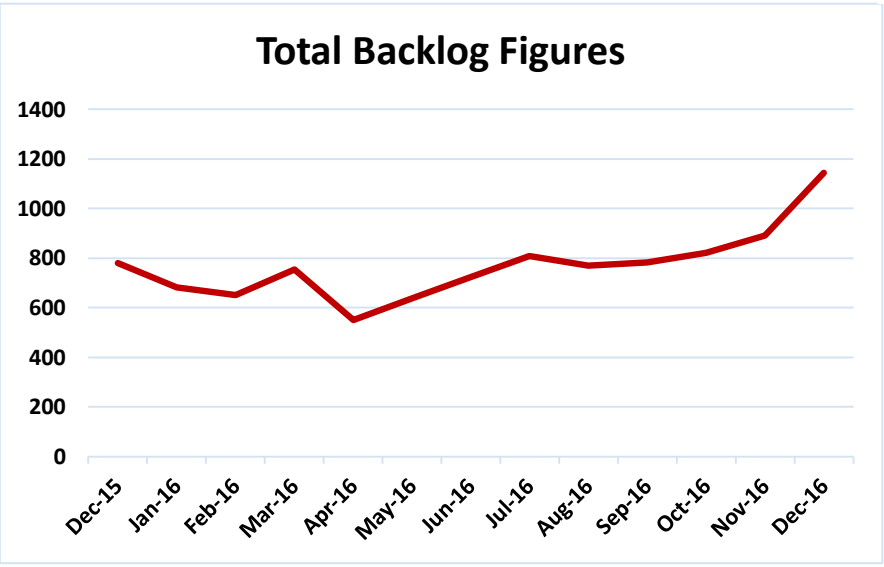
RISKS / ISSUES

Further work is underway on the production of meaningful reports from the In Touch system and the sharing of this information across specialties.

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets - RTT	Target / Trajectory	Actual (Dec16)	Actual (YTD)
52 Weeks Waiters	-	37	300
18 Weeks Incomplete	92%	86.65%	90.78%
NHSI Performance Targets - Cancer	Target / Trajectory	Actual (Jan17)	Actual (YTD)
Cancer (2 week wait)	93%	100%	100%
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	98.65%
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	96.67%
Cancer (62 days)	85%	71.43%	93.62%

INFORMATION

RTT open pathway performance continues to be the main concern. The backlog continues to increase at a rapid rate for both admitted and non admitted pathways.

The current position is 85%, compared to the unvalidated position for December of 86.27%, which was significantly below the November performance of 89.12%, continuing an established pattern of month on month deterioration. This is a mixture of addressing data quality issues as they are identified as part of the ongoing validation work associated with the 100,000 open pathways, and also pathways through to surgery that are not 18 week compliant for a significant number of surgeons in the majority of specialities.

As at 13th Feb 2017 there are a total of 1,410 patients at 18 weeks or over on the waiting list (admitted / non admitted) which is 40 patients higher than last week; this is 16% of the total waiting list. At each milestone the number of patients at 18 weeks and over has risen since last week. Whilst these figures include both dated and undated patients, the number of patients dated 14 weeks and above is not sufficient to improve the Trust's position.

A retrospective review of waiting list / pathway status has indicated to achieve 92% the Trust's backlog will need to be circa 550 with total pathways around the 7,500 mark. January's performance against the 18 week 92% unfinished target is currently being validated. With a backlog of 1285, the team need to stop 658 clocks to achieve 92%.

The main issues (based on reported performance) are within arthroscopy, foot & ankle and spinal. The number of breaches within the pain service have increased due to consultant manpower, but a rectification plan is in place for this speciality. Rectification plans are being developed and will be completed shortly for the other specialties.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are significant concerns with regard to data quality and the measurement of RTT waiting times. This includes inappropriate clock stops in the Oncology service following biopsy, and the monitoring of services that are not consultant led but are delivered within an 18 week pathway (Therapies) that therefore improve the position. This has been escalated to NHS Improvement. It is likely that the true position, when the reporting anomalies are resolved, will be significantly worse that the current level of performance being reported.

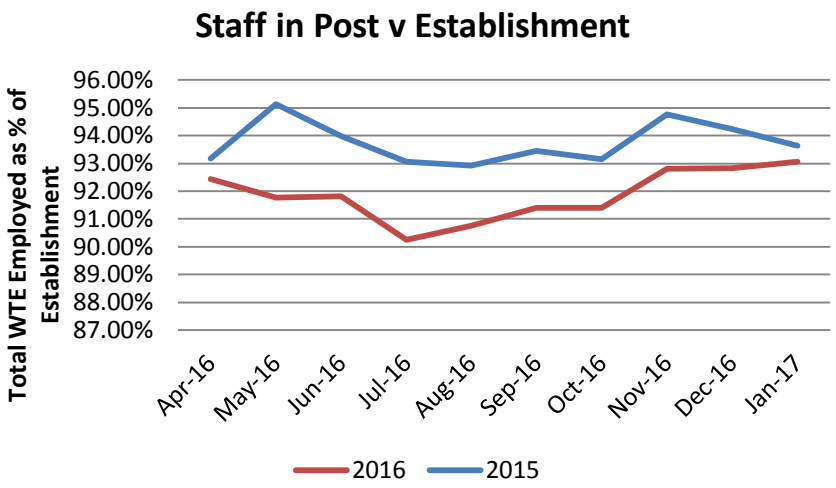
RISKS / ISSUES

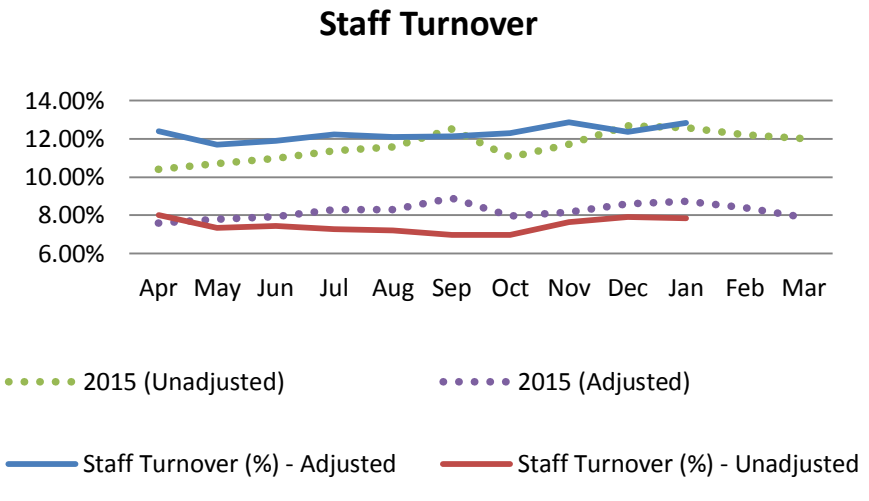
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern.

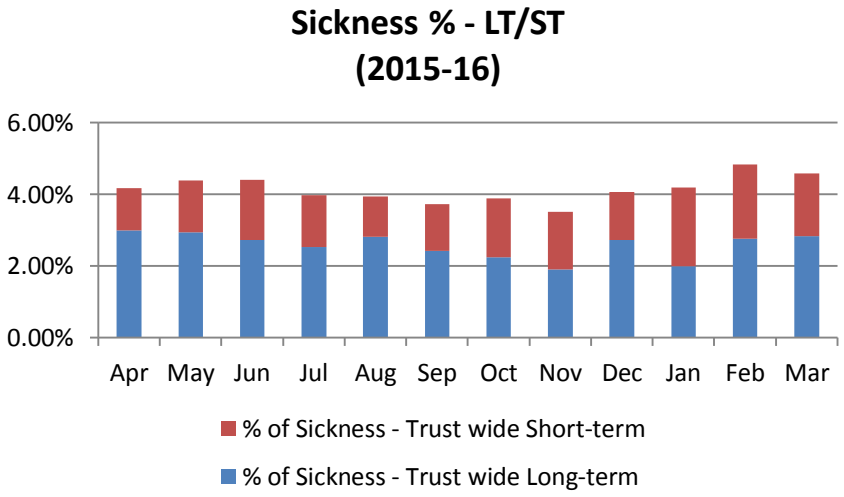
18 weeks: Significant work continues to understand the scale of the challenge with regard to open pathways, and the extent of data quality concerns. The Trust welcomes the input and expertise of NHS Improvement in this area.

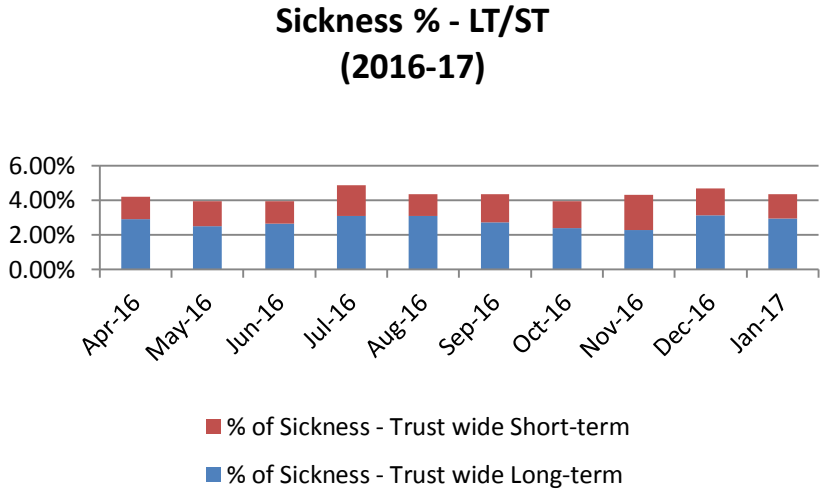
A review is under way with regard to the robustness of cancer waiting times reporting, given the concerns with data quality around the other access targets.

15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

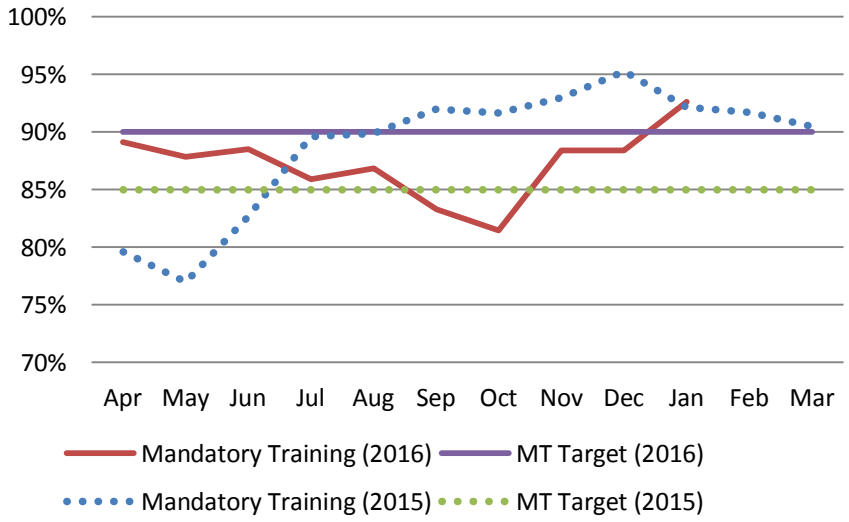




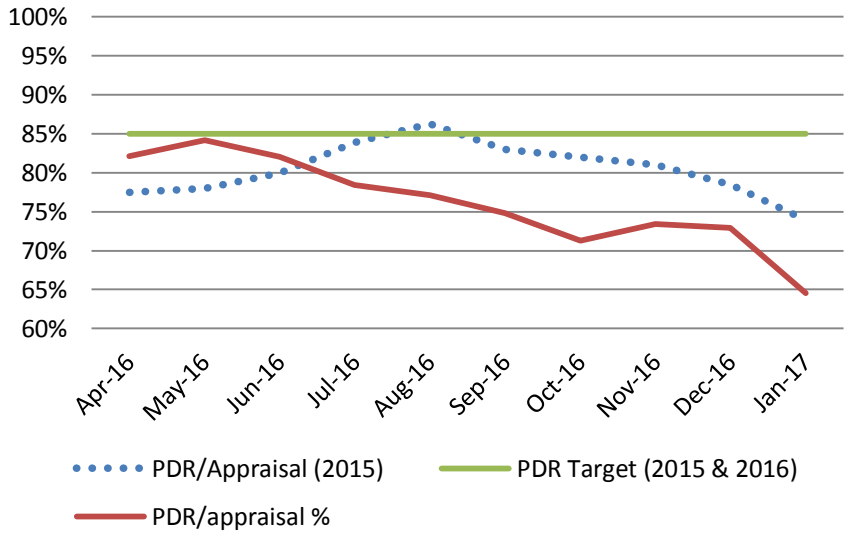




Mandatory Training



PDR/Appraisal



INFORMATION

January 2017 in general terms was a better month for workforce performance than December 2016.

The vacancy position, in terms of staff employed, moved above 93% for the first time in 9 months and turned "green", reflecting continued steady upward progress in recruitment since July.

Sickness absence saw a decrease in both short and long term absence in January (4.34%) versus December's position (4.67%), which is encouraging.

There should be progress to report in the underlying 12 month figure in February (current 12 month average as at end January stands at 4.52%) if we can maintain or improve our current position: February does tend to feature consistently in the top 3 worst months for sickness absence, so there is an opportunity for improvement next month.

The Trust's Mandatory training position increased in January to 92% and was "green" for the first time since March 2016. It is unfortunate that on 23 January 2017 the Trust received a contract performance notice from our commissioners on this issue - although the progress is encouraging to report externally. Maintaining performance now becomes the challenge.

PDR/appraisals have decreased this month to their lowest level since September 2013 as a result of operational efforts to achieve the recovery plan: this will be an area of focus in coming months.

The turnover figures this month were unremarkable: both are within typical ranges of the last 12 months.

ACTIONS FOR IMPROVEMENTS / LEARNING

The importance of remaining compliant in mandatory training was reinforced at Divisional performance reviews In January, discussed at Trust Management Committee in January and has also been core briefed in February.

The appraisal position has been discussed at Divisional Boards in February and trajectories will be re-examined in April: other current operational recovery plan priorities make significant immediate progress unlikely, however.

RISKS / ISSUES

The Trust is under a contract performance notice from our commissioners in relation to statutory and mandatory training currently as above.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

February 2017

EXECUTIVE DIRECTOR:	Garry Marsh	Director of Operations, Nursing & Governance
AUTHOR:	Ash Tullett	Clinical Governance Manager

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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.

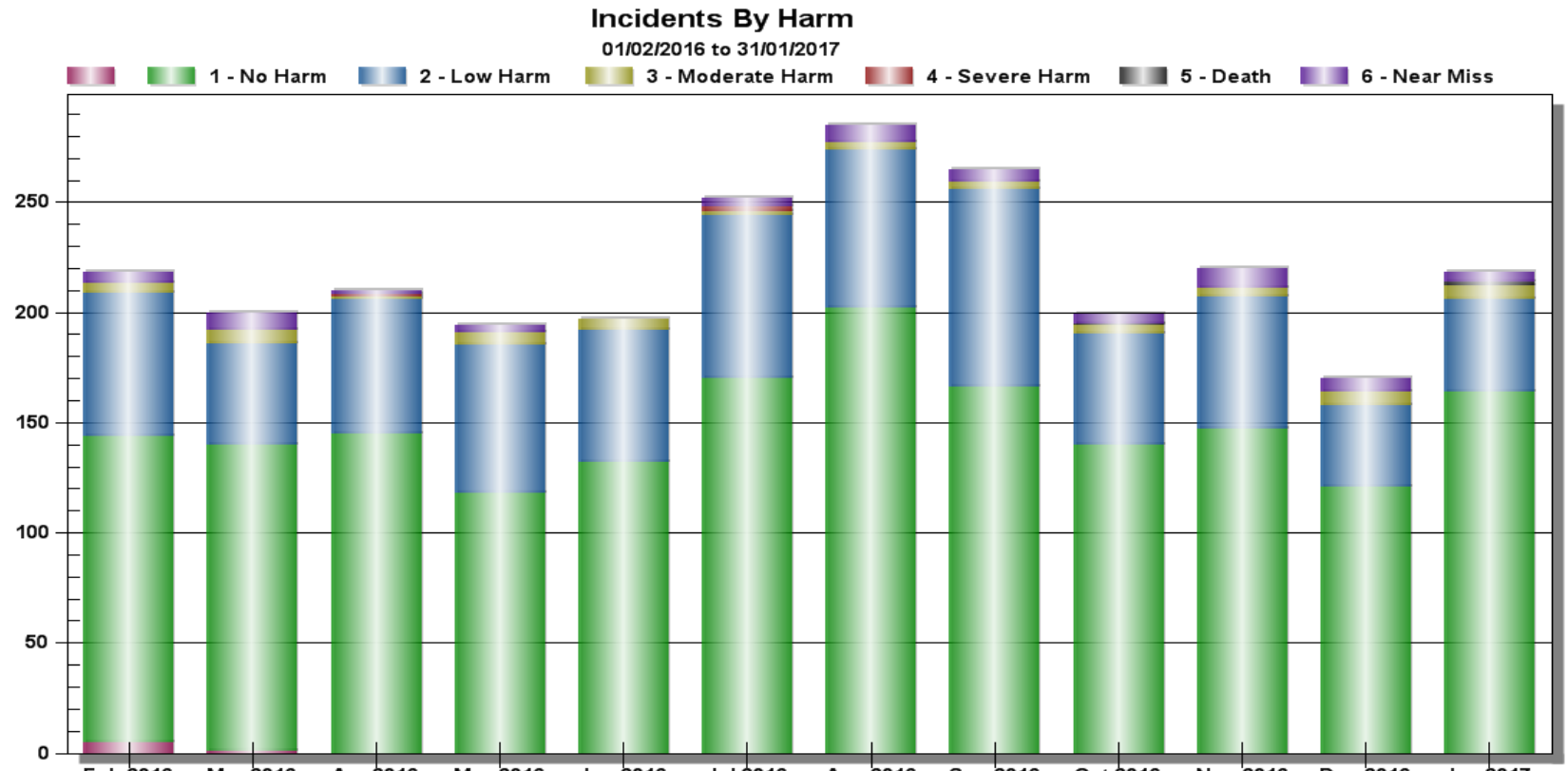
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: 0121 685 4000 (ext. 55641)

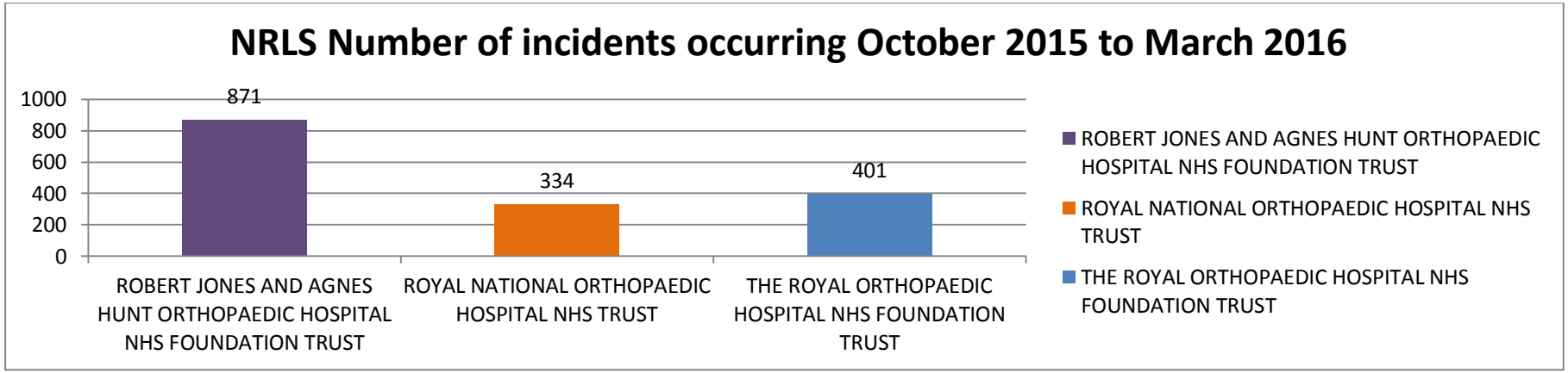
2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.

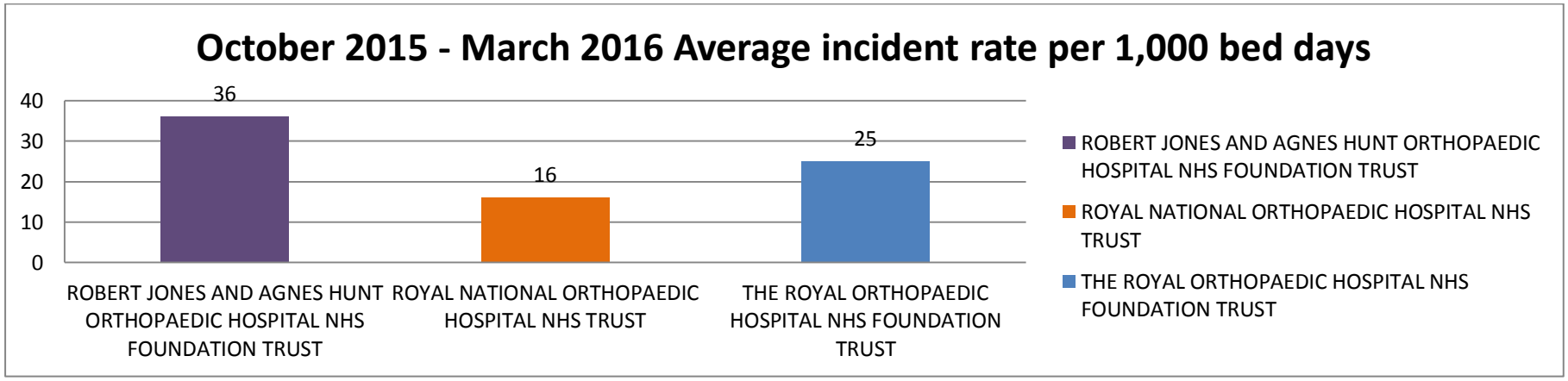


Month and Year	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017
	5	1	0	0	0	0	0	0	0	0	0	0
1 - No Harm	139	139	145	118	132	170	202	166	140	147	121	164
2 - Low Harm	65	46	61	67	60	74	72	90	50	60	37	42
3 - Moderate Harm	4	6	1	6	5	2	3	3	4	4	6	6
4 - Severe Harm	0	0	1	0	0	2	0	0	0	0	0	0
5 - Death	0	0	0	0	0	0	0	0	1	0	0	2
6 - Near Miss	5	8	2	3	0	4	8	6	4	9	6	4

National Reporting and Learning System (NRLS): Every six months NHS improvement publishes national statistics of the organisation patient safety incident reports. This is data for NHS providers on the breakdown of patient safety incidents they have reported to the NRLS.

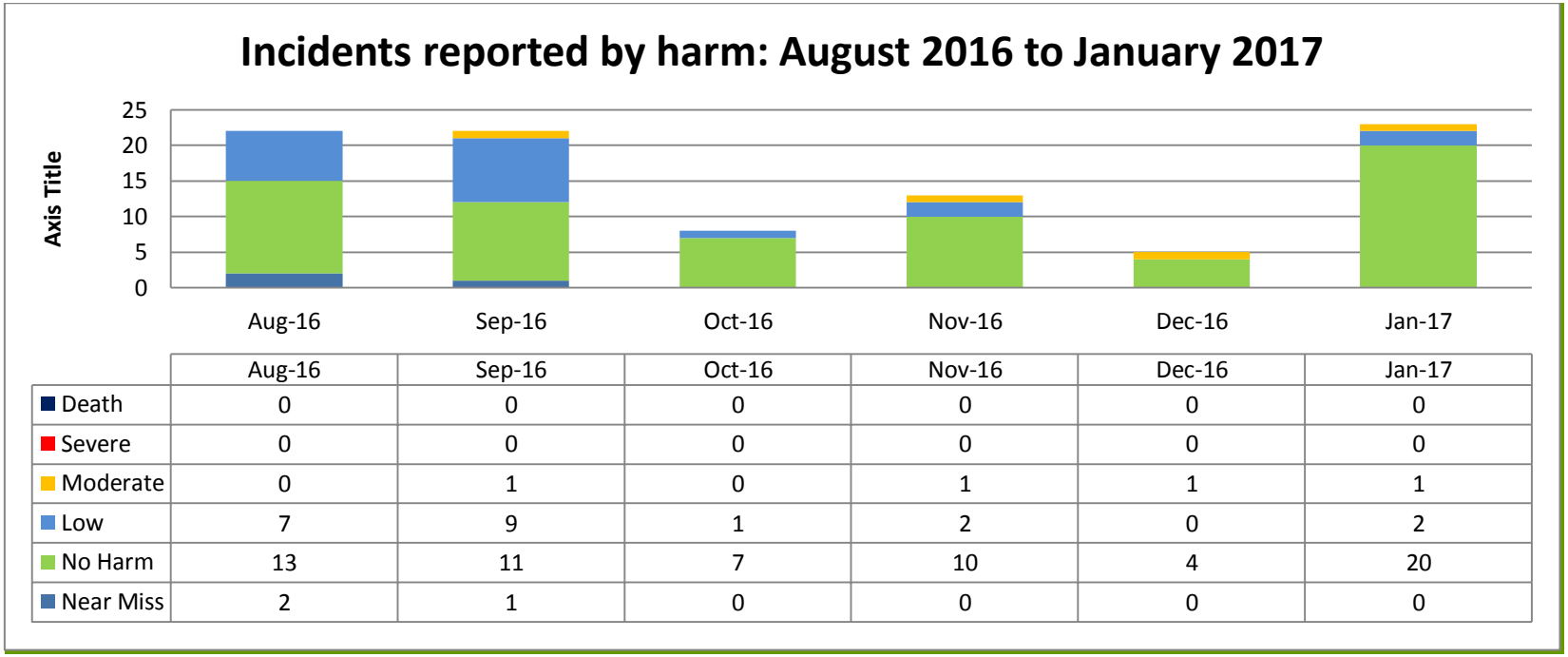
The Data is based on incidents that occurred in England and Wales from 1 October 2015 to 31 March 2016 and were submitted to the National Reporting and Learning System (NRLS) by the 31 May 2016. This is a comparison to other Orthopaedic Trusts.





INFORMATION
There were 218 incidents reported in January 2017; There were six moderate harms and two deaths.
ACTIONS FOR IMPROVEMENTS / LEARNING
The new quality indicators/dashboards will be used for the first time in March 2017. This will include information on incidents and harm. The Quality report now contains data on NRLS national reporting and benchmarking against other Trusts.
RISKS / ISSUES
Incidents are not being reviewed by managers in a timely manner. Reports have been developed on Ulysses to identify these managers and the length of the delays with a view to providing them with support review their incidents accordingly. The first report was sent out in January 2017. Division 2 are undertaking an exercise to ensure that all incidents in the last 12 months have been closed off with appropriate actions. The same process is planned for the other divisions.

Paediatric Incidents – This illustrates all incidents relating to Paediatric Patients that have been reported at ROH on Ulysses by members of staff during the previous 5 months (since when Ulysses was configured to capture the data). The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.



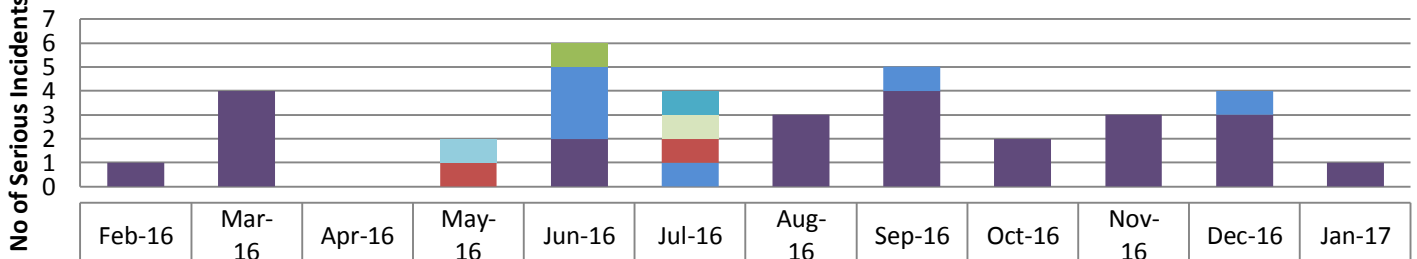
	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Death	0	0	0	0	0	0
Severe	0	0	0	0	0	0
Moderate	0	1	0	1	1	1
Low	7	9	1	2	0	2
No Harm	13	11	7	10	4	20
Near Miss	2	1	0	0	0	0

23 incidents were reported in January 2017 involving Paediatric Patients. A breakdown was provided to the Children's Board in February and these were discussed in detail.

2 Paediatric Incidents that were reported in the Children's quality report resulted in Moderate harm – One of these has since been reviewed and downgraded.

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.**

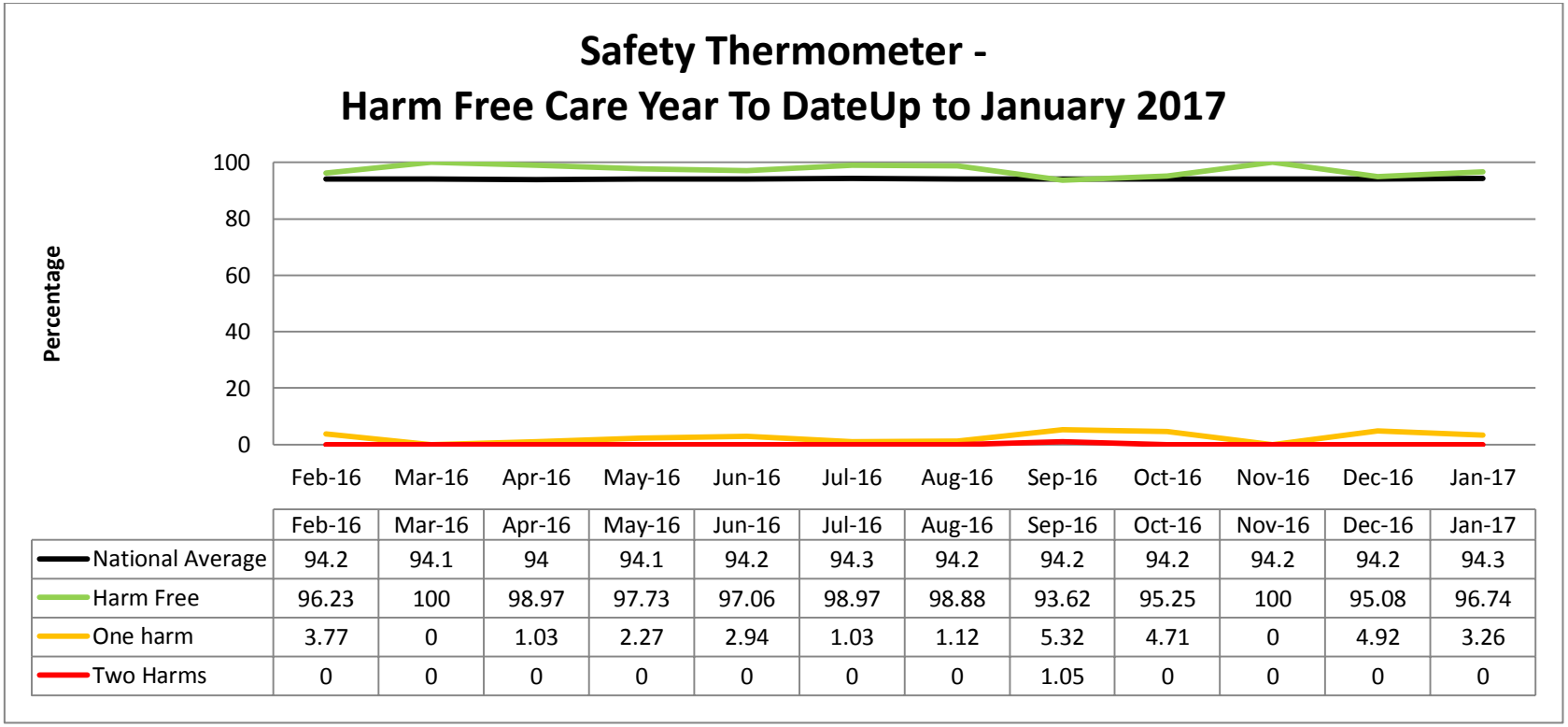
Serious Incidents Declared Year to Date to January 2017



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Staff conduct incidents												
Emergency transfer out of Trust												
Surgical incident meeting SI criteria												
Emergency transfer to HDU												
Failure to act on test results												
Wrong Site Incision						1						
Wrong Implant						1						
Suspension to services					1							
Delayed diagnosis												
Wrong side injection				1								
Unexpected deaths												
Slips, trips & falls				1		1						
Pressure Ulcers				0	3	1		1			1	
VTE meeting SI criteria	1	4	0	0	2	0	3	4	2	3	3	1

INFORMATION
There was one SI declared in January 2017. This is due for submission with the Commissioners April 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
Two Serious Incident reports were submitted to the Commissioners during January 2017. These were both VTEs.
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.**



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
National Average	94.2	94.1	94	94.1	94.2	94.3	94.2	94.2	94.2	94.2	94.2	94.3
Harm Free	96.23	100	98.97	97.73	97.06	98.97	98.88	93.62	95.25	100	95.08	96.74
One harm	3.77	0	1.03	2.27	2.94	1.03	1.12	5.32	4.71	0	4.92	3.26
Two Harms	0	0	0	0	0	0	0	1.05	0	0	0	0

There were three harms reported during January 2017. There was 2 new pressure ulcers and one old pressure ulcer.

Children and Young Persons' Safety Thermometer

The Trust has started to submit data to the Children and Young Persons' Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. The table below illustrates the data that is recorded. The Governance Department will seek to collate National data and data from our comparable specialist Providers for the purposes of benchmarking. A meeting has been arranged for 21st February 2017 to discuss the further understanding of how to interpret the data to give meaningfulness.

January 2017

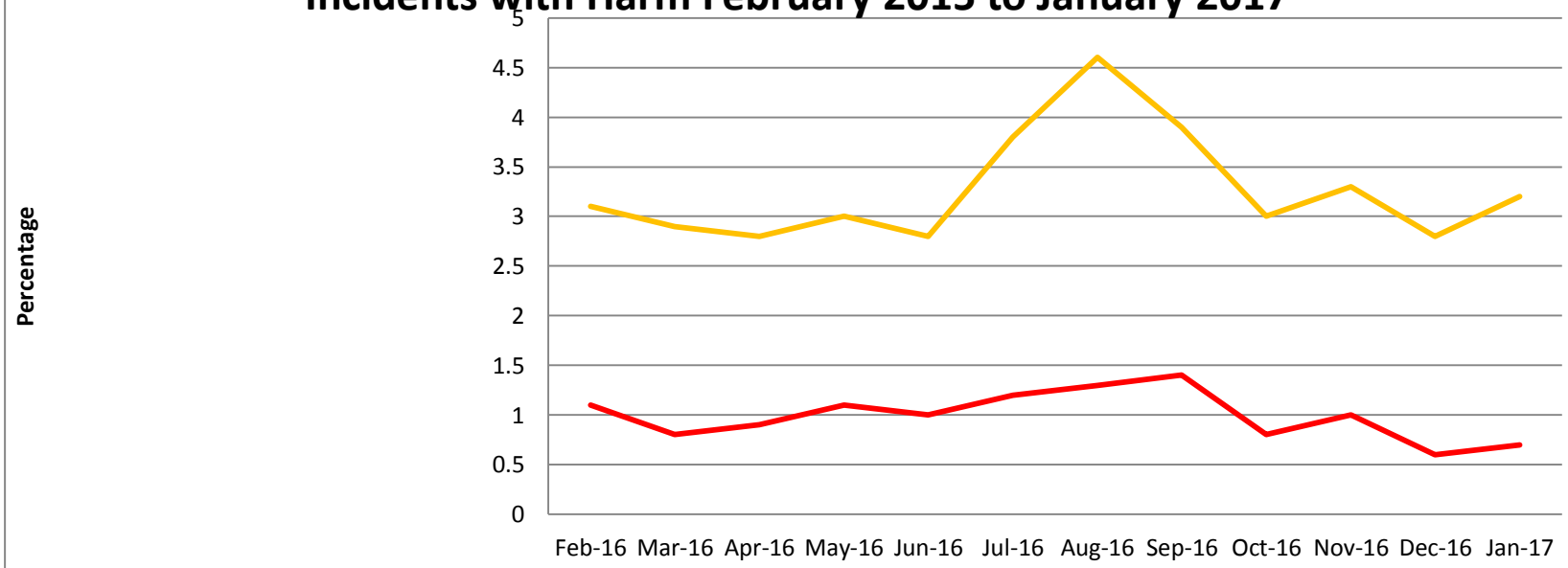
	Local Reference	Gender	Age Group	EWS Completed	Extravasation	Patient in pain?	Pressure ulcer?	Moisture Lesion
1	1	Male	5-9 years old	Yes	No	No	No	No
2	2	Male	10-14 years old	Yes	No	No	No	No
3	3	Female	15-19 years old	Yes	No	No	No	No
4	4	Female	10-14 years old	Yes	No Device	No	No	No
5	5	Female	15-19 years old	Yes	No Device	No	No	No
6	6	Female	10-14 years old	Yes	No	No	No	No
7	7	Male	10-14 years old	Yes	No	No	No	No
8	8	Male	15-19 years old	No	No Device	No	No	No
9	9	Female	10-14 years old	Yes	No Device	No	No	No
10	10	Female	5-9 years old	Yes	No	No	No	No
11	11	Male	10-14 years old	Yes	No	Yes	No	No
12	12	Male	15-19 years old	Yes	No	No	No	No
13	13	Male	15-19 years old	Yes	No	No	No	No

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 January 2017 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
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
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794

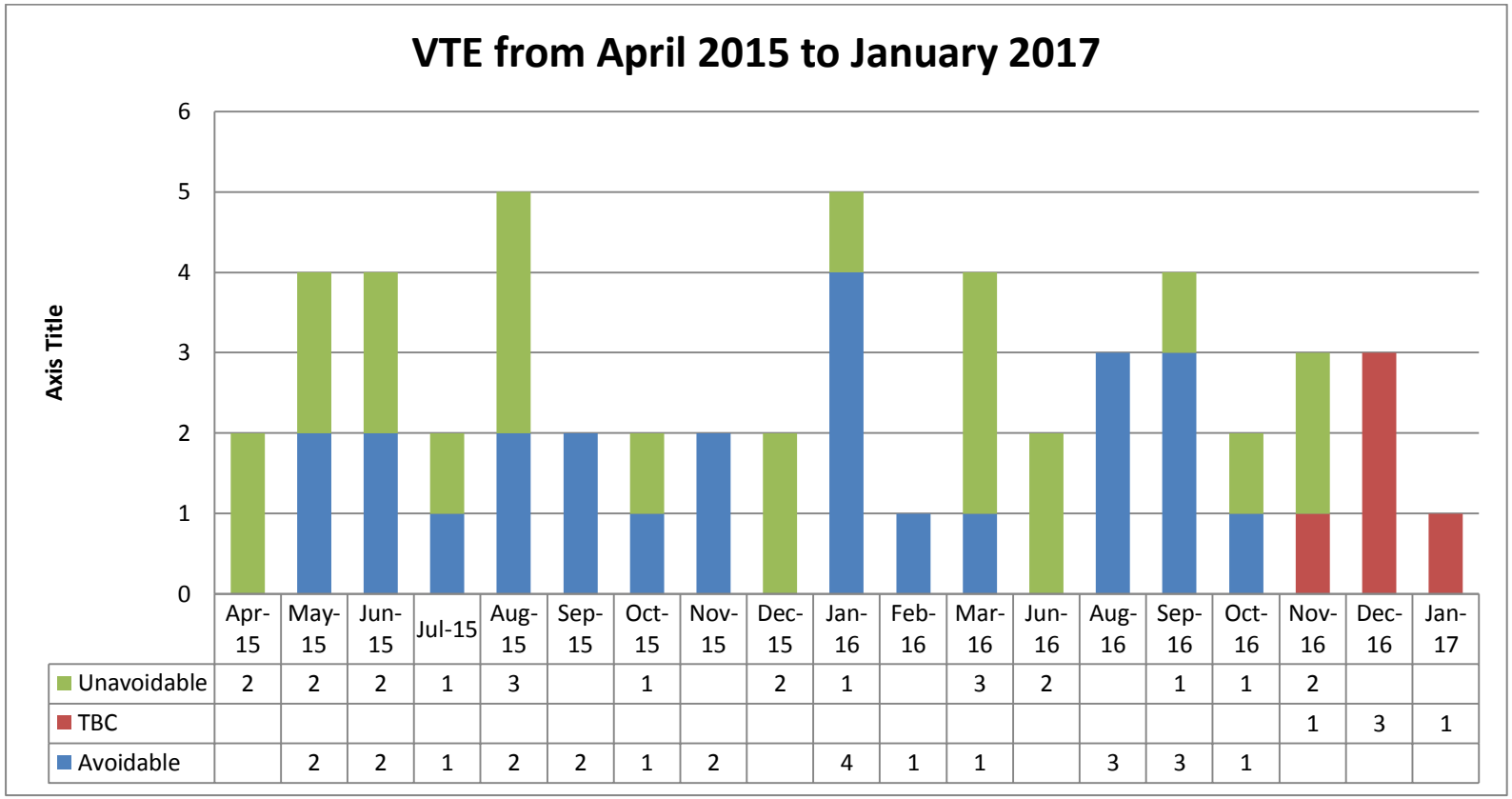
In January 2017, there were a total of 6794 patient contacts. There were 218 incidents reported which is 3 percent of the total patient contacts resulting in an incident. Of those 218 reported incidents, 50 incidents resulted in harm which is 0.7% of the total patient contact.

% of Patient Contact Compared to Number of Incidents and Incidents with Harm February 2015 to January 2017



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
% of Patient Contacts with Incidents Causing Harm	1.1	0.8	0.9	1.1	1	1.2	1.3	1.4	0.8	1	0.6	0.7
% of Patient Contact With All Incidents Reported	3.1	2.9	2.8	3	2.8	3.8	4.6	3.9	3	3.3	2.8	3.2

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).**



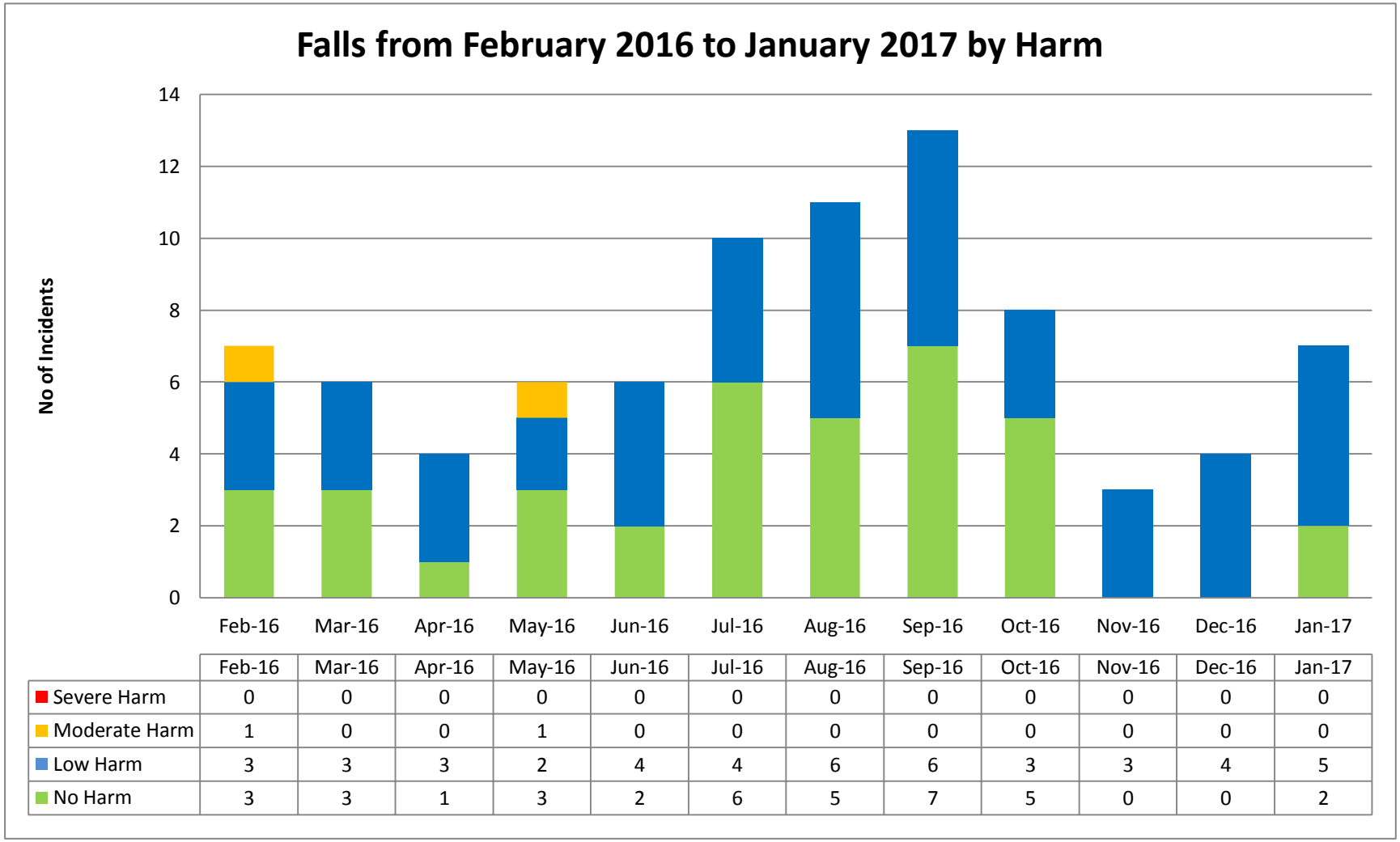
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Jun-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Unavoidable	2	2	2	1	3		1		2	1		3	2		1	1	2		
TBC																	1	3	1
Avoidable		2	2	1	2	2	1	2		4	1	1		3	3	1			

14

Year to date total		Avoidable
15/16	35	18
16/17	18	7

INFORMATION
There was one VTE declared as an SI in January 2017; This is due for submission with the Commissioners in April 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
All commissioner KPIs /audits have been completed and continue to be consistently achieved Medicines link roles have been updated to formalise responsibilities in relation to VTE as this will meet Exemplar Site requirements. Post discharge Hospital acquired VTE patient questionnaire is now built into Ulysses for completion (opposed to being a separate paper version). The Governance team have improved the VTE graph above by highlighting VTEs that are unavoidable or avoidable.
RISKS / ISSUES
Need to ensure VTE action plans are completed on Ulysses to enable appropriate completion and monitoring. On-going key issue identified from RCA's is non-completion of 24 hour risk assessments by Medical staff. This will be a mandatory field once PICS implemented. Shared learning continues. The VTE guidelines are currently under review, it is anticipated they will come to February CQG for approval. This is overdue as had been put on hold to enable the processes required as part of the CQUIN to be agreed.

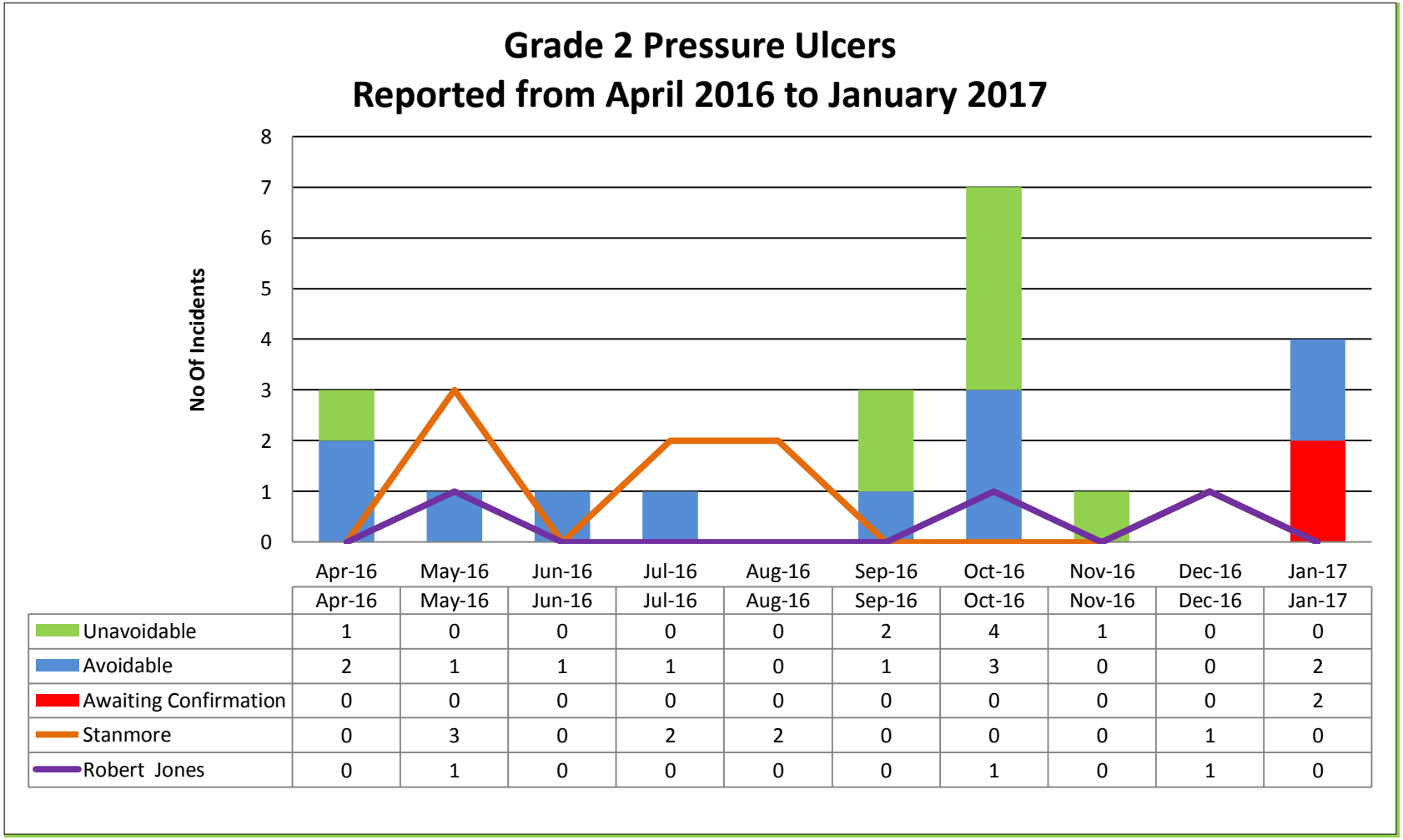
7. **Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident.**



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	1	0	0	1	0	0	0	0	0	0	0	0
Low Harm	3	3	3	2	4	4	6	6	3	3	4	5
No Harm	3	3	1	3	2	6	5	7	5	0	0	2

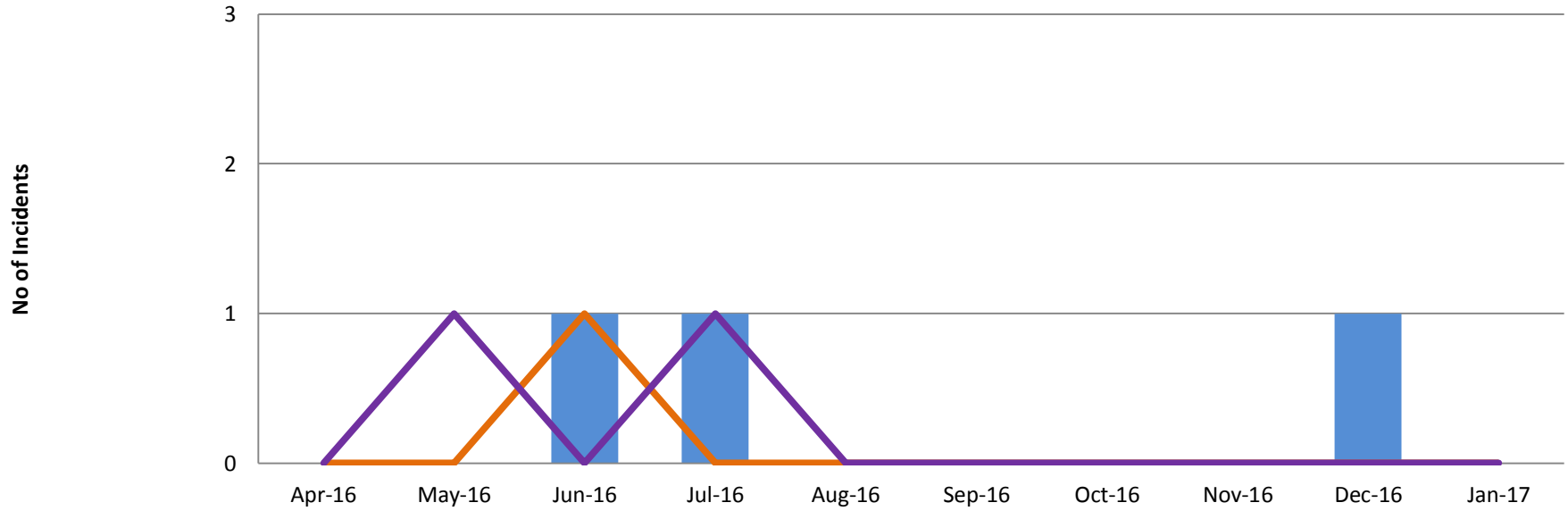
INFORMATION
There were 7 falls incidents in January 2017
ACTIONS FOR IMPROVEMENTS / LEARNING
• The Falls Working Group (FWG) meetings recommenced in December 2016 and are scheduled bi-monthly after the January 2017 meeting. • Through the Falls Working Group the work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller is in progress. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care. • An update regarding the Throne Project is still being sought from therapies. This is being addressed through the Falls Working Group meetings Trend analysis identified that patients fall in the bathroom/toilet. • Falls information boards are to be standardised across all ward areas, with the information being agreed at the FWG meeting in March 2017. 'Walking stick' visual information to be produced on a monthly basis for all ward areas for cascading of information regarding the number of falls per ward, per month to all staff. • To note: annual bed rail audit is due in April 2017.
RISKS / ISSUES
None

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	Oct-16	Nov-16	Dec-16	Jan-17
Unavoidable	1	0	0	0	0	2	4	1	0	0
Avoidable	2	1	1	1	0	1	3	0	0	2
Awaiting Confirmation	0	0	0	0	0	0	0	0	0	2
Stanmore	0	3	0	2	2	0	0	0	1	0
Robert Jones	0	1	0	0	0	0	1	0	1	0

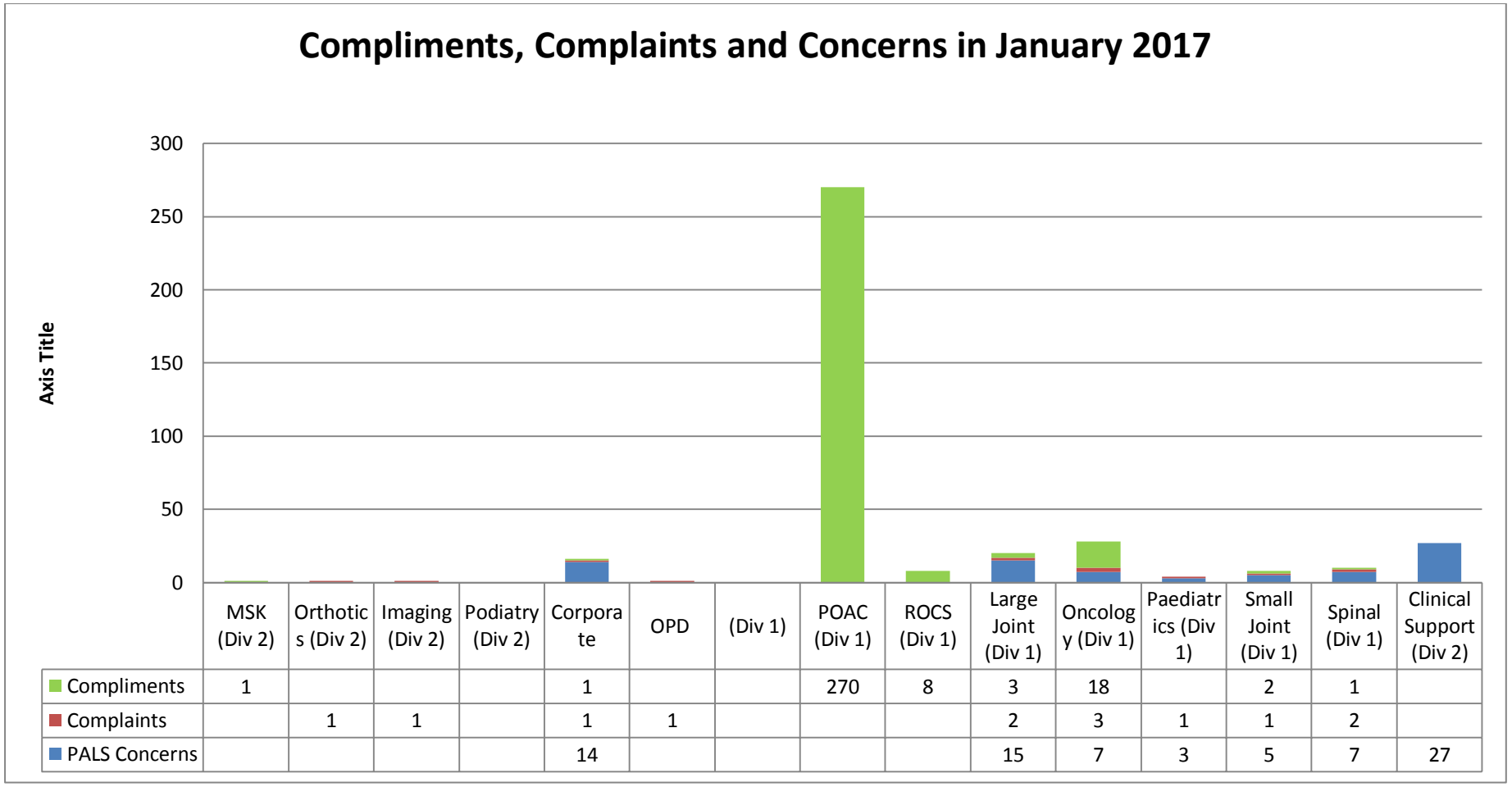
Grade 3 & 4 Pressure Ulcers reported April 2016 to January 2017



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0
Grade 3 (Avoidable)	0	0	1	1	0	0	0	0	1	0
Stanmore	0	0	1	0	0	0	0	0	0	0
Robert Jones	0	1	0	1	0	0	0	0	0	0

INFORMATION
There have been 6 reported grade 2 incidents for January. Two were present on admission from referring Trusts and 4 were hospital acquired 2 of which have been deemed avoidable and two are currently awaiting investigation. Of the one incident outstanding from October this has now been deemed avoidable and is included in the numbers. In total, from 1st April 2016 the Trust has reported the following: **11 avoidable Grade 2 pressure Ulcers** against a limit (target) of 15. (One Grade 2 Pressure Ulcer currently awaiting RCA to establish avoid ability and are therefore not included in these figures) **3 avoidable Grade 3 pressure Ulcers** against a limit of 0. **0 avoidable Grade 4 pressure Ulcers** were reported against a limit of 0.
ACTIONS FOR IMPROVEMENTS / LEARNING
Charitable funds investment to be requested to improve the patient chairs – new chairs will need to meet IPC and TV requirements (built in pressure relieving properties). New bid to be submitted ahead of February meeting to include subsequent liaisons.
RISKS / ISSUES
None

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.**



	MSK (Div 2)	Orthotics (Div 2)	Imaging (Div 2)	Podiatry (Div 2)	Corporate	OPD	(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)	Clinical Support (Div 2)
Compliments	1				1			270	8	3	18		2	1	
Complaints		1	1		1	1				2	3	1	1	2	
PALS Concerns					14					15	7	3	5	7	27

INFORMATION

There were 304 compliments recorded in January 2017
Compliments are helpful ways of letting staff know when they are getting it right. They can be given directly to an individual, team or department, or you can share them with the Patient Experience Team via the telephone, email, and letter. The data collected by the Trust does not include verbal compliments.

The PALS department handled 273 contacts during January 2017 of which 78 were classified as concerns.

There were 13 formal complaints made in January 2017, bringing the total to 145 for the year in total. All were initially risk rated as amber or yellow. This is an increase on the same period last year (10 complaints received in January 2016).

Of the 13 complaints closed in January 2017:

- 4 were upheld
- 7 were partially upheld
- 2 were not upheld

The subjects of this month's complaints were:
Initially Risk Rated Amber:

- Discharge too soon with no aids provided (Div 1, Oncology)
- Fitting and ordering of shoes (Div 2, Orthotics)
- Delays for spinal surgery (Div 1, Spinal)
- Attitude of Staff Member (Div 2, Imaging)
- Delays to follow up appointments (Div 1, Spinal)
- Infection following hip replacement (Div 1, Large Joints)
- Management of allergic reaction (Div 1, Large Joints)
- Failure to notice sufficient healing to progress treatment (Div 1, Paeds)
- OPD apt changes and pt not notified; (Div 1, Oncology)
- Lack of provision of hearing loop (Div 1, OPD)

Initially Risk Rated Yellow:

- Received appointment but not a patient (Corporate)
- Delays to injection in foot (Div 1, Small Joint)
- Approach of secretary (Div 1, Oncology)

ACTIONS FOR IMPROVEMENTS / LEARNING

Learning identified and actions taken as a result of complaints closed in January 2016 include:

- There continues to be issues with long waits in the spinal deformity for children.
  Action: Hospital is contacting MPs to advise of issue. Regular meetings between ROH, BCH and NHS England have begun to attempt to find new solutions.

- Attitude of a member of staff was abrupt and unhelpful, approach not consistent with Trust Values
  Action: Professional conversation undertaken.

- Process of admitting into ADCU not always followed correctly
  Action: Staff have received reminder of processes to be followed.

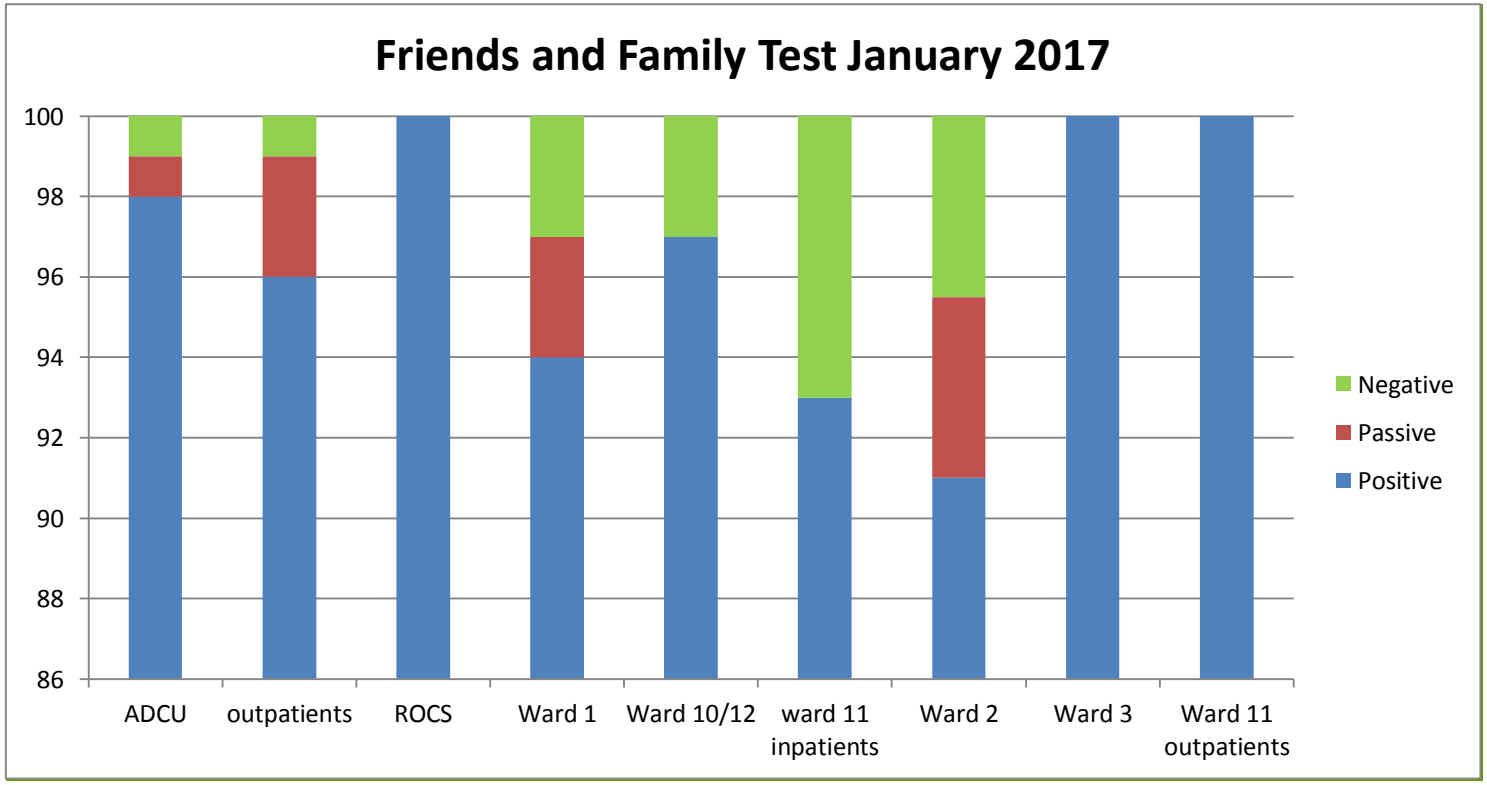
RISKS / ISSUES

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.

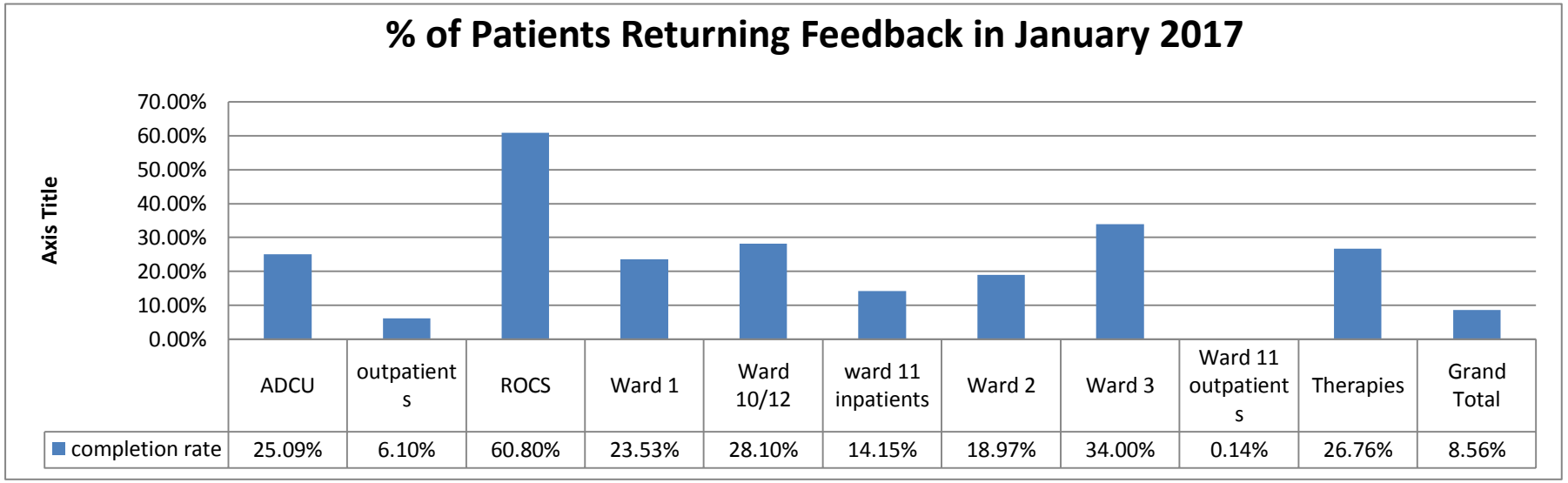
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting 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 January 2017 are 97% of those who responded would promote ROH.



	ADCU	outpatients	ROCS	Ward 1	Ward 10/12	ward 11 inpatients	Ward 2	Ward 3	Ward 11 outpatients	Therapies	Grand Total
completion rate	25.09%	6.10%	60.80%	23.53%	28.10%	14.15%	18.97%	34.00%	0.14%	26.76%	8.56%

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.

There is no national target response set however, as a Trust we are aiming to achieve 35% response rate across all areas in Q1 17/18. This would enable the Trust to gain a richer understanding of the service provision from our patient's perspective.

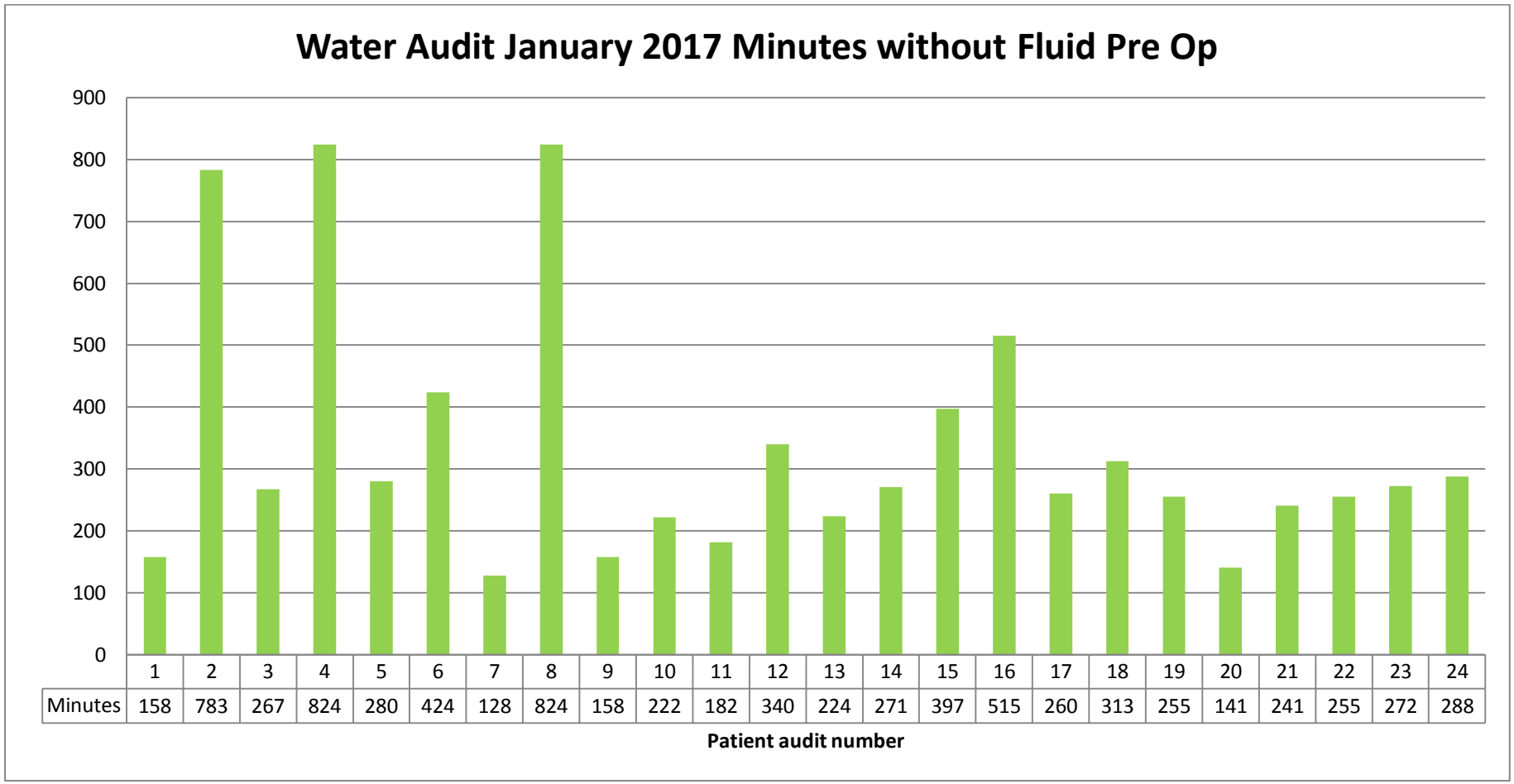
11. Duty of Candour – The Duty of Candour is a legal duty on all providers of NHS Services to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. There is now a statutory duty according to the Health and Social Care Act Regulations 2014: Regulation 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. All DOC is compliant.

12. Litigation

The Trust has received 0 new claims in January 2017;

13. Water audit January 2017; The snap shot audit of 24 patients was carried out on ADCU over seven days. Patients were selected randomly from different theatre and CT lists, with a mix of day case and in patient procedures. These snap shot audits are carried out every other month, therefore the next audit will be carried out in March 2017



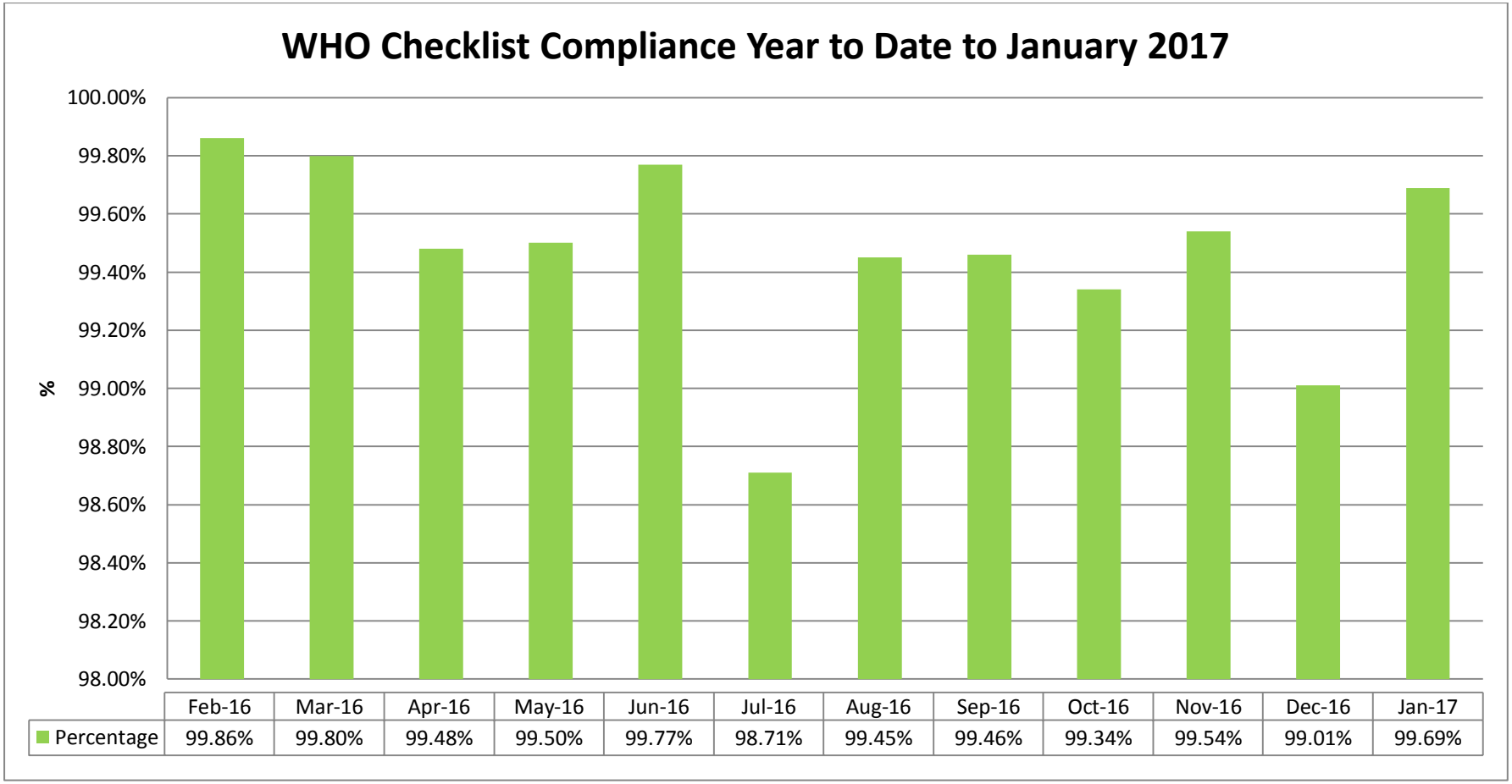
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Minutes	158	783	267	824	280	424	128	824	158	222	182	340	224	271	397	515	260	313	255	141	241	255	272	288

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

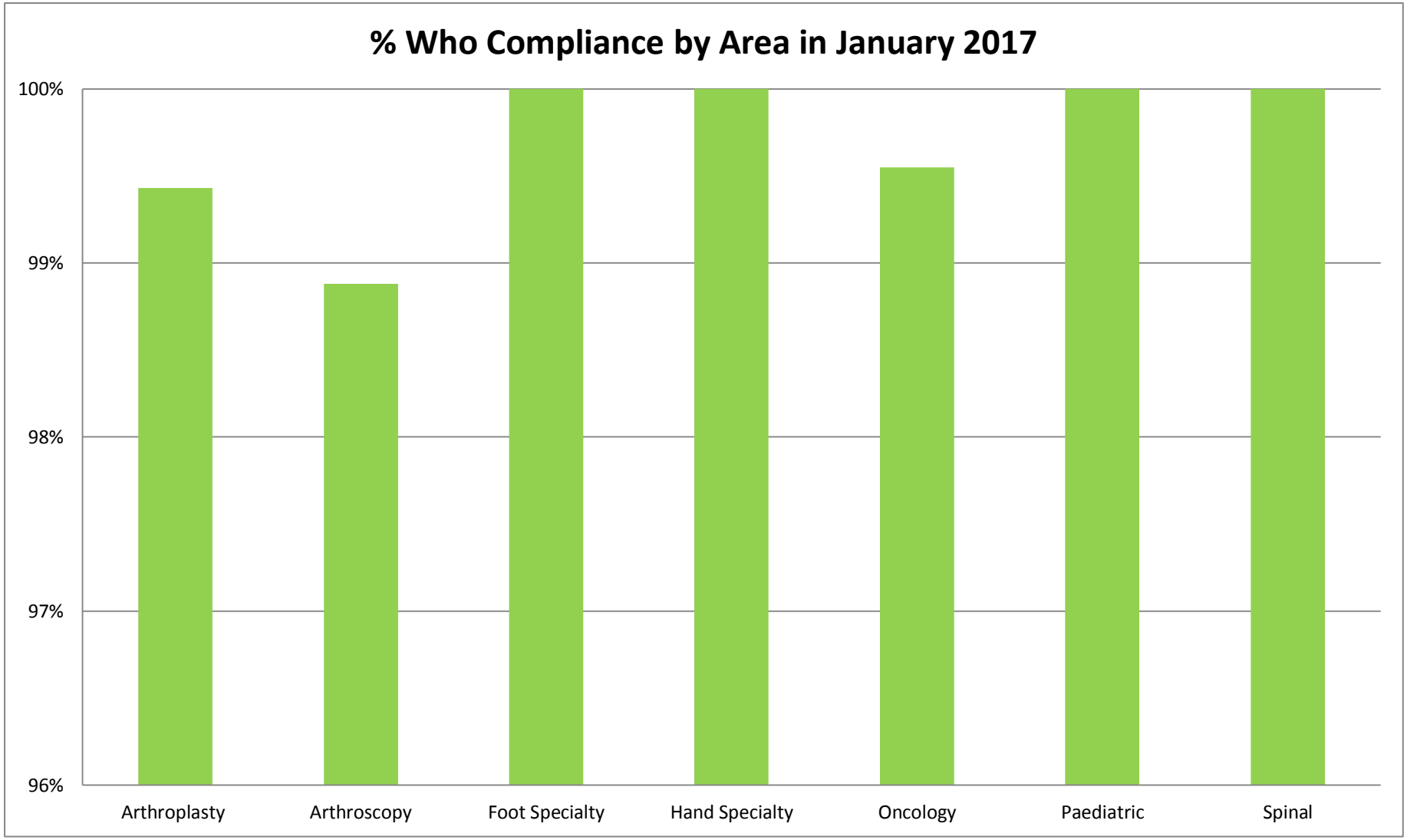
First choice for orthopaedic care

INFORMATION
The Average length of time without drinking pre operatively was 5hrs 30mins. The last snap shot audit that was carried out in November and the average time was 4hrs 30 mins. However, had all of the patients followed the advice given to them in relation to drinking water pre operatively the average length of time would have been 3 hours 50 mins.
ACTIONS FOR IMPROVEMENTS / LEARNING
The results show an increase in the time patients went without water. This is in part due to 4 patients going through the CT department where communication can be less than ideal and changes to list order can mean patients are not allowed water. It was highlighted that better communication from CT/ list lock down is needed. A meeting is February 2017 is due to address this issue further.
RISKS / ISSUES
Better communication from CT/list lock down is needed.

14. 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 perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.



	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Percentage	99.86%	99.80%	99.48%	99.50%	99.77%	98.71%	99.45%	99.46%	99.34%	99.54%	99.01%	99.69%


% Who Compliance by Area in January 2017
100%
99%
98%
97%
96%
Arthroplasty
Arthroscopy
Foot Specialty
Hand Specialty
Oncology
Paediatric
Spinal

30

INFORMATION

January 2017
Total Cases = 766
Total Non -Compliance = 5

Total Compliance == **99.69 % 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.
6. Audit results are also discussed as a standing agenda item at the Theatre User Group meetings

RISKS / ISSUES

All non-compliance was due to Consultants not completing the sign/time out section.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Friday 12 May 2017

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 17th May 2017 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 1445h.

Questions for the Council of Governors should be received by the Associate Director of Governance & Company Secretary no later than 24hrs prior to the meeting by post or e-mail to Associate Director of Governance & Company Secretary, Simon Grainger-Lloyd, Trust Headquarters or via email s.grainger-lloyd@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** 17 May 2017 : 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 15 March 2017 and note of briefing on 12 April 2017 (PRIVATE ITEM)	ROHGO (3/17) 009 ROHGO (4/17) 001	Chair
1410h	4	Update on actions arising from previous meeting	Verbal	SGL
1412h	5	Update on NHS Improvement actions	Verbal	YB
1425h	6	Chief Executive's update	Verbal	JC
1435h	7	DRAFT Annual Report (including Quality Account) & Accounts 2017 (PRIVATE ITEM)	ROHGO (5/17) 002 ROHGO (5/17) 002 (a) ROHGO (5/17) 002 (b) ROHGO (5/17) 002 (c)	SGL PA
1450h	8	18 weeks RTT recovery plan	Verbal	GM
1500h	9	Data quality update	Presentation	PA
1515h	10	Complaints report	Presentation	LK
1530h	11	Update from the Board Committees – Audit Committee and Finance & Performance Committee	Verbal	RA/TP
1545h	12	Governor Matters: • Feedback	Verbal	All
1550h	13	Feedback from Patient and Carers/ Council	Verbal	SN
1555h	14	For information: • Finance & Performance Overview • Quality & Patient Safety Report	ROHGO (5/17) 005 ROHGO (5/17) 006	
	15	Any other business	Verbal	
	Date of next meeting: Wednesday 19 July 2017 @ 1400h – 1600h in Trust Headquarters			

MINUTES

Council of Governors - Version 0.4

Venue Boardroom, Trust Headquarters **Date** 15 March 2017 @ 1400h

Members present

Yve Buckland	Chairman	YB
Alan Last	Lead Governor	AL
Rob Talboys	Public Governor	RT
Brian Toner	Public Governor	BT
Marion Betteridge	Public Governor	MB
Carol Cullimore	Public Governor	CC
Petro Nicolaides	Public Governor	PN
Lindsey Hughes	Public Governor	LHU
Sue Arnott	Public Governor	SA
Paul Sabapathy	Appointed Governor	PS
Karen Hughes	Staff Governor	KH

In attendance

Garry Marsh	Director of Operations, Nursing & Clinical Governance	GM	
Kathryn Sallah	Non Executive Director	KS	
Jo Wakeman	Deputy Director of Nursing & Clinical Governance	JW	[Part]

Minutes	Paper Ref
1 Chairman and Non Executive reappointment and remuneration	**ROHGO (3/17) 002** **ROHGO (3/17) 002 (a)**
[redacted]	

[redacted]	
2 Apologies and welcome	**Verbal**
The Council received apologies from Mel Grainger. Lynda Hindley, Anthony Thomas, Alex Gilder and Changese Khan were not present. Jo Chambers was also not present, however Garry Marsh, Director of Operations, Nursing & Clinical Governance, attended in her place.	
3 Declarations of interest	**Verbal**
There were none.	
4 Minutes of the previous meeting on 18 January 2017	**ROHGO (1/17) 008**
The minutes of the meeting held on 18 January were accepted as a true and accurate record of discussions held subject to minor amendments.	
RESOLVED: The Council of Governors approved the minutes of the meeting held on 18 January 2017	
5 Update on actions arising from previous meetings	**Verbal**
The Associate Director of Governance & Company Secretary reported that there was one outstanding action, which concerned provision of additional information about complaints. Lisa Kealey, Complaints Manager, had been invited to join the meeting in May to present her annual report.	
6 Chief Executive's update	**ROHGO (3/17) 003** **ROHGO (3/17) 003 (a)**
The Director of Operations, Nursing & Clinical Governance reported that the key matters to highlight from the report included the planned recovery days. Those scheduled had not been completed and this had created some discontent. It was noted that beyond the surgeons there was already significant demand on workload. Theatre lists had not been completely filled during the week, therefore there should be no need for Sunday working. It was reported that there had been a reduction in Length of Stay for primary hip patients as a result of the Rapid Recovery initiative. This would be rolled out further	

next year to other procedures. Theatreman would be used to improve the effectiveness of theatre scheduling and listing. This had been delayed to date and two attempts to go live had not been successful. A new date for the introduction was around 20 March, however. Clinicians had been involved in the selection of Theatreman. They were also involved in the 'Go Live' trials and in depth training had been undertaken. It was noted that it was a good thing to have found issues prior to launch and on this basis the delay was sensible.

There was reported to be an ongoing discussion around spinal deformity and long waiting times experienced by patients. Discussions had been held with Birmingham Children's Hospital and there was now better clarity on operating schedules and additional sessions had been offered. The consultants in spinal deformity had attended the Board meeting in January and gave assurance from a clinical perspective that they were looking at spinal deformity waiting list and triaging according to priority. Paediatric HDU estates work had been completed and this facility was now open.

A nurse recruitment day had been scheduled in March 2017 and many staff gave their time at the weekend to make this a success. Twenty one offers of employment had been issued to individuals who would join across the year; this would reduce reliance on agency staff and fill the current vacancies. Six Paediatric nurses had been offered a position as part of the recruitment campaign.

A Contract Performance Notice (CPN) for Mandatory Training had been received and a focussed piece of work had been undertaken to improve quality of information and release frontline clinical staff to attend courses. Compliance had improved as a result.

In terms of CQUIN, full payment for the 'flu vaccination indicator had not been received; there had been an improvement in vaccination rates from the previous year, however this was not to the required level. It was noted that the Trust rarely treated people with 'flu. It was suggested that staff needed to be made aware of the amount of funding attached to the CQUIN as a potential means of incentivising staff to take up the vaccine. It was noted that there were already incentives in place, such as the chance to win an iPad. A targeted piece of work was planned to understand at a departmental level where there was poor uptake of the vaccination and the reasons why this was the case.

The consent policy had been approved, which addressed many of the issues in an internal audit around consent. A new medicines management policy had also been approved, which combined a number of standalone procedures introduced following controlled drugs.

It was reported that the Trust Management Committee was to be replaced by Operational Management Board, as a means of changing the membership to a more appropriate group of individuals and to eliminate duplication of discussions. The Chairman noted that the activity performance was struggling against the recovery plan and there would be regrouping in the new financial year to understand the reasons behind this and the mechanisms to address this. Tariff negotiations had been concluded successfully but this was expected to be more challenging in the next year. The initial staff survey results were noted to be concerning and morale needed to be raised. It was noted that the senior management visibility was a key point to be addressed. The definition of a senior manager needed to be understood however as this did not necessarily mean the Executive Team. There had also been a churn in the senior managers across Operations and Nursing in particular, which would have had an impact. It was suggested that the reason for this turnover needed to be understood. The Director of Operations, Nursing & Clinical Governance reported that this was for a variety of reasons. There was a period where the Operations structure did not have appropriate clinical engagement and this had been rectified through restructuring. The organisation by its nature was also a platform for developing senior managers into higher roles elsewhere. The staff awards session was agreed to have been excellent and well received. It was noted to have been a significantly cheaper occasion than previous events.	
7 STP Update and local context	**Verbal**
The Chairman reported that the CEO of Birmingham City Council had moved on and he had vacated his role as Leader of the STP. Dame Julie Moore had taken over this position. It was reported that the national feedback on the STP was that it lacked vision and cohesion and so a workshop on 7 March had been arranged to agree how to move forward. The STP was the engine for the next five years and there would be an end to the CCG splits and funding allocation across the STP; this was anticipated to drive efficiency and cohesion. The ROH's place in the STP was important and an Orthopaedic pathway, from prevention to tertiary care, needed to be created, which could demonstrate improved outcomes. There was a move to develop Accountable Care organisations and Accountable Care systems, which were more devolved models. The possible future direction for Social Care was discussed. The Council would be kept abreast of the developments and was directed nationally. It was highlighted that there was some collaboration with Robert Jones & Agnes Hunt NHS FT. It was reported that there were also some developments in Shropshire with regard to veterans which the Chairman agreed to investigate. The Royal Free Hospital	

was to take over the Royal National Orthopaedic Hospital NHS Trust. The Vanguard also offered some protection for the ROH and opportunities to work together.	
8 Quality Account – governor selected indicator	**ROHGO (3/17) 004** **ROHGO (3/17) 004 (a)** **ROHGO (3/17) 004 (b)**
Jo Wakeman, Deputy Director of Nursing & Clinical Governance, joined the meeting. The process for the selection of the quality indicators was described, which included a selection of one for the governors to sponsor. It was noted that the Friends and Family Test was a key area of focus, particularly the response rates which were currently low. There was some work through the Communications Team to launch a new system of collecting feedback, this being 'I Want Great Care'. There was some variation at present between wards which needed to be addressed. The possibility of recognition schemes was suggested when individuals were cited in the feedback. It was noted that the indicators from 2016/17 that had not been achieved would be rolled over into the new set of indicators for 2017/18. Pressure ulcers were noted to be a particular concern at present. It was suggested that in terms of the indicator in 2016/17 around cancellations, it needed to be identified whether practice had changed and progress had been made. The reasons for cancellations still needed to be understood however if this was still a key issue, then it was agreed that this should remain the governor-sponsored target. It was agreed that Tim Pile, the Chair of Finance and Performance Committee and Nicky Lloyd, Associate Director of Operations should attend the next meeting to explain progress. In terms of handling patients cancelling their appointments, there was a plan to ensure that the accountability on patients was clear including the cost in financial terms and on other patients who may not be offered an appointment.	
9 CQC regulation – training session	**Presentation**
Brian Toner delivered a presentation on the CQC regulatory environment. It was noted that the people at the front line needed to understand the Trust's strategy and to own it and that managers needed to act as change agents. A key challenge identified as part of inspections was achieving a good rating in the Well Led domain. As part of the comparison with peer organisations, it was noted that the Royal National Orthopaedic Hospital achieved 'Outstanding' in some areas. It was suggested that the 'Outstanding' rating was extreme, given that there was always room for improvement. Staff engagement was reported to be critical to the achievement of 'Good' and 'Outstanding' ratings. It was noted that this was evident by the recent inspection of Birmingham Children's Hospital which had been awarded an overall 'Outstanding' rating, as this organisation was known for its good staff engagement.	

The Council agreed that the presentation was informative and helpful. It was agreed that this could be delivered to some broader groups if required.	
10 Quality & Safety Committee update	**ROHGO (3/17) 005** **ROHGO (3/17) 006**
Kathryn Sallah, Chair of the Quality & Safety Committee reported that the Quality & Safety Committee provided constructive challenge on quality and patient safety matters on behalf of the Board. In terms of patient safety walkabouts, a schedule had been set to start from April. The structure of the visits was in line with the CQC inspection format and provided a 'pulse check' on how the organisation was performing against quality standards. The new national guidance on diabetes was reported to be being reviewed and the implementation of this was being planned. There was discussion around appropriateness of challenge around Operations and Nursing, given that Garry Marsh oversaw both areas. The challenge in terms of nursing would provided by Jo Wakeman, the new Deputy Director of Nursing and Clinical Governance. The use of the WHO checklist had been interrogated and the Associate Medical Director for Division 2 had joined the Committee to present an assurance report. Full compliance was expected. Alex Gilder had joined the meeting to give a presentation on the Quality Impact Assessment process. VTE was also discussed and the plans to improve the position were outlined by the Chair of the VTE Committee. There were low rates of VTEs reported by the ROH compared to benchmarked position. Poor documentation was noted to be a key issue that needed to be rectified. It was noted that there were pockets of staff that were reluctant to report incidents and this was a difficulty nationally. The reasons for lack of incident reporting needed to be understood and further assurance was needed. Monitoring of incident reporting was being undertaken and best practice was being drawn on from other organisations nationally. There remained a concern over the high level of agency staff used in the Trust. The errors with dispensers had been highlighted as a concern, however the Council was advised that this was not that Controlled Drugs had been issued in error but there had been mistakes made in the dispensing process. The incident reporting system showed where errors were more clearly and focused work could be undertaken on this basis. The Medicines Safety Committee would not close an	

incident unless there was sufficient learning and appropriate action from an incident. It was highlighted that the position with reporting incidents was better than the national average. The Friends and Family Test response rate was noted to be variable. Ward 11 results were noted to be poor particularly and the position was to be investigated further as part of the work. Volunteers had historically been used to collect information which was no longer the case, a matter which had caused some variability in results. The engagement of Paediatric patients and relatives had been given more focus as a result of the RCPCH action plan, so this was expected to have a positive impact on the results. The information associated with the WHO checklist compliance position was discussed; non-compliance in future would be treated with professional performance management.	
11 Operations update	**Verbal**
The Director of Operations, Nursing & Clinical Governance reported that from a CQC perspective there was a monthly engagement meeting. Key challenges remained around waiting times in Oncology clinics and further work was underway to restructure them and alter processes. The Trust had appointed a Learning Disability nurse who would join the Trust in April 2017. In Paediatrics, there had been some innovative recruitment, including the use of school children as part of the selection process. The Service Level Agreement with Birmingham Children's Hospital for consultant provision had been signed off and there would be increased presence from May 2017. A HDU Improvement Board and a Children's Board were in place which ensured adequate focus on areas of regulatory concern that had been raised previously. Two areas of challenge were discussed, one of which was around sustained delivery around hygiene code and the governance process to ensure compliance with this. As such a peer review had been arranged as a proactive measure. A further challenge was around the 18 week RTT, firstly around the delivery in some key specialities for a variety of reasons. Diagnostics and recovery trajectories were being developed in line with NHS Improvement requirements. Data quality issues had also been identified with the reporting of external 18 week RTT performance. The diagnostic of this was that the Trust's IT systems were not robust and had not been updated in line with changing national guidance. Training of staff was not to contemporary standards. NHS Improvement had been informed of the position, who had provided a range of diagnostic tools and onsite support. They were confident that the Trust was sighted on the issues and the validation process was underway, supported by some additional resource. A process for managing any harm had been	

developed. It was agreed that a key focus needed to be on theatres and improvement. The staff governor noted that the Trust was quiet at present and asked how this would impact on the recovery plan. It was reported that the position was tight leading up to the year end. It was expected that the financial positon would be achieved but not through activity. Spinal consultants were operating at Birmingham Children's Hospital, but this was creating fallow lists at ROH that needed to be filled. Oncology was under delivering and the reasons for this needed to be better understood. The variance in the scheduling between weeks needed to be reviewed and the 6-4-2 process needed to be improved. The medical secretaries understood the reasons for the inefficiencies in the system and would be engaged with the process. It was highlighted that Council of Governors had been provided with assurances time and again that processes had been revised but this did not seem to have happened or had generated an improvement. The processes around theatre list creation was noted to be concerning. Work was also needed to understand the impact of the fallow lists and lists that were variably full. It was suggested that staff ownership of the issues was needed, with a move away from blaming management. Recovery after school holidays needed to be addressed, to ensure that activity pick up was better. In terms of CQUINs, it was suggested that these needed to be reviewed. Other than the 'flu CQUIN, all would be achieved.	
12 Governor updates	**Verbal**
There were none.	
13 Matters for Information	**ROHGO (3/17) 007** **ROHGO (3/17) 008**
The information provided for information was received and noted. It was noted that the governor sponsored indicator for 2016/17 was in Section 11 of the finance overview. This did show fewer cancellations but there was still far more room for improvement and was a matter of interest for the Finance & Performance Committee, as discussed earlier in the agenda. There was a reminder that all were welcome to public meetings of the Trust Board. The Chairman formally invited the governors to join the June Board meeting (7th). The governors were invited to the Professor Dame Donna Kinnair lecture that was planned for 16 March 2017. It was suggested that the Company Secretary ensured that governors received the e-bulletins in future.	
14 Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 17 May 2017 at 1400h – 1600h in the Boardroom, Trust HQ.	

Finance and Performance Report

MARCH 2017

CONTENTS

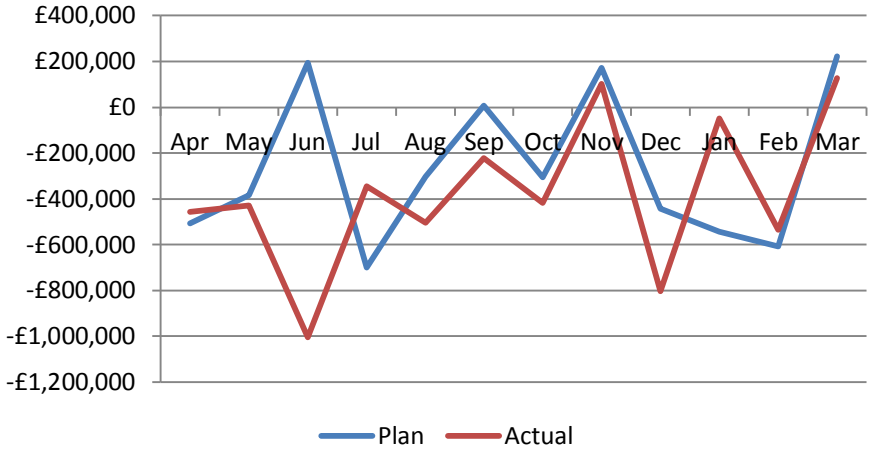
INTRODUCTION

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.

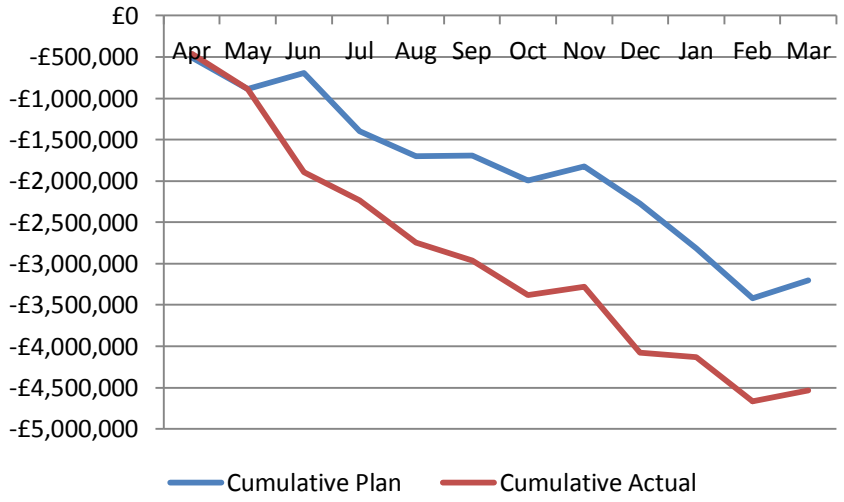
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Monthly Surplus/Deficit Actual vs Plan

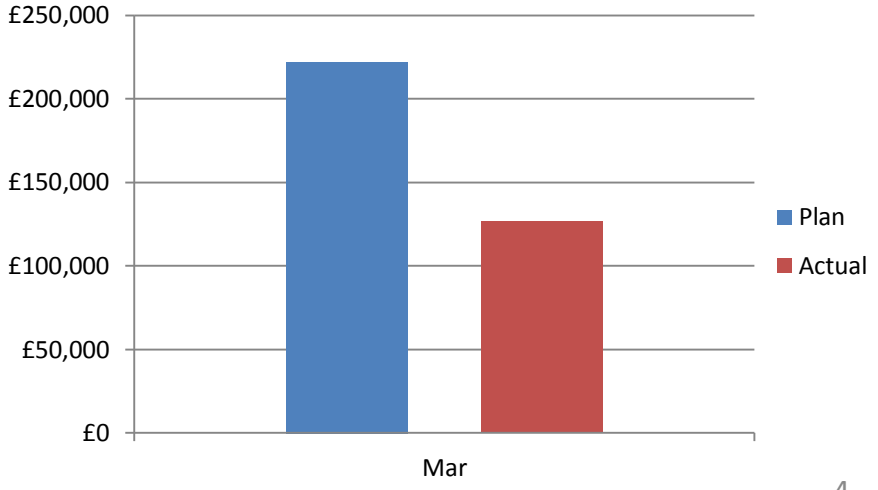


NHSI Use of Resources Rating (UOR)		
	Plan	**Actual**
Capital Service Cover	4	4
Liquidity	2	4
I&E Margin	4	4
I&E Margin – Variance against plan	N/A	3
Agency metric	1	2
Overall UOR	N/A	3

Cumulative Deficit vs Plan



M12 Surplus vs Plan



INFORMATION

The Trust has delivered a cumulative deficit of £4,536,000 as at the end of March against an original planned deficit of £3,200,000. However, this figure contains a number of adjustments such as impairments on the Trust's estate and donated assets which are excluded for NHS Improvement control total calculation purposes. The adjusted outturn was therefore £4,301,000, £1,101,000 behind original plan, but slightly ahead of recovery plan as discussed in the recovery plan paper. In month, the Trust delivered an adjusted surplus of £363,000 against a planned surplus of £222,000. It is important to note that the year position has been influenced by a number of both positive and negative non-recurrent items, which are discussed in further detail in the income and expenditure tabs later in this report.

Excluding the impact of the theatres closure in June (£954,000), the Trust would be behind original plan by £147,000. of which £183,000 relates to unachieved STF monies, meaning that the Trust would have been slightly ahead of original plan by £36,000. Further detail on the key drivers of the financial position is provided in the income and expenditure sections below.

The year end position for CIP savings for the Trust was £3,071,000 of CIP savings, against a plan of £3,671,000. Whilst this represents an underperformance against target of £600,000, this does represent savings of 3.3% of operating expenditure, which is a significant achievement against what was a very challenging in year target. The area of most concern is that £1,708,000 of the savings made (56%) were non-recurrent, resulting in an increased challenge for the Trust in the coming year to deliver the required savings to deliver the financial plan. The in-month savings recognised were £366,000 against a target of £352,000.

With regards to the Trust's Use of Resources Risk Rating (UOR), the deficit position results in the Trust achieving ratings of 4 for Capital Service Cover and I&E Margin metrics. In addition, the Trust's liquidity position has deteriorated to a 4 in month. As the Trust is breaching the agency spend cap, it is scoring a 2 in this metric. I&E Margin against plan, being the measurement of a Trust's variance from the plan set, has remained at a 3 from previous month, an improvement since earlier in the year when it was a 4, representing the steps the Trust have made in trying to recover the position. The overall Trust score has been capped to a 3 as in prior month.

ACTIONS FOR IMPROVEMENTS / LEARNING

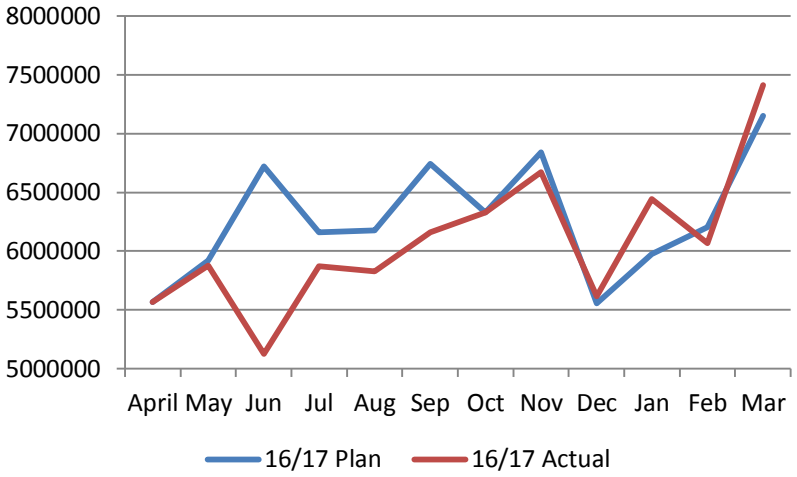
The Trust Executive have a weekly Recovery Board where progress against the action plans of the five recovery workstreams (POAC, theatre efficiency, discharge planning, agency reduction and cost control) is monitored and challenged. Schemes such as implant rationalisation are in progress to improve the Trust's cost efficiency. Whilst the schemes are constantly being reviewed and refreshed, particular focus will be placed on ensuring the cost control plan is reconsidered and takes into account all of the coming planned CIP schemes which need particular Executive oversight.

RISKS / ISSUES

The recovery of the financial plan in the last few months of the year reflects some of the effort that is being made to improve activity and efficiency. The risk is that as a new year begins, focus needs to continue on maintaining that drive early on.

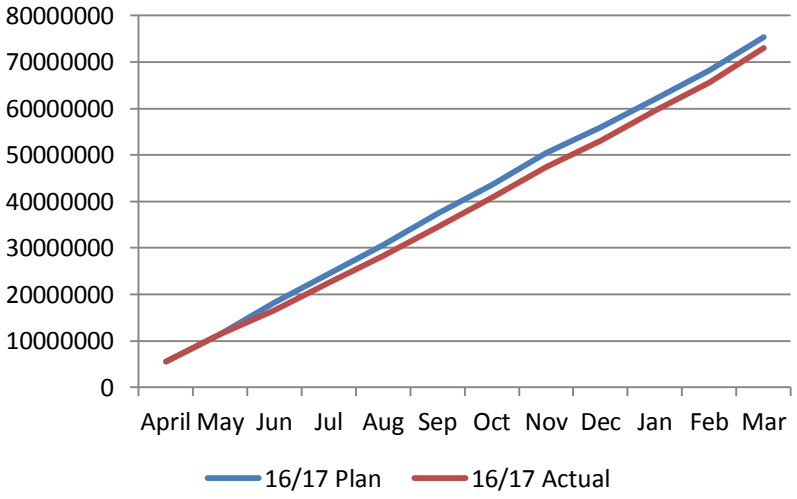
2. Income – This illustrates the total income generated by the Trust in 2016/17, including the split of income by category

Monthly NHS Clinical Income vs Plan 1617



NHS Clinical Income –March 2017			
	Plan	Actual	Variance
Inpatients	3,665	4,383	718
Excess Bed Days	66	23	-43
Total Inpatients	3,731	4,406	675
Day Cases	858	701	-157
Outpatients	781	769	-12
Critical Care	268	208	-60
Therapies	228	207	-21
Pass-through income	228	158	-70
Other variable income	475	473	-2
Block income	585	585	0
TOTAL	7,154	7,507	353

Cumulative NHS Clinical Income vs Plan 1617



NHS Clinical Income – Year To Date 2016/17			
	Plan	Actual	Variance
Inpatients	38,310	37,237	-1,073
Excess Bed Days	843	967	124
Total Inpatients	39,153	38,204	-949
Day Cases	8999	8605	-394
Outpatients	8296	7735	-561
Critical Care	2811	2664	-147
Therapies	2091	2746	655
Pass-through income	2447	2829	382
Other variable income	5339	4481	-858
Block income	6209	6209	0
TOTAL	75,345	73,473	-1,872

INFORMATION

NHS Clinical income over-performed in March. Inpatient income was significant ahead of plan in month, but this was a reflection largely of an agreement to share income increases relating to improvements in the coding of patella resurfacing procedures, which had previously been provided against (c£400,000), in addition to changes to the treatment of income provisions for challenges around CQUIN and other contract disputes. These have been offset against income during the financial year, however they are grossed up and treated as bad debt provisions in the final accounts. This has the impact of increasing income and non pay expenditure by circa £200,000 in Month 12.

Activity itself was below expectations in most weeks in March, although average elective case-mix remained high in March (£6,220 per case).

Day case case-mix also remained high (£1,407 vs £1,486 IN February).

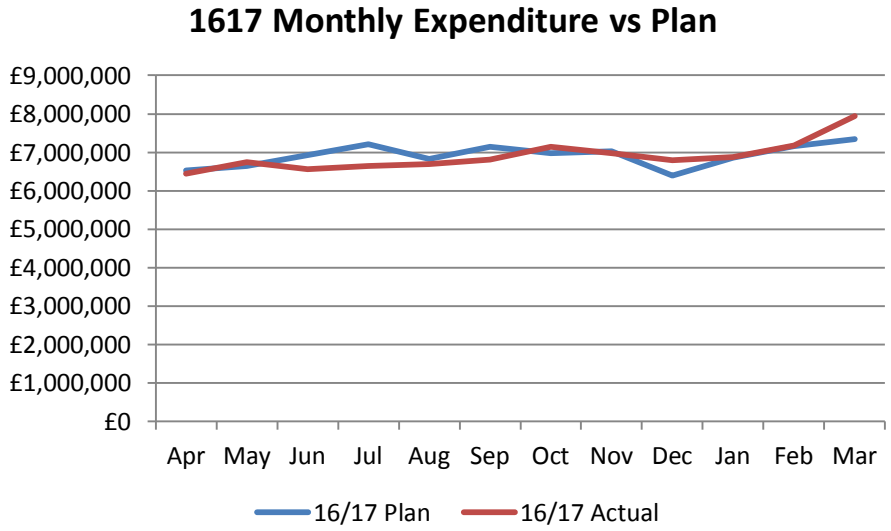
ACTIONS FOR IMPROVEMENTS / LEARNING

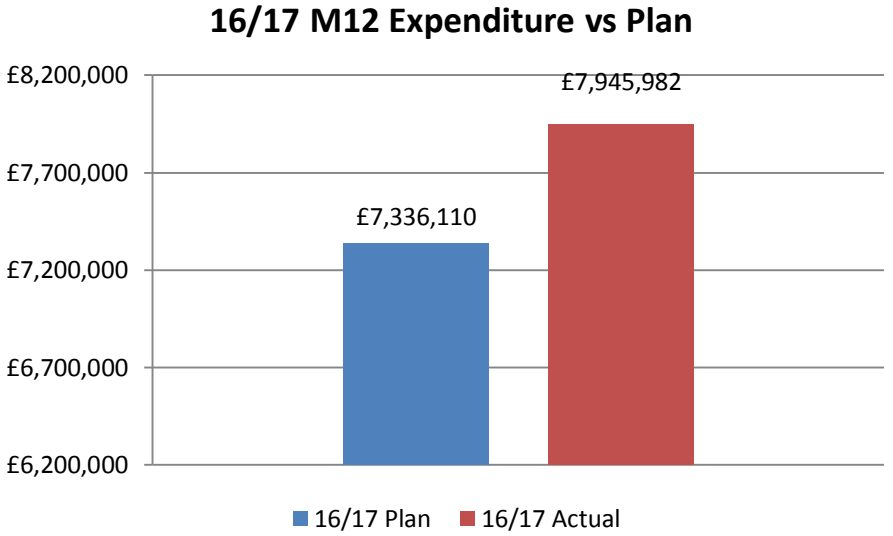
Continued daily focus is taking place to ensure inpatient activity is maximised, whilst work is completed on the relevant patient efficiency workstreams (POAC, theatre efficiency and patient discharge) to ensure capacity can reach required levels.

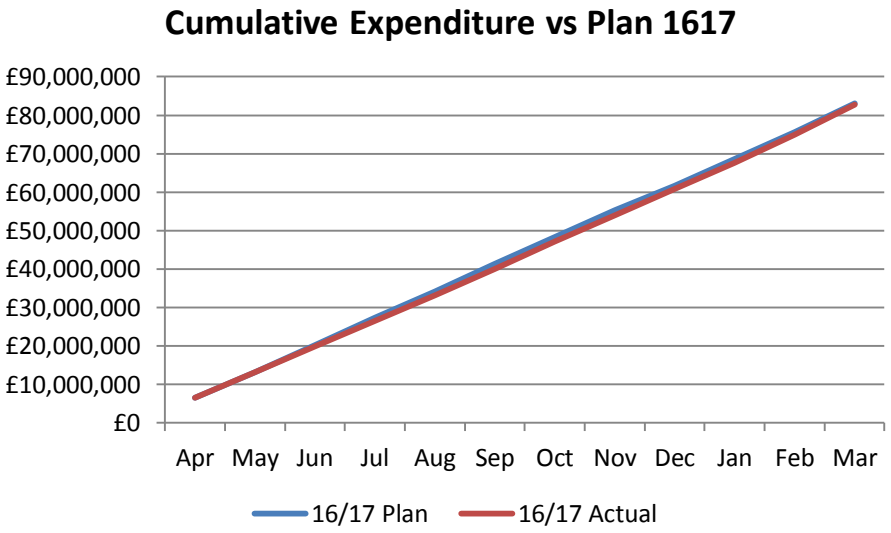
RISKS / ISSUES

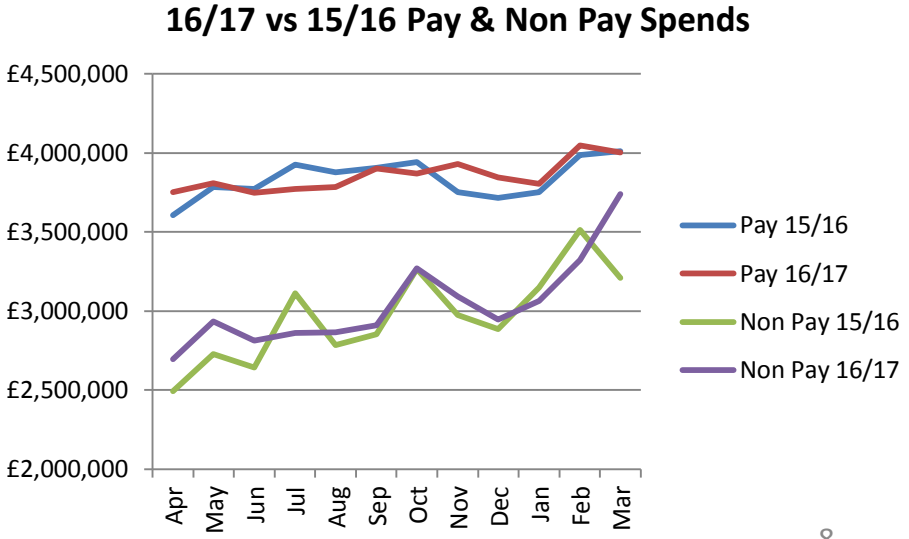
There is a risk that the "push to achieve" year end required targets results in a dip in activity in the early months of the financial year. Continued weekly focus on the activity both planned and actual at an executive level will mitigate some of this risk.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2016/17, compared to historic trends









INFORMATION

Expenditure levels for the year were significantly below the plan set as the start of the year (operating expenditure of £80,512k vs a plan of £80,832k).

In month spend was £609k higher than plan, caused by pay overspends of £175k and non-pay of £434k. Pay spend was includes MARS and expected redundancy costs of £111k. In addition, agency spend was £21k higher than plan, which has been explained in the agency section below.

Non-pay spend included an increase in the bad debt provision of £193k (previously included as an offset against income, but grossed up for the financial statements process) and a stock write off relating to the sterile tray count (£62k) offset by underspends in clinical supplies and drugs (driven through activity underperformance) and lower than expected depreciation due to the timing of the capital plan spend. In addition, the estate is valued at each year end, and this resulted in a £224k expense in M12

ACTIONS FOR IMPROVEMENTS / LEARNING

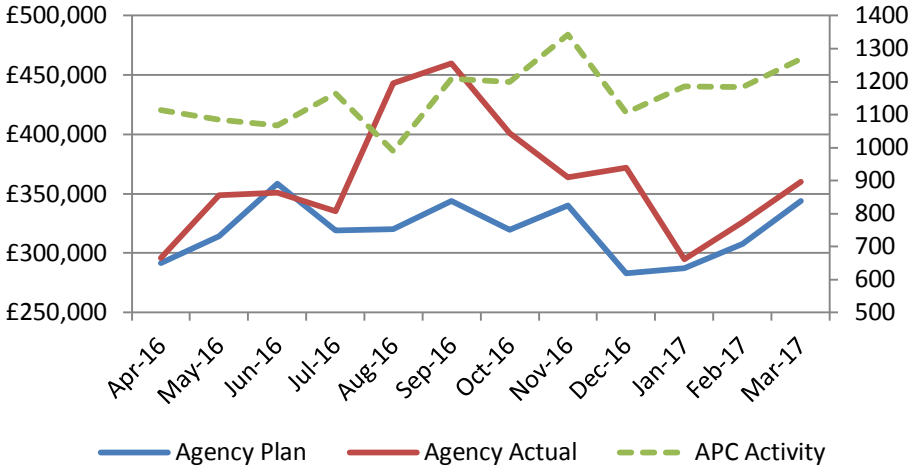
Costs will continue to be scrutinised and minimised. One of the 5 recovery workstreams is cost control, with actions being tracked through the Recovery Board on a bi-weekly basis.

RISKS / ISSUES

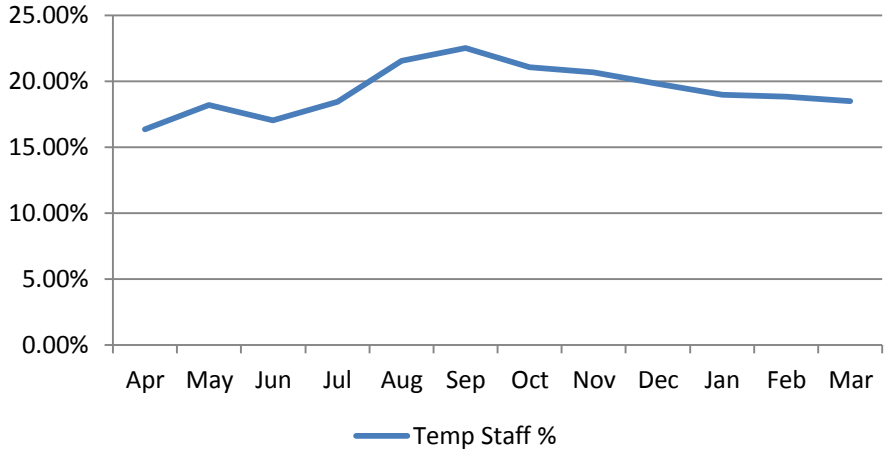
Close management of the stock implant rationalisation will be required to control costs and maximise savings as described in further detail in the CIP section of this paper.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2016/17, and performance against the NHSI agency requirements

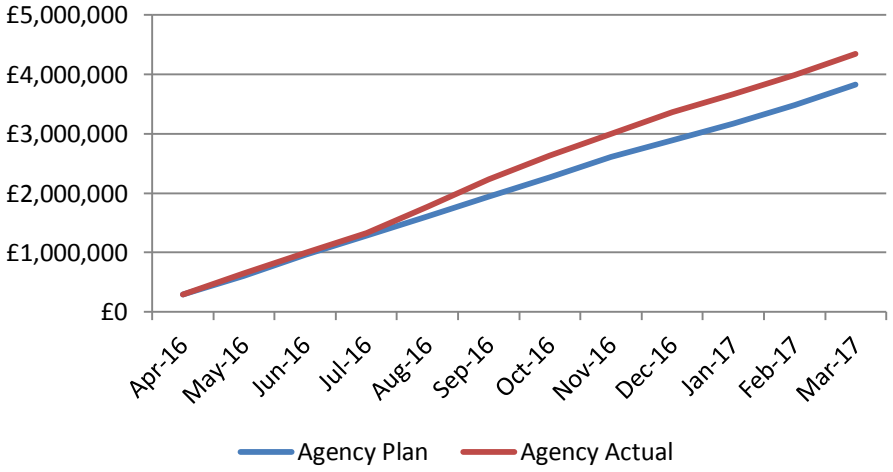
Total Monthly Agency Spend vs Plan



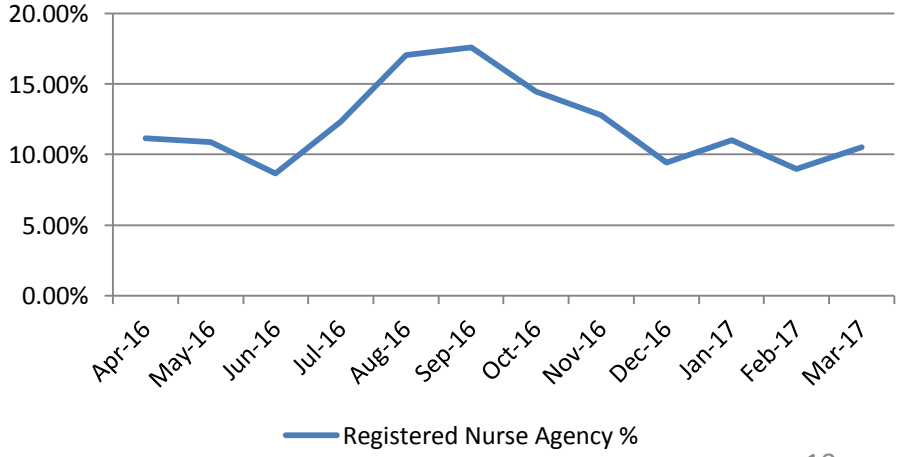
Temp Staff %



Total Cumulative Agency Spend vs Plan



Registered Nurse Agency %



INFORMATION

March showed an increase in agency spend (£326k to £365k) driven by an increase in all of the three categories of agency spend (medical, nursing and other). Some of this increase relates to March being a longer month than February, but in addition Medical spend has increased due to an under provision of GP trainees from the West Midlands Deanery. Aside from these factors spend was roughly in line with expectations.

ACTIONS FOR IMPROVEMENTS / LEARNING

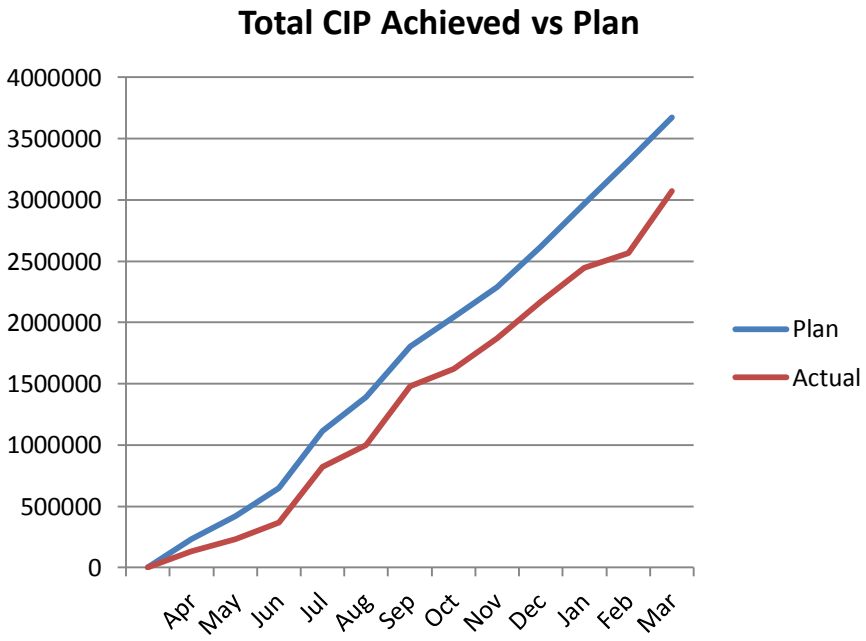
One of the 5 recovery workstreams is reduction in agency spend, and as such a detailed action plan is being reported against on a weekly basis to Recovery Board. This is in addition to the agency group. Ongoing actions to reduce agency spend include reviewing the outputs of Healthroster.

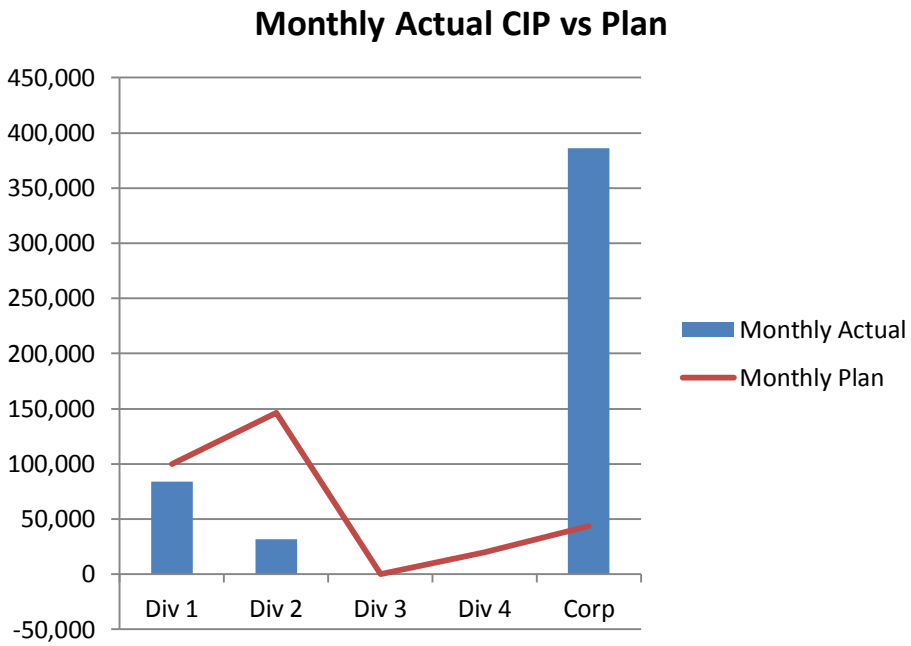
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios. The Trust is currently consulting on a change to rota working patterns as part of this process.

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. The agency spend metric is the only metric, alongside variance from I&E plan, which is stopping the Trust from being financially rated as a 4 for Use of Resources. An overspend against the trajectory will therefore have a direct impact on our regulator ratings.

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2016/17





INFORMATION

The year end position for CIP savings for the Trust was £3,071,000 of CIP savings, against a plan of £3,671,000. Whilst this represents an underperformance against target of £600,000, this does represent savings of 3.3% of operating expenditure, which is a significant achievement against what was a very challenging in year target. The area of most concern is that £1,708,000 of the savings made (56%) were non-recurrent, resulting in an increased challenge for the Trust in the coming year to deliver the required savings to deliver the financial plan. The in-month savings recognised were £366,000 against a target of £352,000.

The Trust is currently progressing through the rationalisation of implant suppliers for non-spinal implants. It will be important to manage the process of transition closely to the new suppliers to maximise on the savings for the new rates and avoid incurring additional cost by ordering non-primary suppliers.

ACTIONS FOR IMPROVEMENTS / LEARNING

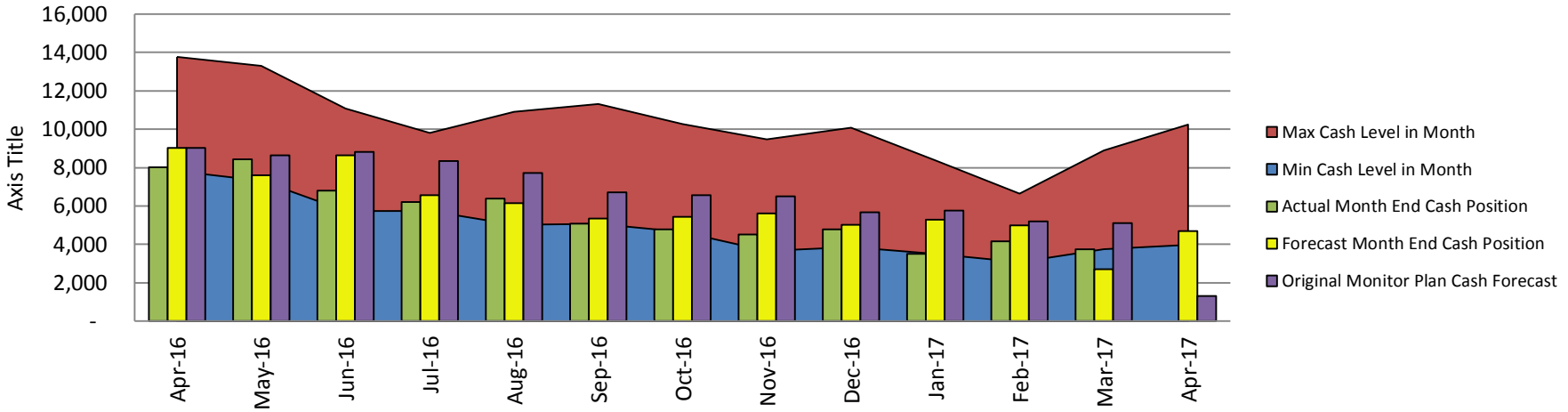
Early focus on unidentified schemes for 2017/18 is needed to ensure the CIP plans are achieved.

RISKS / ISSUES

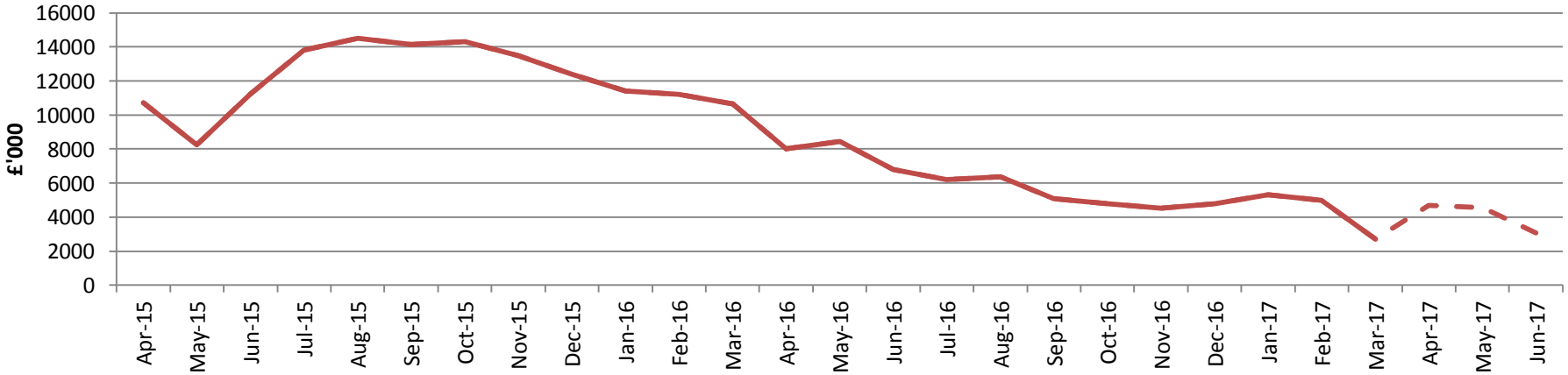
The CIP target for 2017/18 remains challenging particularly given the high level of non-recurrent CIP in 2016/17. Divisional leads have been asked to provide CIPs, plans and QIAs by 28th April in advance of the first divisional performance meetings of the year occurring shortly.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet

Cash Summary



Rolling cash flow forecast



INFORMATION

Cash levels are £1.3m lower than planned levels at the end of March, largely driven by the deficit for the year being significantly higher than the original plan of £3.2m.

Due to the reduction in cash, liquidity levels within the Use of Resources Rating have dropped to a 4, the lowest level. Cash support currently looks to be required in late June or early July.

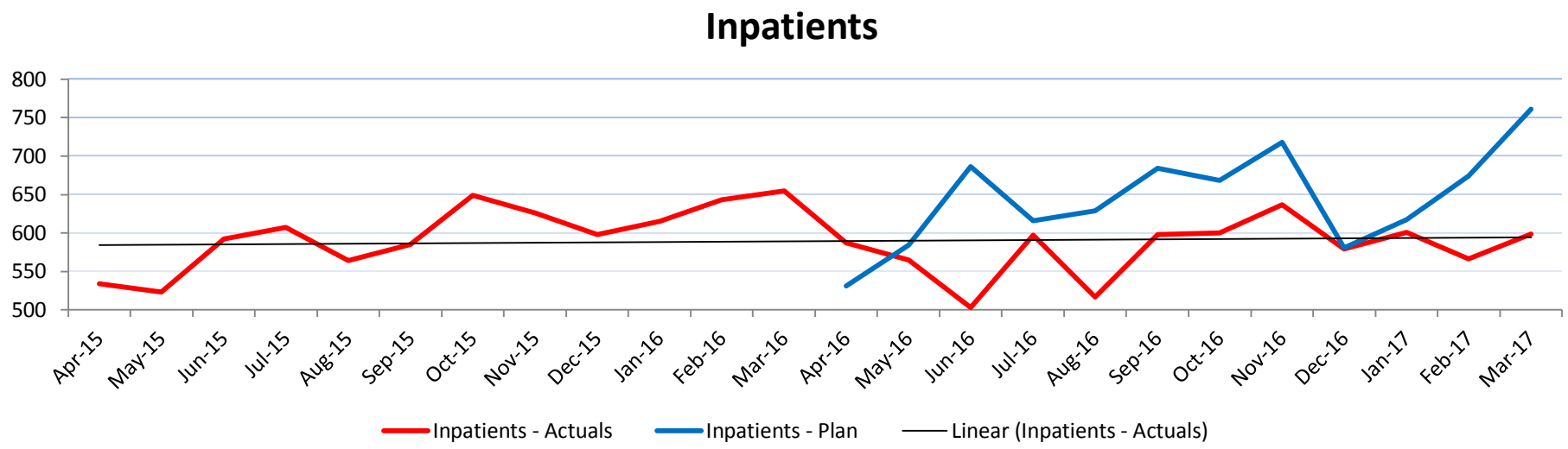
ACTIONS FOR IMPROVEMENTS / LEARNING

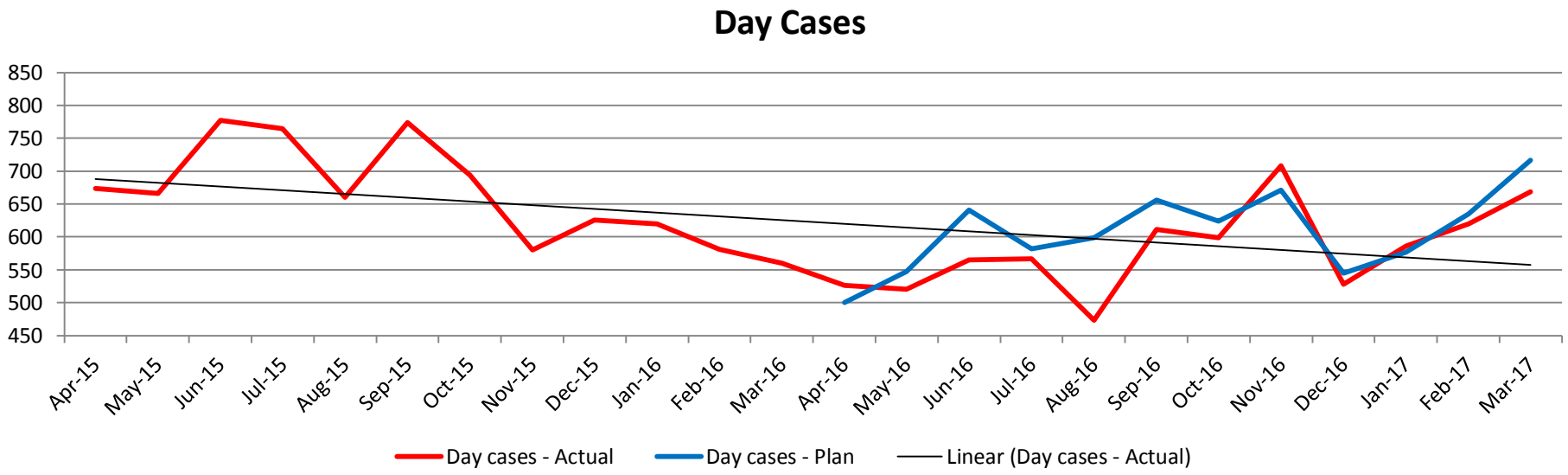
The Director of Finance is aware of the options for the receipt of a cash loan to support the running of the hospital in the new year. The Head of Financial Accounting has set up a weekly cash control committee attending by the DDOF, and representatives from management accounts and the transaction team. The committee is reviewing cash management controls to ensure they are robust, and are beginning to set up arrangements to allow monthly applications of cash from the Department of Health to be actioned.

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

Both inpatient and day case activity has increased from February to March, although an increase would be expected with February being a short month. March is usually a strong month for elective activity, but the activity delivered was roughly in line with that seen in July, September, October and January. Day case activity was better, with activity being the second highest it has been all year, but this was still below the original activity plan set. This suggests that any improvements in activity as a result of the efficiency work streams are impacting day case activity more than elective.

ACTIONS FOR IMPROVEMENTS / LEARNING

3 of the 5 recovery workstreams relate to increasing activity, through increasing POAC capacity, increasing theatre efficiency and making discharge more efficient. These workstreams are being monitored against their detailed action plans and KPIs on a weekly basis through Recovery Board.

Some of the actions taken include the continue work in the "6,4,2" meeting 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.)

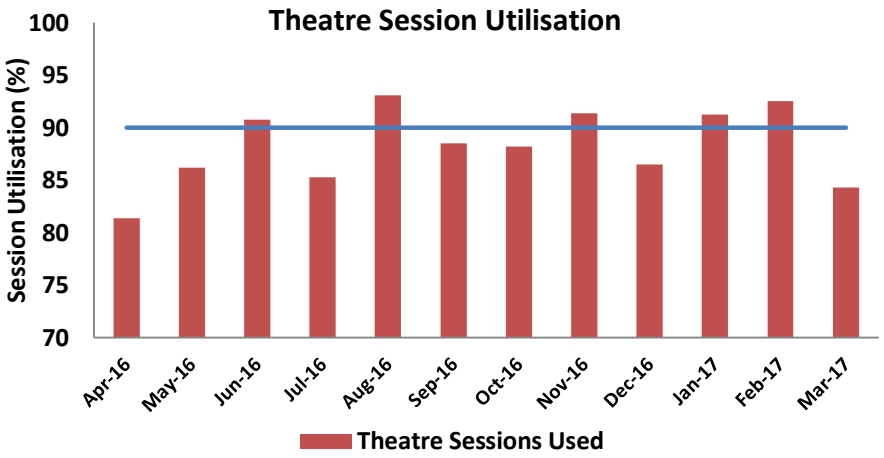
Longer term, there is work as part of team service objectives linked to the job planning round to achieve improved list uptake.

RISKS / ISSUES

Key risks are the willingness of speciality teams to recycle lists, and to put more patients on lists. There continue to be challenges as part of the Trust's decentralised model of administration to ensure the lists are populated sufficiently well in advance to maximise utilisation.

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. There have been some improvements in list pooling in February.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are potentially available (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we aim to use at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis. March utilisation was significantly lower than planned, with high annual leave in a number of specialties.

ACTIONS FOR IMPROVEMENTS / LEARNING

Due to annual leave / study leave, we typically plan that surgeons 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. Job planning is building in buddy arrangements and prospective cover, as well as identifying a need for recruitment to specialities where there are vacancies or that are under pressure from an activity / RTT / 52 week perspective. Further improvements have been made to the communications to surgeons of the availability of fallow lists, enabling more effective utilisation. There are now additional 3 session days in the schedule to facilitate the 2 x scoliosis cases on a list for spinal deformity.

Some theatre lists are now being released by individual surgeons (and offered to be reutilised by other surgeons) to do additional clinics, because some surgeons who are timetabled in theatres have very short waiting lists. All reasonable efforts are made to recycle, including where it is deemed appropriate the use of sessions additional to job plan (paid ADHs.) Since theatres and anaesthetic teams are not yet fully staffed, capacity is flexed up through overtime and bank working, so where lists are not recycled, and deemed 'fallow', the theatre staffing and anaesthetic shifts are removed 1 week ahead, to reduce bank and agency costs.

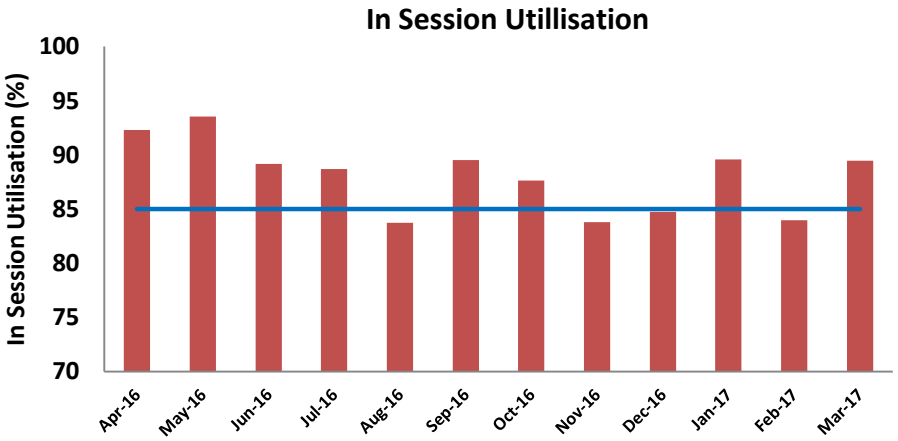
RISKS / ISSUES

Job planning is almost completed for surgeons, with outstanding issues with only 2 surgeons; these are actively being progressed with the involvement of the Associate Medical Director, Clinical Service Manager and Clinical Service Lead.

The new theatre schedules and outpatient schedules are planned to start on 1st May 2017, to match the updated agreed job plans.

The next round of job planning is now being planned and will start by the end of Q1.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained above the target 85% in the majority of months. However, the previous measure (pre June) 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. The March performance has increased and attention will be focussed to ensure that this continues to improve for the coming months.

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. This will be led by the Head of Nursing, Division 2, working on The Productive Operating Theatre principles. The implementation of the new Theatre Management System (Theatreman) has been delayed, despite best efforts of the project delivery team, due to delays by the supplier in providing a fully functioning system which passes all of the Trust's extensive 'Customer Acceptance Testing'. (This has been slipped several times due to PAS interfacing and functionality issues). A revised date for late May is now being targeted for implementation. The prescriptive nature of this software will be a further aid to ensure that lists are optimally booked based on the available time. Scrutiny and challenge is via the weekly 6-4-2 meeting, with instructions back through to the surgical teams to book lists to their maximum potential and to POAC and identify patients well in advance so that specific requirements can be planned for to reduce cancellations.

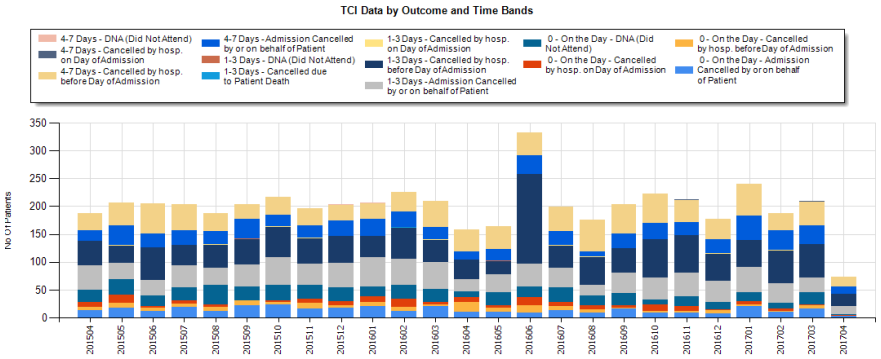
Work on trajectories in the Spinal, Hands, Feet and Arthroscopy specialties has also brought to the fore some opportunities for greater efficiency and the possibility of moving some cases out of the theatre environment. Additional capacity delivery through use of non consultant staff is being explored.

RISKS / ISSUES

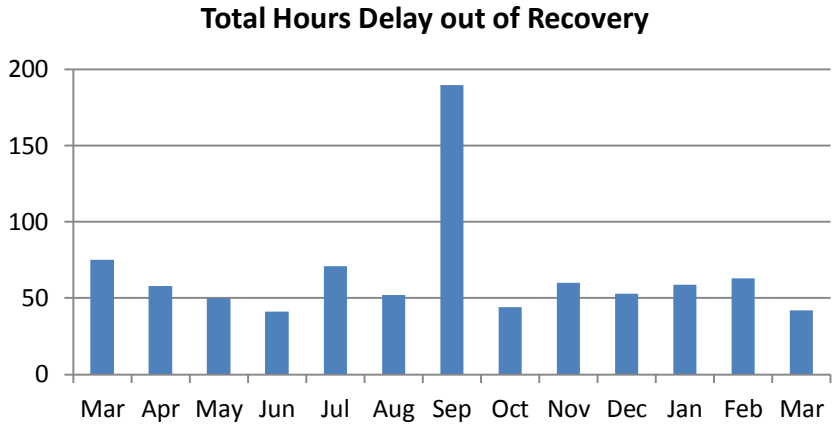
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (e.g. experience in spinal scrub) to ensure the best possible use of available operating time. Availability of radiographers (additional support now in place via agency.) Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit. Gaps in the operational structure, although recruitment is underway.

11. Process & Flow efficiencies – This illustrates how suc… Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

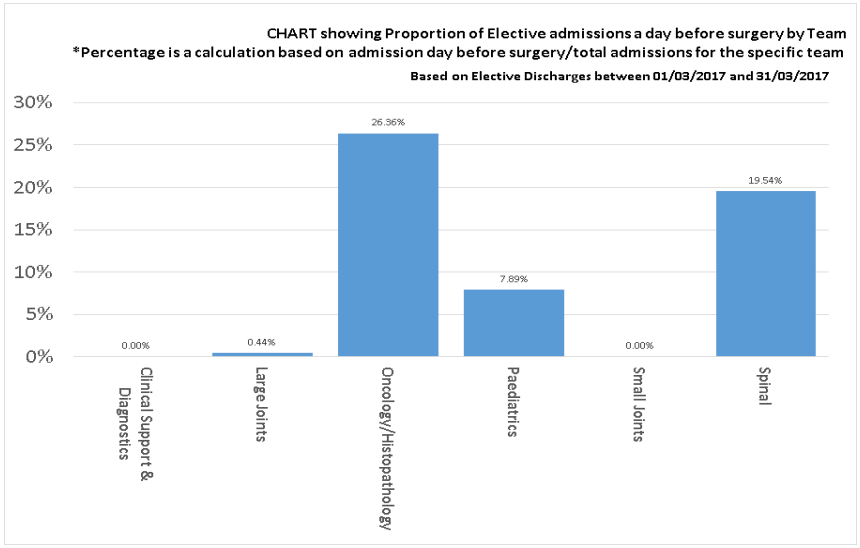
Cancellations by patient / hospital



Delays out of recovery

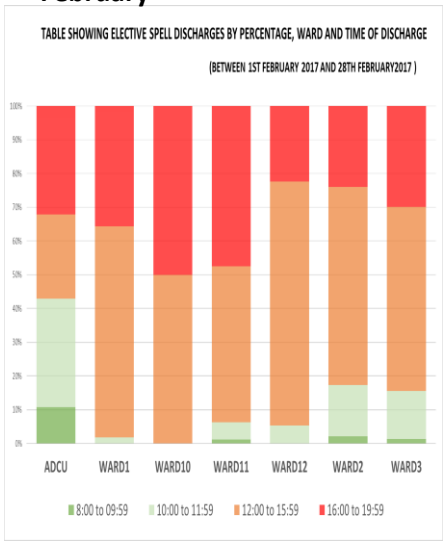


Admission the day before surgery

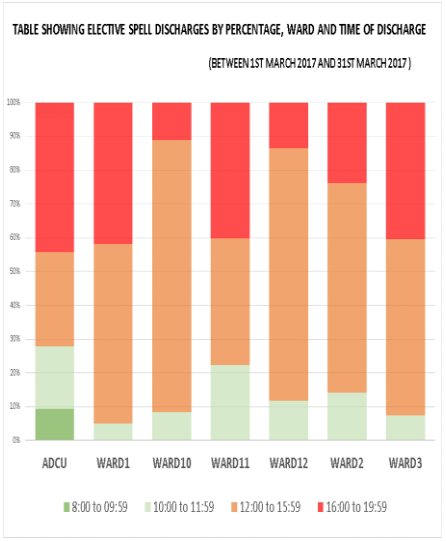


Time of day patients discharged

February



March



INFORMATION

Active management of the Patient Tracking List (PTL) , the establishment of a separate Oncology PTL weekly meeting to track the booking of individual patients, and a separate large joints PTL weekly meeting to track patients is creating a new momentum , with lists being booked several weeks ahead where previously they were being booked only days ahead.

Work on the trajectories for spinal, hands, feet and arthroscopy is identifying opportunities for streamlining referrals, reviewing the use of an operating theatre for cases being undertaken (rather than an OPD setting) and the rebalancing of waiting lists across firms. The implications of these are being worked through with Clinical Service leads and Clinical Service Managers.

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Some of the replacement patients are then booked at short notice. We are working towards booking with 3 week's notice and 2 reasonable offers as per national guidance and our Access Policy.

Now that there are Clinical Service Leads and Clinical Service Managers for each specialty, and regular team meetings, some longstanding issues relating to disparity of waiting lists across consultants, variations in theatre productivity and listing protocols are being addressed and resolved. Work is continuing, with a particular focus on Oncology. There are measurable and encouraging results from this work.

Forensic analysis of cancellations continues, with a focussed analysis by the anaesthetic lead and nursing lead for POAC of the majority cause of cancellations on the day of surgery, namely those who are medically unfit, to ascertain what process changes can be made in POAC or to the 72 hour phone call to reduce this.

ACTIONS FOR IMPROVEMENTS / LEARNING

Now that the longstanding vacancies in Medical secretaries, admin support and operational management have been filled, there is now the capacity for transacting the forward booking of patients for both preoperative assessment and surgery.

This will create a pool of patients available to be called forward earlier at short notice to fill cancellation slots.

Work is still required to agree criteria for admission the day before, to use beds more effectively and reduce length of stay. Bed availability has not been a constraint to delivery, with ward bays being closed during the month to match demand.

Pre-operative assessment improvements have been delivered, so that there are now 32 slots available each day.

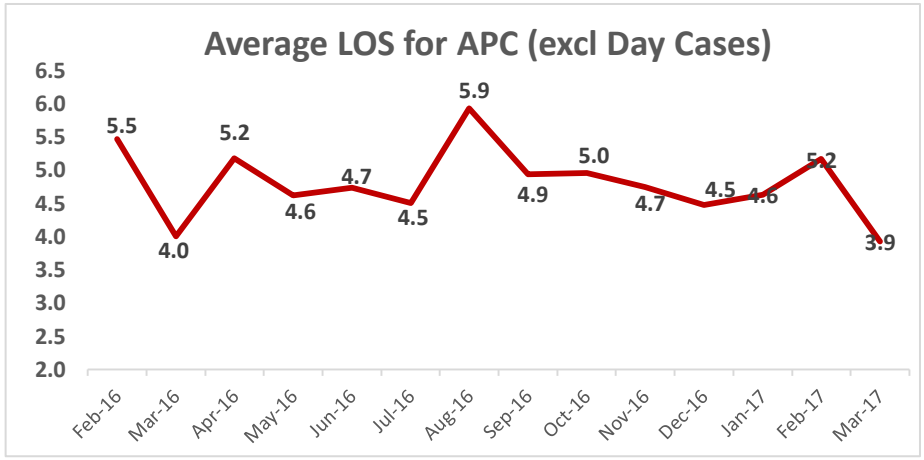
A daily update review by operational management of forward bookings has been established and the 642 and daily huddle is being trialled. Daily statistics on beds , admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to deliver activity and patient flow.

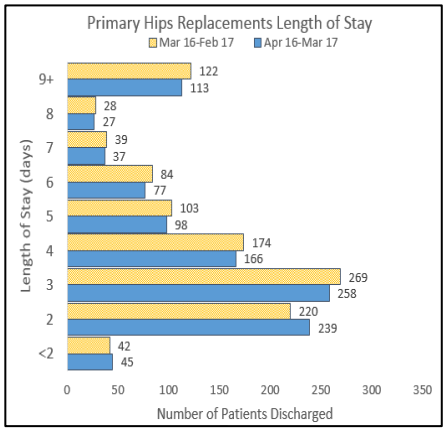
RISKS / ISSUES

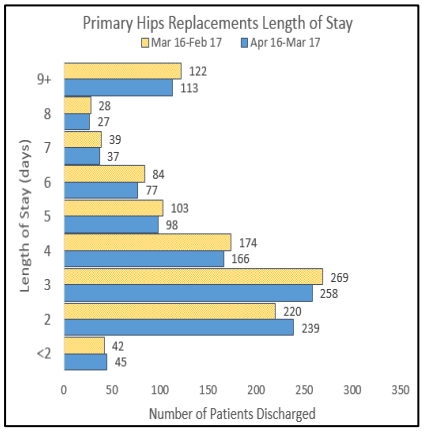
Continued focus with all staff involved to ensure that the operating lists are booked in advance, with sufficient caseloads, together with daily tracking.

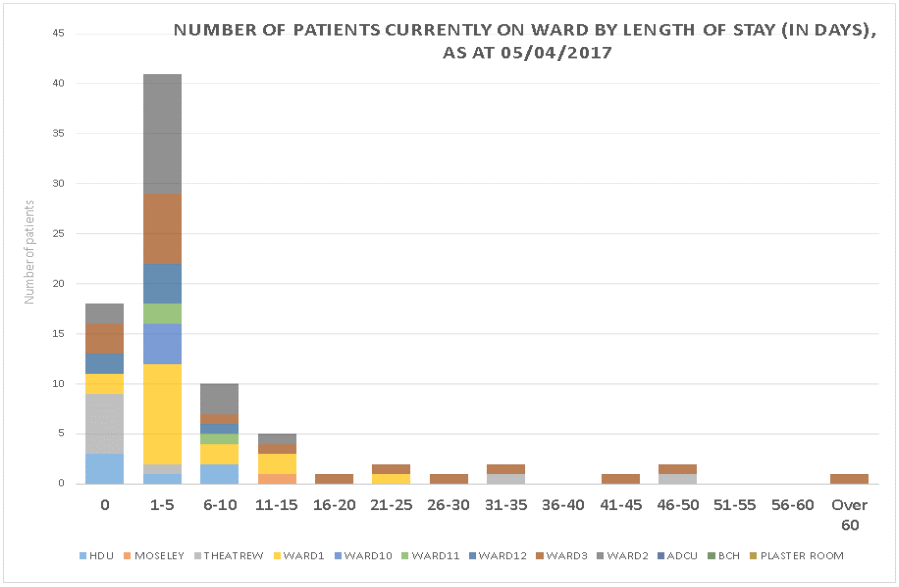
It is currently not possible to identify if the time of day patients are discharged is an accurate reflection of reality, or whether data is being entered onto the system in a delayed manner, making discharges look later in the day.

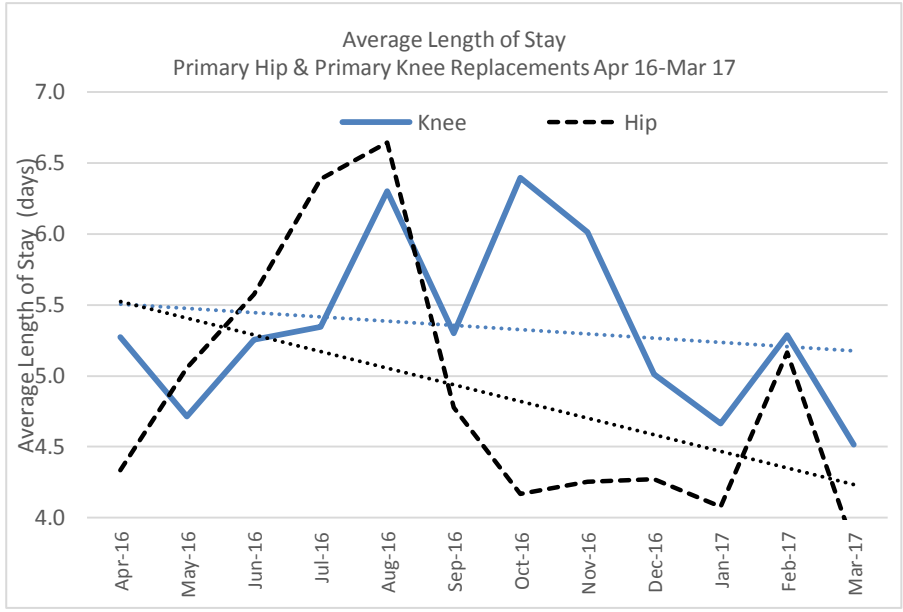
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Length of stay of for primary hips has shown early signs of improvement, and with the extra focus on Estimated Discharge Date and the Rapid Recovery initiative. However, the linear trend for primary knees remains upward, which is disappointing. 'The Home for Lunch' information campaign has been formally launched to staff and patients during Mid February and this will help to reduce length of stay with the expectation setting with staff and patients about when a patient can leave the hospital, and the marshalling of resources to ensure that this occurs as early as possible in the day. This clearly sets out to all concerned that we expect that more than 80% of patients due for discharge that day will leave hospital or be off the ward and in the discharge lounge before midday.

The focus by the matrons on managing length of stay has helped to drastically reduce the 'tail' of patients with long lengths of stay. The Trust has been trialling the Clinical Utilisation Review (CUR) Tool on Ward 1 as part of the 2016/17 Better Care Fund CQUIN scheme. This requires daily assessment by ward staff of whether a patient 'qualifies ' to remain in an acute setting, and is being trialled across all acute trusts in Birmingham to identify where blockages in patient pathways are occurring across the health and social care system. It is planned to roll this useful tool out across remaining wards in Q1 2017/18 to assist further in patient flow improvements.

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.

Daily senior reviews are being formalised as part of job planning, and the rising adherence to recording the Expected Date of Discharge (EDD) (now over 90%) is helping all involved in that patient's care to manage their length of stay more effectively.

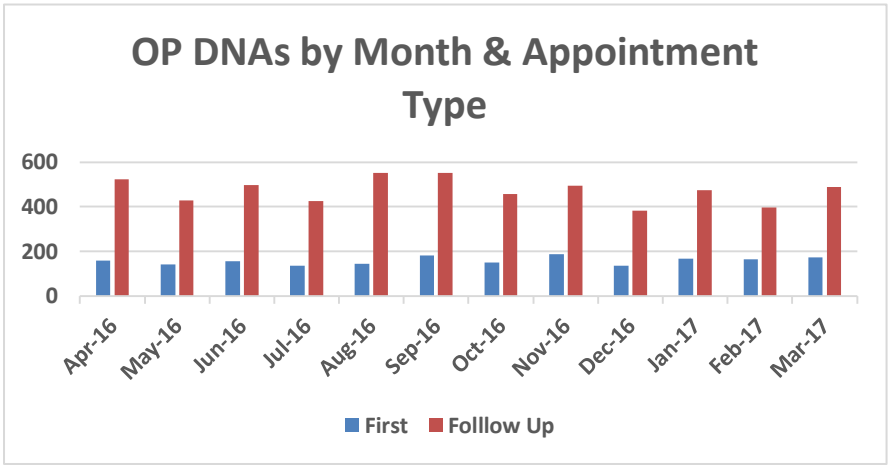
RISKS / ISSUES

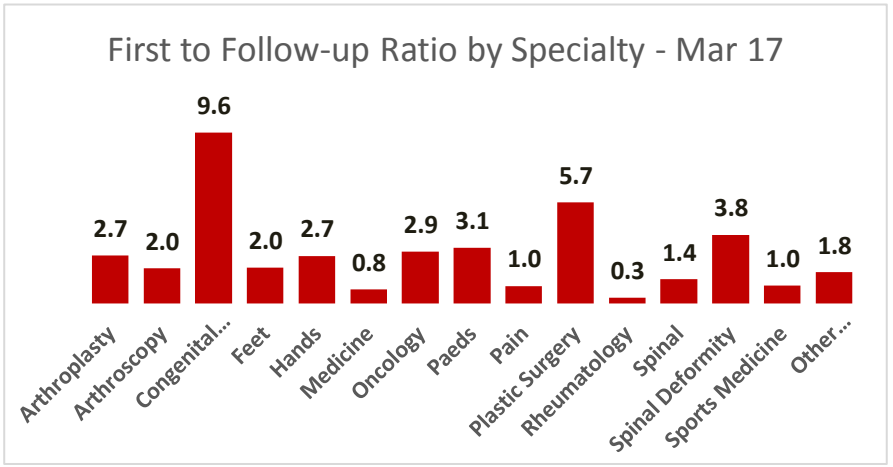
Using individual consultant information, Operational management teams and Clinical Service Leads are reviewing outlying clinical practice to help ensure that all patients are able to go home as soon as possible after their surgery.

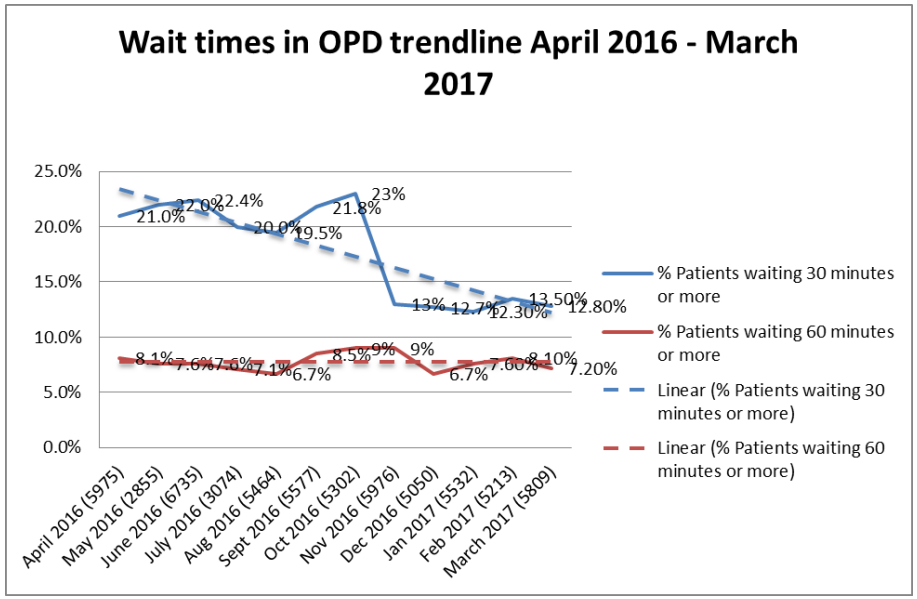
Compliance with achieving discharge on the expected date of discharge is being monitored- When this measure was introduced, non compliance was in excess of 35% and now this is below 5%. This is being tracked through nursing and operations management to drive further improvement.

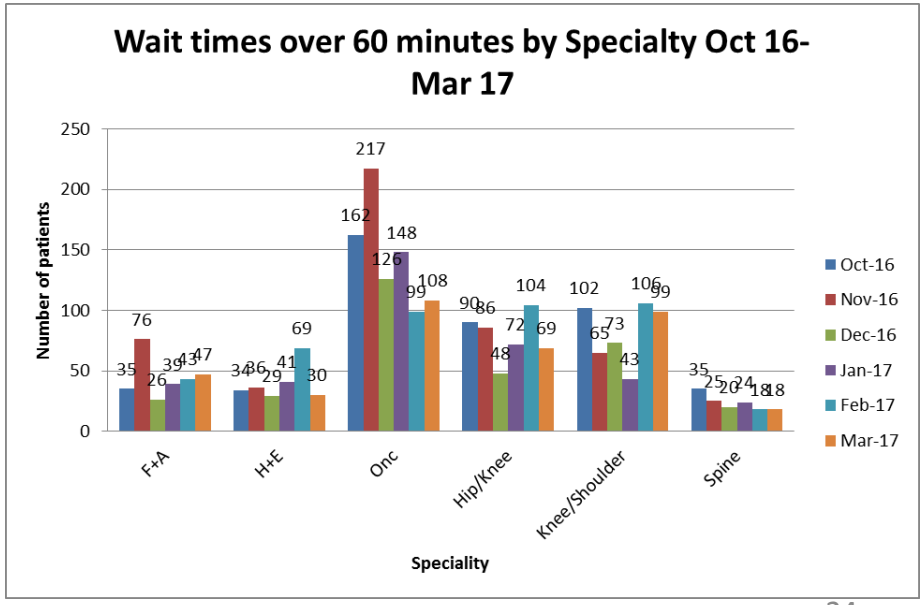
Data Quality reports are now available to show adherence to completion of 'Expected date of discharge' dates- non compliance was at over 50% and is now below 10%. This is being tracked through nursing and operations management to drive further improvement.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients









INFORMATION

Since the initial implementation of the new clinic templates in November there has been a reduction in the 30 minute wait times for patients. Since August 2016, when on average 21% of patients waited more than 30 minutes, this is now reduced to 12.8% of patients waiting in March 2017. Further work is underway, and with the introduction of the new clinic schedules on 1st May 2017, this should further reduce wait times.
There is a new standard operating procedure for any clinic running over 60 minutes late. An incident form is completed and a new drop down analysis is selected by the staff completing the incident which is enabling trends and follow actions to be carried out effectively.

The outpatient department continue to audit its compliance against the SOP for wait time and can demonstrate 100% compliance.

The work undertaken to understand the trajectories for Hands, Feet and Arthroscopy continues and will be will be rolled out across all specialties- initial results are showing very low conversion rates from first OPD appointment to surgery, and also from second OPD appointment to surgery for some specialties.

ACTIONS FOR IMPROVEMENTS / LEARNING

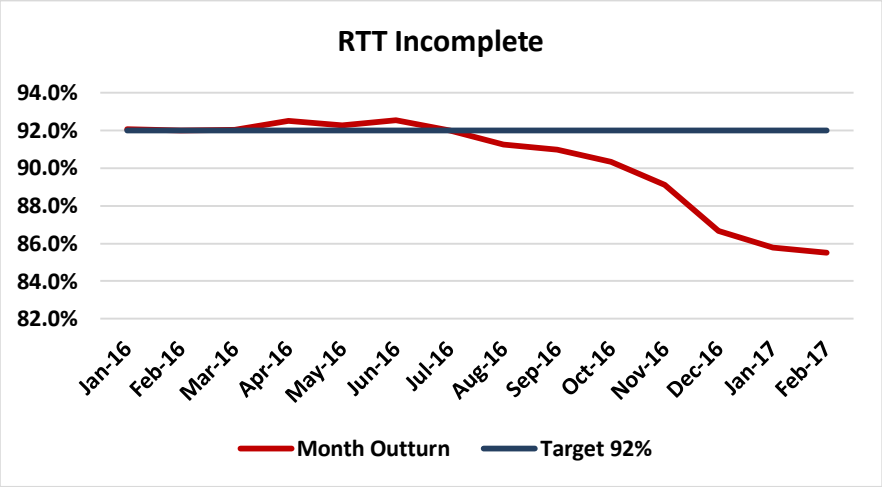
There are a range of actions as part of the CQC action plan and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

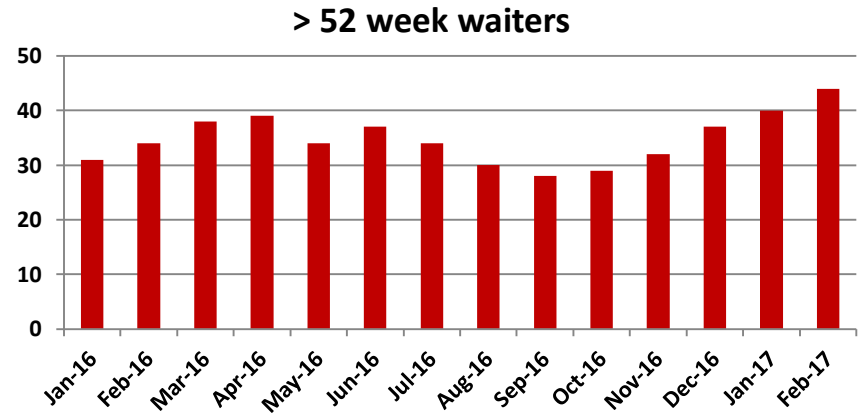
As part of the Trust's RTT recovery work, there will be a focus on out patient pathways and any patients who are in the system awaiting a follow up appointment and have become overdue, for whom a new active RTT clock should be started in line with national guidance. However, if it is found that there is a follow up appointment capacity problem, then this could worsen new to review ratios in the short term. This is being reinforced through RTT training and the clinical service managers working closely with consultants and medical secretaries to ensure that the Trust access policy is being adhered to by all involved.

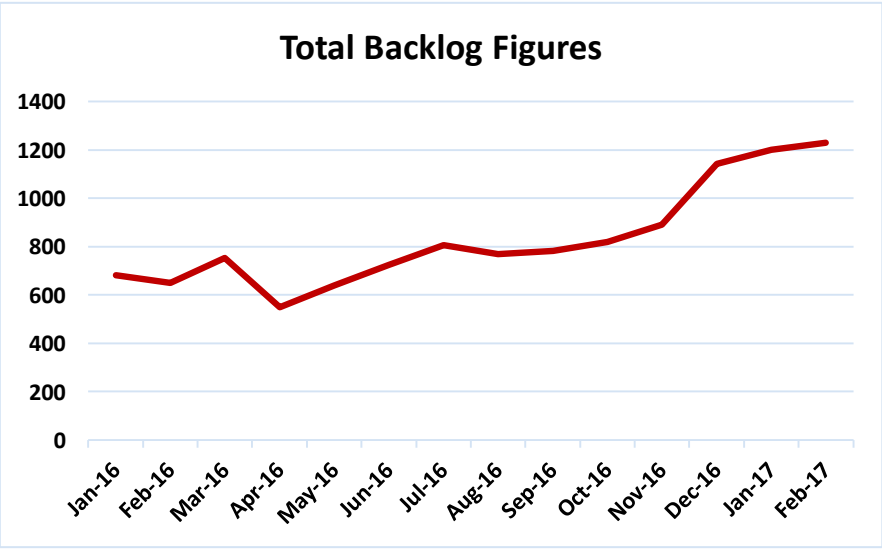
RISKS / ISSUES

Completion of the implementation of all changes to the clinic templates , agreement of Oncology to the Implementation plan , reviewing the SOP for booking of x-rays with divisional 3 team, Feeding back wait times to consultant groups as part of their monthly meetings to understand hidden causes to delays, and a monthly review of incident forms at monthly outpatient meeting.

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets - RTT	Target / Trajectory	Actual (Feb17)	Actual (YTD)
52 Weeks Waiters	-	44	384
18 Weeks Incomplete	92%	85.97%	89.80%
NHSI Performance Targets - Cancer	**Target / Trajectory**	**Actual (Feb17)**	**Actual (YTD)**
Cancer (2 week wait)	93%	100%	100%
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	98.78%
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	96.84%
Cancer (62 days)	85%	80%	92.31%

INFORMATION

RTT open pathway performance continues to be the main concern. The backlog continues to increase at a rapid rate for both admitted and non admitted pathways.

The current validated position is 84.79%, compared to the validated position for February 2017 of 85.51%, which was below the previous month's position of 85.79%, continuing an established pattern of month on month deterioration. This is a mixture of addressing data quality issues as they are identified as part of the ongoing validation work associated with the 100,000+ open pathways, and also pathways through to surgery that are not 18 week compliant for a significant number of surgeons in the majority of specialities.

As at 24th April 2017 there are a total of 1,642 patients at 18 weeks or over on the waiting list (admitted / non admitted) which is 99 patients higher than last week; this is 18% of the total waiting list. At each milestone the number of patients at 18 weeks and over has risen since last week. Whilst these figures include both dated and undated patients, the number of patients dated 14 weeks and above is not sufficient to improve the Trust's position.

During March 2017, the Trust Chair received notification that NHSI were launching an investigation into the Trust's RTT performance. This has included the provision of various reports and data, as well as an on-site visit from 24th to 27th April 2017. An RTT Recovery Board has been established and met for the first time on 27th April 2017.

The main issues (based on reported performance) are within arthroscopy, foot & ankle and spinal. The number of breaches within the pain service have increased due to consultant manpower, but a rectification plan is in place for this speciality. Rectification plans are being developed and will be completed shortly for the other specialties.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are significant concerns with regard to data quality and the measurement of RTT waiting times. This includes inappropriate clock stops in the Oncology service following biopsy, and the monitoring of services that are not consultant led but are delivered within an 18 week pathway (Therapies) that therefore improve the position. This has been escalated to NHS Improvement. It is likely that the true position, when the reporting anomalies are resolved, will be significantly worse that the current level of performance being reported.

RISKS / ISSUES

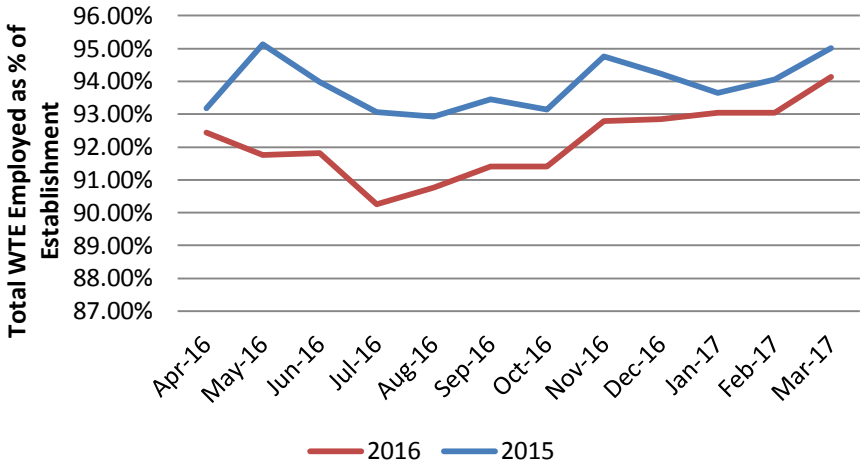
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern.

18 weeks: Significant work continues to understand the scale of the challenge with regard to open pathways, and the extent of data quality concerns. The Trust welcomes the input and expertise of NHS Improvement in this area.

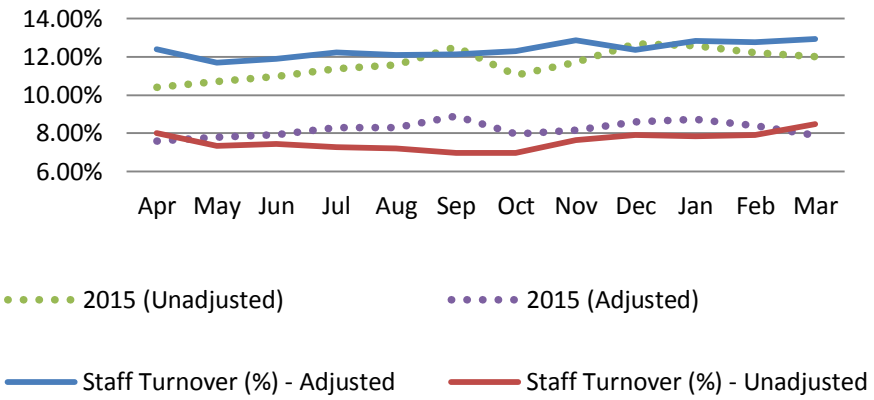
A review is under way with regard to the robustness of cancer waiting times reporting, given the concerns with data quality around the other access targets.

15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

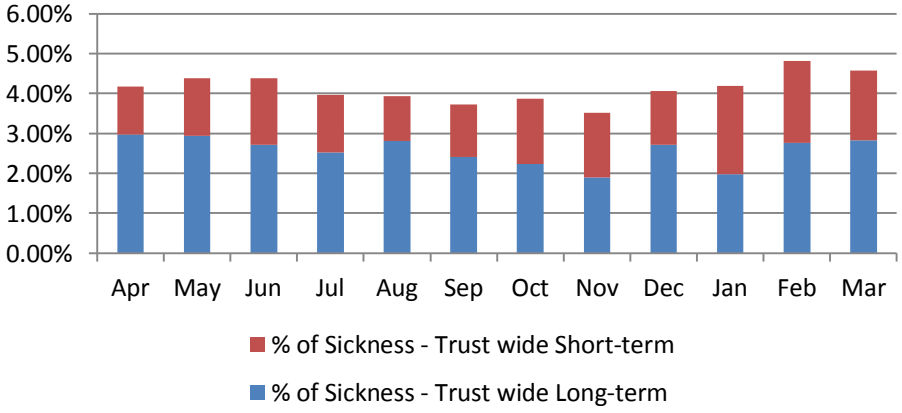
Staff in Post v Establishment



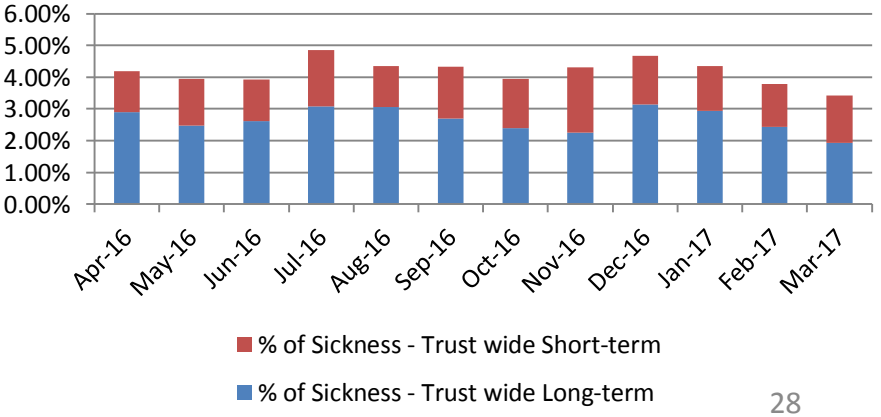
Staff Turnover



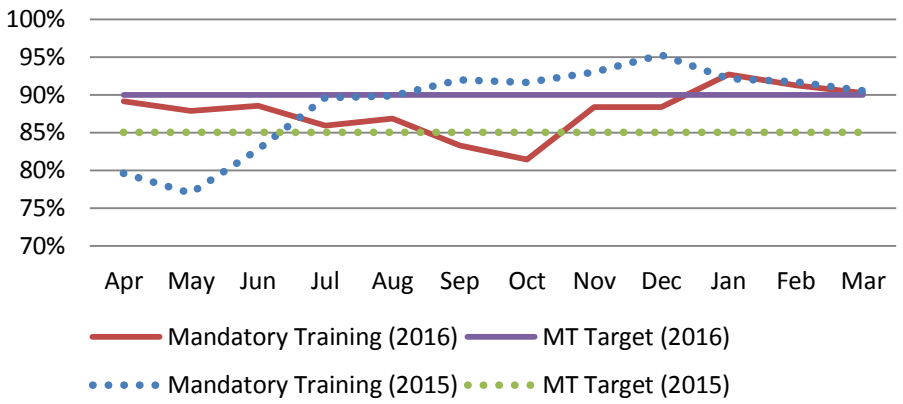
Sickness % - LT/ST (2015/16)



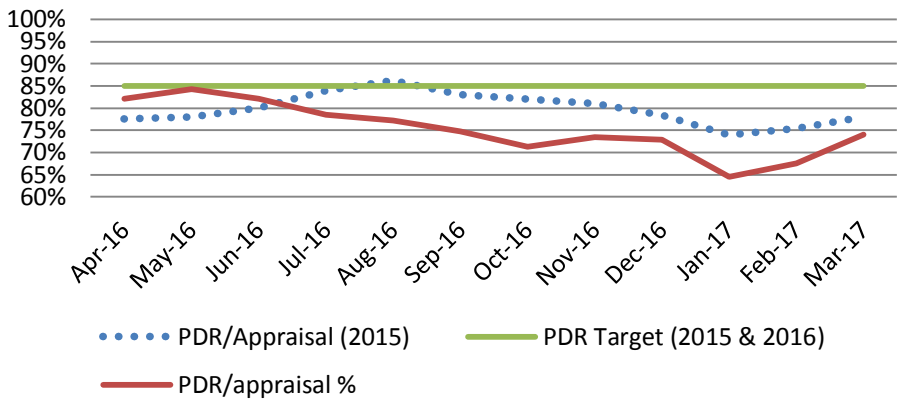
Sickness % - LT/ST (2016/17)



Mandatory Training



PDR/Appraisal



INFORMATION

The vacancy position has improved for the third consecutive month by just over 1%, with the effect that the Trust now has 5.87% of its posts vacant.

March marked the fourth consecutive month where sickness absence has reduced, which is encouraging progress. The reason for the decrease in the last couple of months has been a marked reduction in long term sickness absence.

At 3.43% in month, it represents the lowest monthly figure since August 2013. The 12 month rolling figure fell to 4.32% and is likely to reduce further, if progress on long term sickness in particular is maintained.

Mandatory training was green for the third consecutive month, although it has decreased this month by 1%. The Trust is just "green" at 90.26% overall and this is an area which will need continued operational focus.

The Workforce information Team undertook some work with managers during March regarding data quality of inputting of PDR data. Partly as a result, performance relating to PDR/appraisals increased in March by 6%, halting the recent decline in performance. However, at a current compliance rate of just over 74%, there is clearly further progress to be made in this area.

There was some movement in the February turnover figures. The unadjusted turnover figure (all leavers except doctors and retire/ returners) increased by 0.17% on last month with the adjusted turnover figure ("true leavers," meaning "voluntary resignations") increasing by 0.59%. The true leavers figure is within expected levels and is not a cause for concern – and the unadjusted figure is high this month due to MARS applications and higher than usual expiry of fixed term medical fellow contracts. This top line figure is expected to reduce in coming months.

ACTIONS FOR IMPROVEMENTS / LEARNING

A call to action for improved appraisal performance was made at divisional boards via team brief in mid March2017. HR Managers will pursue improvement with their divisional boards in month, with appraisal performance to be discussed in Divisional performance reviews.

RISKS / ISSUES

The Trust is currently under a compliance notice from our commissioners in relation to mandatory training, although green rated performance in January, February and March is a helpful start to the year in providing assurance, both internally and externally.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

April 2017

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Patient Services
AUTHOR:	Ash Tullett	Clinical Governance Manager

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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.

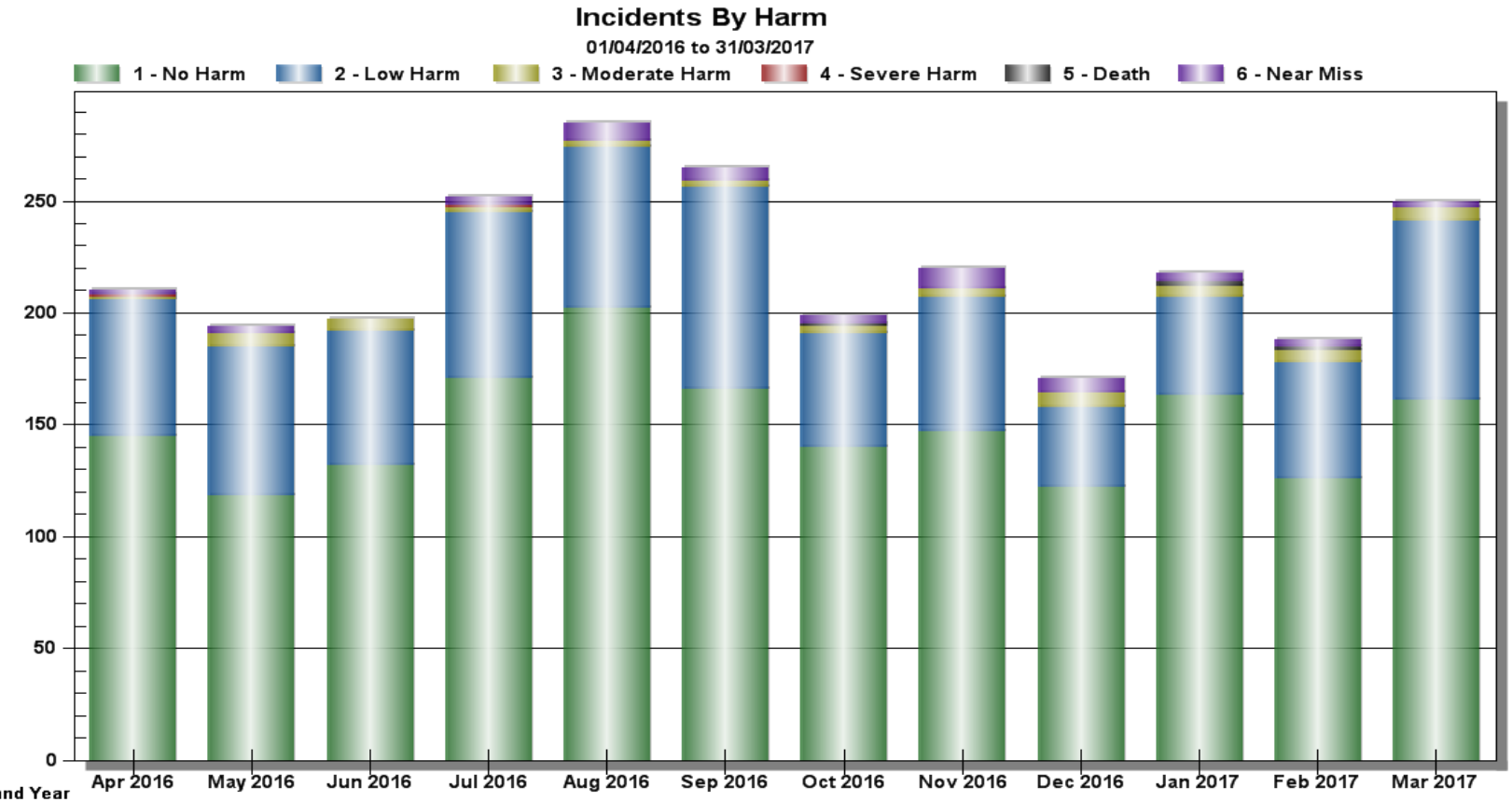
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

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.

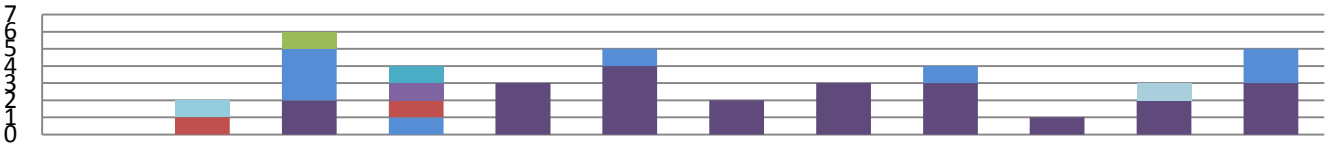


Month and Year	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017
1 - No Harm	145	118	132	171	202	166	140	147	122	163	126	161
2 - Low Harm	61	67	60	74	72	90	51	60	36	44	52	80
3 - Moderate Harm	1	6	5	2	3	3	3	4	6	5	5	6
4 - Severe Harm	1	0	0	1	0	0	0	0	0	0	0	0
5 - Death	0	0	0	0	0	0	1	0	0	2	2	0
6 - Near Miss	2	3	0	4	8	6	4	9	7	4	3	3

INFORMATION
In March 2017 there was a total of 250 Incidents reported on the Ulysses incident management system. **There was 6 Moderate Harms**
ACTIONS FOR IMPROVEMENTS / LEARNING
As of March 2017 the new quality dashboards are in use and include all quality indicators. The Trust now has one central repository for all KPIs that can be used to populate any quality report. This included KPI's on incidents. This dashboard is to replace the ward healthcheck that was previously found in the Quality report.
RISKS / ISSUES
None

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.**

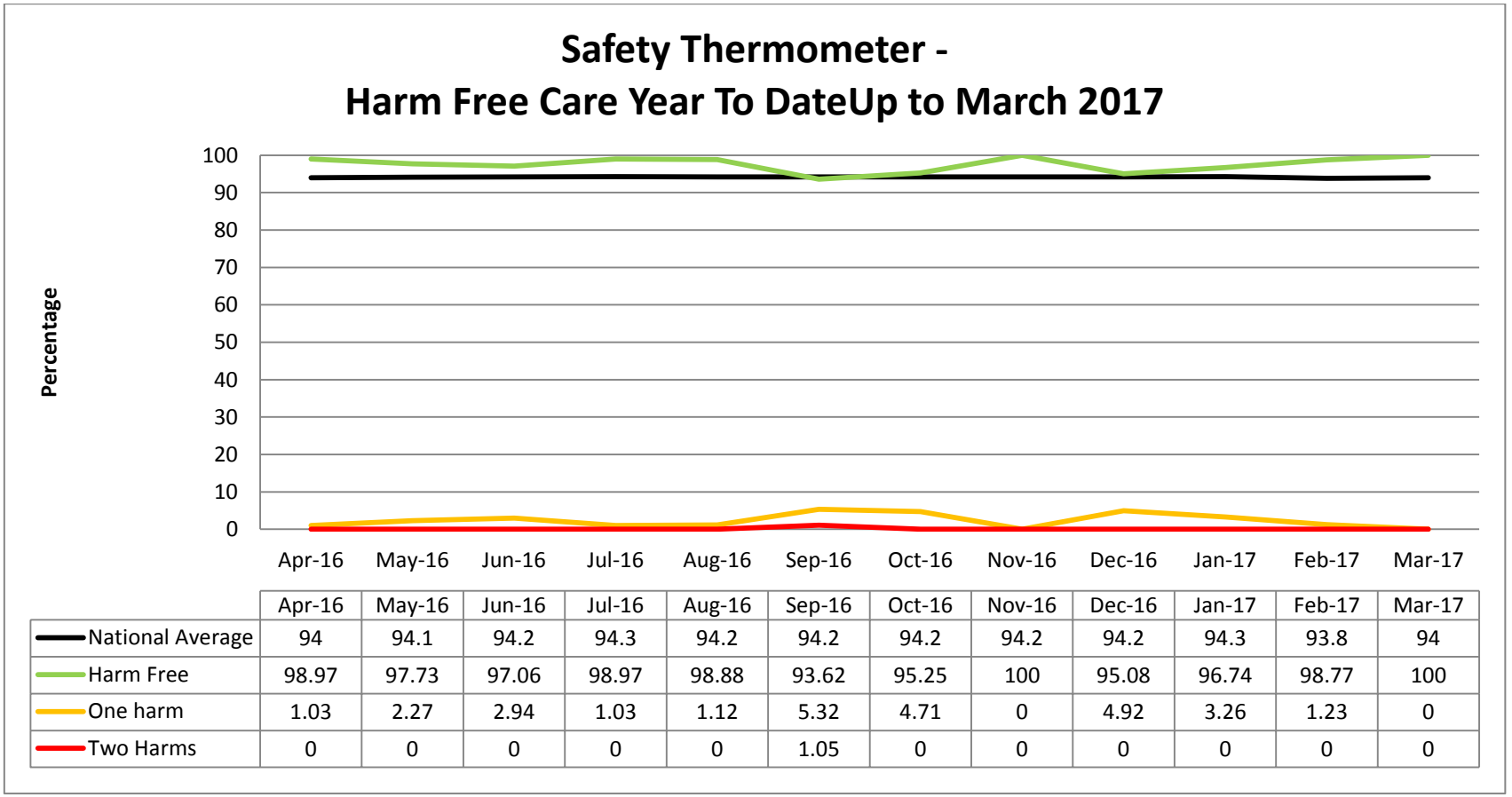
Serious Incidents Declared Year to Date to March 2017



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Exposure to hazardous substance											1	
Staff conduct incidents												
Emergency transfer out of Trust												
Surgical incident meeting SI criteria												
Emergency transfer to HDU												
Failure to act on test results												
Wrong Site Incision				1								
Wrong Implant				1								
Suspension to services			1									
Delayed diagnosis												
Wrong side injection		1										
Unexpected deaths												
Slips, trips & falls		1		1								
Pressure Ulcers		0	3	1		1			1			2
VTE meeting SI criteria	0	0	2	0	3	4	2	3	3	1	2	3

INFORMATION
There were **five** Serious incidents declared in March 2017. These are due for submission with the Commissioners May/June 2017. A more detailed breakdown of these incidents is provided on page 5/6.
ACTIONS FOR IMPROVEMENTS / LEARNING
Three Serious Incident report were submitted to the Commissioners during March 2017. These incidents were reported in the January 2017 Quality report. There was one unavoidable VTE's and 2 avoidable VTEs.
RISKS / ISSUES
None identified.

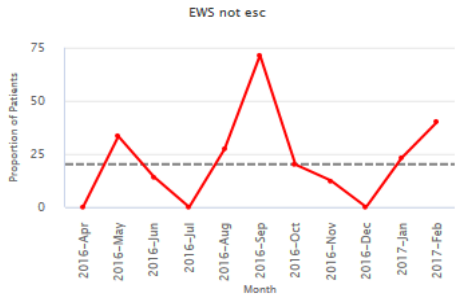
4. **NHS Safety Thermometer - provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.**

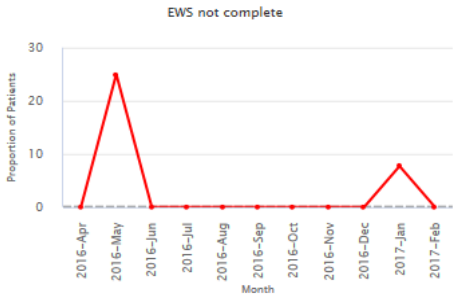


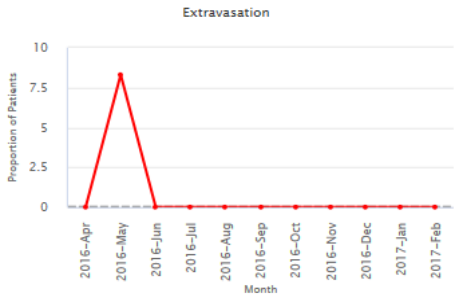
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
National Average	94	94.1	94.2	94.3	94.2	94.2	94.2	94.2	94.2	94.3	93.8	94
Harm Free	98.97	97.73	97.06	98.97	98.88	93.62	95.25	100	95.08	96.74	98.77	100
One harm	1.03	2.27	2.94	1.03	1.12	5.32	4.71	0	4.92	3.26	1.23	0
Two Harms	0	0	0	0	0	1.05	0	0	0	0	0	0

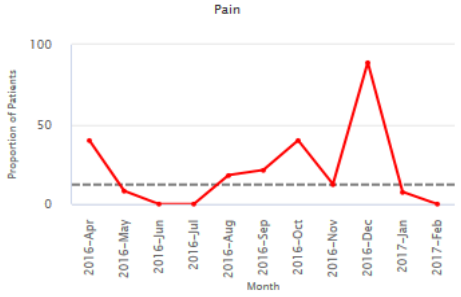
Children and Young Persons' Safety Thermometer

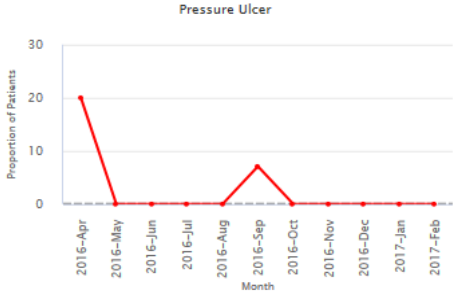
The Trust has started to submit data to the Children and Young Persons' Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. The table below illustrates the data that is recorded.
The Children & Young People's Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in children and young people's services. As a point of care survey it integrates measurement for improvement into daily routines and supports improvement in patient care. Data are collected on a single day each month and enables wards, teams and organisations to understand the burden of harm to children and young people. Data can be used as a baseline to direct improvement efforts and then to measure improvement over time.

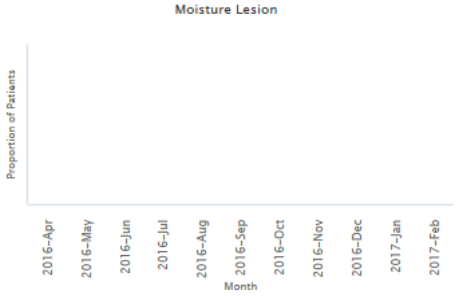










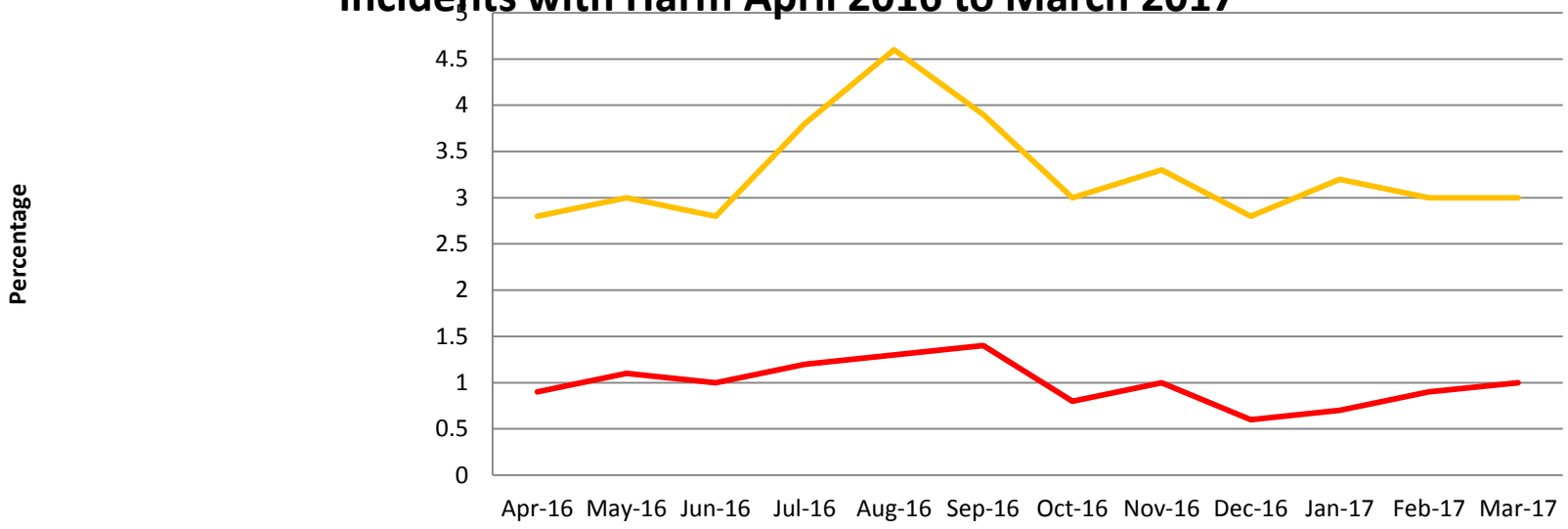


5. **All patient contact and harm – In contrast to the Safety Thermometer which measures the number of harm on one particular day of the month, the following data represents the total number of patient contacts in March 2017 compared to all incidents reported and incidents resulting in harm. Harm includes 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
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
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794
Feb-17	52	5	0	2	59	188	6429
Mar-17	80	6	0	0	86	250	7326

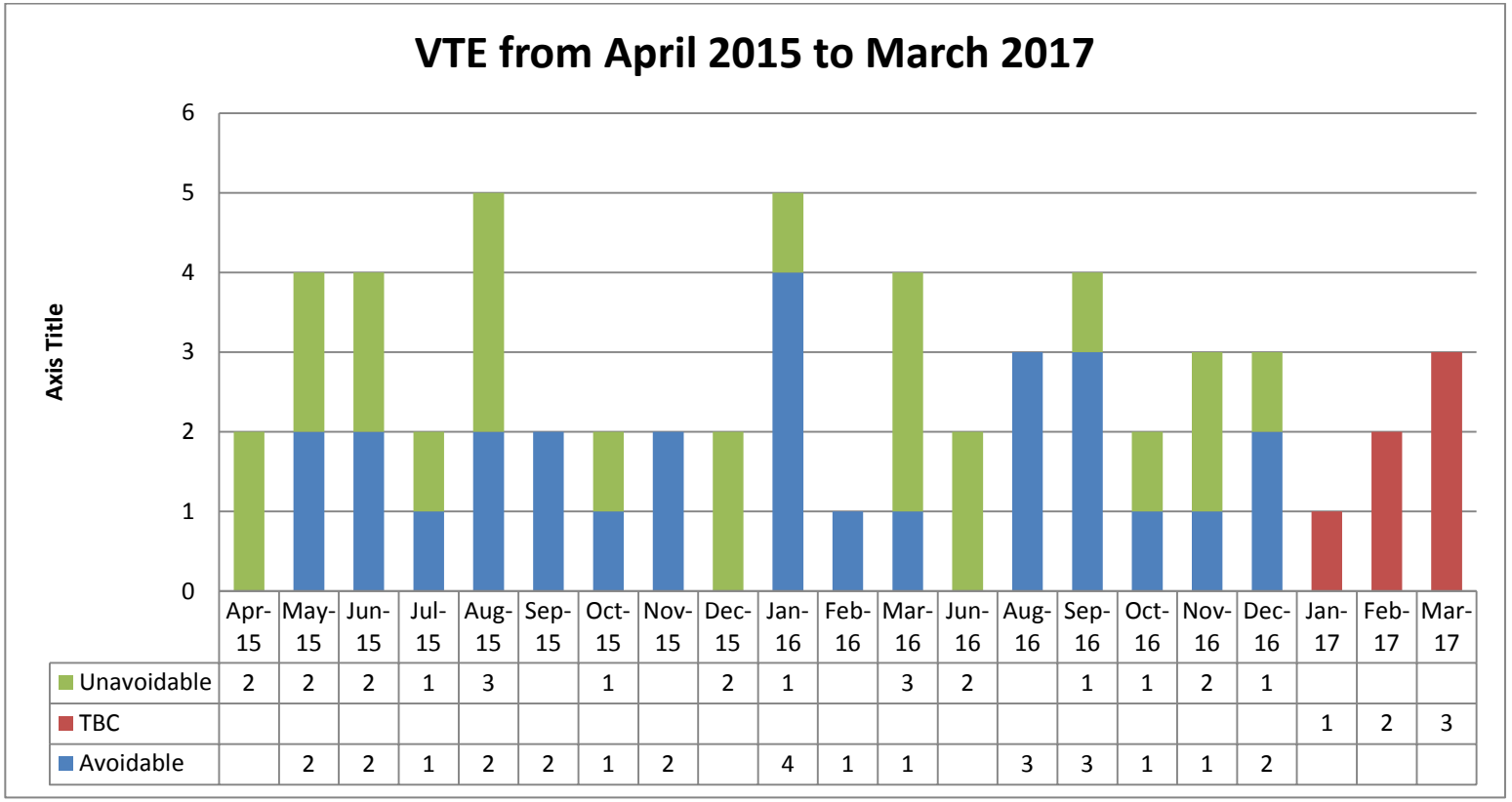
In March 2017, there were a total of 7326 patient contacts. There were 250 incidents reported which is 3 percent of the total patient contacts resulting in an incident. Of those 250 reported incidents, 86 incidents resulted in harm which is 1 percent of the total patient contact.

% of Patient Contact Compared to Number of Incidents and Incidents with Harm April 2016 to March 2017



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
% of Patient Contacts with Incidents Causing Harm	0.9	1.1	1	1.2	1.3	1.4	0.8	1	0.6	0.7	0.9	1
% of Patient Contact With All Incidents Reported	2.8	3	2.8	3.8	4.6	3.9	3	3.3	2.8	3.2	3	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).**



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Jun-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Unavoidable	2	2	2	1	3		1		2	1		3	2		1	1	2	1			
TBC																			1	2	3
Avoidable		2	2	1	2	2	1	2		4	1	1		3	3	1	1	2			

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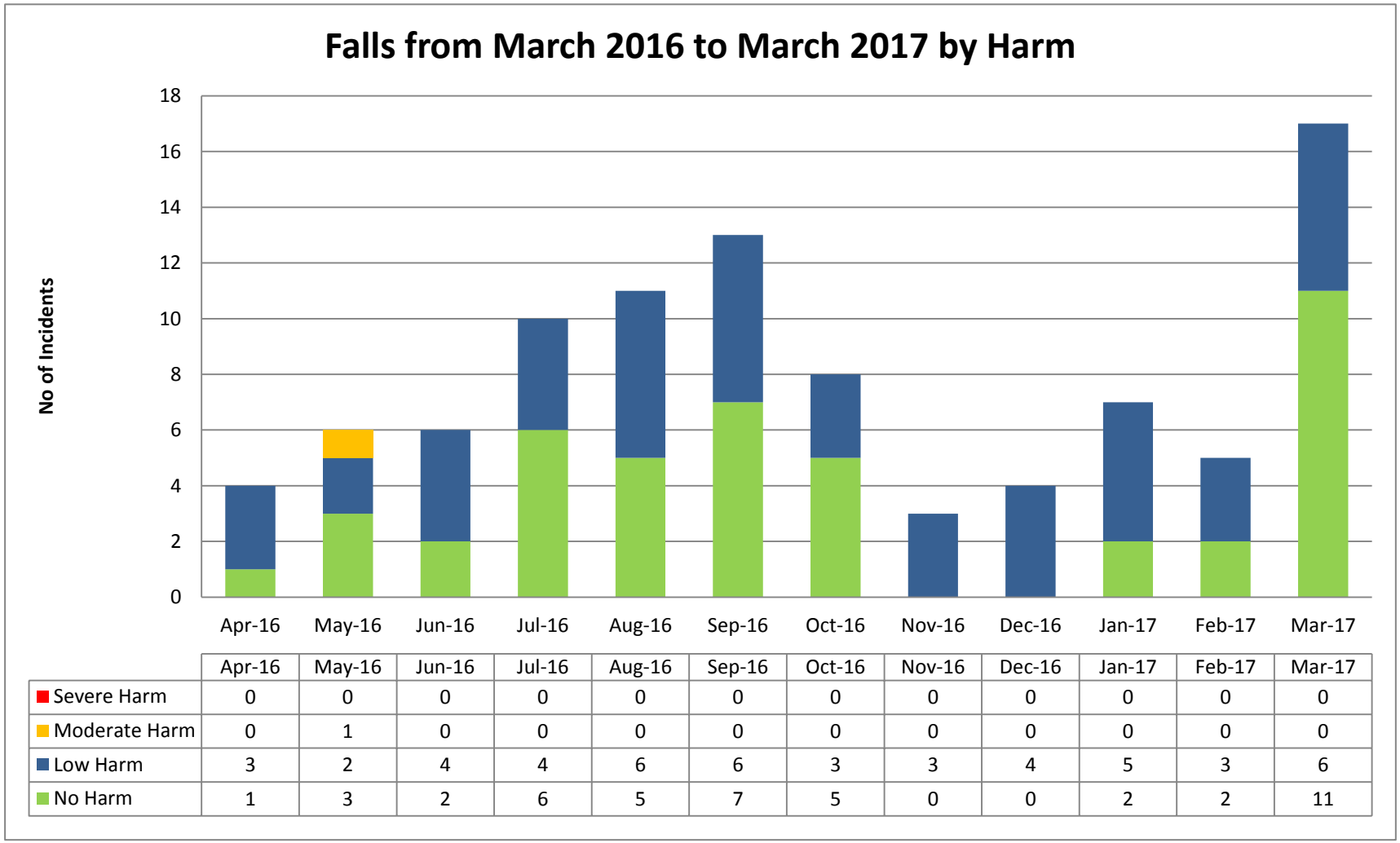
Year to date total		Avoidable
15/16	35	18
16/17	23	10

INFORMATION
There were **three** VTEs declared as Serious Incidents in March 2017; **20049 –** Ward 12 post-discharge VTE **20037 –** Ward 2 - post-discharge VTE **19972 –** ADCU -post-discharge VTE This is due for submission with the Commissioners in June 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
All commissioner KPI's /audits have been completed and continue to be consistently achieved VTE training continues for Student nurses, training for registered and non-registered staff (clinical update days) was suspended in Q4 but will re-commence in April 2017. It is mandatory for clinical staffs 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. Now that the VTE guidelines have been finalised and approved the requirements for meeting exemplar site status are met which has enabled application to be completed in Quarter 4.
RISKS / ISSUES
The Governance team ensure VTE action plans are completed on Ulysses to enable appropriate completion and monitoring. On-going key issue identified from RCA's is non-completion of 24 hour risk assessments by Medical staff. This will be a mandatory field once PICS implemented. Shared learning continues.

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.**



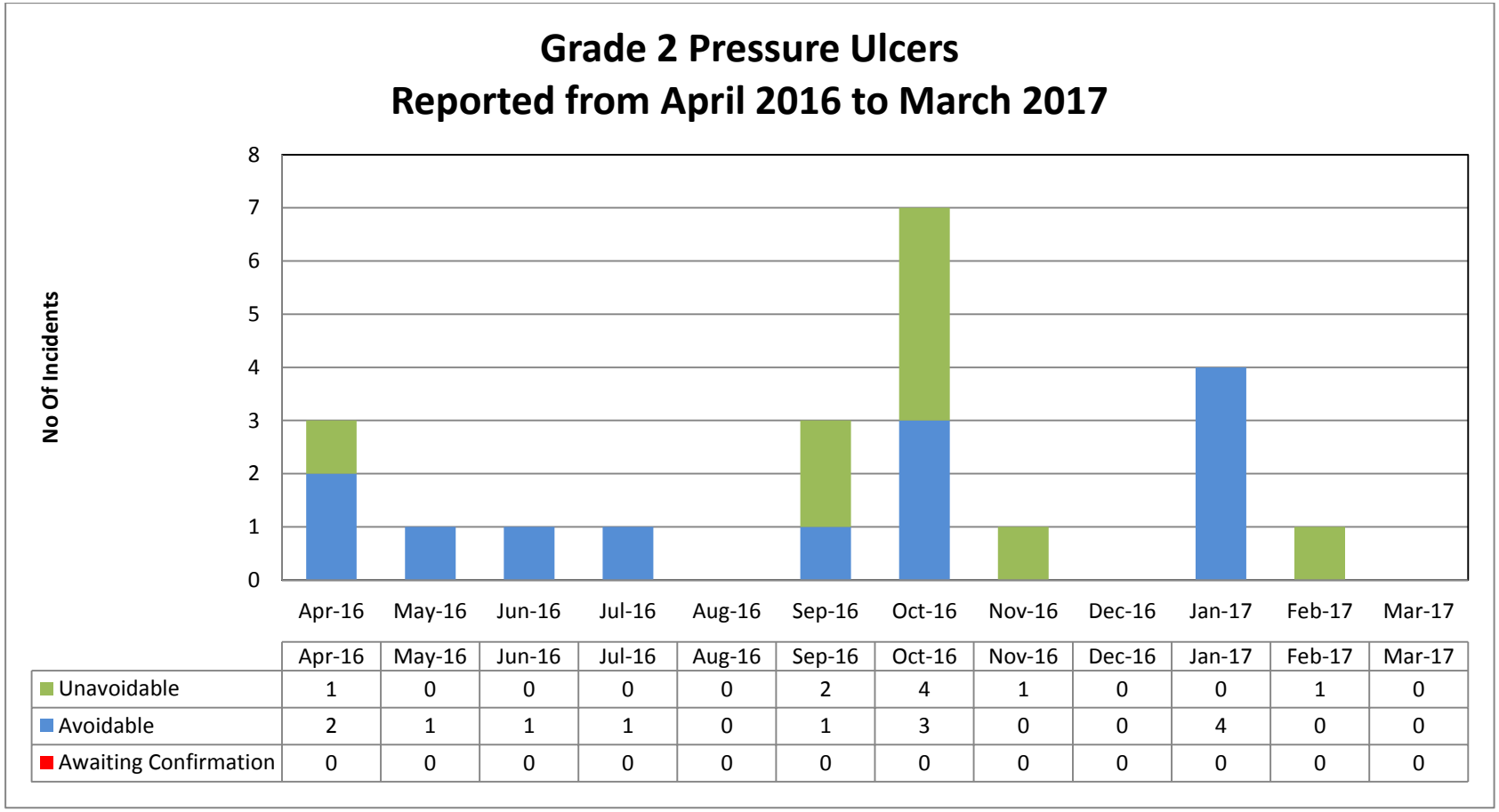
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	1	0	0	0	0	0	0	0	0	0	0
Low Harm	3	2	4	4	6	6	3	3	4	5	3	6
No Harm	1	3	2	6	5	7	5	0	0	2	2	11

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

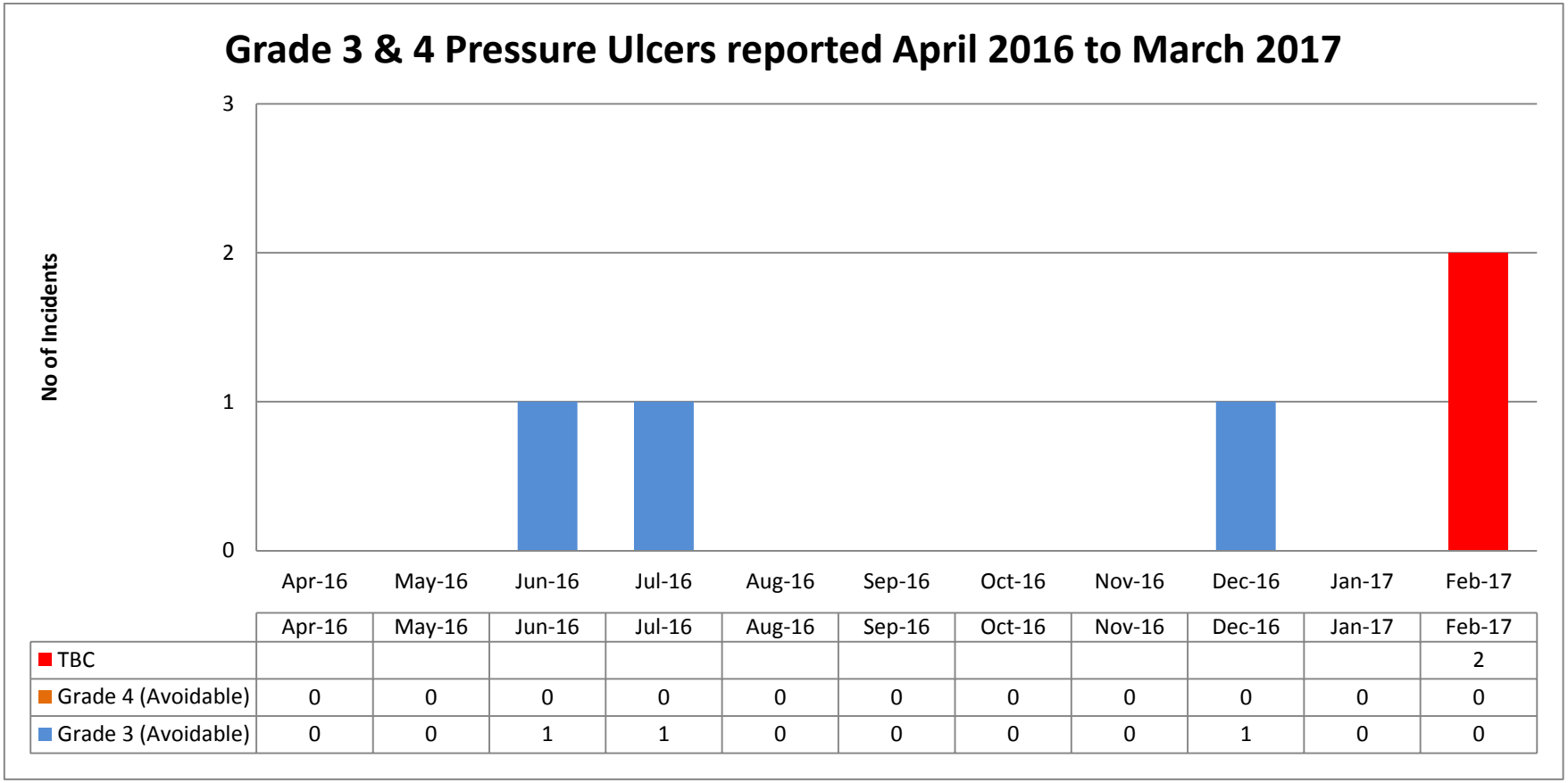
First choice for orthopaedic care

INFORMATION
There have been seventeen reported falls in Division One for March 2017, which is a significant increase. Analysis shows no trend in Ward area, no patient consistency and no links with staffing levels.
ACTIONS FOR IMPROVEMENTS / LEARNING
• The Falls Working Group (FWG) meetings recommenced in December 2016 and are scheduled bi-monthly after the January 2017 meeting. • Through the Falls Working Group the work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller is in progress. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care. • An update regarding the Throne Project is still being sought from therapies. This is being addressed through the Falls Working Group meetings Trend analysis identified that patients fall in the bathroom/toilet. • Falls information boards are to be standardised across all ward areas, with the information being agreed at the FWG meeting in March 2017. 'Walking stick' visual information to be produced on a monthly basis for all ward areas for cascading of information regarding the number of falls per ward, per month to all staff. • To note: annual bed rail audit is due in April 2017.
RISKS / ISSUES
Reassessment of risk assessments need to be completed more consistently.

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	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Unavoidable	1	0	0	0	0	2	4	1	0	0	1	0
Avoidable	2	1	1	1	0	1	3	0	0	4	0	0
Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	0	0



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
TBC											2
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0
Grade 3 (Avoidable)	0	0	1	1	0	0	0	0	1	0	0

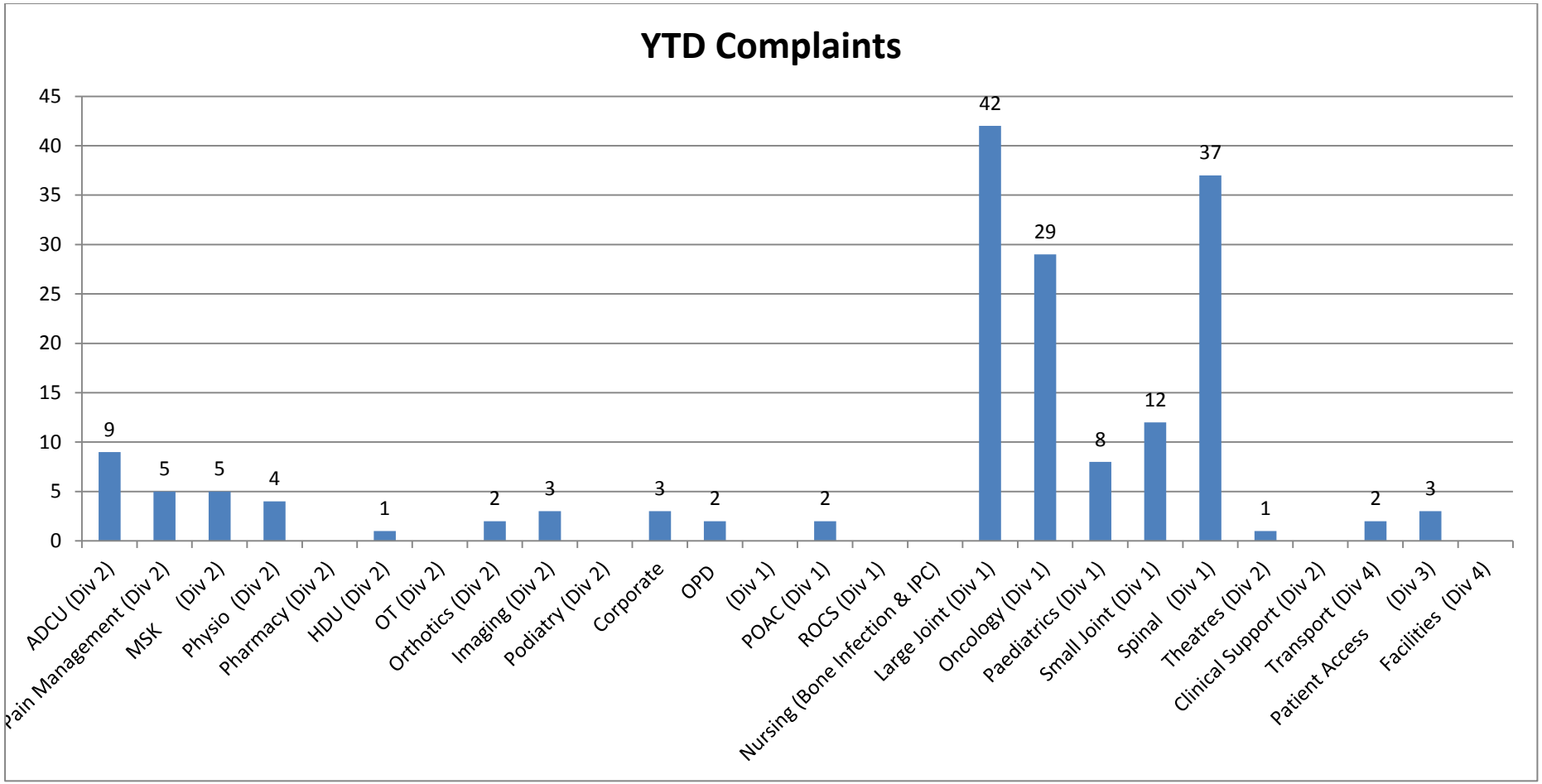
In total, from 1st April 2016 the Trust has reported the following avoidable pressure ulcers:

13 avoidable Grade 2 pressure Ulcers against a limit (target) of 15. (One Grade 2 Pressure Ulcer currently awaiting RCA to establish avoidability and are therefore not included in these figures)

3 avoidable Grade 3 pressure Ulcers against a limit of 0. (One Grade 3 Pressure Ulcer currently awaiting RCA to establish avoidability and are therefore not included in these figures) **0 avoidable Grade 4 pressure Ulcers** were reported against a limit of 0.

INFORMATION
There have been Five reported grade 2/4 incidents for March. All were present on admission from home, nursing home or referring Trust. There was 1 x Grade 3 Pressure Ulcer and 1 x Grade 4 Pressure Ulcer, a letter was requested to be sent by governance to the GP in charge of the patients care, to investigate these. There were 2 x Grade 3 incidents identified upon admission. These were identified under plaster casts, which were applied at The Royal Orthopaedic Hospital. We shall therefore, be investigating these incidents further. **Update from previous report:** The outstanding Grade 2 Pressure Ulcer from the January investigation has now been completed. This has been determined avoidable due to gaps in documentation
ACTIONS FOR IMPROVEMENTS / LEARNING
Charitable funds investment has been accepted and will improve the patient chairs – new chairs will meet IPC and TV requirements (built in pressure relieving properties).
RISKS / ISSUES
None

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.



19

INFORMATION

PALS

The PALS department handled 421 contacts during March 2017 of which 124 were classified as concerns.

Compliments

There were 294 compliments recorded in March 2017, with the most being recorded for Div 1. This is lower than last month with the Pre-Operative Assessment Clinic continuing to receive a significant number of compliments. Areas have been reminded to submit their records for central recording.

Complaints

There were 12 formal complaints made in March 2017, bringing the total to 170 for the year in total.
The subjects of this month's complaints were:

Initially Risk Rated Red:

- Delays to Spinal Deformity Surgery (Div 1, Spinal)

Initially Risk Rated Amber:

- Refused knee surgery as BMI too high (Div 1, Large Joints)
- Nursing Care on Ward (Div 1, Large Joint)
- Lack of contact from Medical Secretary (Div 1, Spinal)
- Outcome of Outpatient appointment, possible IG breech (Div 1, Large Joint)
- Waiting for surgery (Div1, Spinal)
- Communication regarding treatment (Div 1, Oncology)
- Delay to receiving results; attitude of admin staff (Div 1, Oncology)

Initially Risk Rated Yellow:

- Referral process to another service (Div 1, Small Joints)
- Cancellation of short notice injection (Div 2, Theatres)
- Delay in receiving injection (Div 2, ADCU)

- Unhappy with response from clinician (Div 1, Large Joints)

Of the 15 complaints closed in March 2017:

- 9 were upheld
- 6were partially upheld
- 0 were not upheld

All upheld complaints had elements of poor communication that had caused misunderstanding or difficulty for the patients involved.

There were 294 compliments recorded in March 2017, with the most being recorded for Div 1. This is lower than last month with the Pre-Operative Assessment Clinic continuing to receive a significant number of compliments. Areas have been reminded to submit their records for central recording.

ACTIONS FOR IMPROVEMENTS / LEARNING

Learning identified and actions taken as a result of complaints closed in March 2017 include:

- Provision of hearing loops for patients with hearing issues is not consistent in all departments
  Action: Div 1 and Estates working together to identify needs. Complainant is involved in the planning and gap analysis to improve provision.

- Process of informing patients that appointment has been changed is not applied consistently
  Action: Team are reviewing issues and identifying need for changes to process

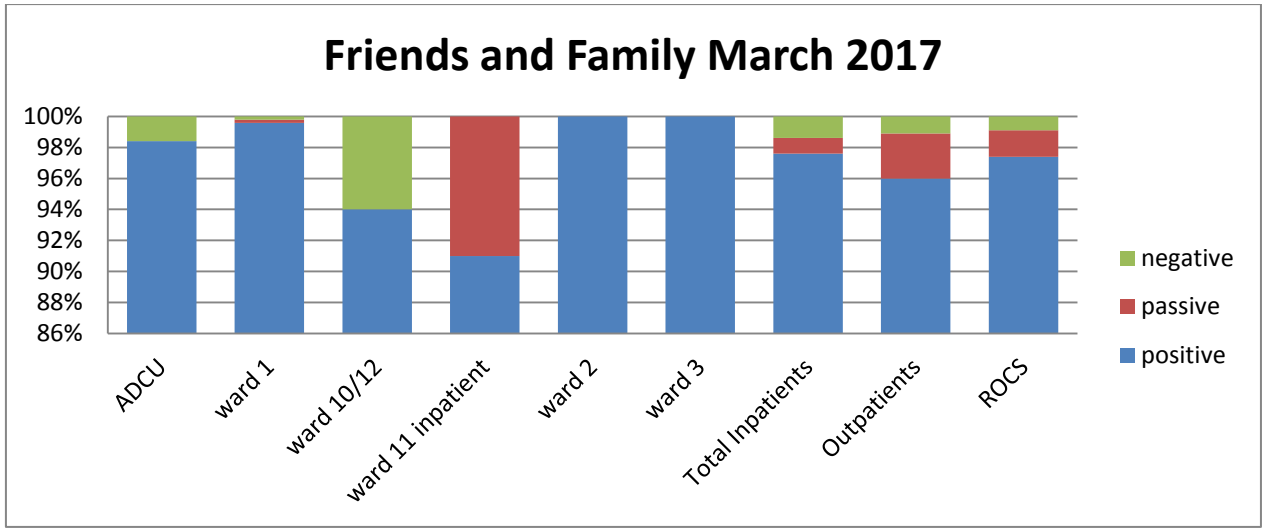
RISKS / ISSUES

None Identified.

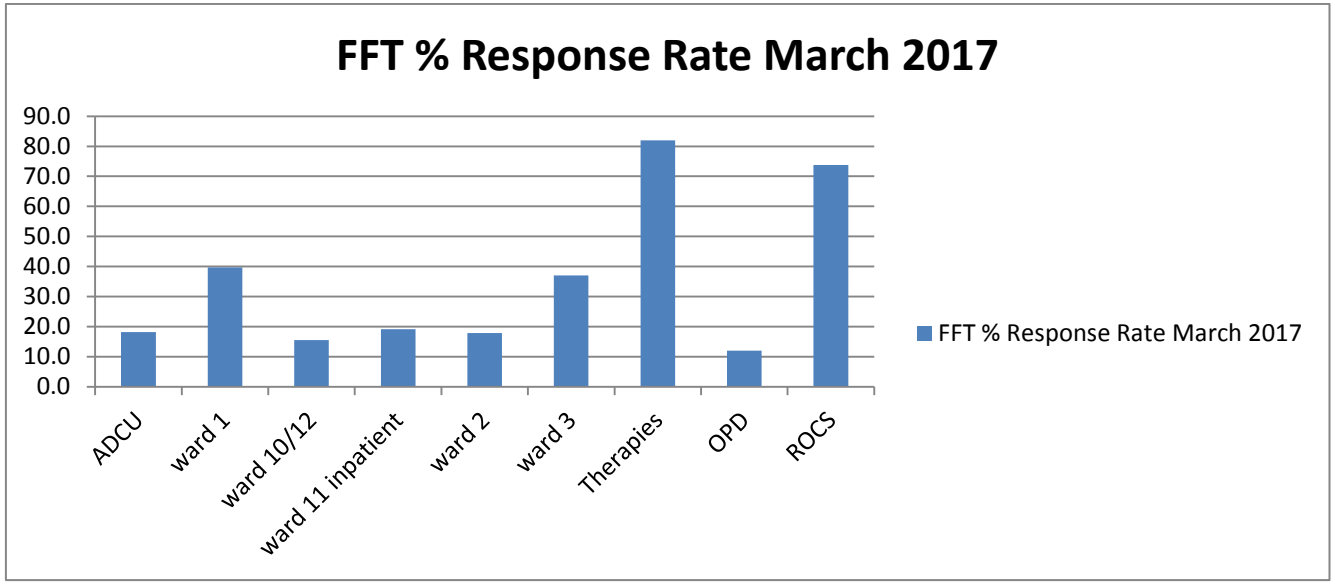
10. Friends and Family Test Results - The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

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 March 2017 are 97% of those who responded would promote ROH.



The highest % return rate for questionnaires is Ward 1 at 58%. The lowest is Ward 11 at 19% Both of these rates is higher than the previous month.

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.

There is no national target response set however, as a Trust we are aiming to achieve 35% response rate across all areas in Q1 17/18. This would enable the Trust to gain a richer understanding of the service provision from our patient's perspective.

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 18 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. All DOC is compliant.

12. Litigation

T515

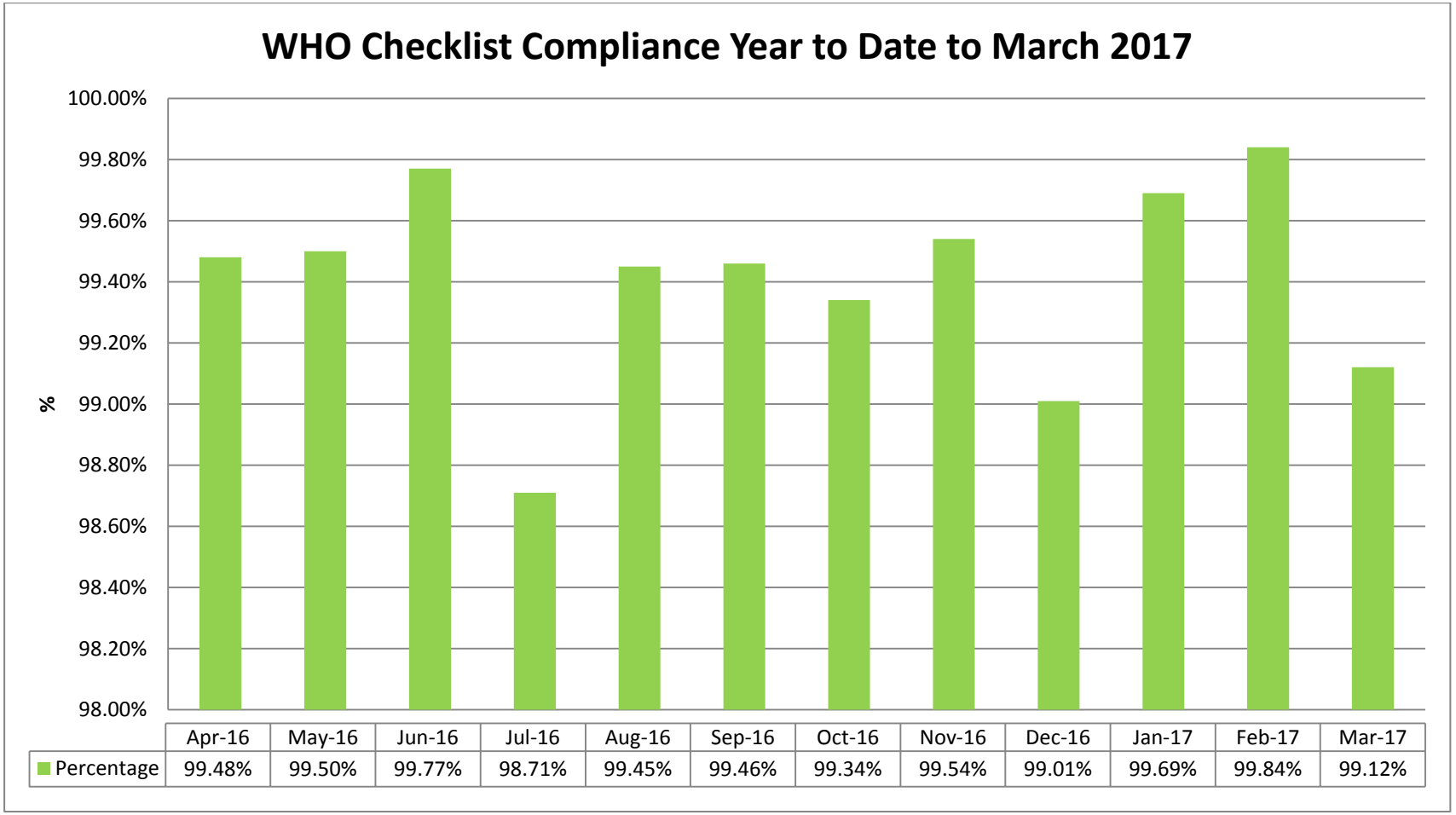
Alleged negligent assessment, care and treatment of VTE, resulting in PE. RCA concluded that VTE was avoidable (post-operative risk assessment missed vital factors, there was a 2 day delay in completing the 24 hour post-operative risk assessment and there were gaps in documentation of VTE prevention methods used).

The formal Letter of Claim from the claimant's solicitor included an offer of settlement which has been accepted by the Trust.

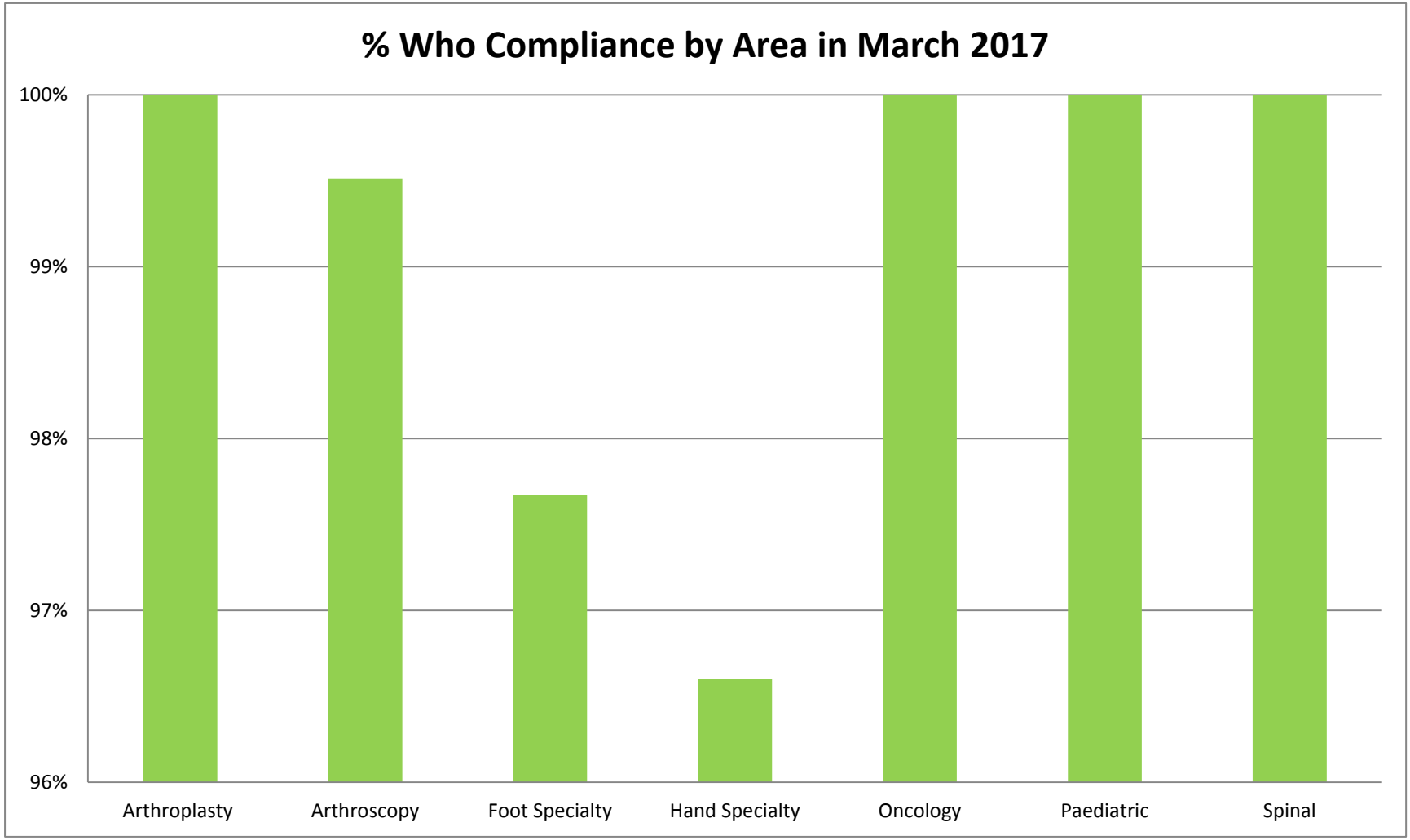
13. Coroner's

No Coroners inquests in March 2017

14. 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 perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Percentage	99.48%	99.50%	99.77%	98.71%	99.45%	99.46%	99.34%	99.54%	99.01%	99.69%	99.84%	99.12%


% Who Compliance by Area in March 2017
100%
99%
98%
97%
96%
Arthroplasty
Arthroscopy
Foot Specialty
Hand Specialty
Oncology
Paediatric
Spinal

INFORMATION

March 2017

Total Cases = 601

Total Non Compliances = 3

Total Compliance = **99.12 %**

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

All non-compliance was due to Consultants not completing the sign/time out section.

The oncology non-compliance discussed in March 2017 report was due one and Team missing a Section off the Time Out – affecting 1 Patient.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 7 June 2017

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 7 June 2017 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, Mary Higgs at the Management Offices or via email mary.higgs@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** 7 June 2017: 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)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Executive Director of Finance & Performance & Acting Chief Executive	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Guests

Ms Elaine Chapman	Patient Engagement Officer	(EC)	[Item 3]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies – Jo Chambers	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	Patient story – Engagement with children and young people	Presentation	EC
1125h	4	Minutes of Public Board Meeting held on the 1 March 2017: *for approval*	ROHTB (3/17) 014	Chair
1130h	5	Trust Board action points: *for assurance*	ROHTB (3/17) 014 (a)	SGL
1135h	6	Chairman's and Chief Executive's update: *for information and assurance*	ROHTB (6/17) 002 ROHTB (6/17) 002 (a)	YB/PA
QUALITY & PATIENT SAFETY				
1145h	7	Patient Safety & Quality report: *for assurance*	ROHTB (6/17) 003	GM
FINANCE AND PERFORMANCE				
1200h	8	Finance & Performance overview: *for assurance*	To follow	PA

GOVERNANCE, RISK AND COMPLIANCE				
1215h	9	Staff survey and analysis: *for assurance*	ROHTB (6/17) 006 ROHTB (6/17) 006 (a) ROHTB (6/17) 006 (b)	PB
1235h	10	NHS Improvement annual declarations – corporate governance statement and governor training: *for approval*	ROHTB (6/17) 007 ROHTB (6/17) 007 (a) ROHTB (6/17) 007 (b)	SGL
1245h	11	Board Assurance Framework 2016/17 – Quarter 4 update	ROHTB (6/17) 008 ROHTB (6/17) 008 (a)	SGL
UPDATES FROM THE BOARD COMMITTEES				
1250h	12	Quality & Safety Committee	ROHTB (6/17) 009 ROHTB (6/17) 010 ROHTB (6/17) 011	KS
	13	Finance & Performance Committee	ROHTB (6/17) 012 ROHTB (6/17) 013	TP
	14	Audit Committee	ROHTB (6/17) 014	RA
	15	Major Projects & OD Committee	ROHTB (6/17) 015	RP
	16	Council of Governors update	Verbal	YB
MATTERS FOR INFORMATION				
1315h	17	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 6th September 2017 at 1100h, Board Room, Trust Headquarters				

Notes

Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 1 March 2017: 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)
Mr Richard Phillips	Non Executive Director	(RP)
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:

Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	Paper Reference
1 Apologies	**Verbal**
Apologies were received from David Gourevitch.	
2 Declarations of interest	
There were no declarations of interest notified in advance.	
3 Patient story - Rapid Recovery	
The Board watched a video transcript of an interview with a patient who had been through the Rapid Recovery pathway. This had initially started through an enhanced recovery programme engineered by Mr Pearson some time ago and which had gained support from the Transformation Team to develop it into the Rapid Recovery pathway. A CQUIN had been set which required fifty patients to have been treated using Rapid Recovery; this had been rolled into the next year	

given its success. There had been much learning from these patients and the pathway was now to be expanded to cover hip patients. The primary objective was to provide great patient experience and feedback showed that there was continuous improvement in the health outcomes of this set of patients. A key member of the Transformation Team involved in this work had left but a new Physiotherapist had been appointed to support the work. This was excellent progress and there were plans to communicate the benefits of 24 hour recovery. Some of the money from the CQUIN could be reinvested into making professional marketing material and a toolkit to harness the lessons learned, benefits realisation and the planning of the work. The success of the work was enhanced by being achieved in a multi-disciplinary way. The Board agreed that this had the potential to be transformational for the Trust and its patients. Thought needed to be given to the means of expediting the work to cover a wider range of individuals through a series of steps and protocols. The discharge planning was noted to be critical to this pathway, as was the post-operative support at home. Good pain control was also needed. It was agreed that an update on this would be useful at a future meeting.	
4 Minutes of Public Board Meeting held 11 January 2017	**ROHTB (1/17) 015**
The minutes of the Private Board meeting held on 11 January 2017 were accepted as a true and accurate record of discussions held.	
5 Trust Board action points	**ROHTB (1/17) 015 (a)**
The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern.	
6 Chairman's & Chief Executive's update	**ROHTB (3/17) 002** **ROHTB (3/17) 002 (a)**
The Chairman reported that: • Herself and Kathryn Sallah had met with Mick Laverty at Bournville Gardens retirement village to see if there was any possibility of engaging with the Gardens over the provision of 'step down' facilities • She had attended Mr Stirling's leaving function and the Staff Awards ceremony on 3 February, where a good night was had by all. It was noted that the Staff awards criteria were to be reviewed in future. • There had been an Informal Board session on 1 February, where the previous work on team working was explored further, particularly in the context of a set of Board 'rules'	

• She had met with Ben Bury, the lead teacher for ROH • A tree dedication ceremony had occurred on 14 February 2017 • A Skype call with the Chair and CEO of Robert Jones & Agnes Hunt was held and a further Chair to Chair discussion was planned • Phil Begg was congratulated on his recent appointment as Director of Strategy & Delivery and Garry Marsh was also noted to have been appointed into the role of Director of Patient Services; these were both voting Executive positions and took effect from 1 April 2017 The Chief Executive highlighted that the Trust had been signed up to the West Midlands Mental Health Concordat. In the last week, she had also undertaken an interview with the Health Service Journal around the Vanguard work. It was reported that some of the meeting structures had been reviewed to eliminate duplication of reporting and as a result, Trust Management Committee had been abandoned. Garry Marsh would use this space for operations discussions instead. Business cases and policies would be presented to the Executive Team in future for approval but would be reported up to the Board through future Chief Executive updates.	
7 Patient Safety & Quality Report	**ROHTB (3/17) 003**
It was noted that the key points of the report were captured in the upward report from the Quality & Safety Committee The detail of the deaths highlighted in the report was outlined. These would be reviewed through the Clinical Audit and Effectiveness Committee in future as part of the mortality report.	
8 Finance & Performance overview	**ROHTB (3/17) 004**
It was noted that the key discussions on finance and performance matters had been covered in the earlier private session. The Board was advised that there had been a deterioration in the performance against the 18 weeks referral to treatment time target. Cash had also deteriorated and paperwork was being prepared to request cash support from the Department of Health from the summer 2017. Tim Pile added that there were a number of positive aspects to the Trust's finance and performance position, with many developments, such as information sharing and a mindset change around the activity position. The impact of the Trust's challenging finance and activity position on quality & patient safety was carefully monitored by Quality & Safety Committee.	

9 Diversity & Inclusion update	**To follow**
It was agreed that this item was to be deferred to the next meeting to allow greater opportunity for discussion.	
10 Quality & Safety Committee & terms of reference for approval	**ROHTB (3/17) 005** **ROHTB (3/17) 006** **ROHTB (3/17) 007**
Kathryn Sallah reported that a greater level of assurance was provided by the Chair of the Drugs and Therapeutics Committee, as part of an upward report considered at the last meeting of the Quality & Safety Committee. The Committee had made comment on the proposed spinal deformity letters to patients and GPs which had been fed back to the communications team. The backlog of NICE guidance had been cleared. There had been a positive report on the actions being taken to ensure compliance with the WHO Checklist. The revised terms of reference for the Quality & Safety Committee were agreed subject to some typographical errors and titles.	
11 Finance & Performance Committee	**ROHTB (3/17) 008**
The Board was asked to receive and accept the assurance report from the Finance & Performance Committee. The key points highlighted were: • Job planning progress was good and positive progress had been made with reducing cancellations and DNAs. • There was an expectation that the Trust would increase its use of text technology month on month as there was better collection of information through 'In Touch'. • The sharing of greater performance management information was a key driver to culture change and clinical engagement. • The essence of the procurement strategy was to be shared at the April meeting. • The deterioration in the 18 weeks RTT position needed to be addressed as a	

priority, however the Committee was assured by the work to develop trajectories and plans by Operations, particularly as the route to resolving this had benefitted from good clinical input. • The use of e-learning to address the mandatory training position was encouraged. • Work was underway to review and amend the processes in Oncology, including a more robust MDT approach • The Committee had noted that the activity plan was less ambitious than last year's plan, although this was explained by a difference in casemix between the two years. • The underperformance on activity detailed in the recovery plan had stabilised to a position below where it was expected to be. • The delay in the implementation of Theatreman was highlighted; this would now go live on 6 March • The two further recovery days planned for March were being reviewed for financial viability.	
12 Council of Governors update	**Verbal**
The Chairman reported that at the meeting of the Council of Governors on 18 January, the following were the key points of discussion: • David Gourevitch was appointed as a new NED for a period of three years • The Council agreed that Rod Anthony's term of office could be extended for a further three year period when his first finished in May • The Council had been given an update on the STP and the Memorandum of Understanding that had been developed • A useful session on NHS finances and the financial positon of the ROH had been delivered by Alex Gilder, Deputy Director of Finance. The Council was also appraised of the impact of the new tariff. • Tim Pile gave an update on the work of the Finance & Performance Committee and the key activities involved in the recovery plan. One of the governors observed that the plan was silent on the issue of workforce in terms of retention, reward and recruitment • Garry Marsh joined the meeting to explain how the new divisional	

management structures and plans would work • Kathryn Sallah talked through the key discussions at Quality & Safety Committee • Stella Noon joined the meeting as the Chair of the Patient & Carer's Council. She advised that the operation of the forum had been difficult recently but new administration arrangements had been put into place which would turn the committee around • Jean Rookes' husband Dr Peter Rookes joined the meeting to address the Council and to thank all for their support following the death of his wife. • A new public governor had been elected, based on a revisit of the last set of elections – this was Lindsey Hughes. She had a good background as a nurse and was looking forward to making a difference on the team.	
13 Any other business	
It was reported that the Trust was to be featured on ITN Tonight where one of the Trust's cases was to be discussed. The Chairman asked for views as to how the meeting had been conducted in line with the Board 'rules' It was agreed that it had felt like a positive meeting and the discussions had eliminated duplication. The strategy discussion in private was positive.	**Verbal**
Details of next meeting	**Verbal**
The next meeting is planned for 5 April 2017 at 1100h in the Boardroom, Trust HQ.	

PUBLIC SESSION

Next Meeting: 7 June 2017, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

1 March 2017, Boardroom @ Trust Headquarters

Members present: Yve Buckland (YB), Tim Pile (TP), Rod Anthony (RJA), Kathryn Sallah (KS), Richard Phillips (RP), Jo Chambers (JC), Paul Athey (PA), Garry Marsh (GM), Andrew Pearson (AP), Phil Begg (PB)

In Attendance: None

Apologies: David Gourevitch (DG)

Secretariat: Simon Grainger-Lloyd (SGL)

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 036	Patient Story - Rapid Recovery	Video	01/03/2017	Update on progress to be brought to a future meeting.	SGL	06-Sep-17		

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):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Paul Athey, Acting Chief Executive**
DATE OF MEETING:	**7 June 2017**

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 Executive Team recently..

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 7 June 2017

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 April 2017.

2 REFERRAL TO TREATMENT (RTT) RECOVERY PLAN

2.1 The Trust continues to work with key external stakeholders (NHS Improvement, NHS England, CQC & local CCG) to provide assurance on actions required to recover the organisation's RTT position. Monthly oversight meetings have been in place since March 2017 to track progress against a series of quality & performance indicators, and an integrated action plan is in development. The Trust has appointed Price Waterhouse Cooper (PwC) as an improvement partner to develop the integrated plan and implement a project management methodology to track progress going forward.

2.2 Specialty level trajectories have been developed to deliver recovery by March 2018 in the majority of specialties excluding Spinal Deformity. Discussions are ongoing in relation to Paediatric Spinal Deformity service delivery in partnership with Birmingham Children's Hospital. A joint stakeholder meeting involving key individuals at the Royal Orthopaedic Hospital and Birmingham Women's and Children's Hospital is being convened, to be chaired by NHS Improvement.

2.3 Staff briefings were held during the week of 22 May 2017 to outline the key challenges that face the organisation, including:

- Validation of significant number of open referrals/pathways on our waiting list system
- Review of long waiting patients & risk of potential harm
- Cancer pathways & cancer reporting
- Patients waiting over 18 and 52 weeks

3 OPERATIONAL IMPROVEMENTS

3.1 Theatreman, our new IT system to support our operating theatres, successfully launched on 24 May 2017. This system now replaces Ormis, and will provide a more comprehensive, efficient means of listing patients for theatre, recording equipment needs and tracking productivity.

3.2 From April 2017, consultants have been provided with monthly performance dashboards, allowing them to access key performance metrics related to their practice, including individual waiting lists (with 18/52 breaches highlighted), average length of stay and DNA rates.

4 STAFF RECOGNITION

4.1 Our Long Service Awards were held on 11 May 2017, celebrating staff who have achieved 20 or 40 years' service in the NHS. This is a significant achievement, and one which was marked by a formal ceremony in the Knowledge Hub, with 29 staff eligible for these awards. Line managers were asked to provide a supportive statement to recognise their team member's achievement, and certificates were presented by the CEO.

4.2 The Trust celebrated International Nurses Day on 12 May 2017, recognising the invaluable contribution towards compassionate care provided by our nursing workforce. This also marked the official launch of the Trust's Nursing Strategy.

5 BICENTENARY CELEBRATIONS

5.1 This year marks our 200 year anniversary as an organisation, and as such, our Communications Team are leading on the delivery of a series of events to mark such an important milestone:

- We have successfully completed a collaborative schools project with Heritage England, culminating in a piece of commemorative artwork which will be displayed during June
- All members of staff and volunteers will receive a bicentenary commemorative pin badges to mark our 200 year history
- The Bicentenary summer fete will be held on Saturday 8 July 2017, open to all staff, patients, external stakeholders & the public – further information can be found at www.roh.nhs.uk/bicentenary
- A Bicentenary book & film are in development, and will be published in September 2017

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:

- West Midlands Provider CEO meeting
- CEO Development session
- Stakeholder Oversight meetings (April & May) with NHSI, NHSE, CQC & CCG
- Paediatric Spinal Deformity meeting with NHSI and NHSE
- STP Board meeting
- STP Development and Delivery Group

7 POLICY APPROVAL

7.1 The following policies have been recommended for approval by the CEO through the Executive Team business meeting:

- Restrictive Interventions policy
- Acute Pain Guidelines

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.

Paul Athey
Executive Director of Finance & Performance (on behalf of Jo Chambers, CEO)
1 June 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

May 2017

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Patient Services
AUTHOR:	Ash Tullett	Clinical Governance Manager

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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 and the CQC for routine engagement visits.

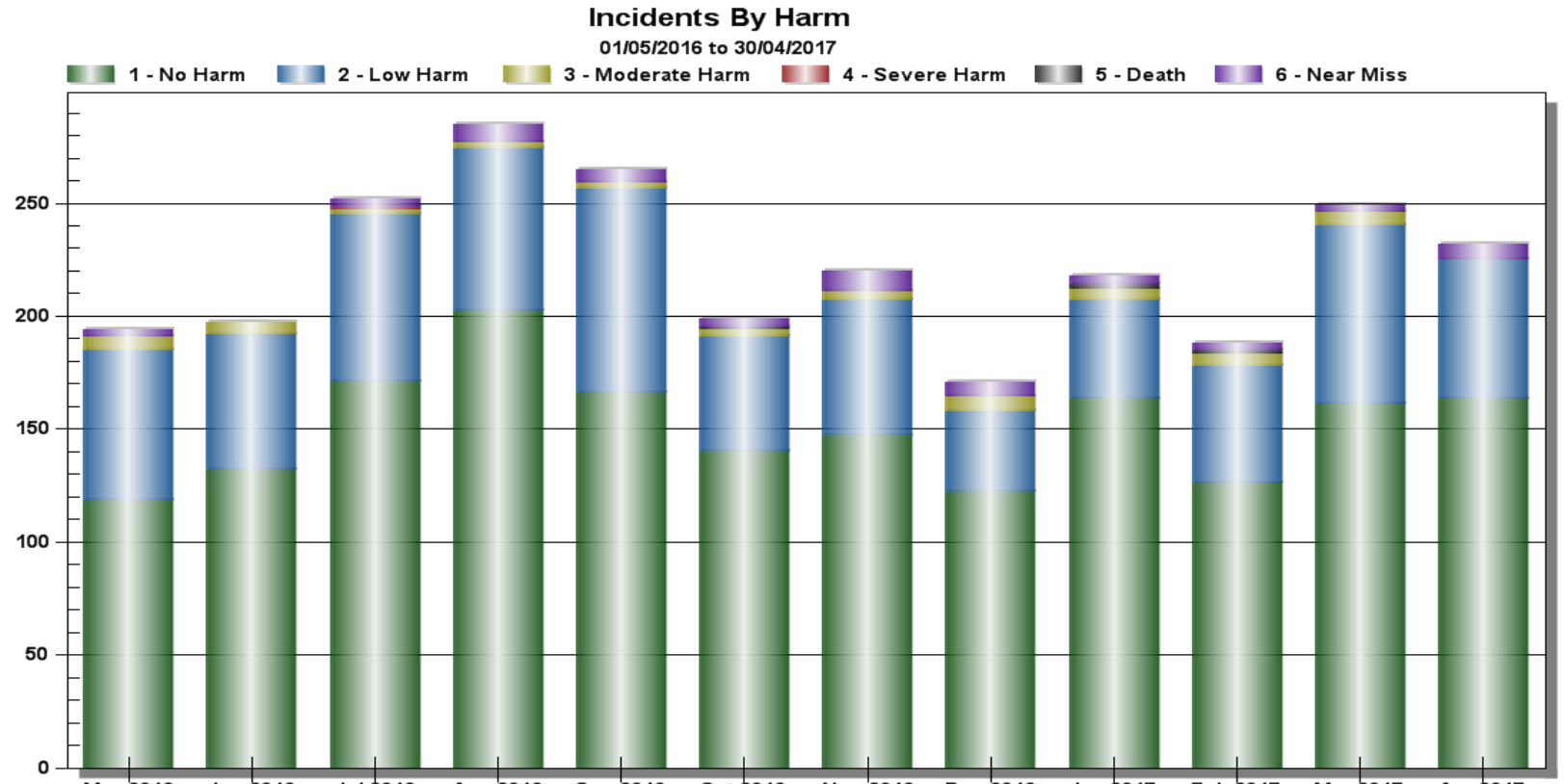
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

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.

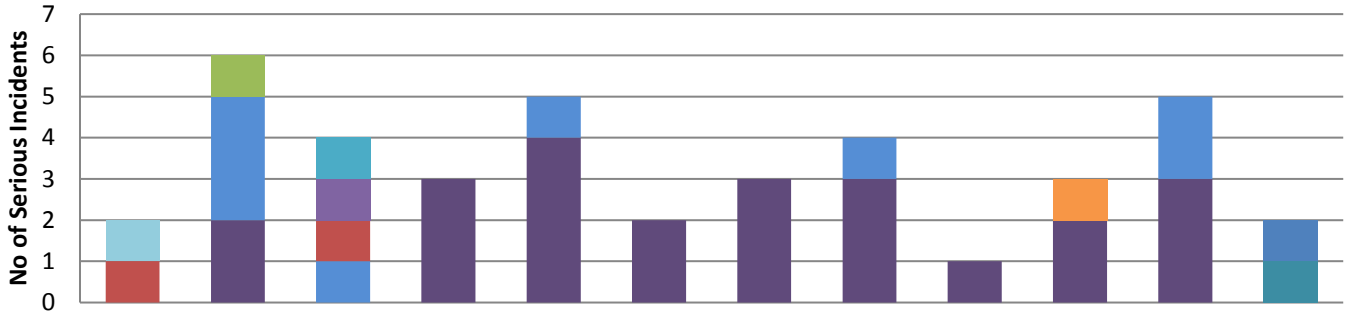


Month and Year	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017
1 - No Harm	118	132	171	202	166	140	147	122	163	126	161	163
2 - Low Harm	67	60	74	72	90	51	60	36	44	52	79	62
3 - Moderate Harm	6	5	2	3	3	3	4	6	5	5	6	0
4 - Severe Harm	0	0	1	0	0	0	0	0	0	0	0	0
5 - Death	0	0	0	0	0	1	0	0	2	2	0	0
6 - Near Miss	3	0	4	8	6	4	9	7	4	3	3	7

INFORMATION
In April 2017 there was a total of 232 Incidents reported on the Ulysses incident management system. All incidents were graded as No Harm and Low Harm.
ACTIONS FOR IMPROVEMENTS / LEARNING
As of March 2017 the new quality dashboards are in use and include all quality indicators. The Trust now has one central repository for all KPIs that can be used to populate any quality report. This includes KPIs on incidents and staffing information. This dashboard is to replace the ward health check that was previously found in the Quality report.
RISKS / ISSUES
The Trust has had issues with managers not reviewing and updating the incidents in a timely manner. The Governance Team have developed reports that highlight those areas with open incidents and these will be discussed at the weekly Governance meetings. The first reports will go live 1st June 2017 and will be available for all areas and departments.

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 to April 2017



	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Exposure to hazardous substance										1		
Wrong Site Incision			1									
Wrong Implant			1									
Suspension to services		1										
RTT Data Issue												1
Wrong side injection	1											
Suspension of Service (BCH Spinal)												1
Slips, trips & falls	1		1									
Pressure Ulcers	0	3	1		1			1			2	
VTE meeting SI criteria	0	2	0	3	4	2	3	3	1	2	3	

INFORMATION

There were **two** Serious incidents declared in April 2017;

20339 - Suspension of Service for Spinal Surgery at Birmingham Women's and Children's NHS Foundation Trust.
20307 - Referral to Treatment delay data issues meeting SI criteria.

These are due for submission with the Commissioners July 2017.

ACTIONS FOR IMPROVEMENTS / LEARNING

One Serious Incident report was submitted to the Commissioners during April 2017. The incident was reported in the February 2017 Quality report. This incident submitted was a avoidable VTE.

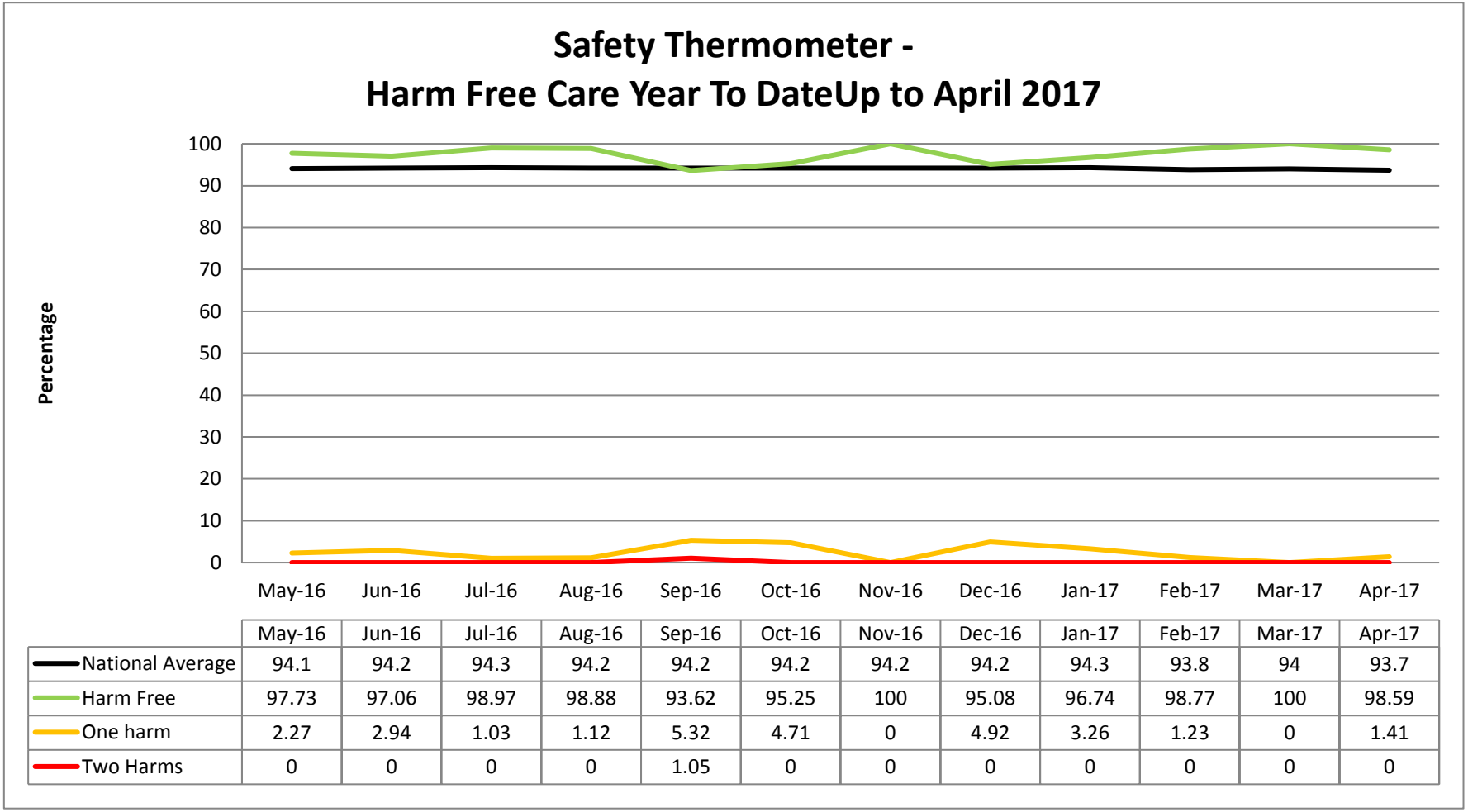
Learning

Risk assessment not completed in entirety (previous history)
Staff to adhere to dosage in trust guidelines

RISKS / ISSUES

None identified.

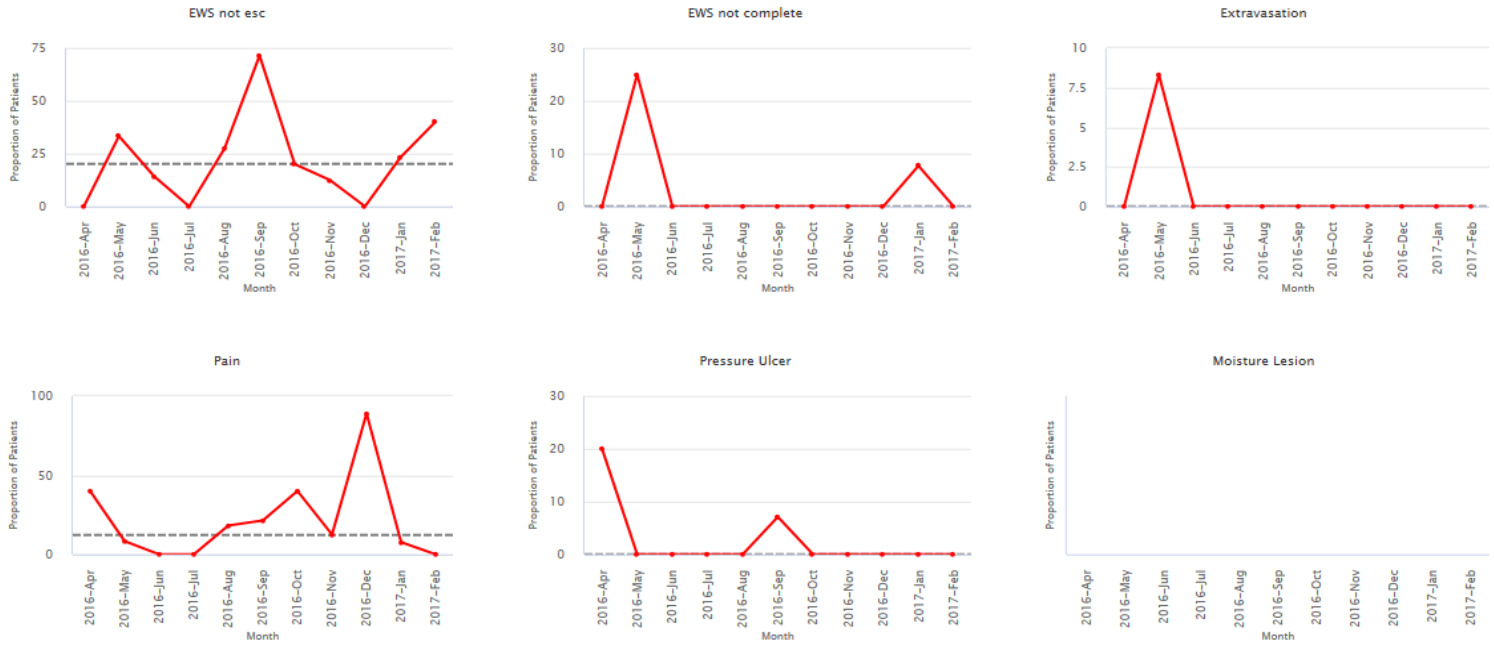
4. **NHS Safety Thermometer - provides a 'temperature check' on harm that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for patients. This is a point prevalence audit which measures the number of pressure ulcers, VTEs, falls and catheter acquired Urinary Tract Infections on a given day every month.**



	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
National Average	94.1	94.2	94.3	94.2	94.2	94.2	94.2	94.2	94.3	93.8	94	93.7
Harm Free	97.73	97.06	98.97	98.88	93.62	95.25	100	95.08	96.74	98.77	100	98.59
One harm	2.27	2.94	1.03	1.12	5.32	4.71	0	4.92	3.26	1.23	0	1.41
Two Harms	0	0	0	0	1.05	0	0	0	0	0	0	0

Children and Young Persons' Safety Thermometer

The Trust has started to submit data to the Children and Young Persons' Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. The table below illustrates the data that is recorded.
The Children & Young People's Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in children and young people's services. As a point of care survey it integrates measurement for improvement into daily routines and supports improvement in patient care. Data are collected on a single day each month and enables wards, teams and organisations to understand the burden of harm to children and young people. Data can be used as a baseline to direct improvement efforts and then to measure improvement over time.



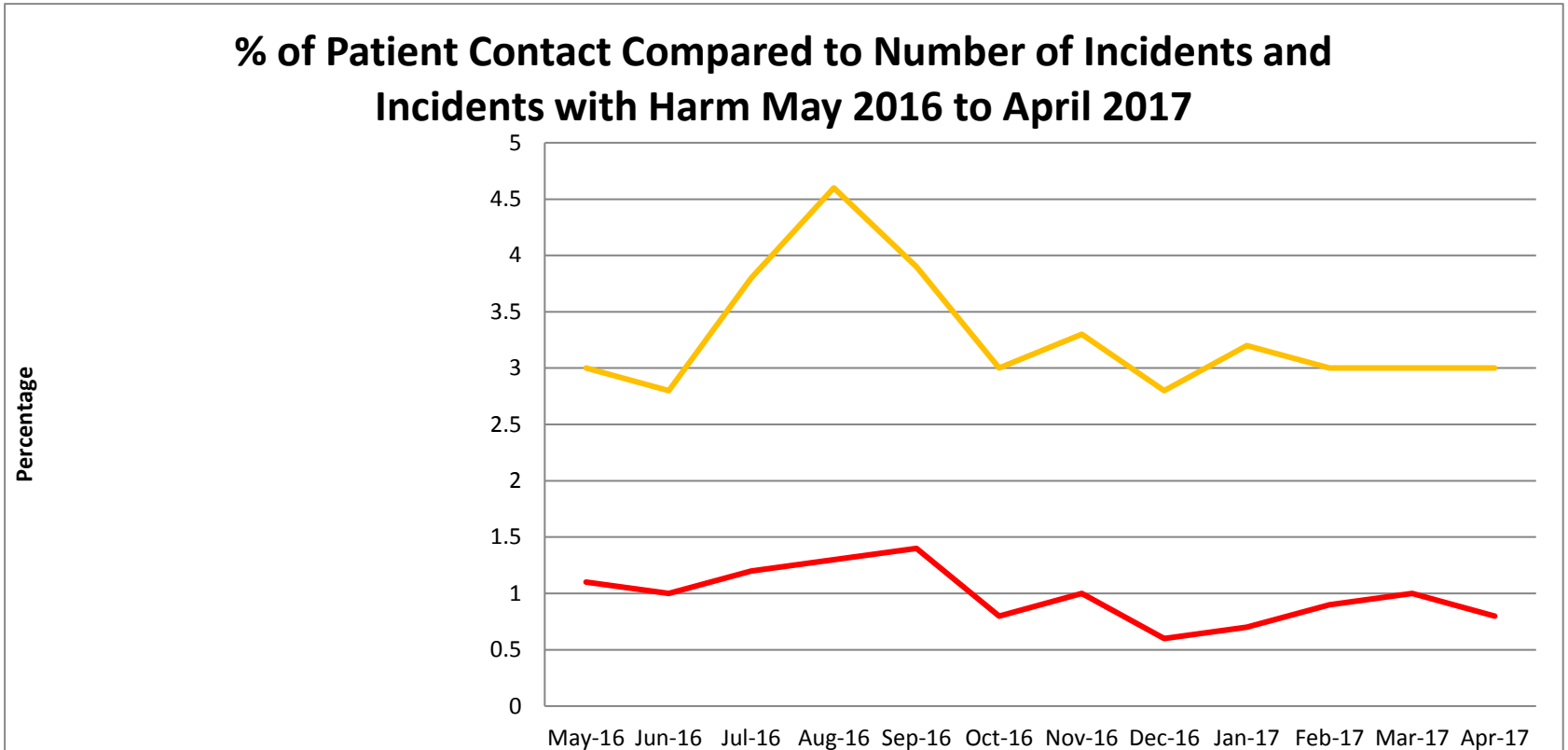
The Staff responsible for collecting the data are to receive web based training from the national team in May 2017

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 2017 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
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
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794
Feb-17	52	5	0	2	59	188	6429
Mar-17	80	6	0	0	86	250	7326
Apr-17	62	0	0	0	62	232	7328

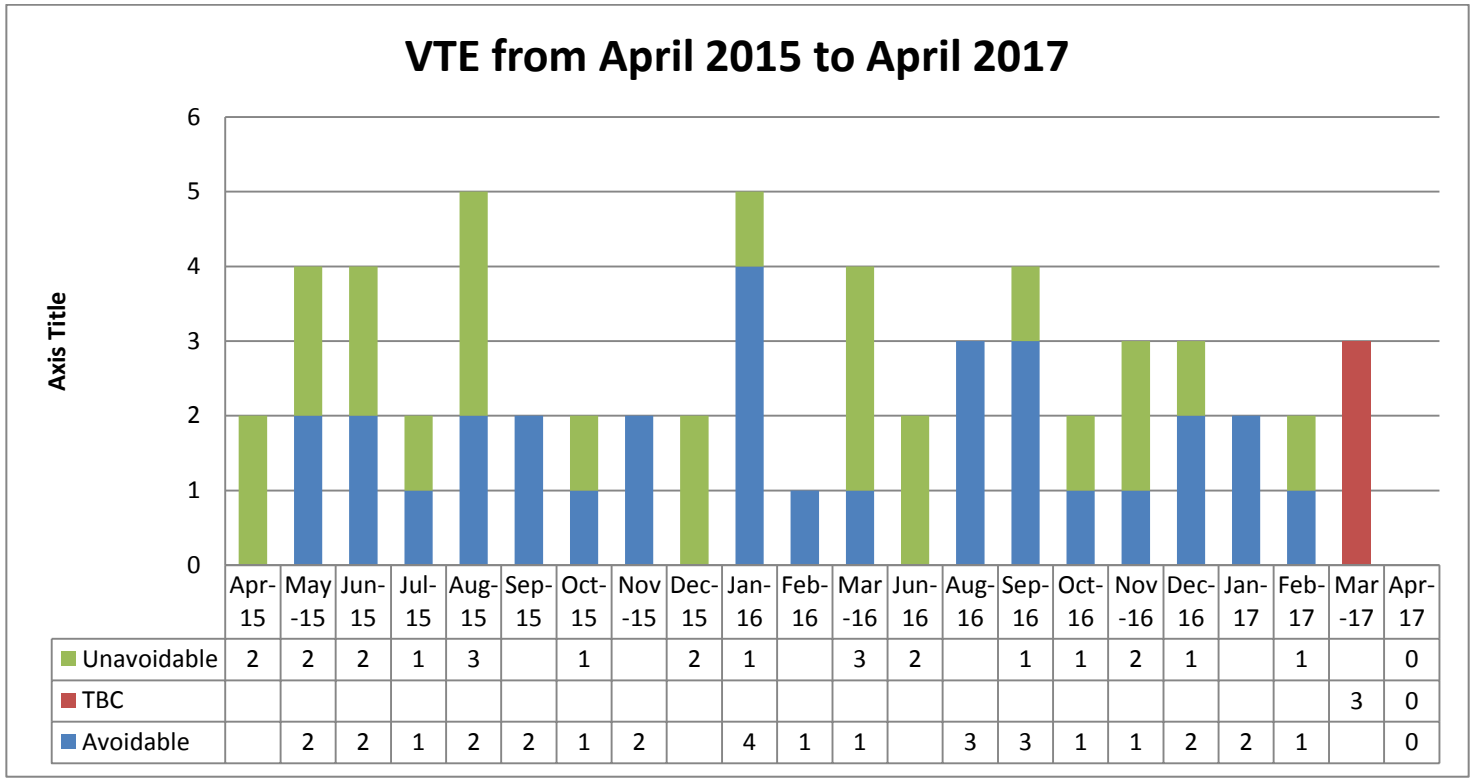
In April 2017, there were a total of 7328 patient contacts. There were 232 incidents reported which is 3 percent of the total patient contacts resulting in an incident. Of those 232 reported incidents, 62 incidents resulted in harm which is 0.8 percent of the total patient contact.

v



	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
% of Patient Contacts with Incidents Causing Harm	1.1	1	1.2	1.3	1.4	0.8	1	0.6	0.7	0.9	1	0.8
% of Patient Contact With All Incidents Reported	3	2.8	3.8	4.6	3.9	3	3.3	2.8	3.2	3	3	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).**



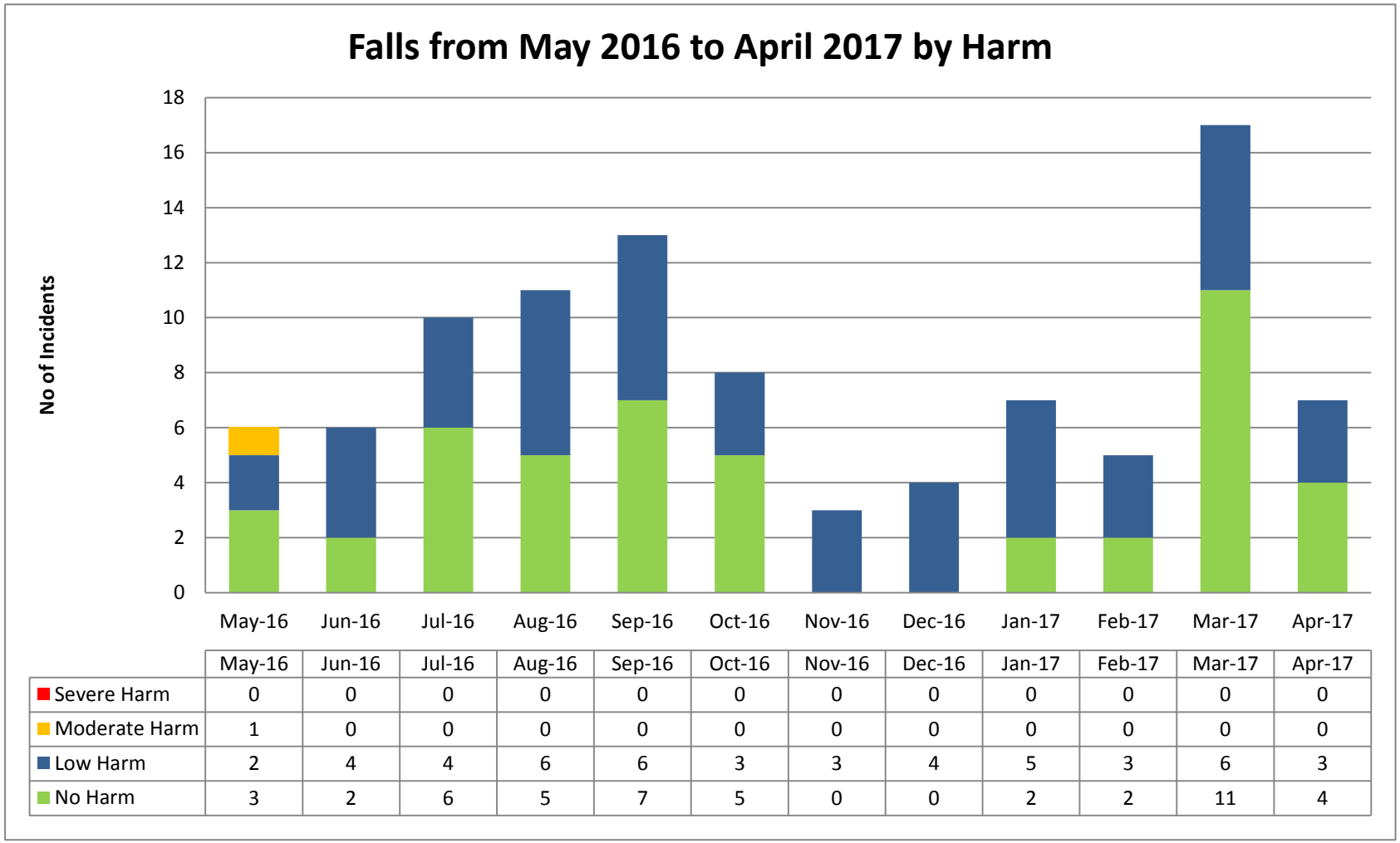
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Jun-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Unavoidable	2	2	2	1	3		1		2	1		3	2		1	1	2	1		1		0
TBC																					3	0
Avoidable		2	2	1	2	2	1	2		4	1	1		3	3	1	1	2	2	1		0

12

Year to date total		Avoidable
15/16	35	18
16/17	23	13

INFORMATION
There were **zero** VTEs declared in April 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
All commissioner KPI's /audits have been completed and continue to be consistently achieved VTE training continues for Student nurses, training for registered and non-registered staff (clinical update days) was suspended in Q4 but will re-commence in April 2017. 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. Now that the VTE guidelines have been finalised and approved the requirements for meeting exemplar site status are met which has enabled application to be completed in Quarter 4.
RISKS / ISSUES
None

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.**



	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	1	0	0	0	0	0	0	0	0	0	0	0
Low Harm	2	4	4	6	6	3	3	4	5	3	6	3
No Harm	3	2	6	5	7	5	0	0	2	2	11	4

INFORMATION

There have been 7 reported falls in April 2017.

Seven fall related incidents were reported across the Trust in April 2017. Five of these related to adult inpatient falls, with one 'fall' classified as a 'controlled/assisted fall' and one outpatient fall in the physio gym. Each in-patient incident has been subject to a post-fall notes review by the ward manager or deputy and a falls questionnaire has been completed for each fall.

The inpatient falls are all reported to CQG via the Divisional Condition reports from the Heads of Nursing.

- Five were in-patient falls (Two falls on Ward 3 were the same patient)
- One was a controlled/assisted fall (Ward 12)
- One fall was in an outpatient area

The inpatient falls are all reported to CQG via the Divisional Condition reports from the Heads of Nursing

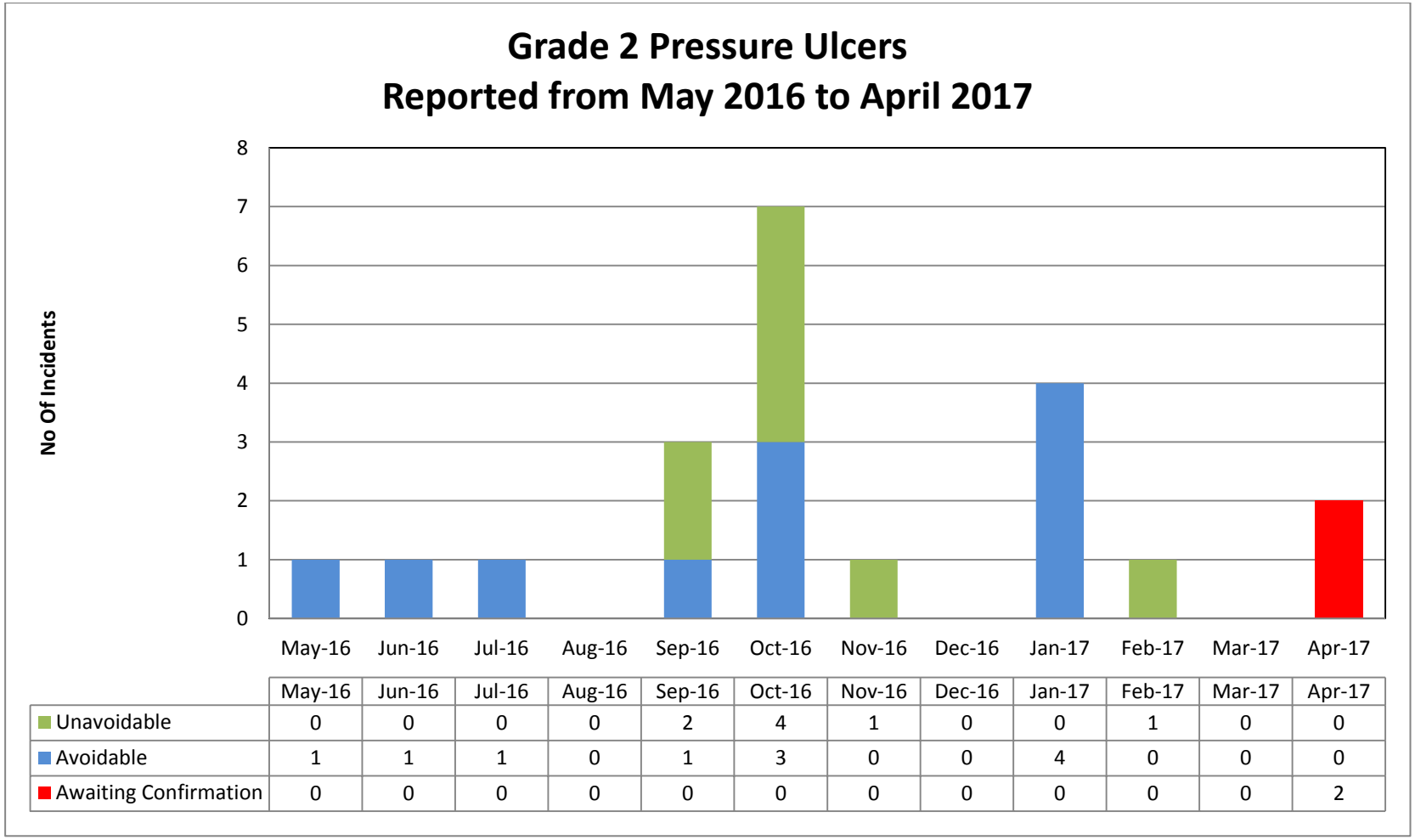
ACTIONS FOR IMPROVEMENTS / LEARNING

- The Falls Working Group (FWG) meetings recommenced in December 2016 and are scheduled bi-monthly after the January 2017 meeting.
- Through the FWG the work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller is in progress. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care.
- An update regarding the Throne Project is still being sought from therapies. This is being addressed through the FWG meeting May 23rd 2017
- Trend analysis identified that patients fall in the bathroom/toilet.
- Falls information boards are to be standardised across all ward areas, with the information being agreed at the FWG meeting in March 2017. 'Walking stick' visual information to be produced on a monthly basis for all ward areas for cascading of information regarding the number of falls per ward, per month to all staff.

RISKS / ISSUES

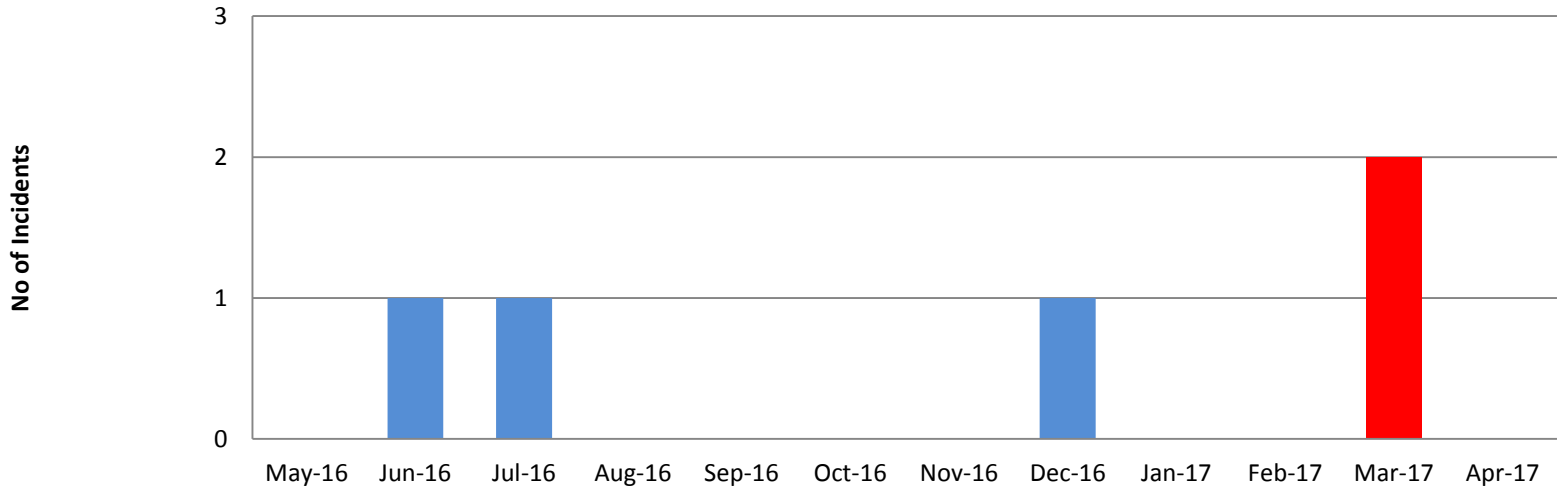
Reassessment of risk assessments need to be completed more consistently.

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-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Unavoidable	0	0	0	0	2	4	1	0	0	1	0	0
Avoidable	1	1	1	0	1	3	0	0	4	0	0	0
Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	0	2

Grade 3 & 4 Pressure Ulcers reported May 2016 to April 2017



	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
TBC											2	
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0
Grade 3 (Avoidable)	0	1	1	0	0	0	0	1	0	0	0	0

INFORMATION

There have been 5 reported grade 2 incidents for April

- Three Grade 2 pressure ulcers were present on admission from home.
- There were 2 x Grade 2 hospital acquired incidents these are currently under investigation to establish avoidability.

In total, from 1st April 2017 the Trust has reported the following avoidable pressure ulcers:

0 avoidable Non Device Related Grade 2 pressure Ulcers against a limit (target) of 12. (Two Grade 2 Pressure Ulcers currently awaiting RCA to establish avoidability and are therefore not included in these figures)

0 avoidable Device Related Grade 2 pressure Ulcers against a limit (target) of 12.

0 avoidable Grade 3 pressure Ulcers against a limit of 0. (One Grade 3 Pressure Ulcer currently awaiting RCA to establish avoidability and are therefore not included in these figures)

ACTIONS FOR IMPROVEMENTS / LEARNING

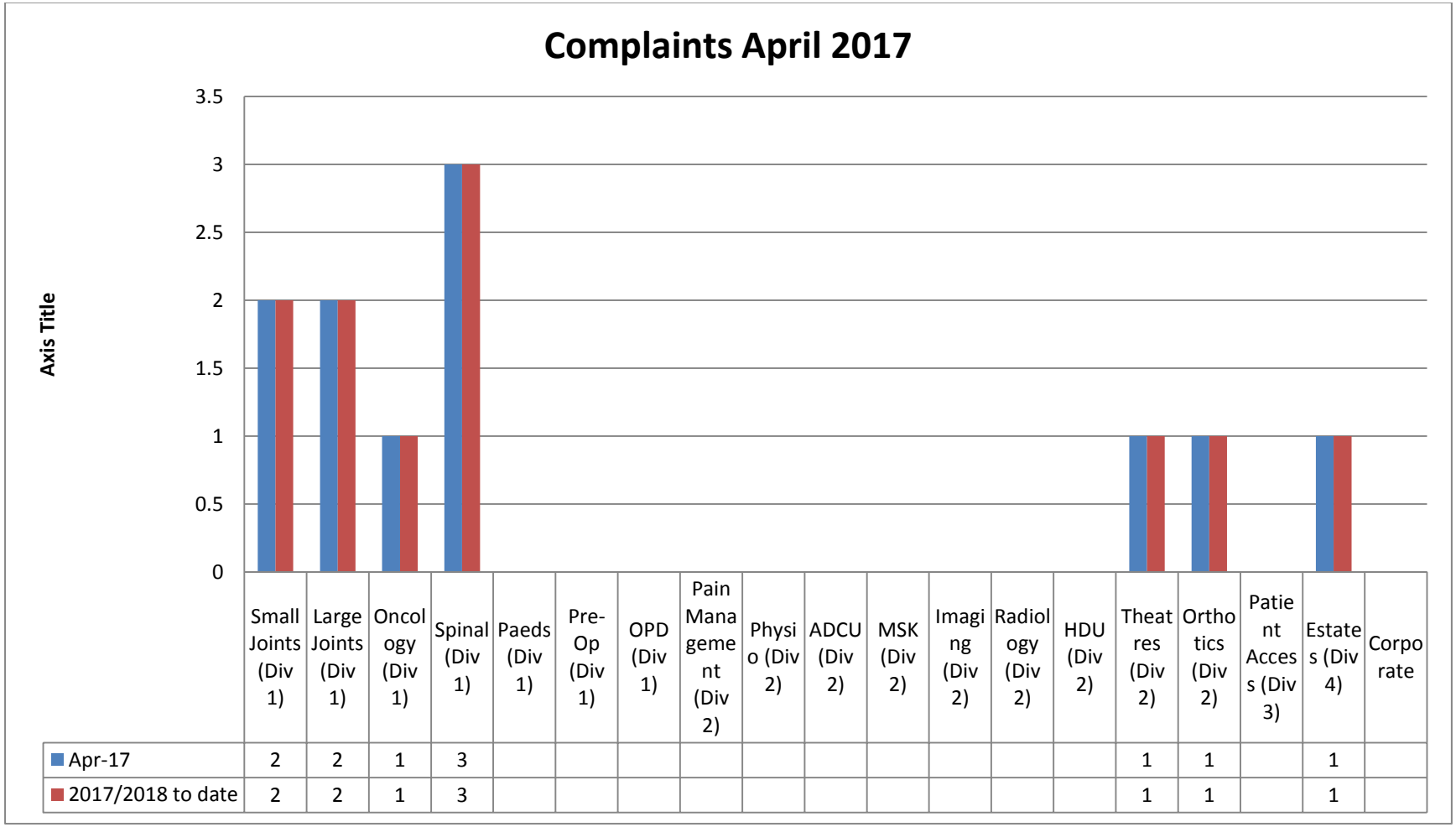
Updates:

- The 2 x Grade 3 pressure ulcers in March 2017 identified on admission under plaster casts, which were applied at The Royal Orthopaedic Hospital, are currently under investigation.

RISKS / ISSUES

None

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.



	Small Joints (Div 1)	Large Joints (Div 1)	Oncology (Div 1)	Spinal (Div 1)	Paeds (Div 1)	Pre-Op (Div 1)	OPD (Div 1)	Pain Management (Div 2)	Physio (Div 2)	ADCU (Div 2)	MSK (Div 2)	Imaging (Div 2)	Radiology (Div 2)	HDU (Div 2)	Theatres (Div 2)	Orthotics (Div 2)	Patient Access (Div 3)	Estates (Div 4)	Corporate
Apr-17	2	2	1	3											1	1		1	
2017/2018 to date	2	2	1	3											1	1		1	

INFORMATION

PALS

The PALS department handled 327 contacts during April 2017 of which 72 were classified as concerns.

Compliments

There were 392 compliments recorded in April 2017, with the most being recorded for Div 1.

All compliments are sent electronically to the Patient Experience Team who holds the records. A Compliment is recorded if there is tangible evidence such as a card, a thank you letter, a box of chocolates or an e-mail. Teams are reminded monthly to submit their compliments for central logging.

Complaints

There were 11 formal complaints made in April 2017, bringing the total to 11 for the year. 1 was initially risk rated as red with the rest rated as amber or yellow. This is comparable to the same month last year

Initially Risk Rated Red:

- Repeated appointment changes to paediatric first appointment (Div 1, Spinal)

Initially Risk Rated Amber:

- Cancellation of paediatric spinal op due to no HDU bed
- Management of complications during anaesthetic
- Approach of clinician and contents of clinic letter
- Wait for a surgery date
- Delay to receiving diagnosis
- System for car parking

Initially Risk Rated Yellow:

- Approach of clinician and outcome of appointment
- Approach of administrator
- Administrative processes around imaging appointments and OPD)

Of the 12 complaints closed in April 2017:

- 7 were upheld
- 3 were partially upheld
- 2 were not upheld

All upheld complaints had elements of poor communication that had caused misunderstanding or difficulty for the patients involved.

ACTIONS FOR IMPROVEMENTS / LEARNING

Learning identified and actions taken as a result of complaints closed in April 2017 include:

- Provision of hearing loops for patients with hearing issues is not consistent in all departments
  Action: Div 1 and Estates working together to identify needs. Complainant is involved in the planning and gap analysis to improve provision.

- Process of informing patients that appointment has been changed is not applied consistently
  Action: Team are reviewing issues and identifying need for changes to process

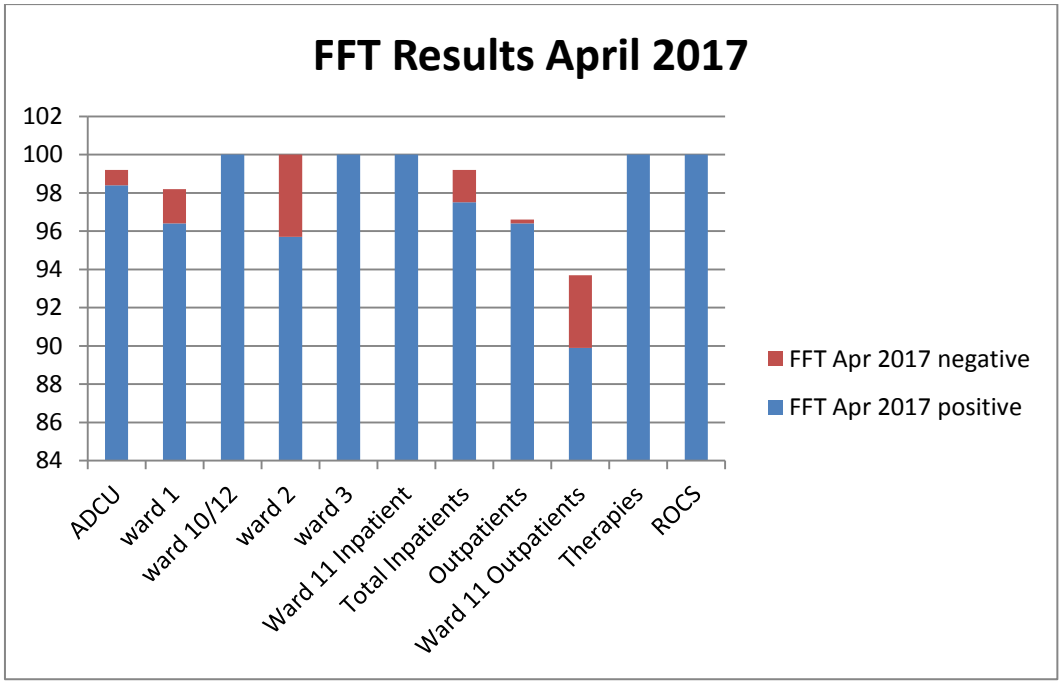
RISKS / ISSUES

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.

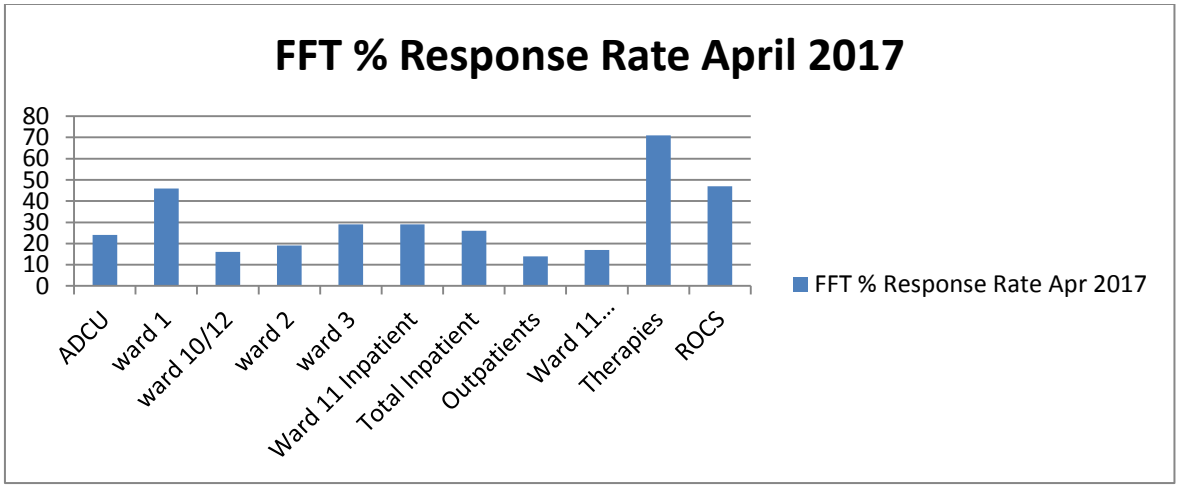
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting 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 April 2017 are 97% of those who responded would promote ROH.



The highest % return rate for questionnaires is Therapies at 70%. The lowest is OPD at 13%.

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.

There is no national target response set however, as a Trust we are aiming to achieve 35% response rate across all areas in Q1 17/18. This would enable the Trust to gain a richer understanding of the service provision from our patient's perspective.

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. All DOC is compliant.

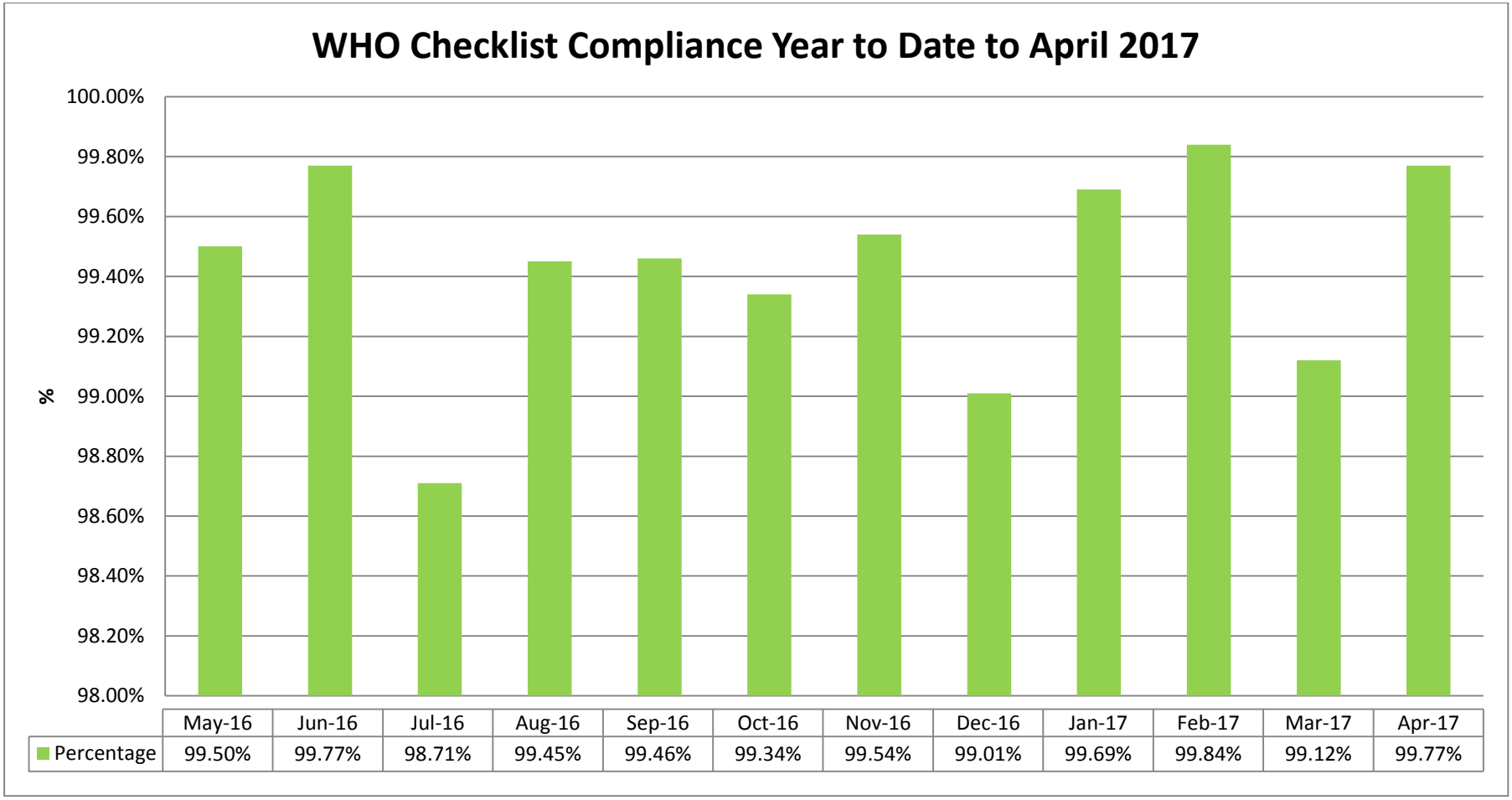
12. Litigation

There was no new litigation to report in April 2017

13. Coroner's

No Coroners inquests in April 2017

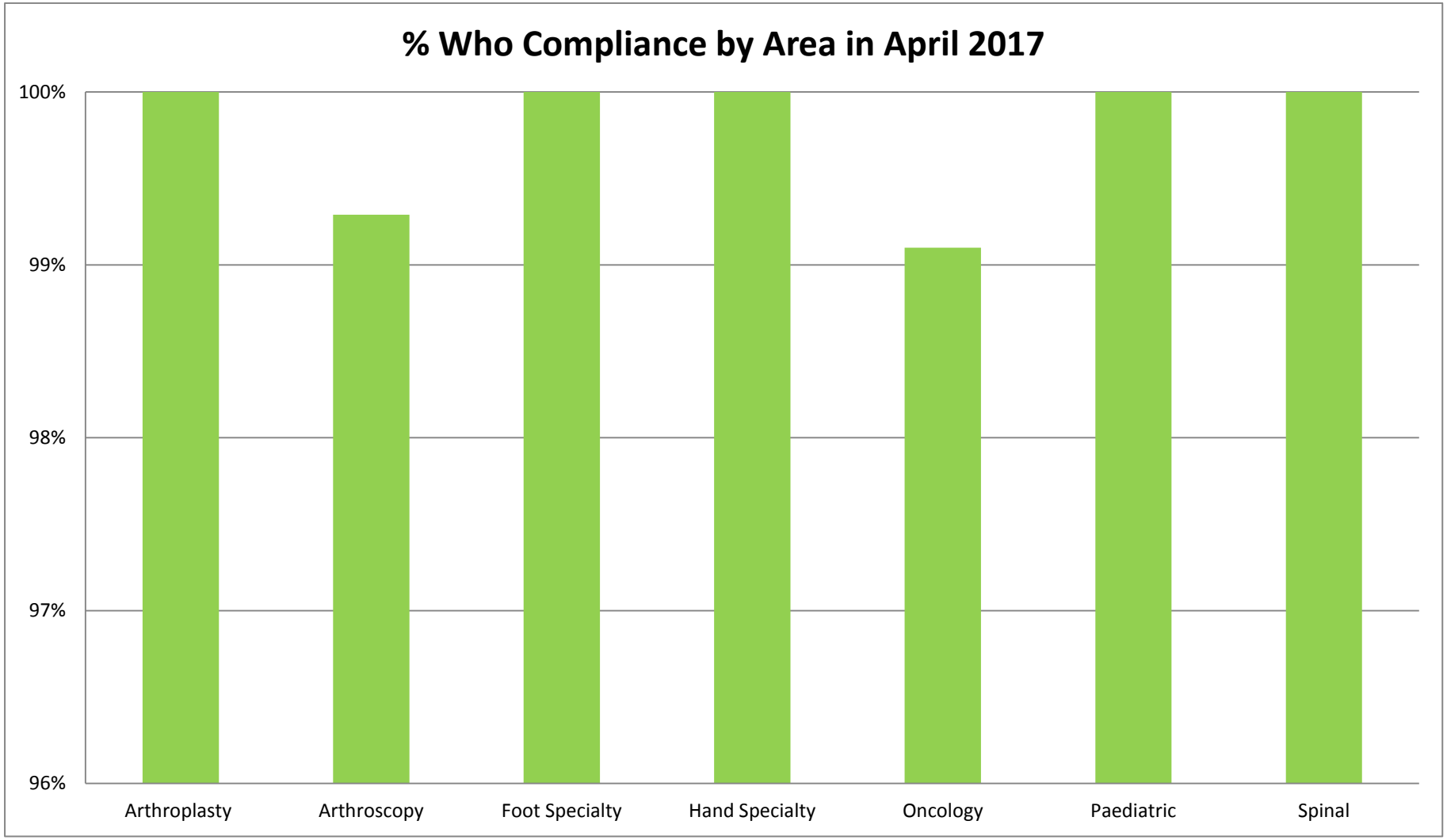
14. WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.



	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Percentage	99.50%	99.77%	98.71%	99.45%	99.46%	99.34%	99.54%	99.01%	99.69%	99.84%	99.12%	99.77%

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care


% Who Compliance by Area in April 2017
100%
99%
98%
97%
96%
Arthroplasty
Arthroscopy
Foot Specialty
Hand Specialty
Oncology
Paediatric
Spinal

INFORMATION

April 2017

Total Cases = 517

Total Non -Compliance = 2

Arthroscopy Consultant and team missed a section off the Sign In - affecting 1 patient.
Oncology Consultant and team missed a section off the Sign In - affecting 1 patient.

Total Compliance = **99.77 %**

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

All non-compliance was due to Consultants not completing the sign/time out section.

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**National Staff Survey Results 2016/17**
SPONSOR (EXECUTIVE DIRECTOR):	**Professor Philip Begg – Executive Director of Strategy & Delivery**
AUTHOR:	**Mrs Claire Mair – Head of OD and Inclusion**
DATE OF MEETING:	**7st June 2017**

EXECUTIVE SUMMARY:

Each NHS Trust is required to participate in the national staff survey on an annual basis. An external data management provider is required to administer the survey, and for ROH this partner is Capita.

Due to the size of the ROH Trust, all permanent staff members are invited to participate either online or via a paper based survey. For 15/16 this equated to 955 staff members in total with a 46% completion rate.

The results from the survey 15/16 are officially published in March 2017.

Following results publication, a number of key activities have taken place in order to start to develop an action plan. These include:

- Working with Capita to provide further analysis on the different areas of the Trust
- Sharing the results with senior leaders and key staff stakeholders to ensure final action plans incorporate local actions
- Publication of the high level results across the Trust via Team brief and other communication channels
- Commitment to staff via Team brief that there will be a robust plan put in place to improve on any areas of weakness
- Review of other key action plans in the Trust to ensure all current issues that impact engagement are incorporated

The report includes the results, data analysis and more importantly the context to be reviewed by Trust Board Committee members. There is also a recommended Trust action plan that we ask the Trust Board to review and comment on. It is requested that a further update is provided to the Trust Board at the September board meeting

REPORT RECOMMENDATION:

The Trust Board is asked to receive the report and results of the 2016/17 and note the actions planned to dissemination across the organisation.

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	**X**	Legal & Policy		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:

Safe, efficient processes that are patient centred.

Fully engaged patients and staff

Creating a culture of excellence innovation and service

PREVIOUS CONSIDERATION:

This is the first time the Trust Board will have received these results with analysis, however they have been discussed with the Executive Team and managers within the Trust.

ROHTB (6/17) 006 (a)

Report to ROH Trust Board 7th June 2017

National Staff surveys results

1. Background

The National Staff Survey is undertaken across the NHS on an annual basis with all permanent staff members. The survey in ROH was undertaken between 10th October and 2nd December 2016 with a census of all permanent staff. The timing of the survey is set by NHS England with a small amount of flexibility on start and end dates. For ROH, the survey completion timetable coincided with staff briefings on our financial pressures and the start of NHSi visits. The announcement of a MARS scheme was also announced towards the end of the survey window in December.

As part of NHS England requirements, the survey distribution and data collection for ROH is managed by an external partner - Capita. The data is used by the National Survey Co-ordination Centre to provide benchmarking reports which are published nationally in March every year.

For the second year running, all ROH staff were surveyed. In total **955** staff members were invited to complete the survey and this was completed by **428** staff. The response rate is **46%** which is higher than the national rate of 43%. However this rate is lower than last year (2015) which was **55%.** 101 staff were asked to complete the survey via paper based method. All other staff were asked to fill in the form online.

In this year's report, the findings from the questionnaire are summarised in the form of **32 Key Findings** (see attached spreadsheet) with an overall **Staff engagement** result. The key findings are either a percentage score or scale summary.

2. Progress since the last survey 2015

- Individual plans for departments were compiled (information available) – not followed up due to change in management
- Engagement strategy (Part of People Strategy) signed off by Exec Team in August led by Director of OD and Head of Communications
- Changes to communication channels e.g. Team brief
- Refresh of Equality and Diversity action plan signed off by Exec Team and Trust Board in 2017
- Introduction of the Freedom to speak up Guardian
- Introduction of the 'Leading with Compassion' award
- Focus on completion of mandatory training
- Continuation of the Management Skills programme
- Continuation of training to support HR mandatory activities e.g. Value Based recruitment, effective PDRs

- Additional non mandatory workshops e.g. assertiveness, coaching in line with feedback from staff
- New patient feedback system
- Review of management structure by Exec Team

3. Key findings

The key findings listed below indicate 4 areas that have improved since the national survey in 2015 This is encouraging as it can be linked to the areas of focus in 2016 listed above and highlighted in green e.g. recruiting the Freedom to speak up Guardian.

4 areas better than average
12 areas at the average
16 areas worse than average
3 areas deteriorated since 2015
29 areas showed no statistically significant change since 2015.

A breakdown of these key findings are listed at the end of this document

4. Work on the results to date on survey results

The overall results have been shared with the staff at the Trust through the Team brief end of March 2017.

- Working with Capita to provide further analysis on the different areas of the Trust
- Sharing the results with senior leaders to ensure action plans incorporate local actions
- Publication of the high level results across the Trust via Team brief and other communication channels
- Commitment to staff that there will be a robust plan put in place to improve on any areas of weakness
- Review of key plans in the Trust to ensure all areas are covered

The initial results have been shared with the Chief Executive and Executive Director of Strategy and Delivery.

Further analysis has been provided by Capita (data partner) to give more detailed information for different departments and areas. This has been cross referenced with staff data on **PDRs** completed, **absenteeism** and **completion of mandatory training** to see if there is a correlation between staff engagement and management in the area (see attached spreadsheet).

The overall results have been discussed at Divisional meetings asking managers to start to review their data in preparation for agreed next steps (subject to review by the CEO).

Other Trust action plans and key priorities have been reviewed to ensure that any interdependencies are considered in order to deliver on the staff survey action plan.

Following data analysis there are 3 organisational actions that ROH will concentrate on:

Performance – every staff member to have a clear understanding of what they need to do and how it fits with the Trust strategy

Communication – to ensure that all staff are well informed about the Trust and have the opportunity to meet and feedback to management on a regular basis

Resources – to ensure all staff have the correct resources to do their job and are empowered to make the right decisions

Professor Phil Begg
Executive Director of Strategy & Delivery

2 June 2017

5. Breakdown of key findings - National Staff Survey: ROH Key Findings 2016/17

	Description
Key findings were the Trust is better than average	
KF15	Percentage of staff satisfied with the opportunities for flexible working patterns (57%)
KF18	Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves (49%)
KF27	Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse (49%)
KF29	Percentage of staff reporting errors, near misses or incidents witnessed in the last month (95%).
Key findings where the Trust is worse than average	
KF 1	Staff recommendation of the organisation as a place to work or receive treatment (3.74)
KF 2	Staff satisfaction with the quality of work and care they are able to deliver (3.99)
KF 3	Percentage of staff agreeing that their role makes a difference to patients / service users (90%)
KF 4	Staff motivation at work (3.90)
KF 5	Recognition and value of staff by managers and the organisation (3.38)
KF 6	Percentage of staff reporting good communication between senior management and staff (24%)
KF 13	Quality of non-mandatory training, learning or development (3.97)
KF 14	Staff satisfaction with resourcing and support (3.37)
KF 16	Percentage of staff working extra hours (75%)
KF 19	Organisation and management interest in and action on health and wellbeing (3.55)
KF 24	Percentage of staff / colleagues reporting most recent experience of violence (52%)
KF 25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (24%)
KF 28	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (33%)
KF 30	Fairness and effectiveness of procedures for reporting errors, near misses and incidents (3.65)
KF 31	Staff confidence and security in reporting unsafe clinical practice (3.61)
KF 32	Effective use of patient / service user feedback (3.57).
Key findings where the Trust has deteriorations since 2015	
KF 2	Staff satisfaction with the quality of work and care they are able to deliver (3.99)
KF 11	Percentage of staff appraised in last 12 months (84%)
KF 14	Staff satisfaction with resourcing and support (3.37).

6. Action plan

National Staff Survey: ROH 2016/17 Action Plan

Activity	Who	When	Status
Briefing with CEO	CM PB	End of May 2017	
Paper for the Trust Board, presenting the results.	CM, PB	7th June 2017	
Initial results to be shared with all staff and Board members	AC	March 17	
Briefings with senior managers and key stakeholders in the Trust to share initial data and agree support required	CM	May – July 2017	**Started**
Communicate results and suggested organisational actions to the Executive team.	PB	May/June 2017	**Started**
Different departments to confirm action plans (using agreed areas of priority)	Senior Managers supported by CM	May – June 2017	**Started**
OD to review any training requirements needed to support action plans	CM	Mid July 2017	
Comms Team to provide key update briefing information for all staff	AM CM	July, October 2017	
OD to review all local action plans and provide summary and update to the Executive Team and Trust Board	CM	End of August 2017	
Comms and OD to produce 'You Said, We will improve' briefings for staff	AM/CM/PB	October 2017	
OD to review actions against Equality and Diversity actions	CM	July, October 2017	
OD to support departments on progress with local action plans	CM	July to December 2017	

The Royal Orthopaedic Hospital NHS Foundation Trust
National Staff Survey 2016

Indicative Key Findings

This report provides Indicative Key Findings for each of the areas of work selected by the Trust.

The report compares the 32 Key Findings and the overall employee engagement score of each of the selected area of work to the overall Trust unweighted results provided by the NHS England coordination centre.

This report details key findings only. The data used in this report is unweighted.

- When a key finding is phrased positively, the higher the score the better
- When a key finding is phrased negatively, the lower the score the better.

A column has been add confiming which score is better for each finding.

- Where an area has scored better than the Trust score, the cell is coloured green;
- Where an area has scored worse than the Trust score, the cell is coloured red;
- Where an area has scored the same as the Trust score, the cell is coloured grey.

If a cell has been left blank there were no available results for this key finding as staff did not meet the pre requiste key finding criteria i.e. no staff responded to the questions within the key finding or

While every care has been taken to match the coordination centre guidance for cleaning and preparing the key finding information it should be noted that our key findings should only be considered indicative.

If you have any queries please don’t hesitate to contact us.

KEY FINDINGS FROM ROH NATIONAL SURVEY 2016/17

	Key Finding Wording	Key Finding Type	Score is better when...	Central Functions (Medical SIFT, Commissioning, PMO CSU Management, Governance, Chaplaincy, Corporate Nursing Admin, E rostering team, Outcomes, Public Engagement,	Corporate and Board	Critical Care	Estates and Facilities	Finance	IT	Oncology	Outpatients (ROCS, ADCU, Outpatients)	Paediatrics	Patient Access	Patient Support	Radiography	Research and Teaching / Research and Development	Small and Large joints	Spinal	Theatres	Therapy Services	Workforce and OD	Organisation Scores (Coordination Centre Unweighted Data) compared and colour coded against Acute Specialist Trust results	Acute Specialist Trusts Results	Variation from Average Specialist Acute Trust score
																							For reference	=/-'
Number of completed replies received for each department				38	15	15	50	21	11	19	26	25	17	18	14	11	32	15	44	46	11			
				Results for each department compared and colour coded against **Organisation Scores**																				
KF01	Staff recommendation of the organisation as a place to work or receive treatment	Score	Higher	3.18	3.91	3.51	4.29	4.07	4.06	3.14	3.47	3.69	3.31	3.98	3.88	3.73	3.60	3.56	3.82	3.77	4.06	3.73	4.07	-0.33
KF02	Staff satisfaction with the quality of work and care they are able to deliver	Score	Higher	3.78	3.56	4.11	4.34	4.50	3.96	3.94	4.22	3.83	3.90	4.17	4.12	4.05	3.84	3.35	3.91	4.05	4.29	3.98	4.04	-0.06
KF03	Percentage of staff agreeing that their role makes a difference to patients / service users	%	Higher	81	69	100	83	67	90	94	100	88	82	82	100	80	90	93	90	100	100	89	91	-2
KF04	Staff motivation at work	Score	Higher	3.65	4.00	4.05	4.19	3.73	3.88	4.09	3.94	3.89	3.67	3.98	3.85	3.85	3.95	3.73	3.67	3.86	3.97	3.88	3.94	-0.06
KF05	Recognition and value of staff by managers and the organisation	Score	Higher	3.24	3.73	3.17	3.86	3.51	3.64	3.30	2.80	3.39	3.06	3.44	3.24	3.79	3.02	2.98	3.27	3.61	3.70	3.38	3.52	-0.14
KF06	Percentage of staff reporting good communication between senior management and staff	%	Higher	16	47	27	39	38	36	11	12	20	6	44	21	18	13	7	23	22	27	23	36	-13
KF07	Percentage of staff able to contribute towards improvements at work	%	Higher	76	80	73	76	86	91	79	73	64	59	89	79	82	59	80	68	89	82	76	73	3
KF08	Staff satisfaction with level of responsibility and involvement	Score	Higher	3.84	4.00	3.94	4.12	4.01	3.96	4.04	3.66	3.97	3.50	3.87	3.94	4.18	3.73	3.71	3.78	4.15	3.83	3.91	3.93	-0.02
KF09	Effective team working	Score	Higher	3.90	3.92	3.58	4.02	3.68	4.26	3.54	3.90	3.81	3.56	3.80	3.31	4.07	3.72	3.58	3.68	3.94	3.91	3.80	3.81	-0.01
KF10	Support from immediate managers	Score	Higher	3.84	3.86	3.48	4.29	3.79	4.17	3.45	3.04	3.88	3.71	3.87	3.68	4.20	3.48	3.39	3.62	4.17	3.99	3.79	3.78	-0.01
KF11	Percentage of staff appraised in last 12 months	%	Higher	55	79	87	87	76	91	89	85	84	69	82	93	82	100	85	83	98	55	84	87	-3
KF12	Quality of appraisals	Score	Higher	2.94	3.24	3.20	3.53	3.41	3.40	3.04	3.30	3.64	2.52	2.91	3.10	3.74	3.11	3.00	2.94	3.34	3.22	3.21	3.16	0.05
KF13	Quality of non-mandatory training, learning or development	Score	Higher	3.84	4.21	4.07	4.14	3.80	4.17	4.04	4.02	4.11	3.86	4.12	3.64	4.10	3.83	4.06	3.83	3.96	3.87	3.97	4.04	-0.07
KF14	Staff satisfaction with resourcing and support	Score	Higher	3.17	3.58	3.03	3.81	3.73	3.42	3.14	3.48	3.25	3.32	3.43	2.75	3.52	3.38	2.97	3.15	3.51	3.59	3.37	3.43	-0.06
KF15	Percentage of staff satisfied with the opportunities for flexible working patterns	%	Higher	55	73	50	73	71	91	58	54	64	35	67	36	73	44	20	41	63	73	57	53	4
KF16	Percentage of staff working extra hours	%	Lower	76	87	80	54	48	91	84	65	92	76	67	64	64	78	87	89	74	64	74	72	-2
KF17	Percentage of staff feeling unwell due to work related stress in the last 12 months	%	Lower	55	13	33	10	33	36	32	35	42	29	22	21	18	31	47	36	37	45	32	33	1
KF18	Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	%	Lower	50	47	47	27	33	45	63	46	50	71	39	43	55	47	53	57	43	82	49	57	8
KF19	Organisation and management interest in and action on health and wellbeing	Score	Higher	3.47	3.63	3.33	4.07	3.45	3.73	3.37	2.98	3.50	3.38	3.67	3.25	3.95	3.38	3.20	3.57	3.65	4.05	3.55	3.69	-0.14
KF20	Percentage of staff experiencing discrimination at work in the last 12 months	%	Lower	8	7	0	4	5	9	21	12	12	12	0	7	0	6	0	7	13	18	8	10	2
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	%	Higher	79	89	70	94	88	78	77	71	94	64	91	100	100	86	100	74	97	80	85	87	-2
KF22	Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	%	Lower	0	0	21	2	0	0	6	0	20	0	0	0	0	13	7	7	7	0	5	7	2
KF23	Percentage of staff experiencing physical violence from staff in last 12 months	%	Lower	0	0	0	2	0	0	5	0	4	6	0	0	0	0	0	7	0	0	2	2	='
KF24	Percentage of staff/colleagues reporting most recent experience of violence	%	Higher			50	0			100		80	100				25	0	33	67		52	68	-16
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	%	Lower	14	7	40	8	0	0	37	23	64	44	0	29	0	34	53	18	43	0	24	21	-3
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	%	Lower	28	27	20	10	14	9	32	27	32	47	22	29	9	25	20	45	13	18	24	24	='
KF27	Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse	%	Higher	45	60	33	50	33	0	50	50	56	40	75	29	100	42	40	74	28	0	47	45	2
KF28	Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	%	Lower	39	14	46	2		9	60	33	67	18	28	15		48	69	46	30	20	31	28	-3
KF29	Percentage of staff reporting errors, near misses or incidents witnessed in the last month	%	Higher	92	100	100	100		100	78	100	92	100	100	100		93	100	100	91	100	95	92	3
KF30	Fairness and effectiveness of procedures for reporting errors, near misses and incidents	Score	Higher	3.43	3.97	3.33	3.83	3.67	3.40	3.49	3.52	3.70	3.24	3.98	3.66	3.63	3.77	3.27	3.66	3.56	4.05	3.63	3.81	-0.18
KF31	Staff confidence and security in reporting unsafe clinical practice	Score	Higher	3.42	3.90	3.61	3.83	3.50	3.68	3.45	3.63	3.56	3.47	3.56	3.61	3.36	3.61	3.43	3.48	3.70	3.77	3.59	3.73	-0.14
KF32	Effective use of patient / service user feedback	Score	Higher	3.27	4.00	3.39	4.02	3.67		3.95	3.48	3.52	3.00	3.50	3.83	3.78	3.58	3.48	3.39	3.63	3.67	3.58	3.79	-0.21
ngagemer	Overall engagement score	Score	Higher	3.54	3.99	3.82	4.10	3.94	3.97	3.67	3.61	3.74	3.35	3.96	3.86	3.83	3.69	3.66	3.70	3.87	3.99	3.80	3.92	-0.12
November 2016																								
Absenteeism November (4.1%)						0.0	2.9	0.0	7.6	6.7	0.0	6.0	5.7		0.0			1.9	6.2	-	-	4.3		
Stat and Mandatory November (90%)						70.0	96.7	100.0	67.2	83.0	83.3	84.0	95.3		85.8			83.6	91.3	94.0		88.4		
PDR November (85%)						50.0	90.8	62.0	81.8	63.0	73.0	68.0	66.7		89.3	-	-	74.0	68.6	81.0		73.5		
February 2017																								
Absenteeism February (4.1%)						6.8	5.3	0.2	3.2	0.7	3.1	6.9	9.6	3.3	2.5	-	-	6.3	4.3	2.3	-	3.8		
Stat and Mandatory November (90%)						100.0	96.2	87.3	80.2	85.1	85.1	85.1	91.9	93.1	100.0			85.1	91.9	92.4		92.0		
PDR February (90%)						33.3	80.4	76.9	58.3	63.3	54.1	51.5	78.8	70.7	9.3	-		68.2	57.9	81.7	-	67.5		

Please review notes below to understand set up of the spreadsheet

2. Each area (e.g. Central Functions) is **compared against the Organisation Scores** and highlighted in red (worse than), grey (same as) or green (better than) appropriately

3. Some areas have been amalgamated as departments with 10 or less responses can not be reported on

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:	**7 June 2016**

EXECUTIVE SUMMARY:

It is a requirement of the governance condition of the Trust's licence that the Trust publishes a statement within three months of the end of the financial year setting out whether it believes it has complied with the required governance arrangements of its licence (Condition FT4 (8)).

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 or otherwise the statements relating to the Corporate Governance statement and other declaration.

It is proposed to declare '**Not Confirmed**' to the statement that the provider has complied with required governance arrangements, largely on the basis of the regulatory concerns around the Trust's management of the 18 weeks RTT position and long term sustainability outlined in the draft letter from NHS Improvement received in May.

NHS Improvement also requires the Board to make a declaration regarding:

- 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.

Foundation trusts are also required to make annual declarations to NHSI regarding their systems for compliance with provider licence conditions (General Condition G6). The licence condition declaration was discussed at the May private session on 30 May, but is attached as Appendix B 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 and Governor training
- Approve in principle the declarations proposed, subject to formal agreement by a committee of the Chairman and Acting Chief Executive
- Note the licence conditions declaration which was agreed on 30 May 2017
- Agree to publish the declarations to the required deadline

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 NHS improvement's self certification guidance issues in April 2017 and specifically compliance with the Trust's licence to operate.

PREVIOUS CONSIDERATION:

The licence condition declaration was discussed at the May private session on 30 May 2017

The Royal Orthopaedic Hospital 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 judgements under the Single Oversight Framework by NHS Improvement.** NHS Improvement Corporate Governance ratings for 2015/16: Q1= Green (Risk Assessment Framework); Q2 = Segment 2; Q3 = Segment 2; Q4 = TBC. • **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 of risk management, governance & internal control to ensure it remains adequate and effective'. • Further progress during the year with strengthening the Board Assurance Framework and risk management systems & processes. **Minutes from Audit Committee and Quality & Safety Committee confirming the improvements made.** • **Audit Committee annual report**	ADG&CS

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time		• **Trust Board paper outlining changes from the Risk Assessment Framework to the Single Oversight Framework in October 2016.** • **CEO reports to Board highlighting new guidance issued.** • There has been new guidance issued by NHS Improvement around Non Executive appraisal which the Trust is required to satisfy **– e-mails between Associate Director of Governance/Company Secretary and NHS Improvement** • **New national guidance issued on annual self-certification and declarations of interest** • Routine bulletins from NHS Improvement are received and reviewed by the Executive Team – **bulletins**	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 Major Projects & OD Committee for oversight of staff engagement, leadership and development, together with governance oversight of the major initiatives being undertaken by the Trust. **Paper proposing the establishment of a Major Projects & OD Committee considered at the January 2017 Board meeting.** • The **terms of reference for the Committees** have been reviewed and amended during the year • All Committees report back at each Board meeting on key highlights and matters needing to be escalated via an **assurance report**. • **Annual Governance Statement** 2016/17 outlines the Board & Committee structure. • The Board and Committees have **annual workplans**.	ADG&CS

DECLARATION	SUB REQUIREMENT	RATIONALE AND CORE EVIDENCE	LEAD
		• Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (4) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	
	(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 Major Projects & OD Committee was established during 2016/17. **Paper proposing the establishment of a Major Projects & OD Committee considered at the January 2017 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 disestablished during the year, with the Executive Team weekly meeting now being the main advisory group to the Chief Executive. **Agendas of Executive Team business meetings**	ADG&CS

	(c) Clear reporting lines and accountabilities throughout its organisation.	• The structure of the Executive team and the portfolios of the Executive Directors have been reviewed during the year. The remit of the Director of Nursing & Clinical Governance (now the Director of Patient Services) has been refocussed to provide additional accountability for operational matters. The remit of the Director of Strategy & Transformation (now Director of Strategy & Delivery) was revised to include Workforce, OD, Estates and Facilities. The responsibility for performance was made more explicit within the role of the Director of Finance (now Director of Finance & Performance) **Job descriptions for Executive Directors. Report to the Remuneration Committee in December 2016.** • An Associate Director of Governance & Company Secretary holds 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 revised divisional structure has been implemented during the year to create clearer accountability and greater capacity within the operational areas. **Papers and presentations outlining the divisional structure as part of Team Brief** • **Job descriptions and divisional management structures may be used to evidence compliance with this requirement.** • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (4) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	CEO

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.** • **Financial recovery plan actions and assurance monitoring**	DOF
	(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 2016/17 by the additional of a Major projects & OD Committee. **Paper proposing the establishment of a Major projects & OD Committee considered at the January 2017 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 statutory regulators of health care professions;	• **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 2016/17. 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. At the request of the CQC, the Trust also hosted an inspection by the Royal College of Paediatrics and Child Health (RCPCH) in summer 2016, which identified a set of improvements needed. A task and finish group was set up to develop and monitor the delivery of an action plan to address these shortcomings. This action plan is also reviewed by the Trust board in private at each formal meeting. • **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 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 quarterly by the Quality & safety Committee**. • **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.	DPS

		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.** • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (5 (a, b, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	
	(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);	• 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.** • Performance meetings held between Executive and Divisions ensure appropriate challenge and control; these meetings are held monthly with Divisions 1 and 2 and quarterly with Divisions 3 and 4. **Agendas and minutes 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.	DOF

		• 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. • The Board met formally on a monthly basis during the year, with board workshops & development sessions being additional to this. **Board minutes and workshop papers** • 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. Assurance reports.** • **Workplans for the Board & its Board Committees** ensure that there is a forward view of matters needing to be considered several months ahead. • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (5 (a, b, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	Ch
	(f) To identify and manage (including but not restricted to manage through forward plans)	• **Declaration submitted by 31 May 2017, 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.	Ch/ ADG&CS

	material risks to compliance with the Conditions of its Licence;	• 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.** • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (5 (a, b, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	
	(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 2016/17. **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. Internal Audit progress reports.** • Delivery of audit recommendations is monitored at Audit Committee via **recommendation tracking reports.** There have been concerns raised during the year about the robustness of closing these recommendations, with a date of September 2017 being set for the trackers to be fully updated.	ALL

	(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 three years and sets out the framework in which the Trust is to operate. • The Board is not aware of any other material issues that would place it in contravention of any legal requirements. 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 processes to ensure:	(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	• The Board keeps the balance of its skills and competencies under review to ensure completeness and appropriateness for the requirements of the Trust. Within the year, the Trust has been joined by two new Non-Executive Directors, with particular skill sets in partnership working/commercial acumen and a Non-Executive who is currently a practicing clinician at University Hospital Birmingham. **Board member profiles in annual report.** • During the year and in response to a request from our regulators, the Trust reduced its management overhead, resulting in a streamlined Operations structure and smaller Executive team. **Board structure in annual report. Paper to Remuneration Committee in December 2016.** • 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.**	Ch

		• Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	
	(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, although it has been identified that further work is required to strengthen this process during the coming year. **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. • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	DPS

	(c) The collection of 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. **WHO compliance, VTE reports, mortality reports**. • The Board considers a monthly **Finance & Performance Overview**, which includes a set of metrics including key national priority indicators and regulatory requirements. • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	DPS
	(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. **WHO compliance, VTE reports, mortality reports**. • A formal quality assurance walkabout schedule has been introduced during year which involves a number of staff from across a range of disciplines and areas. The outputs of these are considered by the Quality & Safety Committee. **Paper to the Quality & Safety Committee on quality assurance walkabouts**	DPS

		• Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement	
	(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	• Data is reported through into the **Patient Safety & Quality Report** which includes 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.** • A **schedule of walkabouts** is in place, overseen by the Deputy Director of Nursing & Clinical Governance, which involves patient representatives and Non-Executive Directors • A governor attends meetings of the Quality & Safety Committee as an observer **Minutes of Quality & Safety Committee** • Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement.	DPS

	(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 Executive Director of Patient Services, the Medical Director and the Chief Executive. **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 and safeguarding. 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. • 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 and update to the Quality & Safety Committee on the development of the Knowledge Hub (April 2017).**	DPS

		• Notwithstanding the evidence above, in a draft letter from NHS Improvement in connection with concerns over the Trust's management of its 18 weeks RTT list, it was suggested that licence condition FT4 (6 (a, c, d, e & f)) which refers to the establishment and implementation of effective board and committee structures and clear reporting lines may have been breached. On this basis, ahead of a formal letter being received, it is felt prudent to declare non-compliance with this element of the corporate governance statement	
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. There have been two changes at Non-Executive Director level this year, with two NEDs completing their term of office. Both of those have been replaced with suitably qualified appointments and Governor approval. In addition there has been a reconfiguration of the Executive director's portfolios, with an overall reduction in the Director team. The Director of Operations left the organisation in July 2016 and the Director of Workforce and OD in March 2017. The new structure has been approved by the Board, restructuring director portfolios to have 4.4 WTE Executives (reduction of 2 WTE) consisting of the Chief Executive, Executive Medical Director, Executive Director of Finance and Performance, Executive Director of Patient Services (incorporating Operations, Nursing and Governance) and Executive Director of Strategy and Delivery (incorporating Strategy, Estates, catering and Facilities, Knowledge Hub: Research, Training, medical and non-medical education, Workforce and Organisational Development). **Board structure in annual report.** • As per the **declaration to NHS Improvement concerning availability of resources (Continuity of Services Condition 7)**, there remain some risks in relation to sufficient medical and theatre workforce, but these are not believed to be sufficiently serious to impact upon NHS Improvement'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.	DSD

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 knowledge they need to undertake their role.		New governors receive induction during which any specific training issues are identified and addressed. Bespoke training is provided in-house each year for all Governors on topics identified by them; the sessions held during the year have included NHS Finances and the CQC regulatory framework. Further work is planned during 2017/18 to strengthen the partnerships with governors of other peer organisations. **Minutes from Council of Governors meetings. Training material on CQC regulatory framework and NHS finances.**	ADG&CS

KEY:

Abbreviation	Job Title
CEO	Chief Executive Officer
DOF	Director of Finance & Performance
DPS	Director of Patient Services
DSD	Director of Strategy & Delivery
ADG&CS	Associate Director of Governance and Company Secretary
Emboldened text indicates evidence available to confirm compliance	

Self-Certification Template - Conditions G6 and CoS7

The Royal Orthopaedic Hospital NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These Declarations are set out in this template.

Templates should be returned via the Trust portal.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 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 (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied 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.	**Not confirmed**	Please complete the explanatory information in cell E36

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

An overview of the assessment and evidence available to make a judgement as to compliance is attached to this declaration.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Paul Athey	**Name**	Yve Buckland
Capacity	Acting CEO	**Capacity**	Chairman
Date	30 May 2017	**Date**	30 May 2017

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A The Trust is declaring non-compliance with Condition FT4, NHS foundation trust governance arrangements, on the basis of the breaches that NHS Improvement has identified within its draft undertakings letter, received in response to concerns over the Trust's management of its 18 weeks RTT position, associated data quality issues and the long terms sustainability of the Trust.

ROHTB (6/17) 008

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Quarter 4 2016/17 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Chambers, Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**7th June 2017**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at the end of March 2017.

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 have been no new risks added to the BAF since the Board last reviewed it in January 2017

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

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 January 2017

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK Q4 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	5	4	20	May 2017: The Trust has agreed a financial plan and startpoint budgets that will deliver the control total agreed with NHS Improvement for 2017/18. SFIs are in place to ensure that financial expenditure is controlled within these agreed plans. Monitoring is in place as described in the Assurance section to ensure plans are achieved and/or rectification action takes place where necessary. Local tariffs were negotiated with NHSE to mitigate some impact of tariff changes Working capital support has been agreed with NHSI to mitigate going concern risks	F&P Report; Monthly & Quarterly Divisional Performance Reviews; Audit Committee – Review of contract risk; Weekly activity / income reports at Exec Business Meeting	4	4	16	↔	Integrated Action Plan for RTT recovery will provide additional control around achievement of activity and associated income targets Work to identify an improvement partner will provided additional support and control around required efficiency improvements Additional resources identified by Trust Board to support key delivery actions	Ongoing	2	4	8
582	WFOD	Phill Begg	Risk of non-delivery of strategic objectives associated with leaders' ability to lead change, including cultural change.	Highly motivated, skilled and inspiring colleagues	Major Projects & OD Committee	4	4	16	April 2017: Progress made on management programmes. MSP programme underway. Work currently being undertaken on consultant induction (onboarding) programme and CSL development programme. 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	3	4	12	↔	Implementation of the People Strategcy approved by the Trust Board in October 2016. Further development of the Leadership Strategy which is due for delivery during 2017/18.	Q 4 2017/18	2	4	8

798	WFOD	Phill Begg	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	Major Projects & OD Committee	3	5	15	May 2017: The Trust has undertaken a review of the Executive level roles and responsibilities, and has now restructured the executive team. This action now sits with the new Executive Director of Strategy and Delivery, who is now reviewing the outputs from the recent staff survey and the impact on the culture of the organisation.	New Organisational Structure	3	4	12	↔	Throughout 2017/18 a review, and action plan will be developed to improve the staff and stakeholder engagement and work proactively with the variety of staff groups across the Trust to improve and develop the capacity and culture of change across the organisation	Ongoing	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	May 2017: After a pause in development on a BI Portal, due to a range of data quality issues. The new BI portal is now planned to go live on the 8th May 2017. The BI portal will give users access to the a range of information, including referrals, outpatients, inpatients, referral to treatments. Reports will be available at a trust, directorate, and consultant level and cover a range of indicators e.g. DNA rates, Hospital Cancellations, Average Length of Stay, etc.	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	↔	Development of the data warehouse and ongoing development of in house intelligence	Ongoing	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 and STP 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	Phil Begg	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	May 2017: The Trust has undertaken a review of the Executive level roles and responsibilities, and has now restructured the executive team. This action now sits with the new Executive Director of Strategy and Delivery, who is now reviewing the outputs from the recent staff survey and the impact on the culture of the organisation.	Staff Survey results; FFT for staff; Incident numbers;% staff participation in improvement activity; Improvements in high priority patient areas – outpatients + ADCU	3	4	12	↔	Throughout 2017/18 a review, and action plan will be developed to improve the staff and stakeholder engagement and work proactively with the variety of staff groups across the Trust to improve and develop the capacity and culture of change across the organisation	Ongoing	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	May 2017: The Trust has been working proactively with the STP and the NOA Vanguard in developing a 'placeholder' in the STP strategy. In April 2017, outline agreement for a BSOL STP footprint review of orthopaedic care was agreed, the Trust is awaiting the decision of the STP chair to formally establish as working group.	Transformation Committee meetings and regular reports to Trust Board; Staff satisfaction; Patient satisfaction; Clinical engagement	3	3	9	↔	During 2017/18 a Strategic Outline Case for the future of the Trust will be developed in line with an overall Strategy Refresh, staff across the organisation will be involved and engaged in the development of both of these strategic plans	Ongoing	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, STP and strategic partnerships.	Q2 2017/18	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	May 2017: The tariff for 2017/18 - 18/19 has been received and has been modelled for impact. The risks associated with operating with this tariff have been made clear in discussions with regulators & commissioners and outlined within the Trust's operational plan submission for 2017/18 - 18/19. As a result, an additional £2.2m of tariff has been negotiated by the DOF for some of the Trust's more complex procedures.	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	↔	Trust is working as a road map partner with NHS Improvement to improve orthopaedic costing and help drive the future accuracy and appropriateness of orthopaedic tariff.	Mar-18	1	4	4

S800	CoSec/DPS	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	↔	New starters in the Governance Team to take up post. Continued support to Divisional Governance Board meetings. Review of Trustwide committee meetings structure and enhanced control on the operation of corporate fora.	Q1 2017/18	1	3	3
S832	Ops	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	April 2017: Membership of 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	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	April 2017: 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. Board members visiting wards and departments speaking directly to patients and staff. Formal programme of Board walkabouts.	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 continue routinely observing Quality & safety Committee meetings; continued patient stories at Trust Board; improved membership engagement and plans to redevelop the membership & governor engagement plan.	Q2 2017/18	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	May 2017: All vacancies have now been appointed to, currently awaiting onboard of new recruits and for them to become operational. Risk rating to be reviewed once staff are in post	CQC action plan; SOPs; critical care passport evidence portfolio; presentation for CQC Quality Summit.	2	4	8	↔	Re-assess staffing levels/needs once new recruits are in post	Q1 2017/18	2	2	4
269	Fin	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	April 2017: Operational Plan agreed by NHS Improvement. Weekly monitoring of activity by the Executive Team. Additional operational resource secured to support the 6-4-2 process. Integrated recovery plan provides a range of actions designed to ensure that the trust regains its performance recovery. Finance & Performance Committee scrutiny.	Integrated action plan; minutes of Trust Board & Finance & Performance Committee; Finance Overview; Executive Team papers.	3	4	12	↔	Implementation of Improvement Board. Delivery of the integrated action plan.	Q2 2017/18	2	4	8

7	OPS	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	April 2017: Currently suspended surgery at BCH due to intergirty of packaging of sterile equipment used in surgery. No date yet available for predicted restart of service at BCH. Commissioners have now given the go ahead for recruitment of additional spinal deformity surgeons. As of 20.04.17 specialised commissioning contract not yet agreed.	Weekly updates to Exec Team	4	4	16	↔	Discussions with NHSE and BCH are ongoing. Board decision to be taken in Q1 2017/18 regarding the future direction of spinal deformity services. NHSE are visiting ROH w/c 24.04.17 as part of a regulatory review of delivery of 18 & 52 week RTT compliance.	Q1 2017/18	2	4	8
27	WFOD	Phil Begg	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	February 2017: There continues to be a reduction in agency spend across the Trust. Further review of locum usage underway. Daily scrutiny of requests for short term agency staff cover in hard to recruit areas (e.g. paeds, HDU continues.	Updates to Major Projects & OD Committee. Minutes from Workforce & OD Committee. Agency staffing presentation to Trust Board workshop on 13 January. Agency staffing cost position as outlined in the Finance Overview received by the Board on a monthly basis.	3	3	9	↔	Re-establishment of the agency and locum reference group.	Q1 2017/18	2	4	8
275	DPS	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	April 2107, January 2017 & 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 QSC and Board Clinical Audit meeting shared events/claims/SIRIs/Incidents Directorate Governance meetings	3	4	12	↔	Trust clinical audit days 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.	Ongoing	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	April 2017 - The latest available data for 2015-2016, as at Feb-17 shows: • Our Oxford Score and EQ-5D Health Outcome Score for Primary Hip replacement remains significantly above England Averages. • Our Oxford Score and EQ-5D Health Outcome Score for Revision Hip replacement remains above England Averages • Our Oxford Score for Primary Knee replacement remains significantly above England Averages • Our EQ-5D Health Outcome Score for Primary Knee remains replacement remains above England Averages. • There is insufficient data to show a trend for revision knee replacements	Report to QSC; national comparative data; PROMs scores by consultant	2	4	8	↔	Continued monitoring by the Clinical Audit & Effectiveness Committee	Ongoing	1	4	4
770	Ops	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	3	4	12	May 2017: The risk will continue to remain as a very significant risk until the Trust invest in a new Theatre Block and the likelihood of problems will increase as time goes on. Further motor problems during December 2016 and closure of the theatre suite was narrowly averted, hence increase to likelihood score. Continued maintence where possible.	Estates maintenance schedule	4	4	16	↔	Recovery Board to continue to track performance against turnaround workstreams	Ongoing	1	4	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	April 2017 - Network bandwidth upgrade was postponed due to the migration from N3 to HSCN, hence the risk. Timescales for migration to HSCN still not detailed but expected to be late 2017/early 2018. Bandwidth should be upgraded as part of the migration.	IM & T Programme Board minutes	4	4	16	↔	Migration to HSCN	Q3 2017/18	2	4	8
1030	Ops	Garry Marsh	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	F&PC	4	5	20	April 2017: The theatre equipment in use is, in may instances, at the end of its useful life and a replacement regime is being further developed to enable the timely replacement of worn out equipment which is beyond economic repair. A prioritisation exercise was performed in light of recent incidents reports relating to equipment. Creative options, e.g. lease or rental arrangements are being investigated to explore possibilities within the realms of the available capital budgets.	Funding requests. Outputs of the prioritisation exercise. Capital plan.	3	4	12	↔	Further consideration and of the entirety of the capital programme by the Executive Team.	Ongoing	2	2	4

1031	Ops	Garry Marsh	There is a risk that the Trust does not currently have an electronic inventory management system. 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 2017/18.	Safe and efficient processes that are patient-centred	F&PC	4	4	16	February 2017: EDC Gold has been implemented on a pilot basis (1 product) for proof of concept. A project team has been established to lead this project forward through 2017-18. Support from the Finance Team working alongside theatre logistics will continue to enable progress on this proposal.		4	4	16	↔	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. Implementation of EDC Gold is expected to mitigate this risk to target level.	Ongoing	2	2	4
1074	FIN	Paul Athey	Risk of utilising the cash reserves of the organisation, resulting in a risk to going concern and a requirement to seek funding to allow continued organisational operation.	Safe and efficient processes that are patient-centred	F&PC	4	4	16	April 2017: Scrutiny of cash balances continues, and a cash committee is now in place with enhanced cash controls. Other controls continue as previously mentioned. Monthly scrutiny of cash balance and Use of Resources rating (which includes liquidity) through F&P finance report, with additional oversight through TMC and Board.Spending controls through the use of Scheme of Delegation and delegated limits for individuals throughout the Trust.External audit completed at each year end reviews cash and going concern assumption.		4	4	16	↔	Continued focus on efficiency and cost control through the recovery plan	Ongoing	2	4	8
1088	Ops	Garry Marsh	There is a risk that the organisation's reported position against the 92% target is inaccurate due to data quality issues	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	5	5	25	May 2017: Validation team in place (7) with one further validator commencing 24/4/17. Block 1 validation commenced with weekly tracking. Training programme for all admin teams complete, they will not be retested to determine competence. Consultant teams will be engaged with to improve knowledge of 18 weeks RTT using the medical structure through CSLs. All issues are tracked in real time and summarised in the weekly Executive briefing. Action plan completed using the RAP submitted to the CCG.	Weekly report to Exec Team & Ops Board	5	5	25	↔	Deliver validation programme within 8-10 week programme (blocks 1 and 2 – refer to resource proposal). Seeking IST input to support information review and targeted validation. Development of a new business platform with which we will manage 18 week RTT Development of a training programme to improve knowledge base of RTT in the organisation Continued tracking of all issues discovered through the validation programme↔	Q1 2017/18	4	4	16
1089	Ops	Garry Marsh	There is a risk that the Trust's performance against 92% 18 Week RTT is deteriorating	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	5	5	25	May 2017: Trajectories are being finalised for hands, feet and arthroscopy for submission to NHSI. Band 7 operational support managers are in place to support the detailed work required to maximise the utilisation of capacity.	Weekly report to Exec Team & Ops Board	5	5	25	↔	Trajectories developed for services with increasing backlogs e.g. hands, feet and arthroscopy to be submitted to NHSI describing how these services will be recovered to meet 18 week RTT. Contract performance notice issued by CCG requiring remedial action plan submitted. Discussions in service to agree how the Trust will expand capacity to meet demand.	Q1 2017/18	4	4	16

1117	Ops	Garry Marsh	There is a risk that patients may experience a delay in their clinical pathway due to data quality issues, which may result in harm.	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	5	5	25	May 2017: Standard timeline is being used for an patient identified as having a delay in their pathway. Harm review process in place with the first meeting held 19th April reviewing oncology patients. Any patient found to have errors in their pathway and validated are added to the patient tracker and will be reviewed for the need to complete a harm review.	Weekly report to Exec Team & Ops Board	5	5	25	↔	Development of a SOP for the review of patient timelines to provide a consistent approach and level of detail for patients. Use of the harm process to review patients who are perceived to have had a delay in the pathway. Tracker to keep track of these patients.	Q1 2017/18	4	4	16

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	29 March 2017
Guests	Ms Sally Xerri-Brooks, Head of Communications
Presentations received	National reporting & Learning System
Major agenda items discussed	• Friends & Family Test improvement plan • 18 weeks RTT and cancer services harm review • Quality & Patient Safety report • Learning from deaths – Royal College of Physicians guidance • CQC action plan update • Quarterly CQUIN performance report and contract quality scorecard • Never Event external review report • Consent Internal Audit • Quality Account indicators 2017/18 shortlist • Upward report from Clinical Quality Committee • Upward report from Children's Board • Divisional governance update
Matters presented for information or noting	• Nurse staffing update
Matters of concern, gaps in assurance or key risks to escalate to the Board	• As part of the review of the ward assurance reports, it was noted that PDR completion rates were poor • New national guidance had been introduced around learning from deaths. The Trust is required to report all deaths publicly by Quarter 3 2017/18. Families also need to be offered the opportunity to participate in the investigations into deaths and there needed to be demonstration that lessons had been learned. • In terms of the CQC action plan, it was reported that there remained challenges regarding Outpatient clinic waiting times. There remained some Paediatric nurse vacancies. Paediatric consultant cover also needed to be addressed as a priority as interim cover had not been secured as planned. • The Committee was advised that the Trust was unlikely to achieve the CQUIN target around 'flu vaccination, despite there being an improvement on the previous year's position. Spinal deformity was cited as a further area of risk in terms of CQUINs, although list uptake of those

	offered by Birmingham Children's Hospital had been good • The contract quality scorecard highlighted that a Contract Performance Notice in respect of mandatory training had been received – conflict resolution and resuscitation training were particular areas of concern. Financial penalties would be likely to be levied. • There was also a Contract Performance Notice around 18 weeks Referral to Treatment Time performance that had been received. The Committee was advised that a letter had been received from NHS Improvement signalling that they were planning to undertake a formal review of the Trust's position on 18 weeks RTT. The patients who had been waiting for in excess of 52 weeks were being tracked on a weekly basis and effort was being directed into improving the Patient Tracking List more generally. • The Committee reviewed a report produced as an outcome of an external review into the Trust's Never Events. A number of recommendations were those that the Trust was already addressing, however an action plan would be developed to capture progress.
Positive assurances and highlights of note for the Board	• The Committee was provided with an update on the implementation of the new Friends and Family Test system, 'I Want Great Care'. The system had improved the level of response rates from that seen previously, particularly in Outpatients. There was still further work to do around engaging ward managers with the results from their areas and making the most of electronic solutions to capture the feedback. • The Committee was reassured to hear that a process was in place to review patients that had been waiting for treatment in excess of 52 weeks for harm and a harm review panel was to be established, which would include a member of the CCG. Further updates on this were promised to the Committee over coming months. • New ward assurance dashboards had been developed, which helped triangulate information that was currently presented within the Quality & Patient Safety reports • The Committee was advised that completion of the WHO checklist had improved overall, aside from a dip in Oncology, which would be explained at the next meeting • A series of Quality Assurance walkabouts had been arranged, which would commence from April 2017 • A presentation was delivered around the Trust's compliance with the use of the National Reporting & Learning System, a matter which had been of concern a few months previously. The System was a national tool used to capture incidents reported. Much work had been undertaken to improve the processes around incident

	reporting; there remained more work to do around the quality of feedback, however. • The Committee reviewed an accepted the shortlist of Quality Account indicators for 2017/18 • As part of the consideration of the upward report from the Clinical Quality Group, it was noted that there had been much work undertaken to strengthen the Division 1 risk register. • The Committee noted good progress on the development of the Children's Board.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Circulate the new harm review process to the Committee • Provide a narrative around the medicines incidents on Wards 10 & 12 in the next Quality & Patient Safety report • Consider the involvement of the Executives in the quality assurance walkabouts • Present an update on the Trust's plan to achieve compliance with the Learning from Deaths guidance in June 2017 • Present the CQC action plan at the next meeting • Present the updated CQUIN & contract quality scorecards at the June 2017 meeting • Present the action plan to address the recommendations in the external review of Never Events at a future meeting • Present a standalone report on the various Quality Indicators that had been rolled over from 2016/17 to demonstrate progress over time • Present the quality & patient safety extract of the Corporate Risk Register at the next meeting • As part of the consideration of the upward report from the Clinical Quality Group, it was agreed that a case study demonstrating where changes had occurred as a result of learning would be presented at a future meeting. • Report back on how safeguarding requirements are met in respect of visitors to the Trust, particularly if they are to come into contract with children as part of their visit; it was suggested that HR should be invited to the next Children's Board to discuss this. • Establish progress with revising the Quality Impact Assessment process, a matter being led by the Deputy Director of Finance • Divisional Heads of Nursing are to be invited to join the Committee in future to present their divisional governance updates
Decisions made	• None beyond actions above

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

For the meeting of the Audit Committee scheduled for 25 April 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	26 April 2017
Guests	Dr Graham Caine, Pathology Manager Prof Phil Begg, Executive Director of Strategy & Delivery Matron Evelyn O'Kane, Safeguarding Lead Mrs Janet Cairns, Head of Nursing for Division 2
Presentations received	• Update on the Knowledge Hub
Major agenda items discussed	• Harm review process • Quality & Patient Safety report • Human Tissue authority report and action plan • CQC action plan • Upward report from the Clinical Quality Group • Upward report from the HDU Improvement Board • Upward report from the Infection Control Committee and feedback from the Infection Control peer visit • Upward report from the Safeguarding Committee • Progress with strengthening the governance of trustwide committees • Quality & safety risks on the corporate risk register • Divisional governance update • Quality Impact assessment process
Matters presented for information or noting	• Draft Quality Account
Matters of concern, gaps in assurance or key risks to escalate to the Board	• The harm review process was discussed; there were ninety patients included on the harm review tracker. The harm review panel had sat and reviewed Oncology patients included on the harm review tracker, with the intention that when the panel sat in early May, spinal defomtiy patients would be reviewed. The harm identified in Oncology patients was reported to be moderate, not severe. • As part of the presentation of the Quality & Patient Safety report, a number of issues and risks were raised: there had been an increase in incidents reported, this being reflective of the additional incidents raised in connection with the 18 weeks RTT validation work; three serious incidents had been reported, these being VTEs, the Root Cause Analyses for which identified that there had been poor documentation; the Children's Thermometer information

	suggested that there were some children triggering on the early warning scores and these had not been escalated, therefore work was underway to understand the reasons for this; there had been a significant increase in the number of falls across all inpatient wards – work was planned to change Ulysses to more accurately record the nature of falls; there were three cases of non-compliance with the WHO checklist • Although good progress was reported on the CQC action plan, it was highlighted that the increased presence by the Paediatrican from Birmingham Women's and Children's NHS FT (BWC) was still not in place. The Committee was concerned about this and asked the Director of Patient Services to write to BWC asking then to address this as a priority. • The governance around the Royal College of Paediatrics and Child Health (RCPCH) was to be reviewed, particularly the ongoing role of the taks and finish group. • A number of risks were outlined as part of the infection control update including: the need to strengthen the board to ward processes around infection control; a lack of vision on infection prevention and control matters from within the Infection Control team; vacancies in some key infection control positions, including the lead nurse; and the absence of a water safety plan. A verbal update from the recent peer review of infection control was provided by the Director of Patient Services. He highlighted that the Trust might face regulatory concern if it was inspected by the CQC at present on the basis that there were some hand hygiene and bare below the elbow non-compliance witnessed; there were some breaches to COSHH legislation; soiled commodes and toilets had been identified; management of bed heads in theatres needed to be reviewed; dust had been found on resuscitation trollies. The findings from the review did not however, reveal any issues that the Trust was unware of and was handling. • The update from the Drugs and therapeutics Committee was deferred as papers were provided late to the Committee • A further audit of Trustwide committees had identified some shortfalls in terms of having appropriate Terms of reference, central storage of papers and discussion of a risk register – this work would be addressed by the Associate Director of Governance/Company Secretary by July
Positive assurances and highlights of note	• Dr Graham Caine joined the meeting to present the highlights of the Human Tissue Authority (HTA) action plan.

for the Board	The last visit of the HTA was in June 2016, which had identified some minor shortfalls against the national guidance. The action plan developed in response had good oversight by the Associate Medical Director and would address the issues identified. • An informative update on the work of the Knowledge Hub was received. A Chair in Orthopaedics had been agreed, which was a joint appointment between the ROH and University of Birmingham. There had been an increase in the number of research studies being undertaken. Work was underway to improve the use of e-learning in the Trust. • A new HDU Improvement Board had been established to oversee the work identified by the CQC at its last review • The monthly trajectory of mandatory training had been met. • The new acting CEO of Birmingham City Council and chair of the Safeguarding Board had praised the Trust's safeguarding arrangements • An update from the divisions on their governance arrangements showed that there were some positive discussions happening at the divisional governance board meetings. Further positive points included the good progress with strengthening the risk registers and the consideration of the learning from Serious Incident Root Cause Analyses. Division 1 meetings and discussions were noted to be particularly effective and work was underway to instil a similar level of rigour in Division 2
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Revise Ulysses to more accurately capture falls information • Advice to be sought from an external source on the Trust's VTE prophylaxis policy • Inclusion of the HTA action plan with the Committee's workplan • Write to BWC to ask that the additional presence by a Paediatrician be arranged as a priority • Further update on the outcome of the Infection Control peer review at the next meeting
Decisions made	• None beyond actions above

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

For the meeting of the Trust Board scheduled for 7 June 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	31 May 2017
Guests	None
Presentations received	None
Major agenda items discussed	• Quality & Patient Safety report • Harm review update • Upward report from the Clinical Quality Group • Never Event action plan • Nurse staffing updates • Feedback from the Infection Control peer visit • Quality & safety risks on the corporate risk register
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Board	• As part of the presentation of the Quality & Patient Safety report, a number of issues and risks were raised: it was suggested some context to the 'near miss' incidents was needed in future; there had been two serious incidents reported, including the suspension of spinal deformity services at Birmingham Womens and Children's NHS FT as a result of decontamination concerns; the Children's Thermometer information needed to be updated; seven falls had been reported during the month; two Grade 2 pressure ulcers had been reported; 11 complaints had been lodged; there had been two cases of non-compliance with the WHO checklist requirement – it was agreed that ownership of this process would be discussed with the Associate Medical Director of Division 2 • The progress with the harm review was discussed. Oncology and spinal deformity patients had been reviewed to date and a set of patients had been identified who were affected by harm. The next cohort of patients to be reviewed would be those having waited for treatment between 41 – 52 weeks. It was agreed that the frequency of the harm review meetings and the chairmanship of these should be reviewed to ensure that the governance around this process was as robust as it could be. • The Committee discussed the ongoing acceptance of patients onto the spinal deformity waiting list, ahead of the Board meeting planned for 7 June when a decision

	would be made. It was agreed that although the Committee could make a judgment based on the quality & patient safety perspective, then a wider conversation was needed which took into account the legalities of halting acceptance of referrals and the financial implications of the decision. The lack of PICU beds system-wide was an ongoing issue that needed resolution as this was a limiting factor to the treatment of spinal deformity patients. • The Committee was provided with an update on the outcome of the peer review of infection control. The review had graded the Trust as being at 'amber' status, however there was a concern that this might be regraded 'red' whe the Trust was visited in July, should the issues identified not have been addressed. Non-compliance with the water safety code needed to be rectified. The quality of upward reports from the Infection Control Committee and its annual report needed to be strengthened to better highlight key issues and risks. A decontamination forum was to be set up. • The Never Events action plan was reviewed, which contained a number of actions in response to recommendations arising from the NHS England external review of the Trust's Never Events. The action plan would be monitored at the stakeholder oversight meetings. • There had been an increase in the number of PALS concerns reported, which were associated with the Trust's car parking arrangments. Payment on exit rather than entry would address these concerns. • It was reported that there had been a dip in observations of care, however work was underway to address this and establish whether registered nurses rather than Healthcare Assistants were undertaking this duty. • The Committee was concerned at the lack of attendance from the Chair of the Drugs and therapeutics Committee and the report submitted stimulated a number of queries and concerns. On this basis, the Committee agreed that it received no assurance from this report, a matter which the Director of Patient Services would pick up with the operational leads for this committee. • There were some concerns raised around the level of Disclosure & Barring Scheme (DBS) checks made on those having access to inpatient areas, particularly some groups of ancillary staff. This was being investigated. • In terms of the Ulysses system, it was highlighted that the functionality of this system was currently not fit for purpose and was being revised by the Clinical Governance Manager. There was a backlog of incidents that remained open on the system and work was underway to

	understand the level of risk presented by this issue.
Positive assurances and highlights of note for the Board	• As part of the nurse staffing updates, it was highlighted that the Trust's use of agency staff had reduced significantly as a result of having successfully recruited substantive individuals. The review of nurse establishments needed to be presented to the Board in July. • The operation and administration of the Clinical Quality Group had improved. Attendance at the meeting needed to be reviewed however, to ensure that there was sufficient representation from medical staff and general management. • It was reported that there was increased Paediatrican cover provided by BCW now and this would be increased further to five days per week from September. • There had been two quality assurance walkabouts pilots that had occurred in April and May, which had reviewed Wards 1 & 3 and HDU & theatres. Staff had been receptive to the visits. There was good representation from across the Trust on the May walkabout. Learning from the walkabouts is to be developed further and the system streamlined, which will be fed back to the Committee.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The Heathwatch commentary on the Quality Account is to be presented at the next meeting • An update on the cost of the Orthopaedic Chair is to be provided at the next meeting • Agreement of ownership of the WHO checklist process with the Associate Medical Director (Division 2) • A report on medical staffing and other staffing groups is to be presented at a future meeting • Director of Patient Services to write to the Chair of the Drugs and Theraputics Committee to express the Committee's concerns at the lack of assurance provided by his upward report and non-attendance at the meeting
Decisions made	• None beyond actions above

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

For the meeting of the Trust Board scheduled for 7 June 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	28 March 2017
Guests	None
Presentations received and discussed	None
Major agenda items discussed	• Update on job planning • Cancellations and DNAs • Finance & Performance Overview – Month 11 • Financial recovery: workstream update • Feedback from NHS Improvement • Cash planning 2017/18
Matters presented for information or noting	• Extract of the Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• It was reported that 90% of job plans had been completed with implementation of all planned for 1 May 2017, this being a delay to the original date of 1 April 2017. It had been identified that some of the job plans bore a cost pressure that had not previously been apparent and the need to pay back pay in some cases; this was to be further understood and the challenge around these investigated. The extent to which this created a risk to the delivery of the financial plan for 2017/18 was to be assessed. Three job plans were due to go to mediation with the Medical Director. • The financial performance in February had been poor and there had been a larger than planned deficit. This presented a challenge in terms of achieving the end of year financial position. Activity was also below the levels in the recovery plan and against the same position in 2015/16. • The Committee acknowledged that the underlying business was not at the right sustainable level at present and although case mix was richer there were a number of beds that had been closed and theatre sessions remained under utilised • Significant amounts of annual leave had been taken in Quarter 4 by some of the most productive surgeons, thereby impacting on activity levels handled. This suggested that the Trust's own policy for annual leave

	planning was not being applied robustly. • The 6-4-2 process was inefficient, with lists not being filled completely at 6 weeks, and only a short forward look at lists due to happen. • In Oncology, there was a range of issues that needed to be addressed, including making the MDT fit for purpose, an inefficient medical secretary team model and the need for a manager to be put in place in the team. • In arthroscopy, the backlog position was growing as a result of the failure to plan for the retirement of a key surgeon. In foot and ankle there had been an increase in service demand which had not been properly responded to. • The Committee was advised that there needed to be a change to the current acceptance of named-referrals, to an arrangement where waiting lists were pooled in some specialities and centralised booking to be implemented • Expenditure was above plan both on pay and non-pay. There were pressures in pay as a result of job planning, including an on call supplement dating back to 2009 providing a significant cost pressure • Theatreman implementation had been delayed until April, this being concerned with ongoing issues found as part of the User Testing Acceptance prior to 'go live'. • The booking processes as part of 6-4-2 needed to be improved. • It was noted that there was further work to ensure consistency between the POAC view of fitness for surgery and that provided on the day surgery, this being a reason for some of the hospital-instigated cancellations • The waiting times in Oncology outpatient clinics where there remained a high level of 30 and 60 minutes waits were still causing concerns and was attracting regulatory criticism • In terms of 18 weeks RTT performance, it was noted that although data quality was an issue the absolute performance was poor. • The number of patients waiting 52 weeks or more had increased to 47, with not all of these being in spinal deformity • The Chief Executive reported that she had discussed with NHS Improvement the planned review of the Trust's 18 weeks RTT position. It was the intention to develop an integrated development plan for the long waits, to include the 52 week waits which would also address the Contract Performance Notice around this under performance
Positive assurances and highlights of note	• From a spinal deformity services point of view, the fallow lists that had been offered by Birmingham Children's

for the Board	Hospital had risen significantly during Quarter 4 in an attempt to meet the CQUIN • The Medical Leadership challenge in Division 1 was expected to be addressed through the joining of the new Associate Medical Director shortly. • Overall income was largely in line with plan, due in part to increased training monies which were non-recurrent. • There had been a notable drop in nursing spend as a result of e-rostering • There had been an improvement in the pre-operative assessment area and the process of booking had been amended to make it more efficient and further ahead of the planned procedure date. • There was good progress with the discharge workstream, with there being a move to ensuring patients had an Estimated Date of Discharge. There was also increased focus on reducing length of stay • There was noted to be a year end shortfall against the CIP plan, although cost savings amounting to c. £3m would be achieved, which was a good performance • There was optimism that the year end revised control total would be achieved
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• An update on job planning to be presented at the next meeting • Activity and financial contribution is to be presented at a future meeting • Present the benefits realisation of the e-rostering system in July • A further update on cancellations and DNAs is to be presented at the next meeting • Present a paper to the Trust Board setting out the terms of the cash loan and to seek delegated authority for the Finance & Performance Committee to monitor this • The Committee is to receive an extract of the Corporate Risk Register at the next meeting
Decisions made	• The Committee agreed to recommend to the Board that cash support should be sought from the Department of Health via a series of loans

Mr Tim Pile
VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 7 June 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	3 May 2017
Guests	None
Presentations received and discussed	None
Major agenda items discussed	• Update on job planning • Cancellations and DNAs • Finance & Performance Overview – Month 12 • Financial recovery: workstream update • Preparation for the Confirm and Challenge meeting with NHS Improvement
Matters presented for information or noting	• Extract of the Corporate Risk Register
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The Committee was advised that the Trust was nearly at the end of the job planning exercise and new theatre templates were in place, although the Committee was concerned that the process for covering fallow lists using prospective cover did not appear to be fully embedded. • The Committee spent a large element of the meeting looking at the financial recovery progress. • There was a concern that annual leave planning was not robust and the Trust's own policy to ensure equitable leave was taken across the year was not being applied • Agency spend needed to be reduced further to ensure that the ceiling imposed for 2017/18 could be met. The current locums working in POAC needed to be reviewed in particular. • There was concern that Theatreman had not been implemented and the go live date had been postponed a couple of times. • The effectiveness of the 6-4-2 process remained a concern, however an interim operations manager had joined the Trust who would provide additional support and scrutiny to the process • The Month 12 and year end positon was reviewed and it was noted that income was reasonable against plan, however the current 'run rate' was reported to be c. £100k away from what was needed to deliver the required

	control total for 2017/18. • There was concern that for the current year, CIP schemes and quality impact of those had not yet been fully identified. • Cash support would need to be accessed from summer, a process that the Board had needed to approve. • The number of patients waiting over 60 minutes for an outpatient appointment remained a concern. • The performance against the 18 week RTT target had deteriorated further. It was reported that the RTT issue was not just in a couple of specialities but across a significant number of individual consultants. • Preparation for the NHS Improvement Confirm and Challenge meeting was a major item for discussion, particularly around the plans to develop an integrated action plan. The Committee was very concerned that a plan had not been developed and may not be ready for the Confirm and Challenge meeting. • The development of speciality-level trajectories was a challenge, given that as the validation work progressed on the open pathways this meant the trajectories were a 'moving feast' • Additional resources were to be identified to assist with delivery at pace. • The Trust needed to take a view and advice on whether it should cease reporting its 18 week performance until the issues had been resolved • A harm review had been introduced which, based on a clinical assessment, prioritised some patients found needing treatment as a result of the validation work • In terms of spinal deformity cases, access to PICU beds continued to be an issue, meaning that the number of patients waiting 52 weeks or over could not be reduced. The Board needed to consider whether to close the waiting list for these patients.
Positive assurances and highlights of note for the Board	• Good work was reported to be underway through the clinical service leads to ensure that there was absolute ownership at a consultant level of their activity targets • The Committee was keen to see a centralised model of booking theatre slots introduced; this is in place in other organisations. The Trust had signed up to the NHS Improvement Productive Theatre scheme which would help improve theatre productivity, although the timescales for this programme still needed to be clarified. • The previously named 'Recovery Board', which was an Executive forum, would be rebranded at 'Improvement Board' given that recovery was a wider matter now than just financial. Separately a 'RTT Recovery Board' would also

	be implemented. • There had been some good work in POAC to reduce cancellations, basically so that the views of the anaesthetist in POAC and that assessing fitness for surgery on the day of the operation were harmonised better. • To address inefficiencies caused by DNAs, overbooking clinics would be implemented in the same way it is in some service industries, such as airlines. • The year-end control total had been met, where a deficit of £4.301m had been achieved – this was not due to satisfactory activity & associated income however, but was due to some non recurrent benefit from clinical coding changes and some changes in the implants used for spinal deformity procedures. • Although the CIP programme had not been fully delivered in 2016/17, there still had been a huge amount of savings achieved, more than in any other previous year. • There had been a reduction in the amount of patients waiting for 30 minutes to been seen in an outpatient clinic.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The procurement strategy to be presented at the next meeting • Update on the application of annual leave controls to be provided at the next meeting • An update on the use of Physician Associates and the plans to reduce locum costs is to be presented at the next meeting of the Major Projects & OD Committee • An update on the implementation of Theatreman is to be presented at the next meeting • A decision over the continued acceptance of referrals onto the spinal deformity waiting list is to be considered by the Trust Board in June • The resourcing plans for the recovery work are to be presented to the Board in June
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 June 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	25 April 2017 and 30 May 2017
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 annual report and Head of Internal Audit opinion • External audit progress report • Counterfraud progress report • Recommendation tracking • Draft annual report and accounts including the draft Annual Governance Statement • Losses and compensations register • Breaches of waivers and SFIs register • Declarations of Interest register • Hospitality register • Audit Committee review of effectiveness • Audit Committee workplan
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The internal audit, external audit and counterfraud recommendation trackers were reviewed, although they were noted to require updating. It was agreed that the current position was unacceptable and the Executive agreed to update the trackers as a matter of urgency. • The internal audit recommendation tracker was noted to incorporate the recommendations from the advisory 18 weeks RTT pathway audit, although many of these overlapped with the work required to demonstrate recovery to NHS Improvement • It was agreed that the internal audit plan needed to, on a risk-based approach, incorporate elements where previously substantial or full assurance had not been received previously • The counterfraud team highlighted that staff opening up fraudulent e-mail was a key risk to the Trust as cyber crime was on the increase. The work undertaken internally was described including the issuing of a dummy phishing e-mail, which was used to identify the likelihood of staff

	opening such e-mails and used as a lesson learned across the Trust. This was ahead of the major cyber attack which occurred some days after the meeting • As part of the discussion of the draft annual accounts, the position concerning stock was outlined, where there were some adjustments planned, although the treatment of these needed to be discussed further with auditors on the basis of their materiality; this position would be resolved in time for the approval of the annual accounts at the Board meeting on 30 May 2017 • The draft Annual Governance Statement was reviewed, which had been prepared in line with the national guidance. Key weaknesses in internal control were cited as being concerned with: 18 weeks RTT data quality & performance issues; cancer waiting time tracking; Never Events; theatres closure as a result of a spike in infections; and the void in reporting of incidents into the national system • The annual report and accounts were reviewed at the meeting held on 30 May – a qualified opinion on the use of resources aspect of the Trust's operations. Key risks identified as part of the audit includes revenue recognition and provisions; valuation of the Trust's property assets; and financial sustainability and going concern. The opinion on the accounts also reflected the wording of the draft letter from NHS Improvement and associated licence breaches in connection with the 18 weeks RTT challenges which had occurred during the year
Positive assurances and highlights of note for the Board	• The Head of Internal Audit's opinion advised that there was an adequate internal control framework in place within the Trust, although it indicated that there was still room for improvement • The position against the counter fraud self-review toolkit was reviewed, which rated the Trust as being at amber status. The workplan of the counterfraud team was noted to be sufficiently robust as to cover the areas of improvement needed • The draft annual accounts were reviewed, which showed that at £4.302m deficit, the revised control total had been met • The cash positon had improved toward the end of the year, meaning that cash support would not be needed until the summer 2017, rather than from May • The Audit Committee self-assessment overall was positive, however there were some areas of further work around inducting new members and developing them professionally, which the Company Secretary would lead on. Following recent feedback from NHS Improvement as

	part of the 18 weeks RTT challenge, the frequency of meetings would also be reconsidered to ensure that there was more even coverage across the year
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The principal area of follow up from the meeting on 24 April was to ensure that the recommendation trackers were updated with the current position on delivery of actions arising from internal, external and counterfraud audits
Decisions made	• The Audit Committee approved its workplan for 2017/18 • The Audit Committee agreed to recommend to the Board that the annual report should be approved and the annual accounts adopted

Rod Anthony

NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Trust Board scheduled 7 June 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MAJOR PROJECTS & OD COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	5 April 2017 and 26 April 2017 (extraordinary meeting)
Guests	Jonathan Bamford, Transformation Manager Clare Mair, Head of OD & Equality
Presentations received and discussed	At the extraordinary meeting on 26 April, the Committee received a presentation from a potential strategic partner who would work with the Trust to develop and implement performance solutions
Major agenda items discussed (5/4/17 meeting)	• Terms of Reference for the Major Projects & OD Committee • Network Infrastructure Project update • ePMA (electronic prescribing and medicines administration) Project update • OD & Inclusion update
Matters presented for information or noting	• Extract of the Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The network infrastructure project would include external civil works, which would be completed in five phases. All of these phases needed to be completed by the end of August 2017 before the overall programme could progress – there was likely to be some disruption to roads and car parking during phase C of the project but arrangements were being made for patient drop-off and deliveries • The Committee was advised that there had been some issues with the delivery of a stable system for ePMA by its partner organisation and work would continue to ensure an appropriate exchange of information • The risks around training, familiarity and user acceptance testing for the ePMA project were discussed, particularly given that the new system was being introduced to such a large number of staff • It was noted that although the ePMA project was on track, it was also over budget • As part of the discussion of organisational development, it was highlighted that there was significant variability in terms of the quality of appraisals being undertaken across the Trust. Appraisal needs to be linked more closely to the Trust's priorities and strategy. A set of priorities needed to be defined, so that every member of staff could be

	committed to and work towards these. • More work is required to develop succession planning and talent management
Positive assurances and highlights of note for the Board	• Good progress was being made with the network infrastructure project which was in week 6 when the committee met on 5 April • Lessons were being learned as the network infrastructure project progressed and a comprehensive communications plan had been developed • The first phase of the ePMA projects was reported to be on track for delivery in October 2017 – this was dependent on the network infrastructure work, however and the completion of work at BCH • There had been good clinical engagement with the ePMA project • It was noted that ePMA would be a good learning tool and useful as part of conducting Root Cause Analyses • The Committee received a useful update on the organisational development work in the Trust; this was aligned to the People Strategy approved by the Board in Autumn 2016 • It was reported that a Management Skills Programme was being run, with attendees being encouraged to use action learning sets.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Development of a workplan for the Committee which picks up residual matters from the Transformation Committee • Involve the Deputy Director of Nursing & Clinical Governance in the network infrastructure project to ensure that nursing requirements are taken into account • Create a RAG rating system for the network infrastructure project workstreams • The committee gave a strong signal that the People Strategy and Staff Engagement strategy needed to progress rapidly into implementation • Consider ways in which good practice may be better celebrated and communicated • It was agreed that staff engagement was a Board priority and this needed to be taken into account for all projects
Decisions made	• The Committee approved its proposed terms of reference

Mr Richard Phillips
NON EXECUTIVE DIRECTOR AND CHAIR OF THE MAJOR PROJECTS & OD COMMITTEE

For the meeting of the Trust Board scheduled for 7 June 2017

Finance and Performance Report

APRIL 2017

CONTENTS

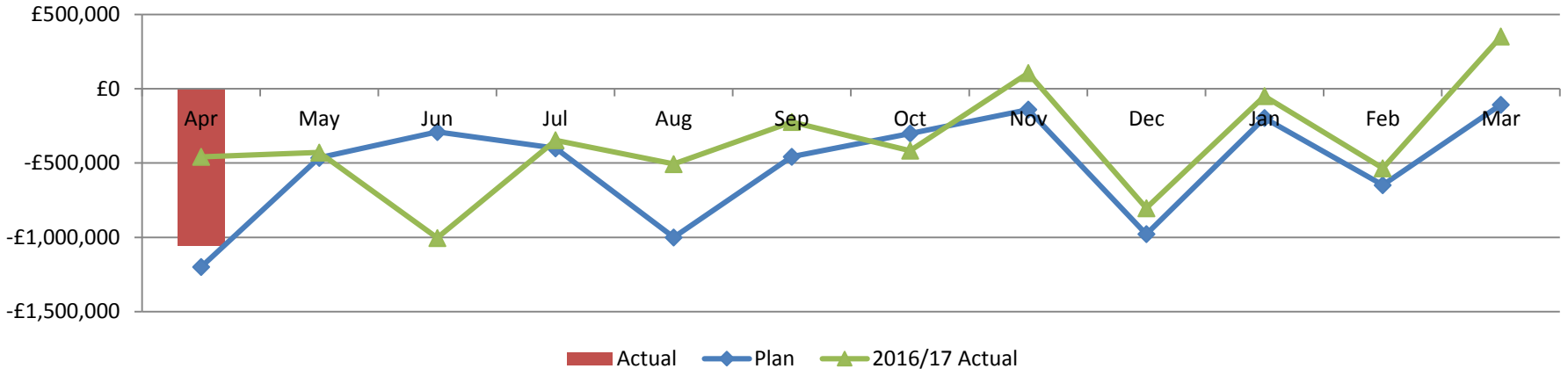
INTRODUCTION

The Finance & Performance Report is designed to provide assurance regarding performance against finance, activity, operational and workforce requirements.

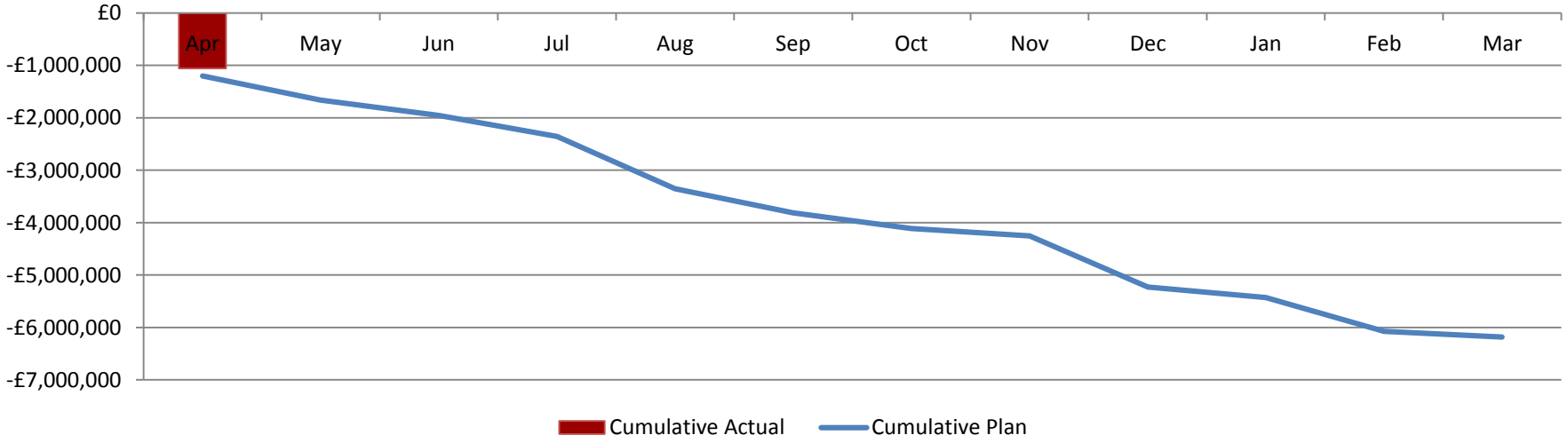
The report will demonstrate in month and annual performance against a range of indicators, with a clear explanation around any findings, including actions for improvement / learning, and any risks & issues that are being highlighted.

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)

Monthly Surplus/Deficit Actual vs Plan



Cumulative Deficit vs Plan



INFORMATION

The Trust has delivered a deficit of £1,057,000 in April against a planned deficit of £1,199,000, and is therefore ahead of plan by £142,000. This is as a result of particularly non-pay costs being able to be controlled to offset income being lower than expected. Spinal Paediatric lists at Birmingham Children's Hospital were suspended during April because of issues with sterile kit, which equated to an income reduction of around £140k and a non pay spend reduction of approximately £100k. This is discussed further in the income and expenditure individual tabs.

The April CIP position was £66,000, against a plan of £266,000. There were CIP schemes provided for the entirety of the CIP requirement for 2017/18 (£3,671,000), however, significant further work is required by the Divisions to provide detailed plans for delivery of the schemes, and to ensure that the potential Quality Impact is assessed appropriately. Operational focus on RTT has meant that provision of this documentation has been slightly slower than expected, and a revised deadline of 7th June has been provided by the Director of Finance for completion of the relevant documentation.

The Trust has not been required to report against the Use of Resources Rating in Month 1, and has yet to receive it's updated Single Oversight Framework score. The score current remains therefore at a Level 2, although it is expected that the outcome of the RTT review by NHS Improvement will result in the Trust being downgraded to a Level 3.

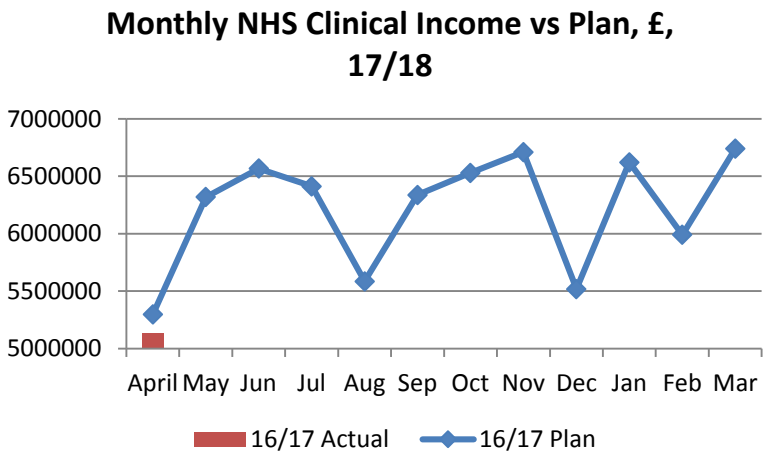
ACTIONS FOR IMPROVEMENTS / LEARNING

The Trust Executive are monitoring weekly progress against the action plan. Schemes such as implant rationalisation are in progress to improve the Trust's cost efficiency. Whilst the schemes are constantly being reviewed and refreshed, particular focus will be placed on ensuring the cost control plan is reconsidered and takes into account all of the coming planned CIP schemes which need particular Executive oversight.

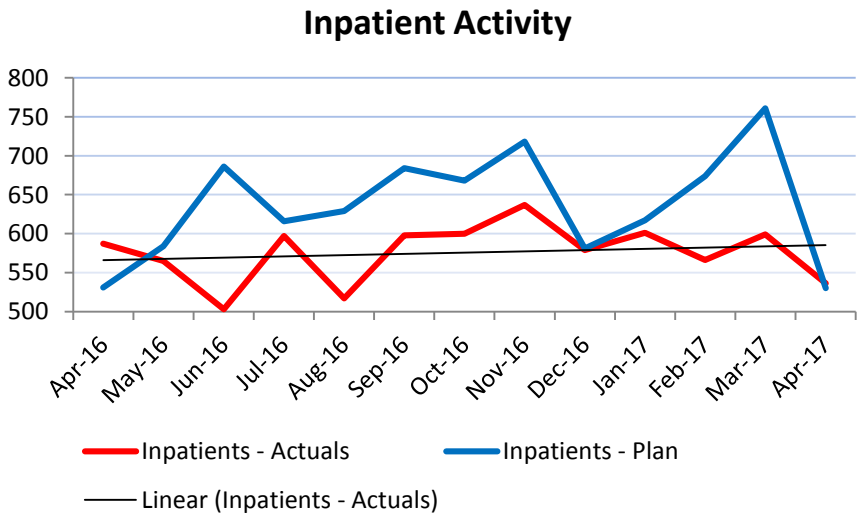
RISKS / ISSUES

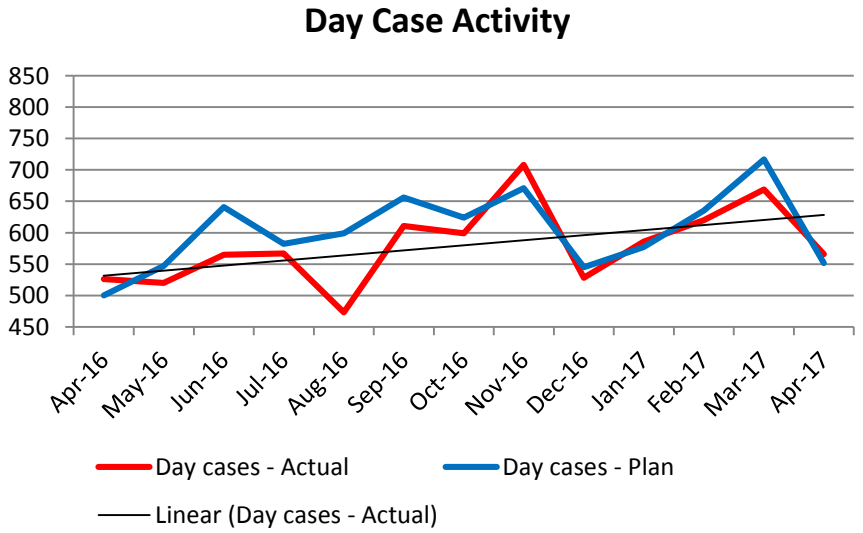
As mentioned above, there is a risk that the focus on RTT and operational activity delivery results in CIP schemes not being implemented in a timely enough manner to ensure the required savings for 2017/18.

2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



NHS Clinical Income – April 2017 £'000			
	Plan	Actual	Variance
Inpatients	2,591	2,728	137
Excess Bed Days	82	49	-33
Total Inpatients	2,673	2,777	104
Day Cases	638	618	-20
Outpatients	510	442	-68
Critical Care	204	181	-23
Therapies	203	193	-10
Pass-through income	182	217	35
Other variable income	311	206	-105
Block income	518	518	0
TOTAL	5,239	5,152	-87





INFORMATION

NHS Clinical income under-performed by 3.1% in April having over-performed by 4.9% in March. Admitted patient care performance was above plan financially and activity levels, with discharged activity 20 above target. April does have decreased levels of activity compared with March which was expected as there was a holiday period in month. Case-mix remained steady in April.

Outpatients continued to under-perform from an income point of view, driven by a reduction in the number of outpatient follow ups undertaken in month compared to plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

PWC are supporting the organisation to track , across 4 work streams (Operations, Process, People, and Data), the actions required to achieve recovery of income and RTT. Continued focussed work continues with clinical service leads and consultants, with the operational managers , to create additional capacity, and using the trajectories, target individual (long waiting) patients to be booked.

RISKS / ISSUES

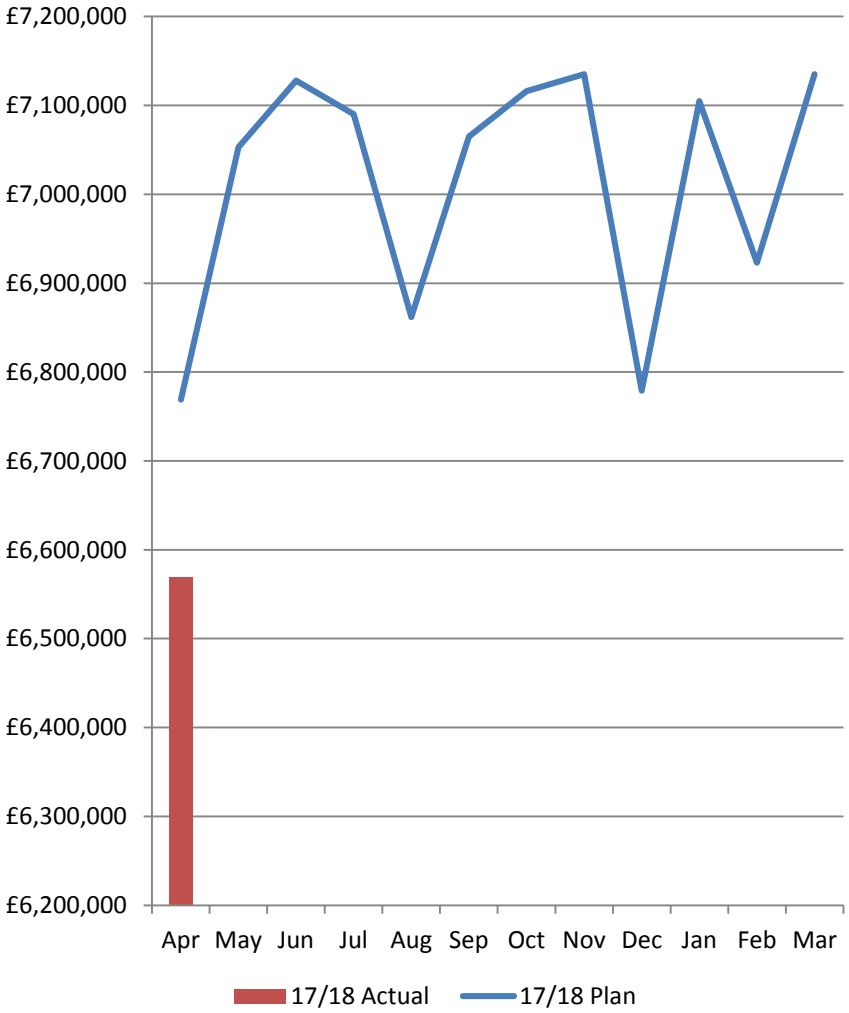
April contained a number of weeks with reduced activity targets as a result of either bank holidays or Clinical Audits. These weeks generally saw an over-performance in activity terms. It will be important to achieve consistency in achievement of the activity when the target is back to a usual full week.

Key risks are the availability of speciality teams to reutilise every fallow list, and to ensure that theatre productivity continues to enable fully booked lists to be delivered. There continue to be a high level of patients who cancel their operation a few days before the planned date, which then means that there are replacement patients scheduled at short notice to achieve full utilisation.

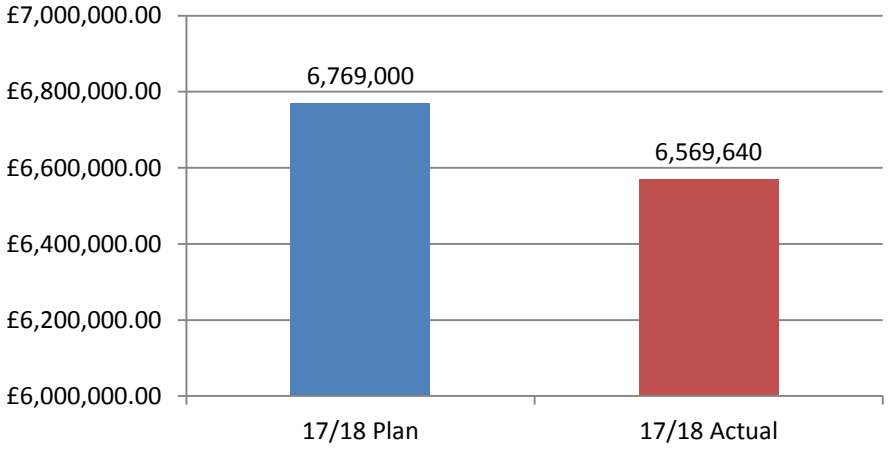
There is increasing clinical engagement in developing improvements to productivity for both operations and out patients. Some consultants have very short, with others having very long, waiting lists, and work is underway to smooth out flows across firms.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends

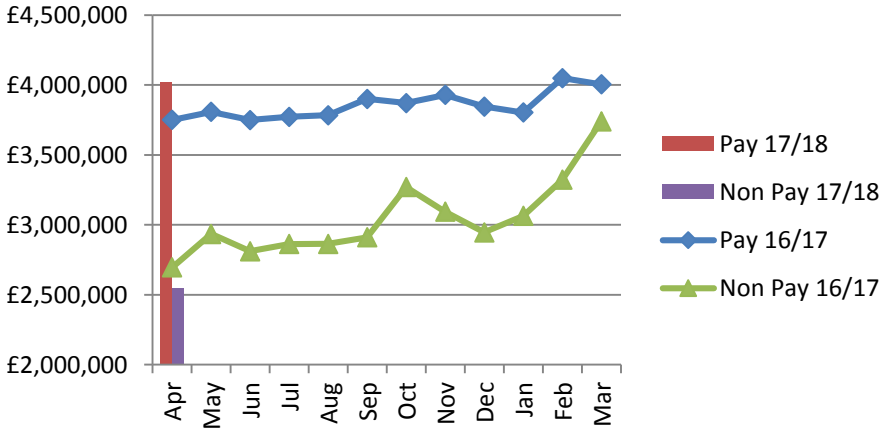
2017/18 Monthly Expenditure vs Plan



2017/18 M1 Expenditure vs Plan



2016/17 vs 2017/18 Pay & Non Pay Spends



INFORMATION

Expenditure levels for the month were £6,570,000, £199,000 behind the in month plan of £6,769,000.

The main reason for the underspend was non-pay spend being lower than planned. Spinal Paediatric lists at Birmingham Children's Hospital were suspended during April because of issues with sterile kit, which equated to an income reduction of around £140k and a non pay spend reduction of approximately £100k. Implants, orthotics and drugs for example were lower than plan as a result of activity being below plan.

Pay spend was in line with plan from a net perspective, but when viewed individually there are significant movements between substantive, bank and agency spend and plan. Substantive pay was £100,000 lower than expected, bank £255,000 higher and agency £57,000 lower. It appears as though the bank plan in particular in the Annual Plan was mistakenly understated in month, with the balance being taken from substantive plan. This is therefore a trend likely to continue in the year, but is being investigated further by the DDOF. Bank spend itself is in line with previous months.

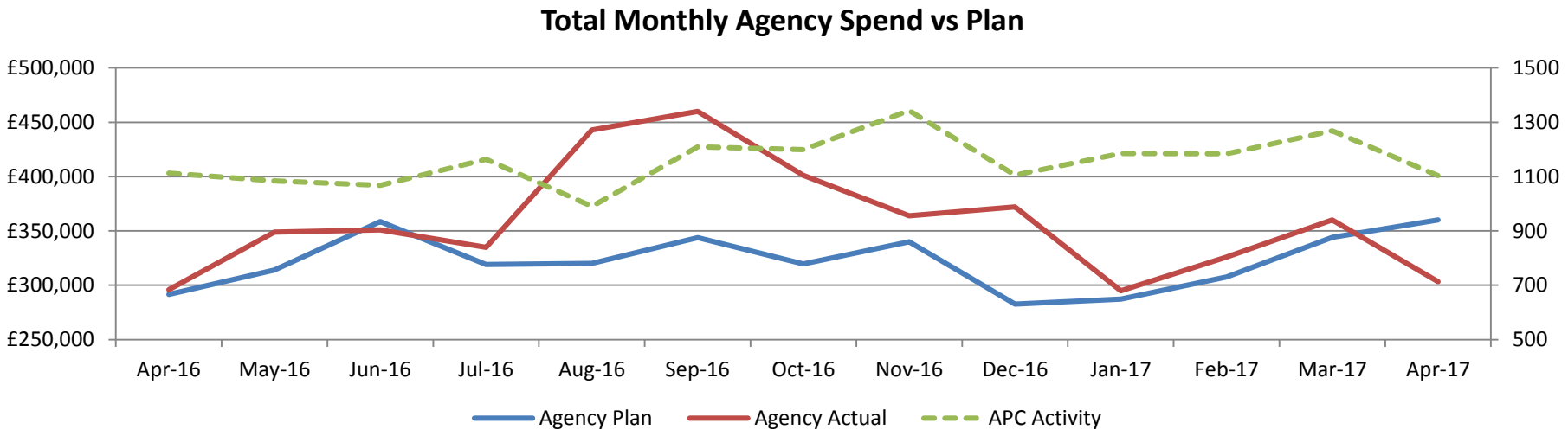
ACTIONS FOR IMPROVEMENTS / LEARNING

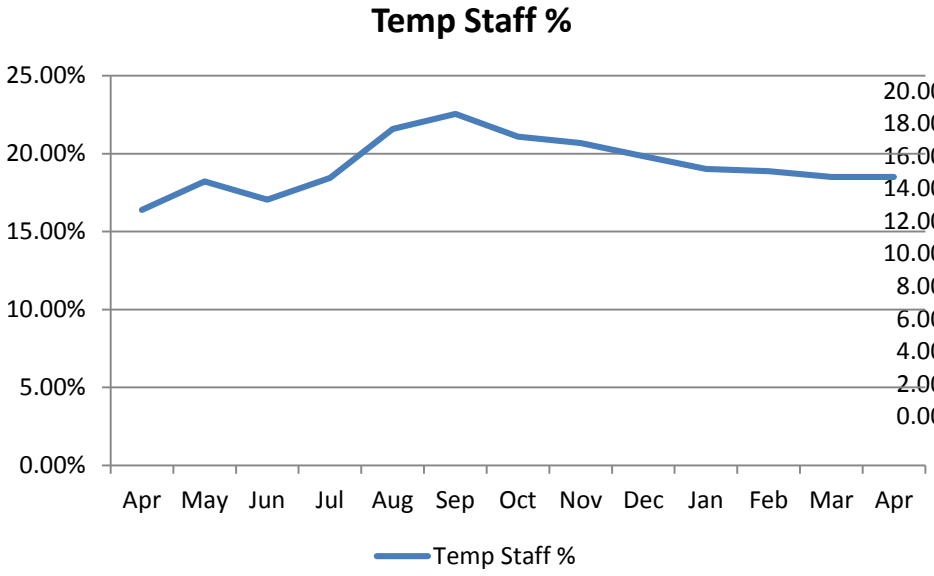
Costs will continue to be scrutinised and minimised. One of the 5 recovery workstreams is cost control, with actions being tracked through the Recovery Board on a bi-weekly basis.

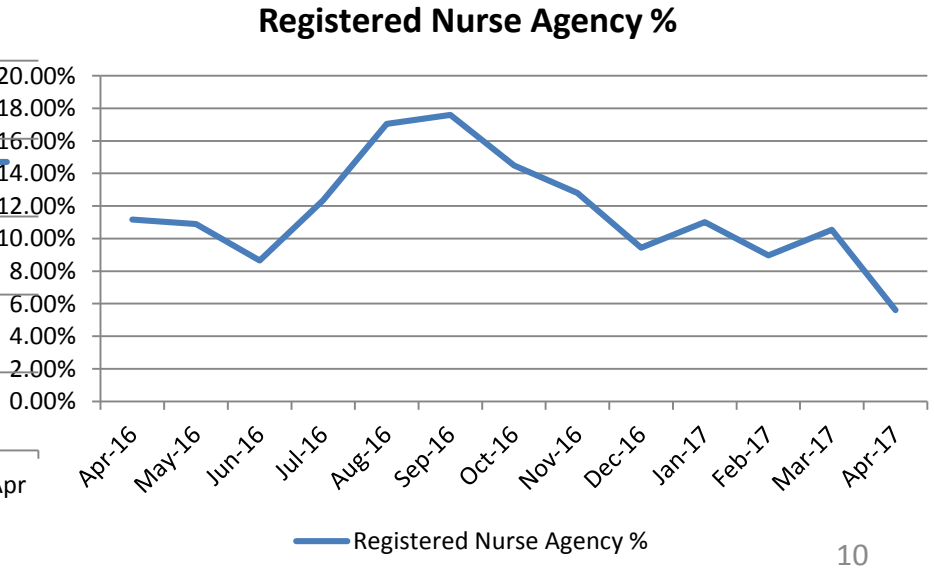
RISKS / ISSUES

Close management of the stock implant rationalisation will be required to control costs and maximise savings as described in further detail in the CIP section of this paper.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements







INFORMATION

April showed a decrease in agency spend (£360k to £303k) driven by an decrease in nursing agency spend. Medical agency spend was quite static and management spend increased slightly as a result of the RTT validators the Trust have introduced. The nursing decrease relates to April being a shorter month than March, but also Healthroster is giving better visibility of rotas. There continues to be a pressure on Medical spend due to an under provision of GP trainees from the West Midlands Deanery.

ACTIONS FOR IMPROVEMENTS / LEARNING

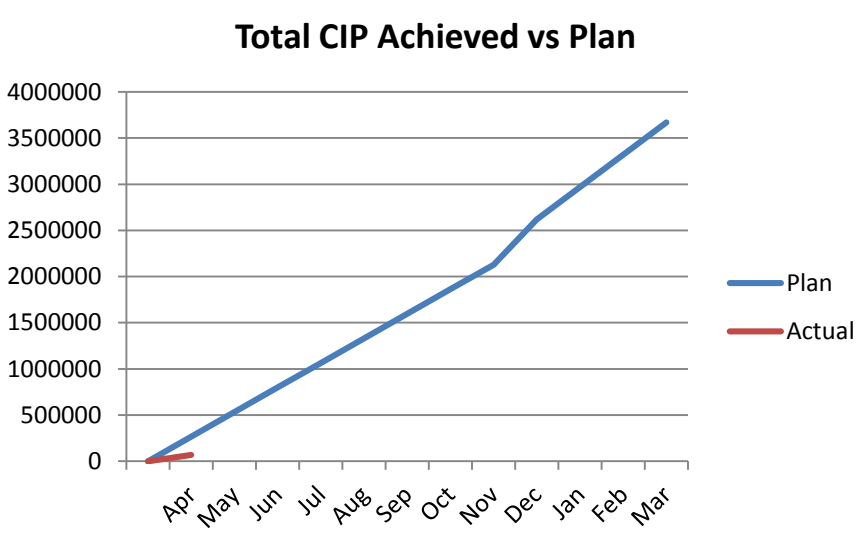
One of the 5 improvement workstreams is reduction in agency spend, and as such a detailed action plan is being reported against on to Weekly Improvement Board. This is in addition to the agency group. Ongoing actions to reduce agency spend include reviewing the outputs of Healthroster.

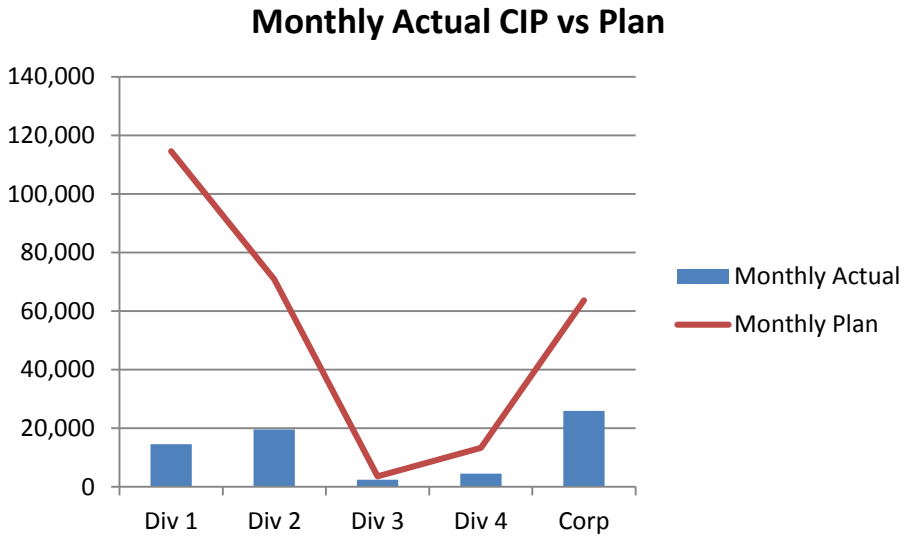
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios. The Trust is currently consulting on a change to rota working patterns as part of this process.

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. An overspend against the trajectory will have a direct impact on our regulator ratings.

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2017/18





INFORMATION

The April CIP position was £66,000, against a plan of £266,000. There were CIP schemes provided for the entirety of the CIP requirement for 2017/18 (£3,671,000), however, significant further work is required by the Divisions to provide detailed plans for delivery of the schemes, and to ensure that the potential Quality Impact is assessed appropriately. Operational focus on RTT has meant that provision of this documentation has been slightly slower than expected, and a revised deadline of 7th June has been provided by the Director of Finance for completion of the relevant documentation. Of the savings recognised to date, 100% are recurrent, which is positive.

The Trust continues to progress through the implementation of the non-spinal rationalisation scheme, and it will remain important to manage the process of transition closely to the new suppliers to maximise on the savings for the new rates and avoid incurring additional cost by ordering non-primary suppliers.

Other significant schemes planned for 2017/18 include continue to implement nurse staffing improvements, in addition to embedding the operational and executive team restructures implemented from 1st April.

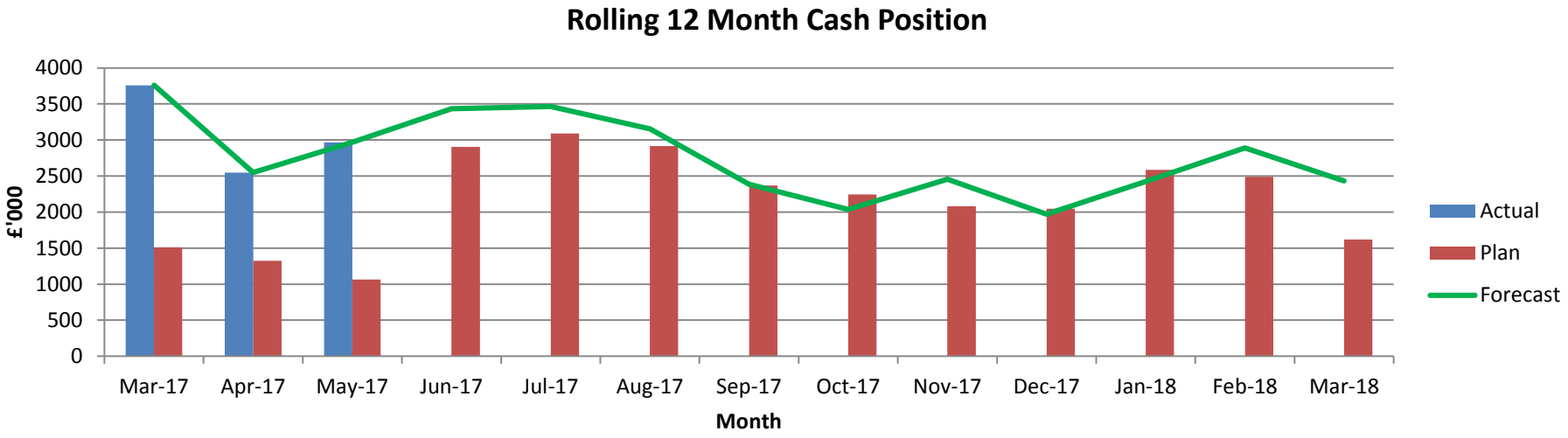
ACTIONS FOR IMPROVEMENTS / LEARNING

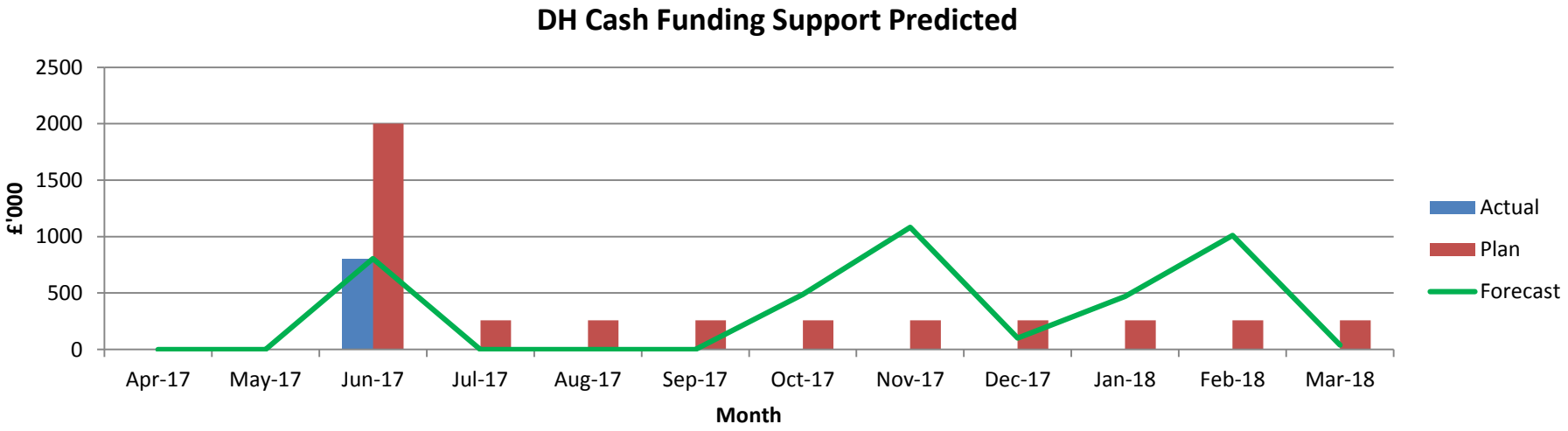
Early focus on unidentified schemes for 2017/18 is needed to ensure the CIP plans are achieved. In addition, a significant proportion of the prior year CIPs were non-recurrent. Focus on ensuring schemes are recurrently delivered will be important in the coming year.

RISKS / ISSUES

The CIP target for 2017/18 will be challenging particularly given the high level of non-recurrent CIP in 2016/17. As explained above, divisional leads have been asked to provide details of their CIPs, plans and QIAs by 7th June. A number of the schemes in 2017/18 are more transformational rather than traditional cost cutting schemes, and it will be vital that the required changes to working are not only implemented but thoroughly embedded to ensure savings are delivered in a consistent manner.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet in addition to expected borrowing requirements from the Department of Health





INFORMATION

Information

Cash levels were £1.2m higher than planned levels at the end of April, largely driven by cash held at the end of March being significantly higher than planned.

Despite this, due to the ongoing reduction in cash over time, liquidity levels within the Use of Resources Rating have dropped to a 4, the lowest level.

The Trust submitted its first request for cash support to NHS Improvement on the 10th May 2017. £804k has initially been requested and based on the current forecast funding support will not be required again until October 2017.

NHS Improvement were satisfied with the Trust's submission and have passed this to the Department of Health for approval. The Trust are awaiting feedback from the DH in relation to this but are hopeful that the funding will be received in the coming week.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Head of Financial Accounting has set up a monthly cash control committee attended by the DDOF, and representatives from management accounts and the transaction team. The committee is reviewing cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications of cash from the Department of Health to be actioned.

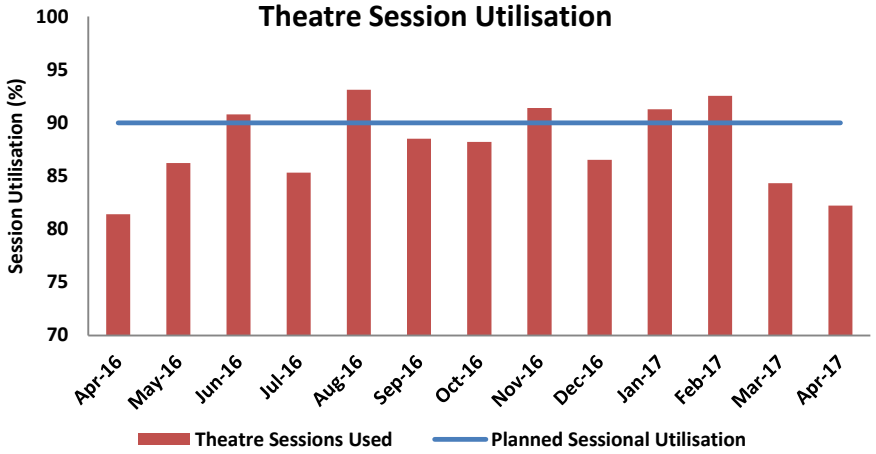
Based on the feedback from NHS Improvement the information provided to request funding was robust. The finance team are however continuing to review this and are looking to gather more information to continue to improve the Trust's management of cash.

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.

There is a risk is in relation to DH not approving a cash loan or approving a lower than requested amount, but the positive feedback to date from NHS Improvement provides assurance that this risk is relatively low.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are potentially available (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we aim to use at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis. April utilisation was significantly lower than planned, with high annual leave in a number of specialties.

Due to annual leave / study leave, we typically plan that surgeons will operate over 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.

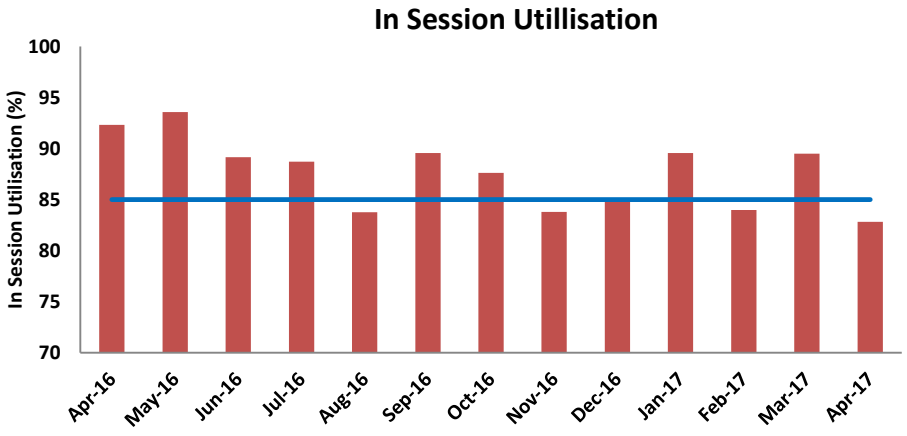
ACTIONS FOR IMPROVEMENTS / LEARNING

Job planning is building in buddy arrangements and prospective cover, as well as identifying a need for recruitment to specialities where there are vacancies or that are under pressure from an activity / RTT / 52 week perspective. Further improvements have been made to the communications to surgeons of the availability of fallow lists, enabling more effective utilisation. There are now additional 3 session days in the schedule to facilitate the 2 x scoliosis cases on a list for spinal deformity. The large joints team are exploring, a regular 3 session day list for those consultants with back log issues. In week twin theatre sessions have started in order to drive efficiency and reduce backlogs.
Some theatre lists are now being released by individual surgeons (and offered to be reutilised by other surgeons) to enable them to have additional clinics, because some surgeons who are timetabled in theatres have very short waiting lists. All reasonable efforts are made to recycle, including where it is deemed appropriate the use of sessions additional to job plan (paid ADHs.) Since theatres and anaesthetic teams are not yet fully staffed, capacity is flexed up through overtime and bank working, so where lists are not recycled, and deemed 'fallow', the theatre staffing and anaesthetic shifts are removed 1 week ahead, to reduce bank and agency costs.
The ops team are proactively monitoring surgeon annual leave up to 12 weeks in advance in order to manage the reduce the number of fallow lists and to offer appropriately to those services that are most challenged.

RISKS / ISSUES

Job planning is now completed for surgeons, with outstanding issues with only 2 surgeons; these are actively being progressed with the involvement of the Associate Medical Director, Clinical Service Manager and Clinical Service Lead.
The new theatre schedules and outpatient schedules are planned to started on 1st May 2017, to match the updated agreed job plans.
The next round of job planning is now being planned and will start by the end of Q1.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained above the target 85% in the majority of months. However, the previous measure (pre June) 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. The April performance has declined and attention will be focussed to ensure that this is turned around and continues to improve for the coming months.

ACTIONS FOR IMPROVEMENTS / LEARNING

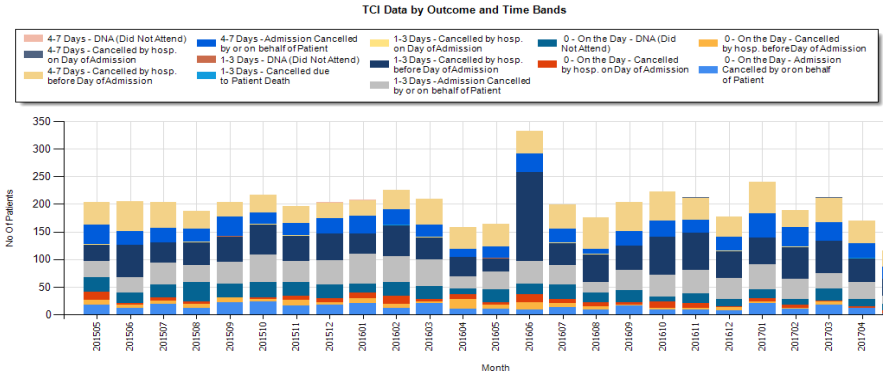
There are a range of actions being undertaken to ensure continual improvement in theatre in session utilisation, focussing on start time, turnaround, optimal list composition and the eradication of unplanned overruns. This will be led by the Head of Nursing, Division 2, working on The Productive Operating Theatre principles. The new Theatre Management System 'Theatreman' was successfully implemented on 24th May 2017, replacing ORMIS. The prescriptive nature of this software will be a further aid to ensure that lists are optimally booked based on the available time. Scrutiny and challenge is via the weekly 6-4-2 meeting, with instructions back through to the surgical teams to book lists to their maximum potential and to POAC and identify patients well in advance so that specific requirements can be planned for to reduce cancellations. Work on trajectories in the Spinal, Hands, Feet and Arthroscopy specialties has also brought to the fore some opportunities for greater efficiency and the possibility of moving some cases out of the theatre environment. Additional capacity delivery through use of non consultant staff is being explored. Detailed action plans have been completed and underpin all of the speciality trajectories, these plans include detailed monitoring of additional activity that feed into the trajectory, month by month.

RISKS / ISSUES

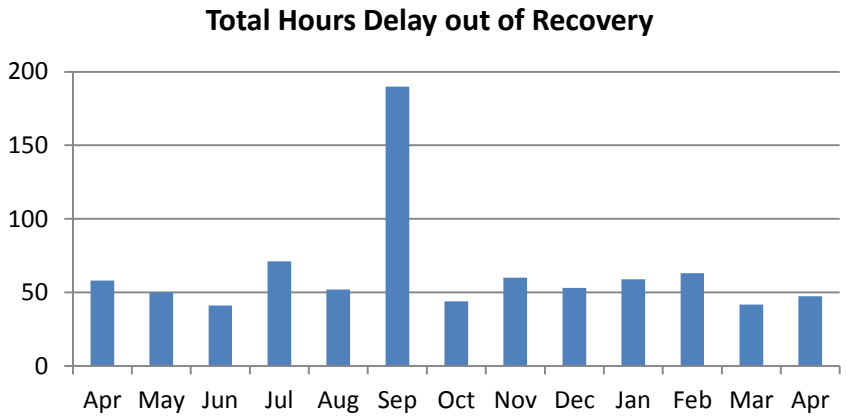
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (e.g. experience in spinal scrub) to ensure the best possible use of available operating time. Availability of radiographers (additional support now in place via agency.) Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit. Gaps in the operational structure, although recruitment is underway.

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

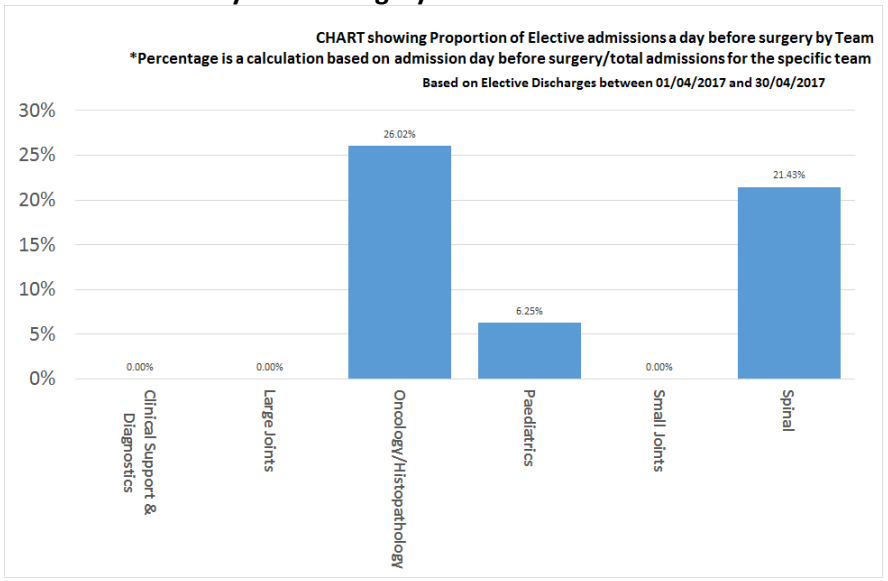
Cancellations by patient / hospital



Delays out of recovery

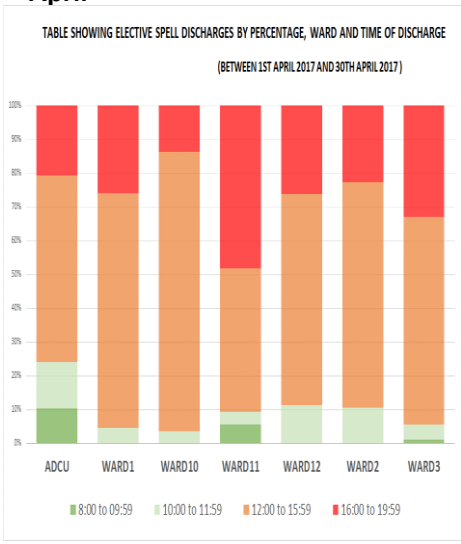


Admission the day before surgery

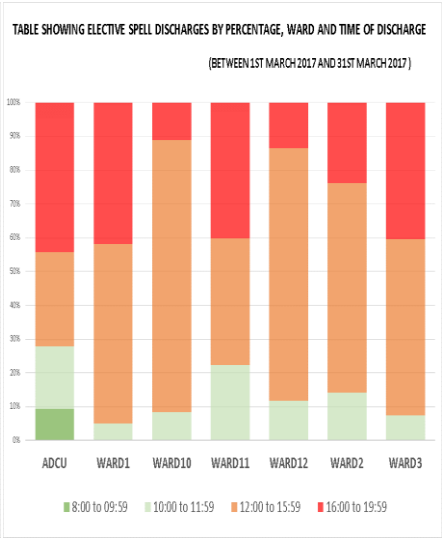


Time of day patients discharged

April



March



INFORMATION

Active management of the Patient Tracking List (PTL) , the establishment of a separate Oncology PTL weekly meeting to track the booking of individual patients, and a separate large joints PTL weekly meeting to track patients is creating a new momentum, with lists being booked several weeks ahead where previously they were being booked only days ahead.

Work on the trajectories for spinal, hands, feet and arthroscopy is identifying opportunities for streamlining referrals, reviewing the use of an operating theatre for cases being undertaken (rather than an OPD setting) and the rebalancing of waiting lists across firms. The implications of these are being worked through with Clinical Service leads and Clinical Service Managers.

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Some of the replacement patients are then booked at short notice. We are working towards booking with 3 week's notice and 2 reasonable offers as per national guidance and our Access Policy.

Now that there are Clinical Service Leads and Clinical Service Managers for each specialty, and regular team meetings, some longstanding issues relating to disparity of waiting lists across consultants, variations in theatre productivity and listing protocols are being addressed and resolved. Work is continuing, with a particular focus on Oncology. There are measurable and encouraging results from this work.

Forensic analysis of cancellations continues, with a focussed analysis by the anaesthetic lead and nursing lead for POAC of the majority cause of cancellations on the day of surgery, namely those who are medically unfit, to ascertain what process changes can be made in POAC or to the 72 hour phone call to reduce this.

ACTIONS FOR IMPROVEMENTS / LEARNING

Now that the longstanding vacancies in Medical secretaries, admin support and operational management have been filled, there is now the capacity for transacting the forward booking of patients for both preoperative assessment and surgery.

This will create a pool of patients available to be called forward earlier at short notice to fill cancellation slots.

Work is still required to agree criteria for admission the day before, to use beds more effectively and reduce length of stay. Bed availability has not been a constraint to delivery, with ward bays being closed during the month to match demand.

Pre-operative assessment improvements have been delivered, so that there are now 32 slots available each day.

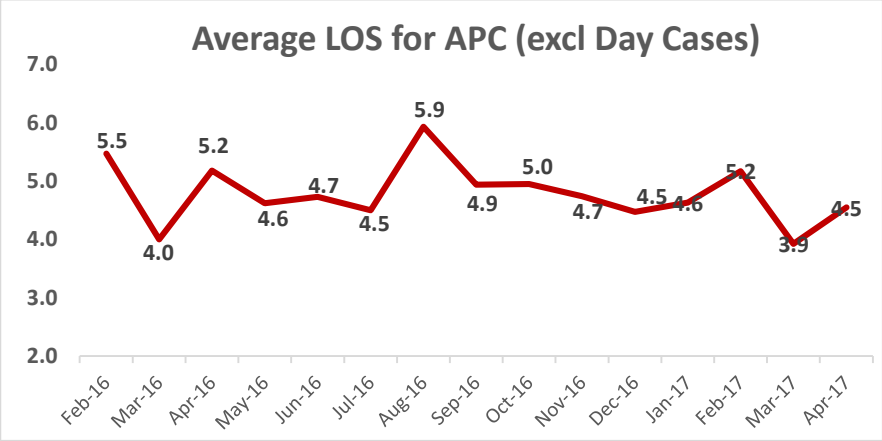
A daily update review by operational management of forward bookings has been established and the 642 and daily huddle is being trialled. Daily statistics on beds , admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to deliver activity and patient flow.

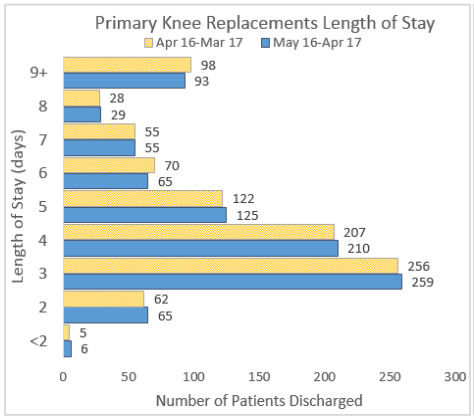
RISKS / ISSUES

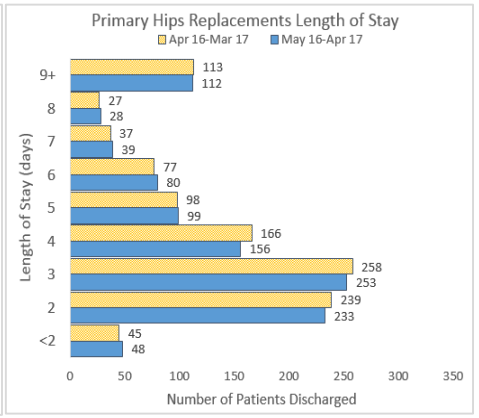
Continued focus with all staff involved to ensure that the operating lists are booked in advance, with sufficient caseloads, together with daily tracking.

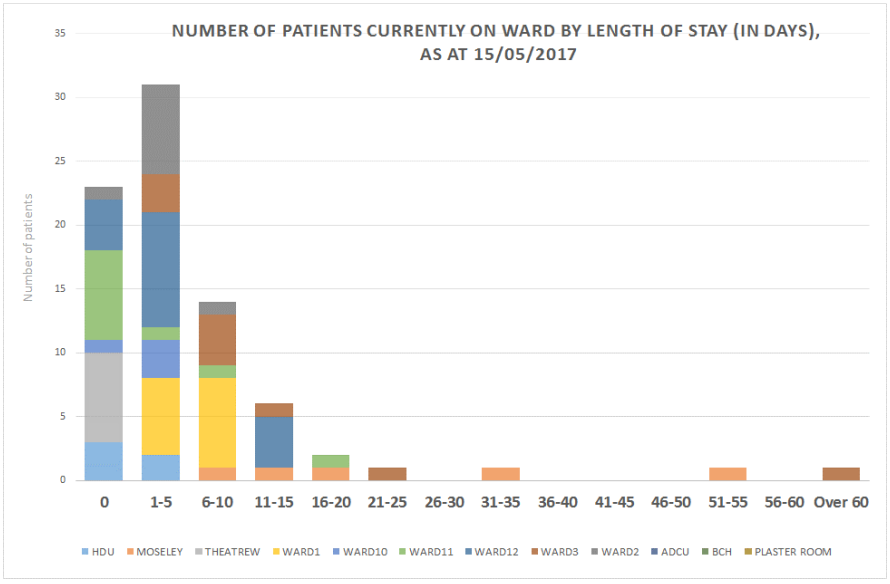
It is currently not possible to identify if the time of day patients are discharged is an accurate reflection of reality, or whether data is being entered onto the system in a delayed manner, making discharges look later in the day.

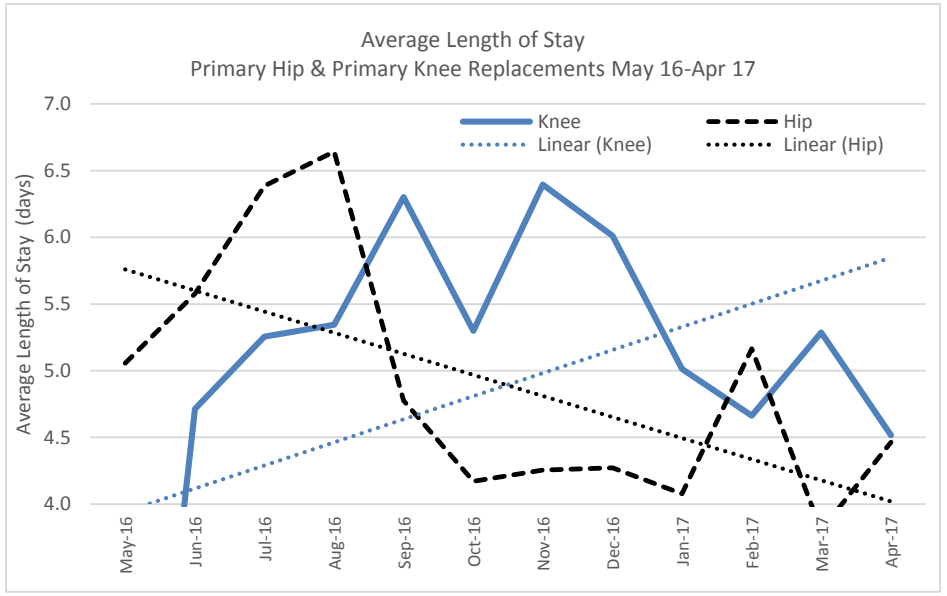
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Length of stay of for primary hips has shown early signs of improvement, and with the extra focus on Estimated Discharge Date and the Rapid Recovery initiative. However, the linear trend for primary knees remains upward, which is disappointing. 'The Home for Lunch' information campaign has been formally launched to staff and patients during Mid February and this will help to reduce length of stay with the expectation setting with staff and patients about when a patient can leave the hospital, and the marshalling of resources to ensure that this occurs as early as possible in the day. This clearly sets out to all concerned that we expect that more than 80% of patients due for discharge that day will leave hospital or be off the ward and in the discharge lounge before midday.
In May 2017, a 'Red/Green' process has been started to force better flow of patients hour by hour , partly to facilitate the rolling ward closures for the site infrastructure cabling installation, and mainly to improve overall patient flow.

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.

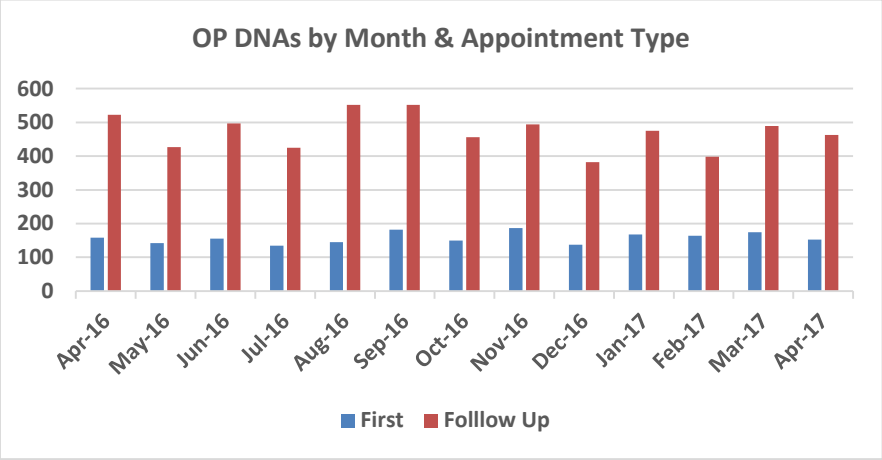
Daily senior reviews are being formalised as part of job planning, and the rising adherence to recording the Expected Date of Discharge (EDD) (now over 90%) is helping all involved in that patient's care to manage their length of stay more effectively.

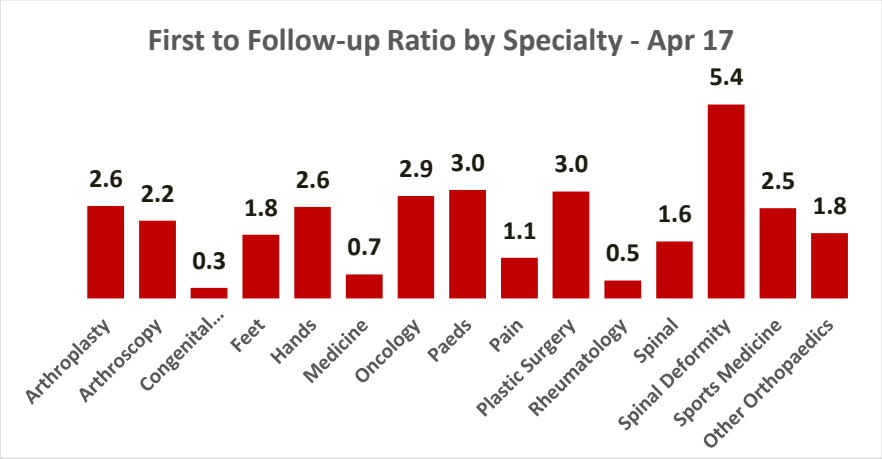
RISKS / ISSUES

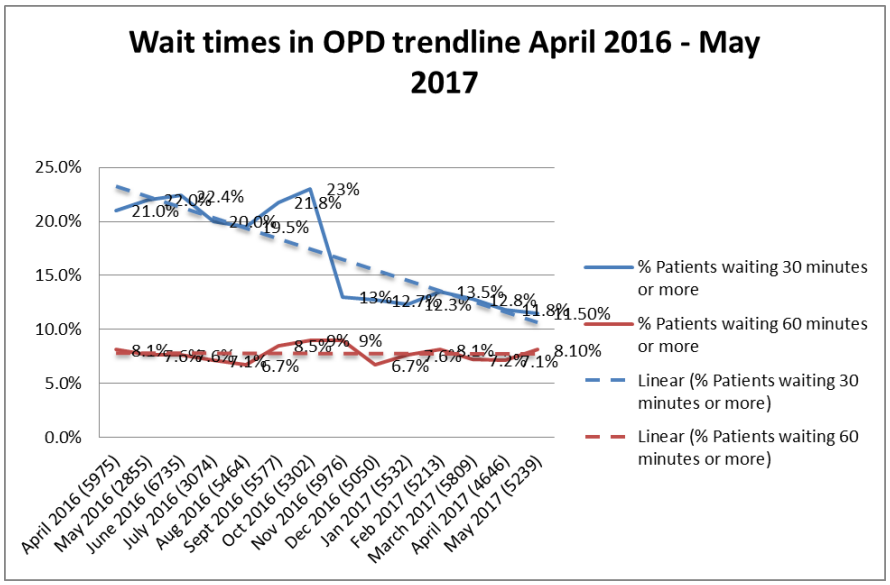
Using individual consultant information, Operational management teams and Clinical Service Leads are reviewing outlying clinical practice to help ensure that all patients are able to go home as soon as possible after their surgery.
Compliance with achieving discharge on the expected date of discharge is being monitored- When this measure was introduced, non compliance was in excess of 35% and now this is below 5%. This is being tracked through nursing and operations management to drive further improvement.

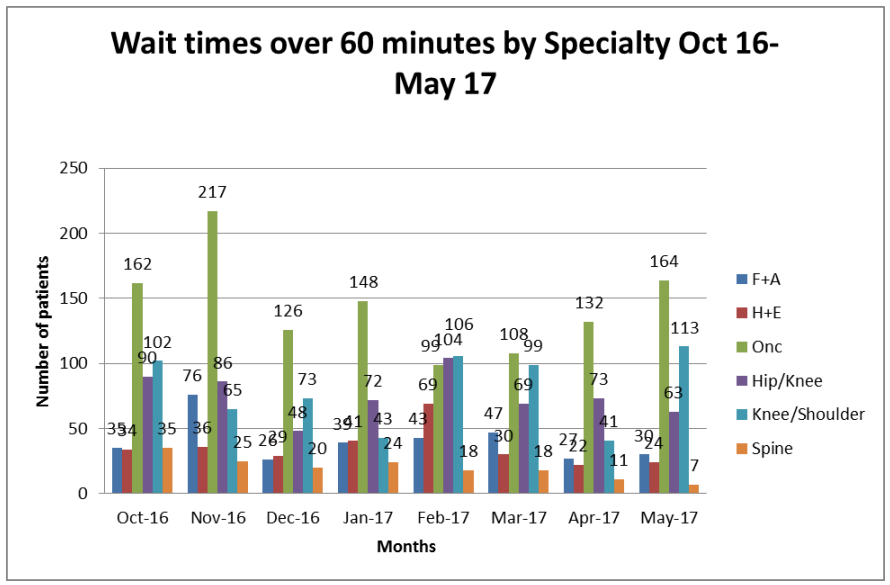
Data Quality reports are now available to show adherence to completion of 'Expected date of discharge' dates- non compliance was at over 50% and is now below 10%. This is being tracked through nursing and operations management to drive further improvement.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients









INFORMATION

Since the initial implementation of the new clinic templates in November there has been a reduction in the 30 minute wait times for patients. Since August 2016, when on average 21% of patients waited more than 30 minutes, this is now reduced to 11.5% of patients waiting in April 2017. Further work is underway, and with the introduction of the new clinic schedules on 1st May 2017, this should further reduce wait times.
There is a new standard operating procedure for any clinic running over 60 minutes late. An incident form is completed and a new drop down analysis is selected by the staff completing the incident which is enabling trends and follow actions to be carried out effectively.

The outpatient department continue to audit its compliance against the SOP for wait time and can demonstrate 100% compliance.

The work undertaken to understand the trajectories for Hands, Feet and Arthroscopy continues and will be will be rolled out across all specialties- initial results are showing very low conversion rates from first OPD appointment to surgery, and also from second OPD appointment to surgery for some specialties.

The new Oncology clinic templates have been implemented from Monday 5th June 2017. All patients booked onto the old clinic template have been transferred across following a dedicated and controlled project management approach.

ACTIONS FOR IMPROVEMENTS / LEARNING

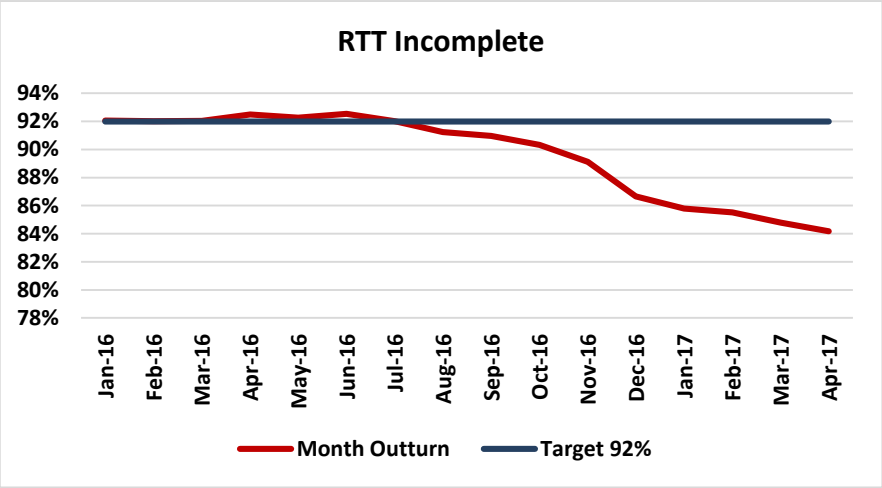
There are a range of actions as part of the CQC action plan and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

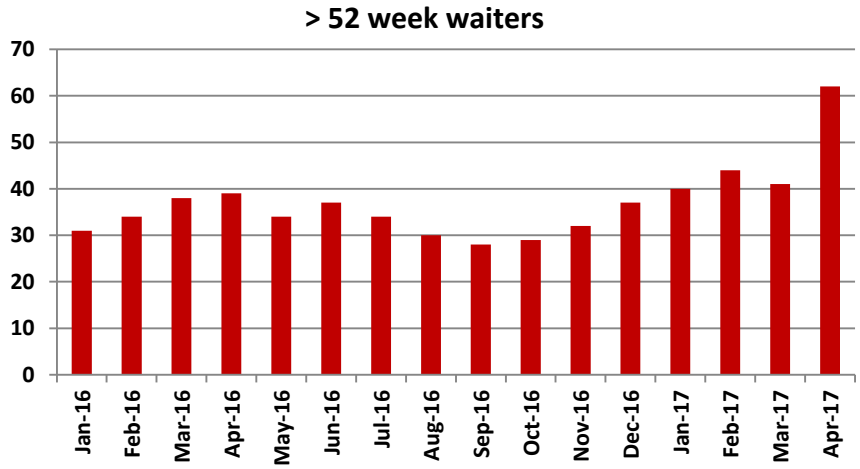
As part of the Trust's RTT recovery work, there will be a focus on out patient pathways and any patients who are in the system awaiting a follow up appointment and have become overdue, for whom a new active RTT clock should be started in line with national guidance. However, if it is found that there is a follow up appointment capacity problem, then this could worsen new to review ratios in the short term. This is being reinforced through RTT training and the clinical service managers working closely with consultants and medical secretaries to ensure that the Trust access policy is being adhered to by all involved.

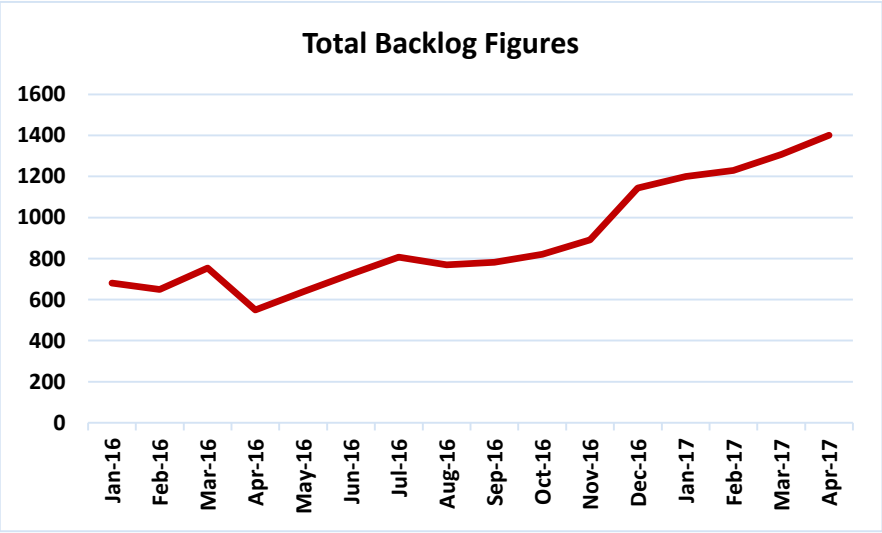
RISKS / ISSUES

Feeding back patient waiting lists to consultants weekly continues, with much focus on improving data quality arising from the validation work that is ongoing .

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets - RTT	Target / Trajectory	Actual (Apr17)	Actual (YTD)
52 Weeks Waiters	-	62	62
18 Weeks Incomplete	92%	84.17%	84.17
NHSI Performance Targets - Cancer	**Target / Trajectory**	**Actual (Mar17)**	**Actual (YTD)**
Cancer (2 week wait)	93%	94%	
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	
Cancer (62 days)	85%	100%	

INFORMATION

RTT open pathway performance continues to be the main concern. The backlog continues to increase at a rapid rate for both admitted and non admitted pathways. The current validated position is 84.1%, compared to the validated position for March 2017 of 84.7%, which was below the previous month's position of 85.5%, continuing an established pattern of month on month deterioration. This is a mixture of addressing data quality issues as they are identified as part of the ongoing validation work associated with the 100,000+ open pathways, and also pathways through to surgery that are not 18 week compliant for a significant number of surgeons in the majority of specialities.

As at 6th June 2017 there are a total of 1,648 patients at 18 weeks or over on the waiting list (admitted / non admitted) which is 6 patients higher than last week; this is 17.5% of the total waiting list. At each milestone the number of patients at 18 weeks and over has risen since last week. Whilst these figures include both dated and undated patients, the number of patients dated 14 weeks and above is not sufficient to improve the Trust's position.

During March 2017, the Trust Chair received notification that NHSI were launching an investigation into the Trust's RTT performance. This has included the provision of various reports and data, as well as an on-site visit from 24th to 27th April 2017. An RTT Recovery Board has been established and met for the first time on 27th April 2017. The Intensive Support Team has been onsite during May and June 2017 and is supporting the Trust to progress the solution of RTT issues. The main issues (based on reported performance) are within arthroscopy, hands, foot & ankle and spinal. The number of breaches within the pain service have increased due to consultant manpower, but a rectification plan is in place for this speciality. Rectification plans are being developed and will be completed shortly for the other specialties.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are significant concerns with regard to data quality and the measurement of RTT waiting times. This includes inappropriate clock stops in the Oncology service following biopsy, and the monitoring of services that are not consultant led but are delivered within an 18 week pathway (Therapies) that therefore improve the position. This has been escalated to NHS Improvement. It is likely that the true position, when the reporting anomalies are resolved, will be significantly worse that the current level of performance being reported.

All consultants now receive an updated copy of their individual waiting list (PTL), this is sent electronically from the Operations Team every Friday to all specialities. It is expected that all medical secretaries will review their PTL with their consultant and ensure that all patients are dated in waiting time/clinical priority. From 12th June 2017 onwards, a sign off sheet will be completed by each consultant once they have reviewed their PTL.

The Operations team meet weekly to scrutinise all patients waiting over 50 weeks across all specialities to ensure all patients have definitive treatment plans and ensuring all patients requiring further validation are identified.

RISKS / ISSUES

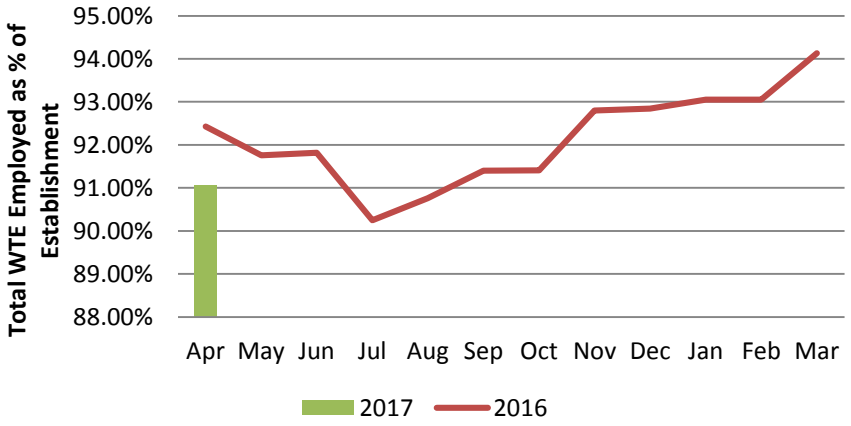
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern.

18 weeks: Significant work continues to understand the scale of the challenge with regard to open pathways, and the extent of data quality concerns. The Trust welcomes the input and expertise of NHS Improvement in this area.

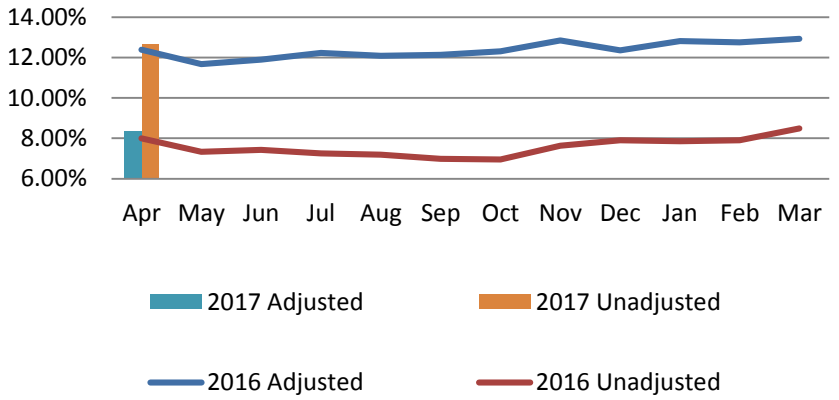
A review is under way with regard to the robustness of cancer waiting times reporting, given the concerns with data quality around the other access targets.

15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

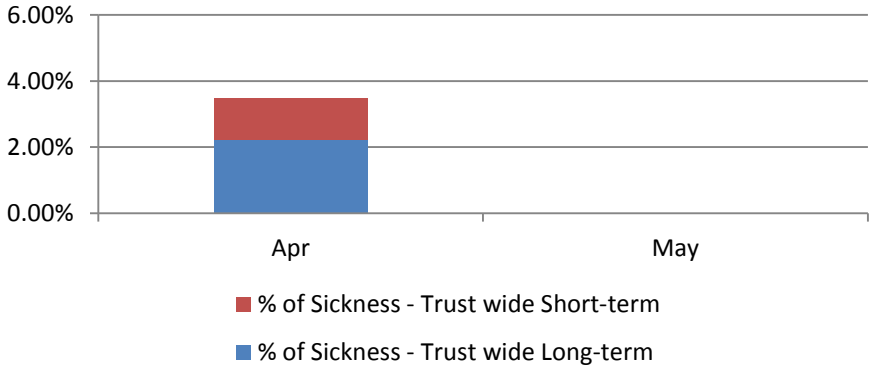
Staff in Post v Establishment



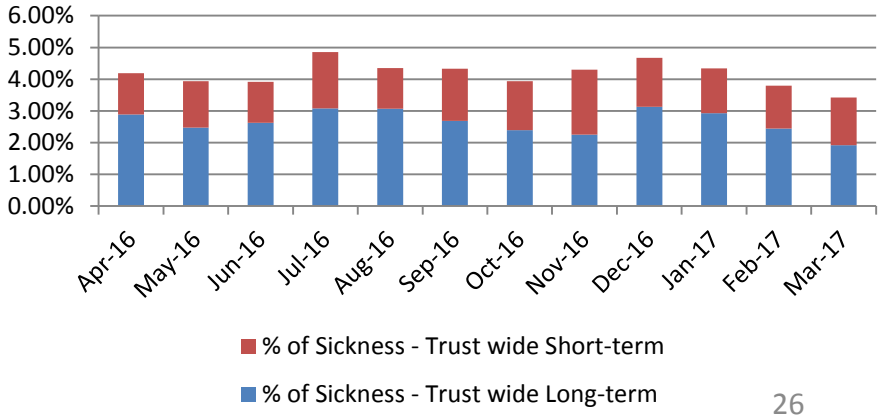
Staff Turnover



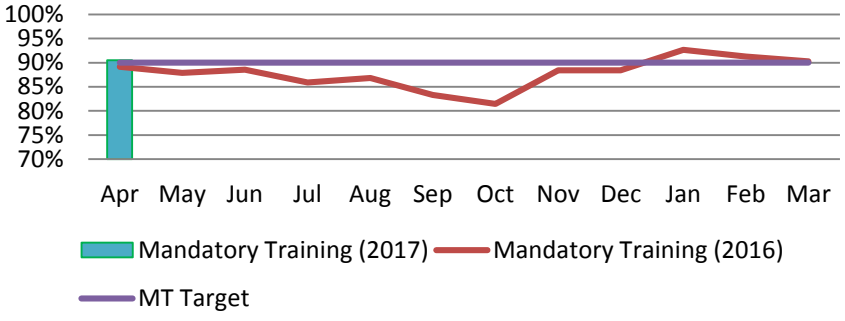
Sickness % - LT/ST (2017-18)



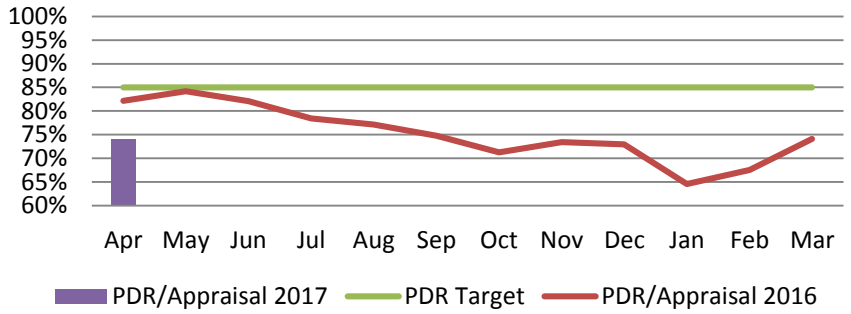
Sickness % - LT/ST (2016/17)



Mandatory Training



PDR/Appraisal



INFORMATION

In general terms, April was an encouraging month for workforce performance. Sickness absence remained relatively low, turnover decreased slightly as expected, statutory and mandatory training remained at target level and appraisal was unchanged since March 2017.

The vacancy position has worsened by 3% since March, mainly as a result of a conversion of bank budget in theatres and recovery into substantive posts in the ledger in the month of April. In context, the number of contracted staff on the ledger actually increased by c5WTE in April versus March's position and turnover decreased in April, so there is no immediate cause for concern.

It will be some time, however, before ongoing recruitment closes the gap for a return to a vacancy position of 7% or less, which is the current target.

Sickness absence saw a very small increase in sickness absence by 0.03% versus March's reported position, with an increase in long term sickness absence being largely offset by a reduction in short term absence. In context, at 3.46% in month it represents the lowest monthly April figure since 2010. This has had a positive effect in reducing the underlying 12 month average figure for sickness to 4.22%, the lowest figure since June 2016.

Mandatory training was green for the fourth consecutive month. It has increased slightly this month by 0.2% and is still green at 90.46% overall. It remains an area of operational focus.

Performance relating to PDR/appraisals in April remained steady at 73.99% (a slight decline of 0.08%) – but with the current compliance rate still low, there is clearly further progress to be made in this area.

There was some welcome downward movement in the April turnover figures. The unadjusted turnover figure (all leavers except doctors and retire/returners) decreased by 0.27% on last month with the adjusted turnover figure ("true leavers," meaning "voluntary resignations") decreasing by 0.13%.

ACTIONS FOR IMPROVEMENTS / LEARNING

HR Managers have continued to pursue appraisal improvement via their respective divisional boards in month: and a different system of allowing managers to check the accuracy of statutory and mandatory training in advance is being piloted in Division 1, to ensure transparency in reporting.

RISKS / ISSUES

The Trust is currently has had its compliance notice from commissioners on mandatory training removed, but it will be key to manage performance in this area going forwards.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 5 July 2017

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 5 July 2017 commencing at **1200h** 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, Mary Higgs at the Management Offices or via email mary.higgs@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** 5 July 2017: 1200h – 1315h

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)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Acting Chief Executive & Executive Director of Finance & Performance	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Nicky Lloyd	Associate Director of Operations	(NL)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Guests

Mr David Marks	Consultant and Guardian of Safe Working Hours	(DM)	[Item 8]

TIME	ITEM	TITLE	PAPER	LEAD
1200h	1	Apologies – Jo Chambers	Verbal	Chair
1202h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1205h	3	Minutes of Public Board Meeting held on the 6 June 2017: *for approval*	ROHTB (6/17) 031	Chair
1210h	4	Trust Board action points: *for assurance*	ROHTB (6/17) 031 (a)	SGL
1215h	5	Chairman's and Chief Executive's update including updated guidance on the Well Led Framework: *for information and assurance*	Verbal ROHTB (7/17) 002	YB/PA
QUALITY & PATIENT SAFETY				
1225h	6	Patient Safety & Quality report: *for assurance*	ROHTB (7/17) 003	GM
FINANCE AND PERFORMANCE				
1235h	7	Finance & Performance overview: *for assurance*	ROHTB (7/17) 004	PA

GOVERNANCE, RISK AND COMPLIANCE				
1245h	8	Guardian of Safe Working update: *for assurance*	ROHTB (7/17) 005	DM
1255h	9	Fire safety: *for assurance*	Verbal	PB
UPDATES FROM THE BOARD COMMITTEES				
1300h	10	Quality & Safety Committee	ROHTB (7/17) 006	KS
	11	Finance & Performance Committee	ROHTB (7/17) 007	TP
MATTERS FOR INFORMATION				
	12	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 6th September 2017 at 1100h, Board Room, Trust Headquarters				

Notes

Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.6

Venue Boardroom, Trust Headquarters **Date** 7 June 2017: 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)
Mr Richard Phillips	Non Executive Director	(RP)
Mr Paul Athey	Acting Chief Executive and Director of Finance & Performance	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]
Miss Elaine Chapman	Patient Engagement Officer	(EC)	[Item 3]
Mrs Alison Warren	Matron for Paediatrics	(AW)	[Item 3]
Mrs Clare Mair	Head of OD & Inclusion	(CM)	[Item 9]

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Jo Chambers. Simone Jordan was welcomed to her first meeting as Associate Non Executive Director. The governors in attendance at the meeting were also welcomed, these being Marion Betteridge, Tony Thomas, Sue Arnott and Alex Gilder. Mandy Johal, Freedom to Speak Up Guardian was also present as a staff observer.	
2 Declarations of interest	**Verbal**
It was noted that the Chairman had been appointed recently as Pro Chancellor of Aston University. There would be no material interests although if there were any issues that arose they would be reported.	

3 Patient story – Engagement with children and young people	**Presentation**
The Executive Director of Patient Services asked the Board to welcome Elaine Chapman, Patient Engagement Officer and Alison Warren, Matron for Paediatric Care. The Board was advised that that this was positive patient story and demonstrated that good progress had been made with addressing the criticism and shortfalls regarding engagement with Children & Young People that had been identified by the Royal College of Paediatrics & Child Health (RCPCH) previously. The Trust Board received presentation on the good work undertaken over recent months to improve engagement with children and young people, including the use of children as part of the interview process for Paediatric senior nurses. The presentation was well received and the Board agreed that this was a good piece of patient engagement overall. The Chairman added that the quality of care for paediatric patients was pleasing and she had personally received some good feedback.	
4 Minutes of Public Board Meeting held 1 March 2017	**ROHTB (3/17) 014**
The minutes of the public Board meeting held on 1 March 2017 were accepted as a true and accurate record of discussions held.	
5 Trust Board action points	**ROHTB (3/17) 014 (a)**
The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern.	
6 Chairman's & Chief Executive's update	**ROHTB (6/17) 002** **ROHTB (6/17) 002 (a)**
The Chairman reported that as the Trust Board had not met in public since March, much had happened to report. She advised that the Trust had hosted a visit by Professor Dame Donna Kinnair visit on 16 March, Director of Nursing, Policy and Practice at the Royal College of Nursing, which had been well received by all. The Trust had also hosted a meeting for Andy Street who had since been appointed Mayor of the West Midlands The Chairman had continued to attend STP Board meetings. She had also been interviewed for her experience of Mindfulness. Of most significance was the increased regulatory interest in the Trust's	

performance, particularly around 18 weeks RTT management and our long term sustainability. The Chairman noted that the Trust had received an offer from the STP to draw on resources and knowledge at University Hospital Birmingham NHS FT (UHB), particularly to support the management and validation of the 18 weeks RTT cases. At the recent STP meeting, it was reported that there was to be a refresh of the strategy and a series of workstreams and pathways would be revised. The expectations of the ROH were to be set out in some of the strategic considerations to be made. The Acting CEO reported that a number of staff briefings had been conducted around the regulatory interest and its implications, all of which had been well attended. The feedback received from staff was noted to be constructive rather than challenging. He added that new Theatreman system had been implemented, which would deliver good improvements in the Trust's operating theatres. Finally, there was a fete on 8 July to celebrate the Trust's bicentenary; this would be a good day for all.	
7 Patient Safety & Quality Report	**ROHTB (6/17) 003**
The Executive Director of Patient Services was reported that the Patient Safety & Quality report had been scrutinised by the Quality & Safety Committee at its last meeting. Two serious incidents has been reported, one around suspension of the spinal deformity service, with the second around the RTT data issues. There had been no Grade 4 pressure ulcers reported during the year. This had been assisted by the purchase of pressure-controlling chairs from Charitable Funds. The Chair of Quality & Safety Committee added that the Children and Young People's Safety Thermometer was still to be developed. This was relatively new within the NHS and NHS England and the CQC cited the Trust as an exemplar and an early adopter of this. Cancellations on the day of surgery were discussed. The focus was on same day cancellations and there had been an improvement. Professional variance in the anaesthetists in the Pre-Operative Assessment Unit and on the day was being addressed to gain professional consistency and thereby avoid cancellations. There was reported to be a lower number of VTEs reported during the month. The key issue regarding VTEs was the reassessment 24 hours after surgery. The Quality & Safety Committee had asked the VTE Committee to look at this standard. There was a view that this had a place in a mixed take acute environment, rather than in an elective setting. Water starvation risks had been addressed which would reduce	

the risk of VTE. There was also better documentation now, including improved recording of when compression stockings were being worn. The Trust also had a stronger system of identifying patients post discharge VTEs. There had been much work on pain control, including input from patients themselves and as a result, there had been a decrease in the number of patients in uncontrolled pain. The number of falls was noted to be concerning. It was agreed that the Throne Project needed to be seen as a patient story in future. The improvement in the Friends and Family Test results was pleasing, this being largely due to the implementation of 'I Want Great Care'. On the WHO checklist, Theatreman would assist with compliance as it would prevent proceeding with the operation or moving onto the next procedure without completion of the relevant parts of the WHO checklist. It was noted that the use of the WHO checklist for patients having a procedure outside of the operating theatre needed to be reviewed. It was noted to be positive that BMI Healthcare had invited the Trust to provide advice around the WHO checklist process.	
ACTION: **GM to arrange for the Throne Project to be used as a patient story at a future meeting**	
8 Finance & Performance overview	**Tabled report**
The tabled finance and performance report was considered. A deficit of just over £1m had been delivered in April, which was ahead of plan. There had been a limited number of operating days in the month due to bank holidays and overall fewer days in the month. The theatre utilisation figures took into account the days of the month but even so, the position had been impacted by annual leave. It was suggested that Theatre 4 needed to be separated out from the theatre utilisation position to reflect that it worked differently. Tim Pile noted that overall, the theatre utilisation position was disappointing and that even by removing the impact of Theatre 4, the underlying issue would not change. The application of an IT software package and rigorous enforcement of the annual leave policy would assist. Agency spend was given good focus and nurse agency had reduced significantly. Bank rates had been amended to better align them with agency costs. A process of seeking a revenue support loan had been undertaken and the first tranche of this support had been taken.	

It was agreed that any further comments on the report would be fed through to Tim Pile as Chair of the Finance & Performance Committee.	
9 Staff Survey and Analysis	**ROHTB (6/17) 006** **ROHTB (6/17) 006 (a)** **ROHTB (6/17) 006 (b)**
The Chairman highlighted that the report built on the briefing issued to the governors and the Board when the results of the staff survey were first received in March 2017. The Board was invited to consider the action plan to address some of the key concerns raised by the survey. Hard copies of the verbatim feedback were available if anyone wished to see it. Clare Mair, Head of OD & Inclusion, was welcomed to the meeting. She advised that the national staff survey occurred each year and the timing of the last report coincided with a number of key organisational challenges, including regulatory interest. The completion rate was 46%, which was higher than the national average. All staff had been provided with a copy of the survey in hard copy. Overall, there were four areas better than the national average, 16 below average, 12 in line with the average. There were 29 areas that showed no significant change from the last survey. An action plan had been developed and work had been undertaken to triangulate some of the results with areas where there was high absenteeism and poor mandatory training and appraisal rates. As a result, there were a number of key areas in which targeted work would be undertaken. The Head of OD & Inclusion advised that the action plan was cross referenced to the leadership strategy action plan and the work with Price Waterhouse Cooper on the integrated action plan. It was suggested that action plans for each area needed to be developed and there needed to be open conversations with hot spot areas. The Board was advised that the information was shared with key managers and discussed at the divisional meetings for them to develop action plans in line with set templates. There was follow up work planned to monitor these local plans. It was agreed that managers needed to take responsibility for developing and delivering the action plans. It was noted that this was the first year that an overall action plan had been developed. The Chairman commented that the results were not acceptable and the position was deteriorating from previous years. As a small specialist Trust a different response was needed. It was noted that there was a poor picture, particularly in the central functions. Leadership and culture change needed to address this, driven	

by the Executives and supported by the Non Executives. It was agreed that there was a need to ensure that objectives of staff were aligned to the needs of the Trust. It was noted that the Finance team appeared to feel that they had little impact on patient service, although this was to be expected given their relative remoteness from front line care. It was suggested that the information needed to be displayed publicly; the key messages from this work also needed to be interpreted, particularly the colour coding if it was intended that this would be displayed. It was suggested that displaying information would create ownership and prompt challenge by patients. The 'You Said, We Did' declarations should be displayed. The communications team would take some responsibility for displaying these messages. Communication with staff was needed as a priority. It was noted that Mandy Johal as Freedom to Speak Up Guardian needed to draw her contributions into the work. She encouraged the survey result to be published and suggested that it would show the Executive Team to be transparent. The delivery of the staff survey action plan would be monitored through the Major Projects and OD Committee. It was suggested that there were some early levers to deliver an improvement to the next year's survey. The Chairman offered the Board's support to the work and it was suggested that role modelling would help. It was agreed that the Head of OD & Inclusion should be invited back to a future Board meeting to update on progress.	
ACTION: **SGL to schedule a further update on the delivery of the staff survey action plan for the September Board meeting**	
10 NHS Improvement Annual Declarations – corporate governance statement and governor training	**ROHTB (6/17) 007** **ROHTB (6/17) 007 (a)** **ROHTB (6/17) 007 (b)**
The Chairman advised that the Trust Board was required to make a set of declarations to NHS Improvement on an annual basis. Previously, the Trust Board had been asked to approve a declaration confirming that it met its licencing conditions, to which the Board had agreed it could not on the basis of draft correspondence from NHS Improvement that cited a number of potential breaches to its licence around the governance conditions. The declarations now to be considered were a further set of two which need to be signed off by 30 June: firstly confirming or denying that the Trust meets a number	

of conditions set out in a Corporate Governance Statement. Secondly, the Trust was required to confirm that it had provided adequate training to governors during the year to be ensure that they were able to do their job of holding the Non Executives to account properly The report presented the suggested declaration of non-compliance with the first of these on the same basis as the licence condition, namely the draft letter from NHS Improvement. It was proposed however, that the Trust had discharged its duty to properly train its governors on the basis that a number of in house training sessions had been held for the governors during the year. It was noted that the guidance around the declarations required that the statements were made 'with regard to the views of governors', therefore as with the previous submission, the Council of Governors would be invited to comment on the paper. On this basis, the Board approved the declarations and agreed that they could be published by 30 June 2017. This would be arranged by the Associate Director of Governance & Company Secretary.	
ACTION: **SGL to arrange for the annual declarations to be published on the Trust's internet by 30 June 2017**	
11 Board Assurance Framework 2016/17 – Quarter 4 update	**ROHTB (6/17) 008** **ROHTB (6/17) 008 (a)**
The Board received and noted the latest version of the Board Assurance Framework (BAF). It was noted that a refresh of the BAF would occur in the summer.	
12 Quality & Safety Committee	**ROHTB (6/17) 009** **ROHTB (6/17) 010** **ROHTB (6/17) 011**
The Chair of Quality & Safety Committee reported that her committee continued to provide challenge and assurance on quality and patient safety-related matters. There was increased attendance at the Committee and now awareness by those invited as what purpose attendance was for. The structures beneath were to be strengthened further over coming months. The Associate Medical Director would attend the next meeting to talk through the WHO checklist process and the use of Theatreman to improve compliance. There was no confidence that in all interventional cases, the WHO checklist had been completed. The risk of not achieving total compliance needed to be evaluated. The Committee had asked for more information on staffing from other professional	

groups. There was a concern about the assurance being provided by the Drugs & Therapeutics Committee and the chair of the committee would be written to set out the expectations. The resources, time and skills for the harm review needed to be reviewed. It was noted that Specialised Commissioners had written to the Trust to ask when the Trust would review all those patients waiting over 18 weeks for treatment for harm.	
13 Finance & Performance Committee	**ROHTB (6/17) 012** **ROHTB (6/17) 013**
The Chair of the Finance & Performance Committee reported that the issues remained as they were including activity levels being below plan. The delivery of the Cost Improvement Programme had been pleasing last year. The level of cancellations also showed some improvement. The RTT issues were a main point of discussion for the Committee, given that there had not been sufficient recovery and the integrated action plan would be scrutinised by the Committee in future.	
14 Audit Committee	**ROHTB (6/17) 014**
The Chair of the Audit Committee noted that his assurance report covered two meetings, where both the draft and final annual report & accounts had been reviewed. The accounts were qualified by the Auditors from a use of resources perspective and the fact that there was no clear plan for long term sustainability. The draft NHS Improvement letters had also been reflected in the auditors' narrative. The accounts had been submitted, based on approval by the Board at its last meeting. It was noted that there was a positive relationship between the Executive and the auditors. There were some areas for improvement identified, particularly around the management of the recommendation trackers. It was reported that the Audit Committee had developed its own improvement plan and the Chair of the Audit Committee would seek to identify any further good practice from Dudley Group of Hospitals NHS FT.	
15 Major Projects & DO Committee	**ROHTB (6/17) 015**
The Chair of the Major Projects & OD Committee reported that the committee had	

met formally twice, once in an extraordinary meeting. There were two major projects being reviewed by the committee, one being the electronic prescribing and medicines administration system and the other being the IT network upgrade. The criteria for defining a major project were still being worked through. The Committee was impressed with the work of Mr Jonathan Bamford, and it was noted that he was an outstanding project manager. The Committee had met with an external supplier who would assist with some technological and operational support. This would be developed further. The Committee welcomed some support from Simone Jordan, Associate Non Executive Director on the OD agenda.	
16 Council of Governors update	**Verbal**
The Chairman reported that the last formal meeting of the Council of Governors was held on 17 May, although they were briefed in April around the regulatory concerns. The key points from the May meeting were: • An update had been given on the 18 weeks RTT position and the Trust's plan to address this by the sourcing of additional resource. The formal letter setting out the legal obligations on the Trust to address the position was expected at the time and was still awaited. • An integrated action plan was being developed by the Executive in conjunction with an external agent. • There was an update on the 52 week waiting times provided and the issue over a lack of PICU beds to be able to undertake the work was highlighted – this matter had been escalated and some legal advice was being taken to establish whether it was appropriate to close the waiting list to new referrals. • The governors had raised concerns over the number of empty beds while many patients seemed to be waiting a long time for appointments; they were also concerned over the apparent lack of theatre capacity and annual leave planning to cover fallow lists. • There was challenge over whether the Trust had taken its eye off the ball at the expense of focusing on finances, however it was noted that RTT would not have been an issue if activity was performing well. • The Non Executives were challenged as to whether they thought the	

Executive Team had sufficient grip on the situation. • The governors were given an update on cybersecurity and the IT team was thanked for their work to protect the Trust. • The draft annual report and accounts were presented. • The Executive Director of Patient Services joined the meeting to provide an update on the 18 weeks RTT recovery plan and described the harm review process. • The Executive Director of Finance & Performance undertook a training session for the governors on data quality and it was agreed that the Head of Business Intelligence would join the next meeting to describe his work with revamping the Data Warehouse. • Rod Anthony had given the governors an update on the work of the Audit Committee and Tim Pile gave an update on the work of the Finance & Performance Committee • Stella Noon joined and gave an update on behalf of the Patient & Carers' Council – a key issue raised concerned the current car parking arrangements.	
17 Any Other Business	**Verbal**
There was none.	
Details of next meeting	**Verbal**
The next meeting is planned for 6 September 2017 at 1100h in the Boardroom, Trust HQ.	

PUBLIC SESSION

Next Meeting: 5 July 2017, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

7 June 2017, Boardroom @ Trust Headquarters

Members present: Yve Buckland (YB), Tim Pile (TP), Rod Anthony (RJA), Kathryn Sallah (KS), Richard Phillips (RP), Paul Athey (PA), Garry Marsh (GM), Andrew Pearson (AP), Phil Begg (PB)

In Attendance: Simone Jordan (SJ)

Apologies: Jo Chambers (JC)

Secretariat: Simon Grainger-Lloyd (SGL)

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 036	Patient Story - Rapid Recovery	Video	01/03/2017	Update on progress to be brought to a future meeting.	SGL	06-Sep-17	ACTION NOT YET DUE	
ROHTBACT. 037	Patient Safety & Quality Report	ROHTB (6/17) 003	07/06/2017	Arrange for the Throne Project to be used as a patient story at a future meeting	GM	04-Oct-17	ACTION NOT YET DUE	
ROHTBACT. 038	Staff Survey and Analysis	ROHTB (6/17) 006 ROHTB (6/17) 006 (a) ROHTB (6/17) 006 (b)	07/06/2017	Schedule a further update on the delivery of the staff survey action plan for the September Board meeting	SGL	06-Sep-17	ACTION NOT YET DUE	
ROHTBACT. 039	NHS Improvement Annual Declarations – corporate governance statement and	ROHTB (6/17) 007 ROHTB (6/17) 007 (a) ROHTB (6/17) 007 (b)	07/06/2017	Arrange for the annual declarations to be published on the Trust's internet by 30 June 2017	SGL	30-Jun-17	Published by 30 June as required.	

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

FOR INFORMATION

The Royal Orthopaedic Hospital NHS Foundation Trust

Report to Trust Board on 5 July 2017

Well-led Framework – Updated Guidance

1 Background

1.1 This paper provides an update to the Well-led Framework following a consultation exercise led by NHS Improvement which started on 20 December 2016. The latest guidance was released in June 2017. It replaces the version from April 2015 and applies to both NHS Trusts and Foundation Trusts.

2 Summary

2.1 The guidance retains a strong focus on integrated quality, operational and financial governance and a new framework of key lines of enquiry and characteristics of good organisations is included.

2.2 The 'comply or explain' basis has been maintained but flexibility around timescales has been increased to account for individual Trust circumstances with a recommendation to discuss timings with their regional managers. The frequency of reviews has changed from the mandatory three year timeframe to being flexible from three to a maximum of five years where risks seem lower. This timeframe can be shortened where the risks are higher. The process for completion of the assessment remains largely unchanged. Trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the framework to safeguard against 'optimism bias' and 'group think'.

2.3 There is increased emphasis on working proactively with partners.

2.4 The new framework seeks to harmonise the view of Well Led with that of the Care Quality Commission.

3 Managing reviews

3.1 The common steps of a developmental review are described in the table below:

Stage	Notes
Initial investigation to determine scope of review	The Board should reflect on its performance with an initial investigation that involves self-review against the framework.
Commissioning an external reviewer	Choosing an external facilitator is the provider's responsibility. Providers should ensure reviewers are suitably independent of the Board.
Detailed review	The external facilitator should carry out detailed review against relevant aspects of the framework using a variety of methods that offer insight into the provider's leadership and governance processes.
Board report and action planning	The external facilitator should work with the provider Board to prioritise the review findings and agree recommendations and developmental actions in response.
Letter to NHS Improvement	Once the action planning is done, providers should send NHS Improvement a letter confirming they have completed the review, highlighting any material issues that have been found and/or any areas of good practice that could be shared with others.
Implementing the action plan	By far the most important part of a review is what the provider does as a result and how this is given priority among other organisational activities. We encourage providers to draw on the support offers and resources available from agencies across the NHS and more widely.

4. Key Lines of Enquiry (KLOEs)

4.1 The guidance provides strengthened content on leadership, culture, system-working, quality improvement and learning, improvement and development, these being additional components to the previous Well Led Framework matrix.

1 Is there the **leadership capacity and capability** to deliver high quality, sustainable care?	2 Is there a clear **vision** and credible **strategy** to deliver high quality, sustainable care to people, and robust plans to deliver?	3 Is there a **culture** of high quality, sustainable care?
4 Are there clear responsibilities, **roles** and systems of accountability to support good governance and management?	**Are services well led?**	5 Are there clear and effective processes for managing **risks**, issues and **performance**?
6 Is appropriate and accurate **information** being effectively processed, challenged and acted on?	7 Are the **people** who use services, the public, **staff** and **external partners engaged** and involved to support high quality sustainable services?	8 Are there robust systems and processes for **learning**, continuous **improvement** and **innovation**?

4.2 KLOE 3 puts the onus on leaders to:

- live and promote a culture of high quality, sustainable care through recruitment, induction (derived from vision, values and strategy), promotion, appraisal, celebrating success, staff survey results.
- promote candour, openness, challenges to poor practice and apologise when things go wrong. Whistleblowers must be supported.
- provide staff with development opportunities.
- encourage compassion, ensure staff feel valued and supported.
- promote equality and diversity.
- promote collective responsibility and positive relationships where conflicts are resolved quickly and constructively and responsibility is shared.

4.3 KLOE 8 calls for

- a strong focus on continuous learning and improvement
- knowledge of methods of improvement and skills needed to use them (at all levels)
- making effective use of internal and external reviews and share learning
- encouraging staff to use information and regularly review individual and team objectives, processes and performance in order to make improvements.
- systems to be in place to support improvement and innovation (objectives, rewards, sharing improvement work).

Simon Grainger-Lloyd
Associate Director of Governance/Company Secretary

30 June 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

June 2017

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Patient Services
AUTHOR:	Ash Tullett	Clinical Governance Manager

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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 and the CQC for routine engagement visits.

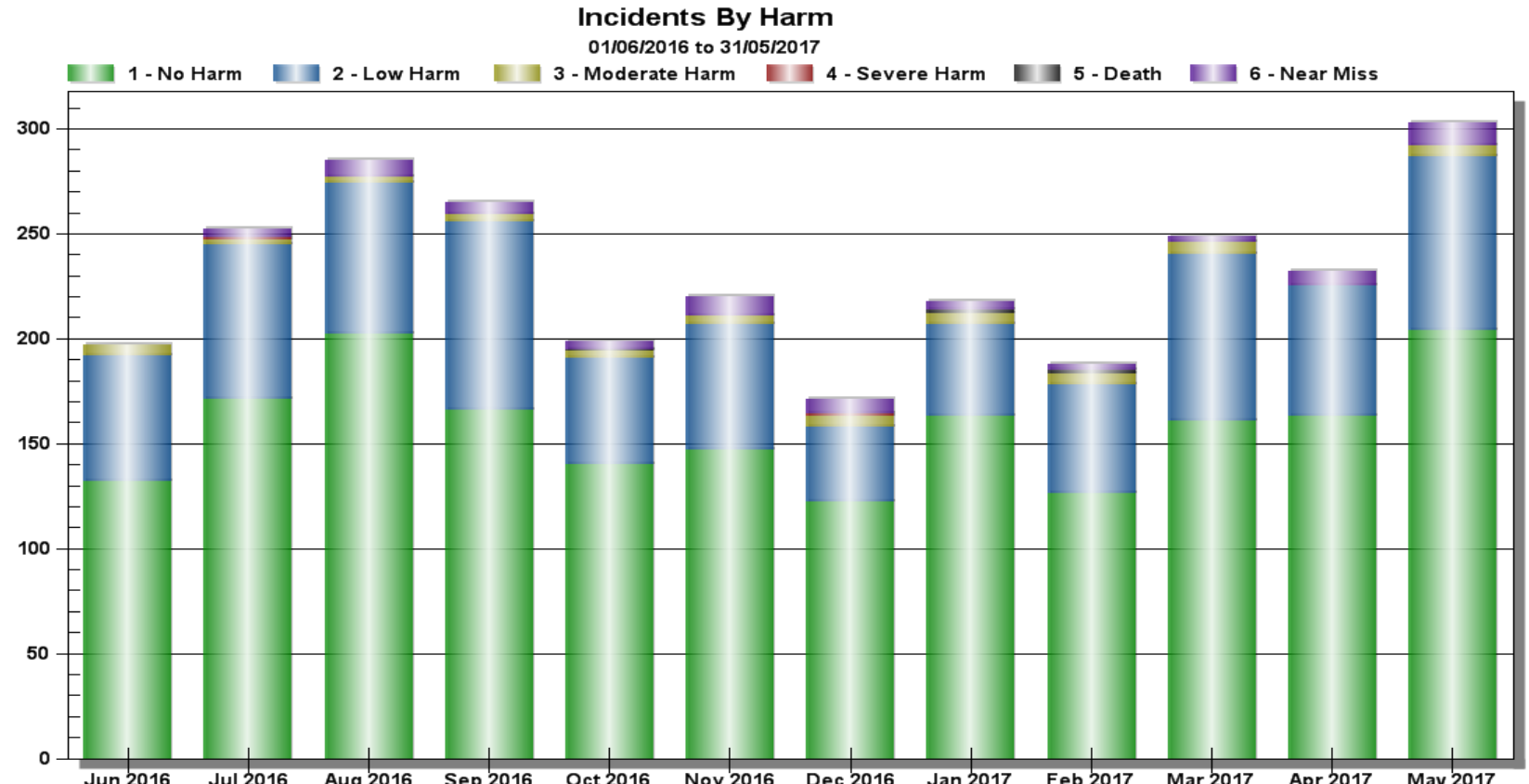
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

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.

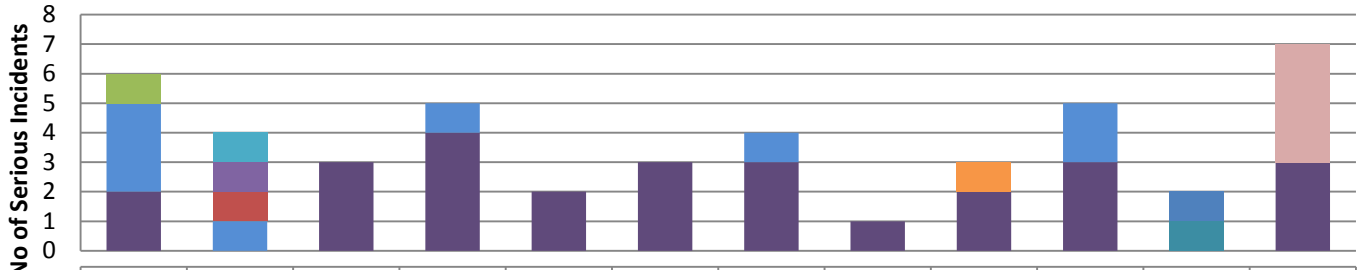


Month and Year	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017
1 - No Harm	132	171	202	166	140	147	122	163	126	161	163	204
2 - Low Harm	60	74	72	90	51	60	36	44	52	79	62	83
3 - Moderate Harm	5	2	3	3	3	4	5	5	5	6	0	5
4 - Severe Harm	0	1	0	0	0	0	1	0	0	0	0	0
5 - Death	0	0	0	0	1	0	0	2	2	0	0	0
6 - Near Miss	0	4	8	6	4	9	7	4	3	3	7	11

INFORMATION
In May 2017 there was a total of 303 Incidents reported on the Ulysses incident management system. This is an increase to the previous month. The increase is likely to be the result of the RTT revalidation work within the trust. The breakdown of those incidents is at follows 204 – No Harm 83 – Low Harm 5 – Moderate Harms 11 – Near Miss
ACTIONS FOR IMPROVEMENTS / LEARNING
As of March 2017 the new quality dashboards are in use and include all quality indicators. The Trust now has one central repository for all KPIs that can be used to populate any quality report. This includes KPIs on incidents and staffing information. This dashboard is to replace the ward health check that was previously found in the Quality report.
RISKS / ISSUES
The Trust has had issues with Managers not reviewing and updating the incidents in a timely manner. The Governance Team have developed reports that highlight those areas with open incidents and these will be discussed at the weekly Governance meetings. The first reports will go live 1st June 2017 and will be available for all areas and departments. An Agenda item is to be added to clinical quality group to address the open incidents that remain in the divisions.

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.**

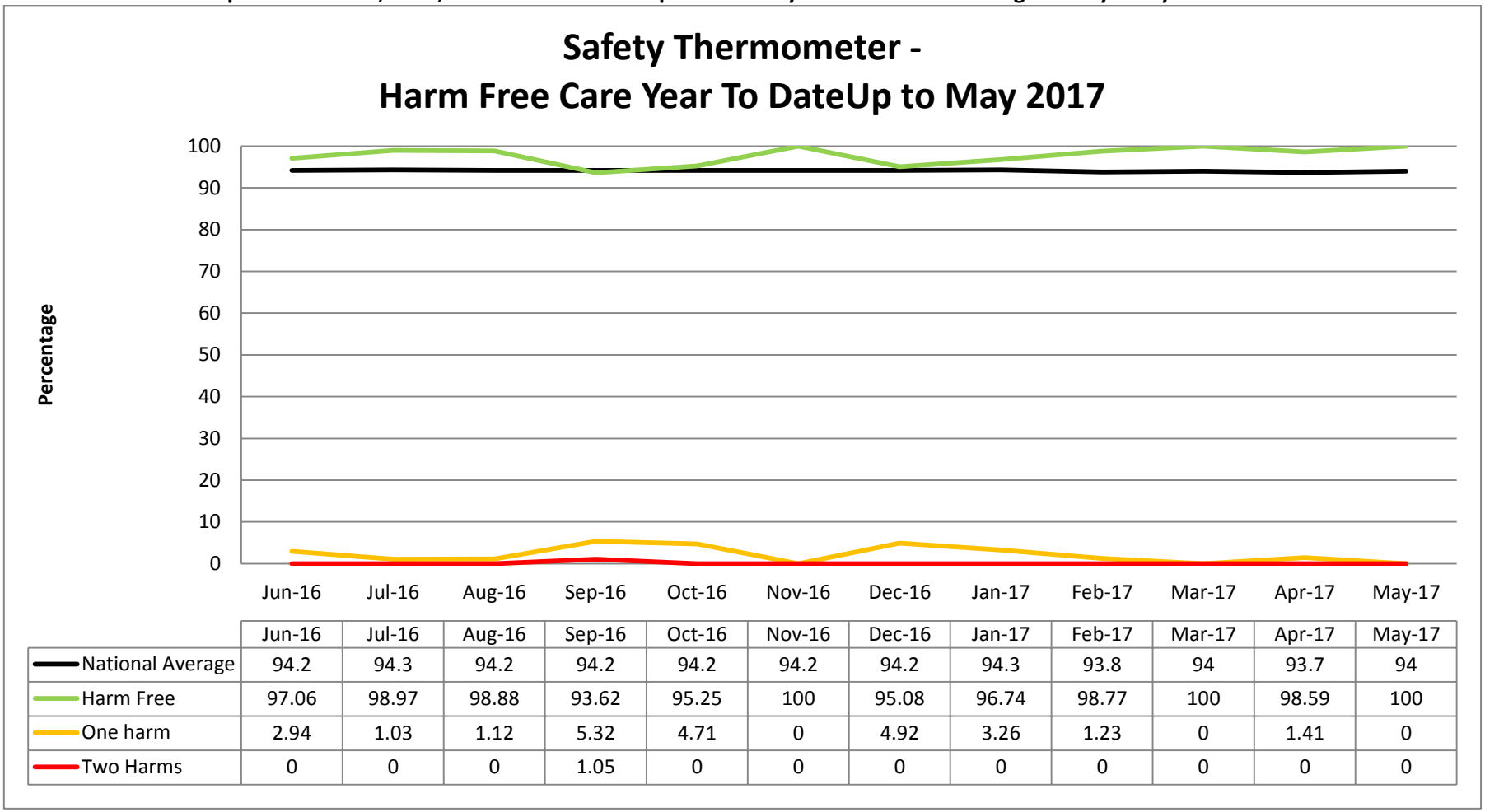
Serious Incidents Declared Year to Date to May 2017



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
RTT Harm review												4
Emergency transfer to HDU												
Exposure to hazardous substance									1			
Wrong Site Incision		1										
Wrong Implant		1										
Suspension to services	1											
RTT Data Issue											1	
Wrong side injection												
Suspension of Service (BCH Spinal)											1	
Slips, trips & falls		1										
Pressure Ulcers	3	1		1			1			2		
VTE meeting SI criteria	2	0	3	4	2	3	3	1	2	3		3

INFORMATION
There were **seven** Serious incidents declared in May 2017; These are due for submission with the Commissioners July 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
Two Serious Incident reports were submitted to the Commissioners during May 2017. The incident was reported in the February 2017 Quality report. This incident submitted was a avoidable VTE **Incident 1** **19881 – Unavoidable VTE** **Learning** With specific regards to prevention of VTE the recommendation is that ROHFT continue to practice in line with current guidance. Recommendations to further improve practice for future patients include: - Ensure 24 hour post admission risk assessment is completed, even if patient admitted on a Saturday - Ensure Recovery documentation clearly details mechanical prophylaxis. - Review weekend physiotherapy protocols to ensure these accommodate the needs of patients planned to be operated on at weekends and whether these patients can be mobilised by competent nursing staff. Staff to adhere to dosage in Trust guidelines **Incident 2** **19815 - Unavoidable VTE** **Learning** Following a thorough review of the notes the patient was risk assessed appropriately, prophylaxis prescribed. Unfortunately the patient didn't ask for help putting the support stockings back on; VTE leaflet given
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.**

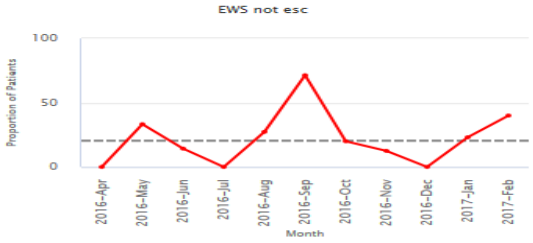


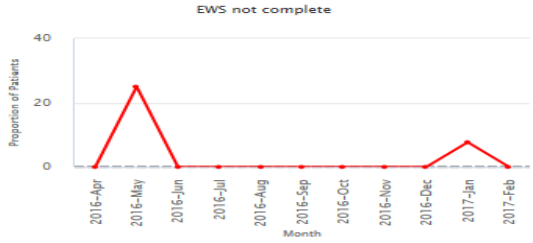
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
National Average	94.2	94.3	94.2	94.2	94.2	94.2	94.2	94.3	93.8	94	93.7	94
Harm Free	97.06	98.97	98.88	93.62	95.25	100	95.08	96.74	98.77	100	98.59	100
One harm	2.94	1.03	1.12	5.32	4.71	0	4.92	3.26	1.23	0	1.41	0
Two Harms	0	0	0	1.05	0	0	0	0	0	0	0	0

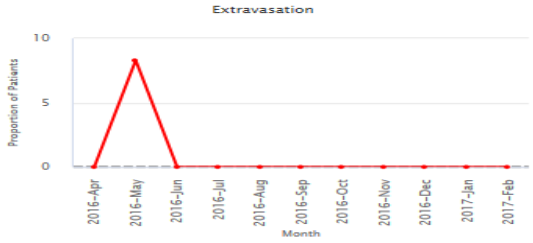
Children and Young Persons' Safety Thermometer

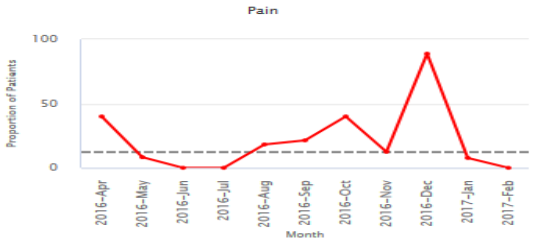
The Trust has started to submit data to the Children and Young Persons' Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. The table below illustrates the data that is recorded.

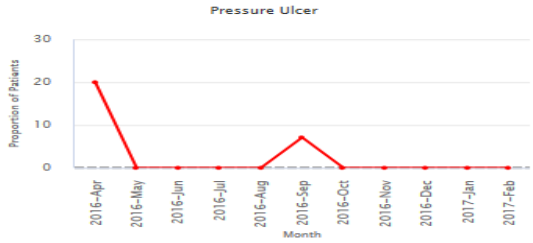
The Children & Young People's Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in children and young people's services. As a point of care survey it integrates measurement for improvement into daily routines and supports improvement in patient care. Data are collected on a single day each month and enables wards, teams and organisations to understand the burden of harm to children and young people. Data can be used as a baseline to direct improvement efforts and then to measure improvement over time.

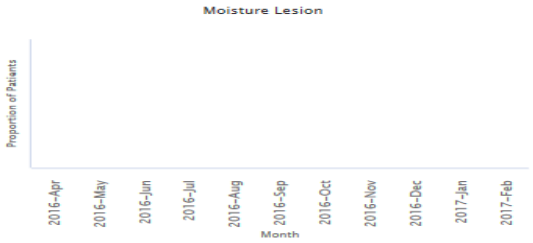


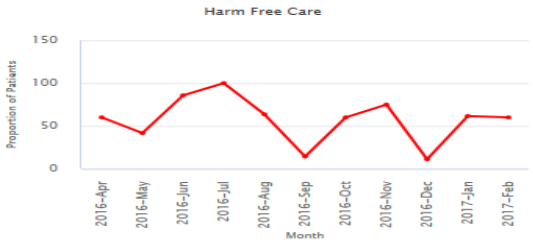












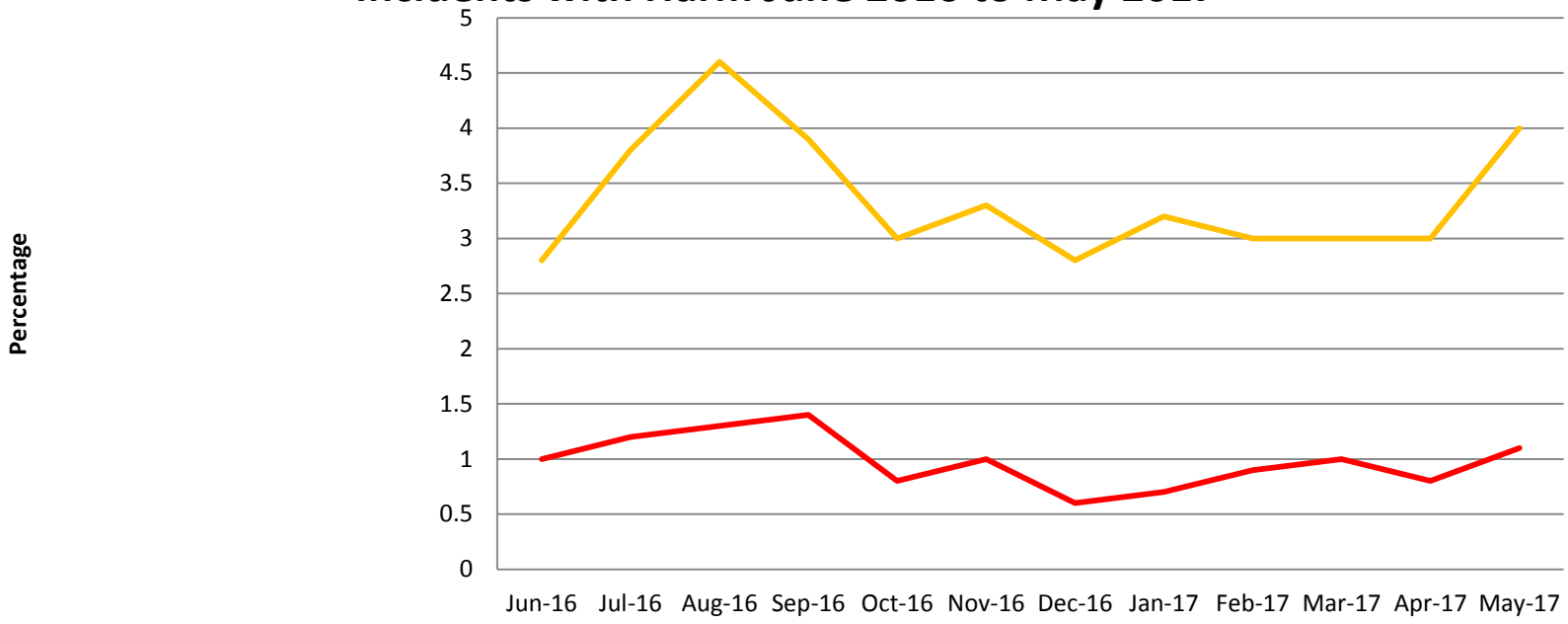
According to the national database, this has not been updated since February 2017. The Matron for Children's and Young Person's and the Trusts informatics team are currently investigating why this hasn't been updated.

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 2017 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
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
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794
Feb-17	52	5	0	2	59	188	6429
Mar-17	80	6	0	0	86	250	7326
Apr-17	62	0	0	0	62	232	7328
May-17	83	5	0	0	83	303	6918

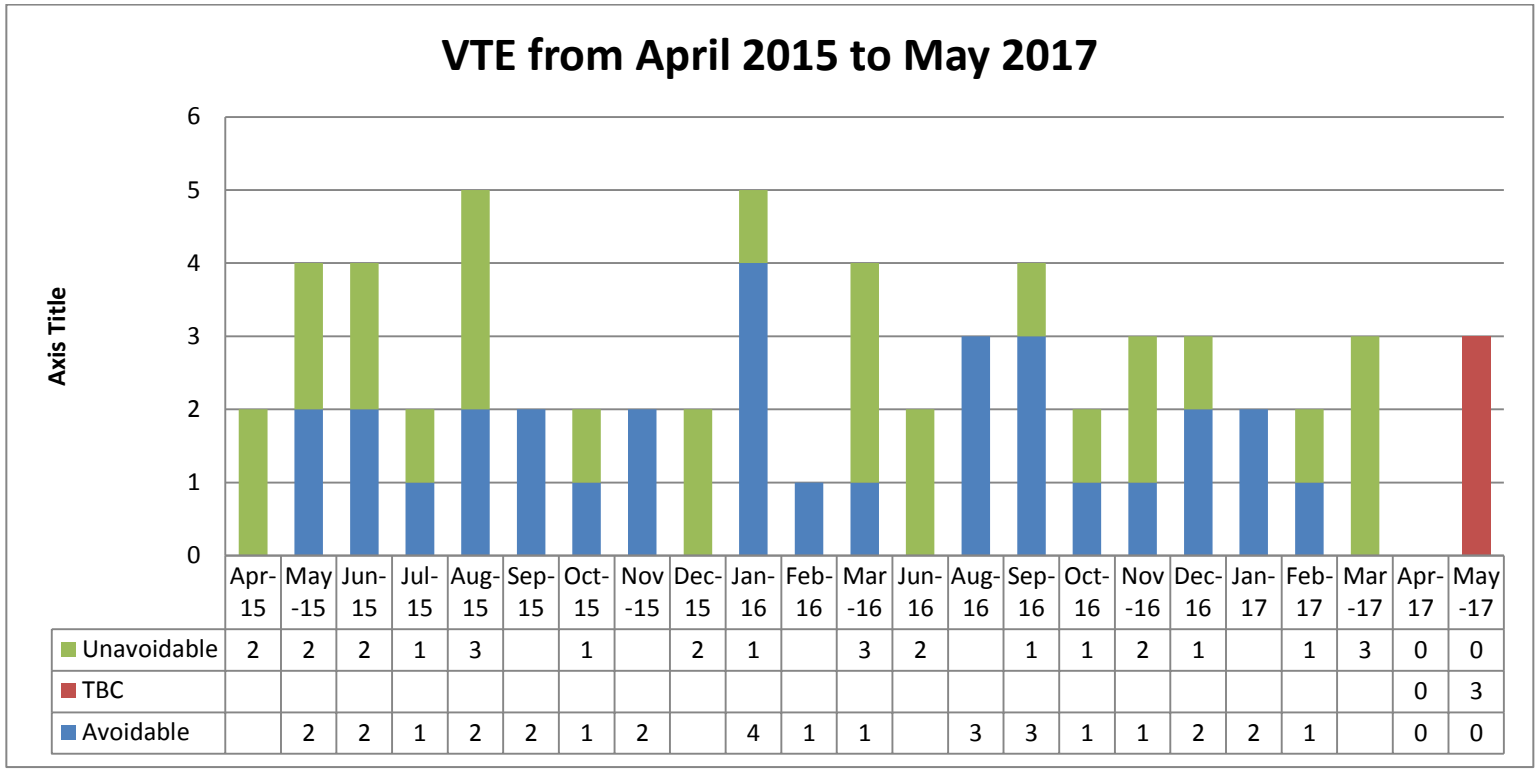
In May 2017, there were a total of 6918 patient contacts. There were 303 incidents reported which is 4 percent of the total patient contacts resulting in an incident. Of those 303 reported incidents, 62 incidents resulted in harm which is 1.1 percent of the total patient contact.

% of Patient Contact Compared to Number of Incidents and Incidents with Harm June 2016 to May 2017



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
% of Patient Contacts with Incidents Causing Harm	1	1.2	1.3	1.4	0.8	1	0.6	0.7	0.9	1	0.8	1.1
% of Patient Contact With All Incidents Reported	2.8	3.8	4.6	3.9	3	3.3	2.8	3.2	3	3	3	4

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).**



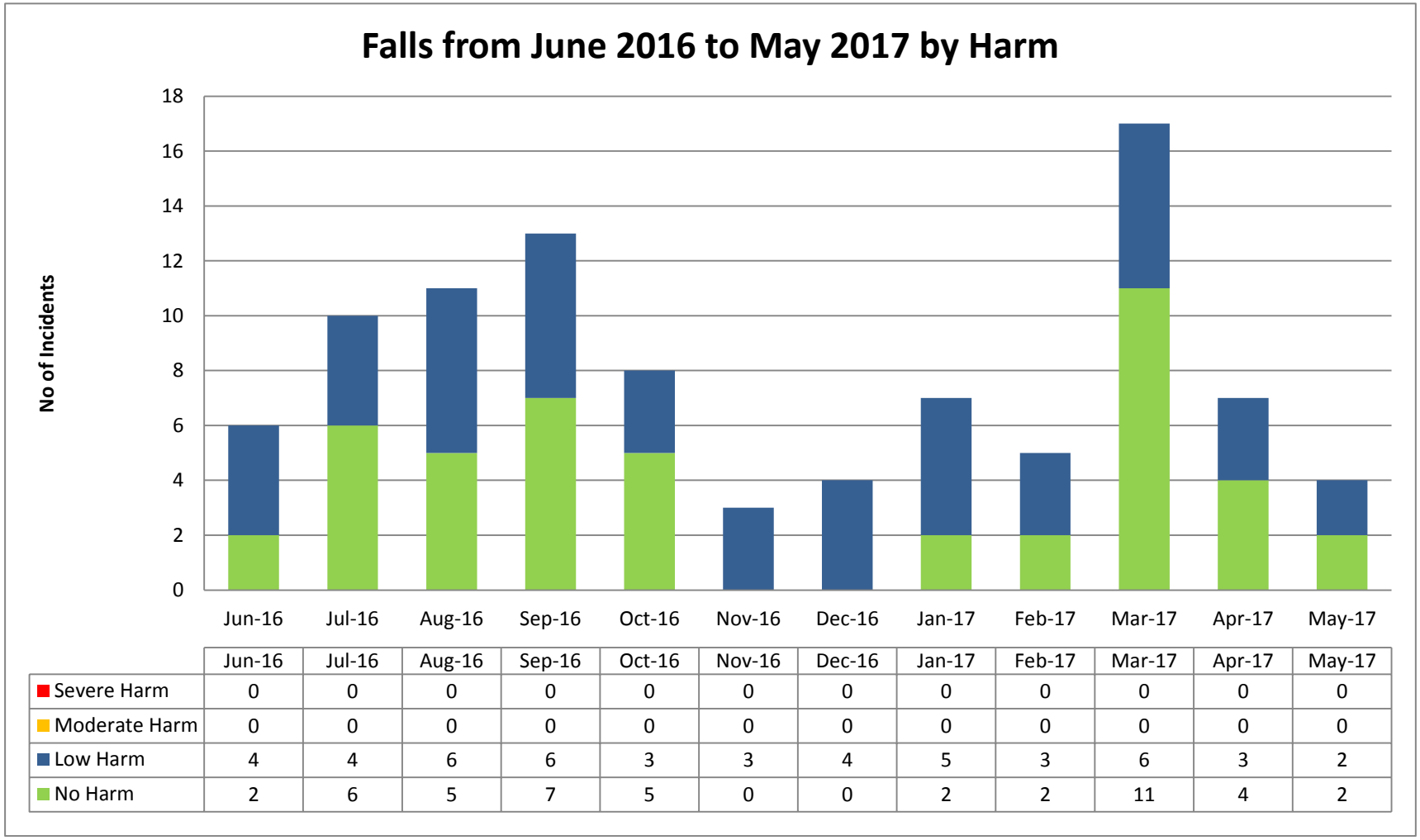
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Jun-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Unavoidable	2	2	2	1	3		1		2	1		3	2		1	1	2	1		1	3	0	0
TBC																						0	3
Avoidable		2	2	1	2	2	1	2		4	1	1		3	3	1	1	2	2	1		0	0

12

total		Avoidable
15/16	35	18
16/17	27	13
17/18	3	0

INFORMATION
There were three VTEs declared in May 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
All commissioner KPIs /audits have been completed and continue to be consistently achieved VTE training continues for Student nurses, training for registered and non-registered staff (clinical update days) was suspended in Q4 but will re-commence in April 2017. 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. Now that the VTE guidelines have been finalised and approved the requirements for meeting exemplar site status are met which has enabled application to be completed in Quarter 4.
RISKS / ISSUES
None

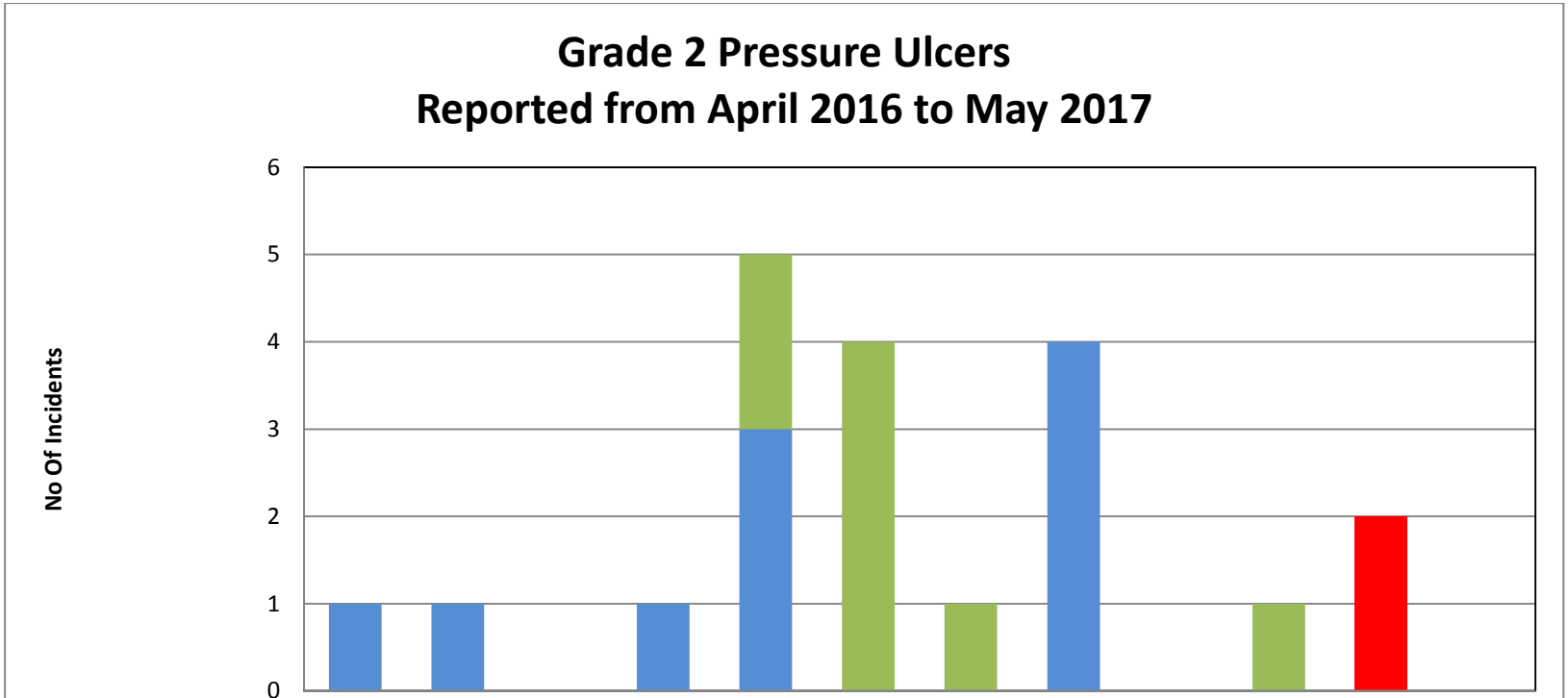
7. **Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident.**



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	0	0	0	0	0	0	0
Low Harm	4	4	6	6	3	3	4	5	3	6	3	2
No Harm	2	6	5	7	5	0	0	2	2	11	4	2

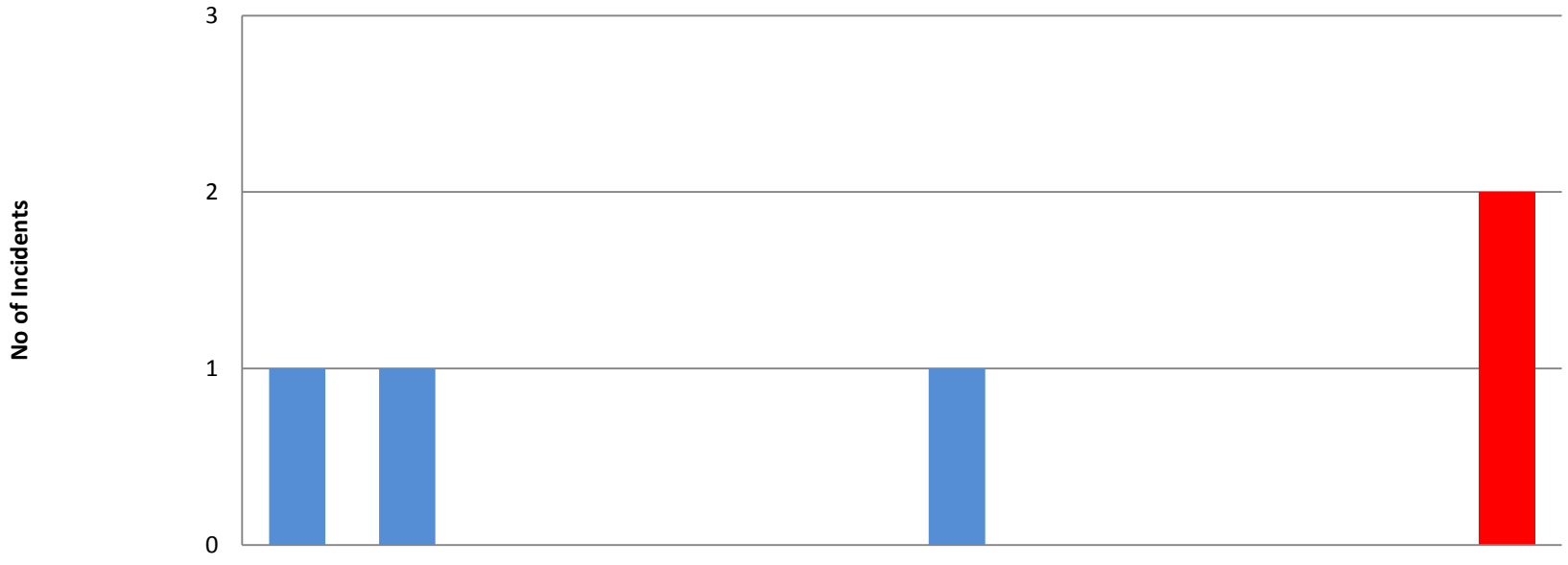
INFORMATION
Overall seven fall related incidents were reported across the Trust in May 2017. Four of these related to adult inpatient falls, with three falls being reported as Staff falls. Each in-patient incident has been subject to a post-fall notes review by the ward manager or deputy and a falls questionnaire has been completed for each fall. The inpatient falls are all reported to CQG via the Divisional Condition reports from the Heads of Nursing. All wards reported that they were fully staffed at the time of the patient falling and all risk assessments had been completed on admission and the post falls reviews had been completed for all patients.
ACTIONS FOR IMPROVEMENTS / LEARNING
• The Falls Working Group (FWG) meetings recommenced in December 2016 and are scheduled bi-monthly after the January 2017 meeting. • Through the FWG the work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller is in progress. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care. • The Throne project was discussed at the Falls Steering Group meeting in May 2017 and it was agreed that Therapies would repeat this audit to: ➢ See if the actions from the audit in 2015 had been carried out ➢ To re-audit to highlight any areas for improvement. This will be reported back to the Falls Steering Group meeting in July 2017 (12th July). Trend analysis identified that patients fall in the bathroom/toilet. • Falls information boards are to be standardised across all ward areas, with the information being agreed at the FWG meeting. 'Walking stick' visual information to be produced on a monthly basis for all ward areas for cascading of information regarding the number of falls per ward, per month to all staff.
RISKS / ISSUES
Reassessment of risk assessments need to be completed more consistently.

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-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Unavoidable	0	0	0	0	2	4	1	0	0	1	0	0
Avoidable	1	1	0	1	3	0	0	4	0	0	0	
Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	2	0

Grade 3 & 4 Pressure Ulcers reported May 2016 to May 2017



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
TBC												2
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	
Grade 3 (Avoidable)	1	1	0	0	0	0	1	0	0	0	0	

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

INFORMATION

There have been 6 reported pressure ulcer incidents for May

- Three Grade 2 pressure ulcers were present on admission.
- There were Two x Grade 3 device related hospital acquired pressure ulcers relating to the same patient these are currently under investigation to establish avoidability.

In total, from 1st May 2017 the Trust has reported the following avoidable pressure ulcers:
0 avoidable Non Device Related Grade 2 pressure Ulcers against a limit (target) of 12. (Two Grade 2 Pressure Ulcers currently awaiting RCA to establish avoidability and are therefore not included in these figures)

0 avoidable Device Related Grade 2 pressure Ulcers against a limit (target) of 12.

0 avoidable Grade 3 pressure Ulcers against a limit of 0. (Two Grade 3 Pressure Ulcer currently awaiting RCA to establish avoidability and are therefore not included in these figures)

ACTIONS FOR IMPROVEMENTS / LEARNING

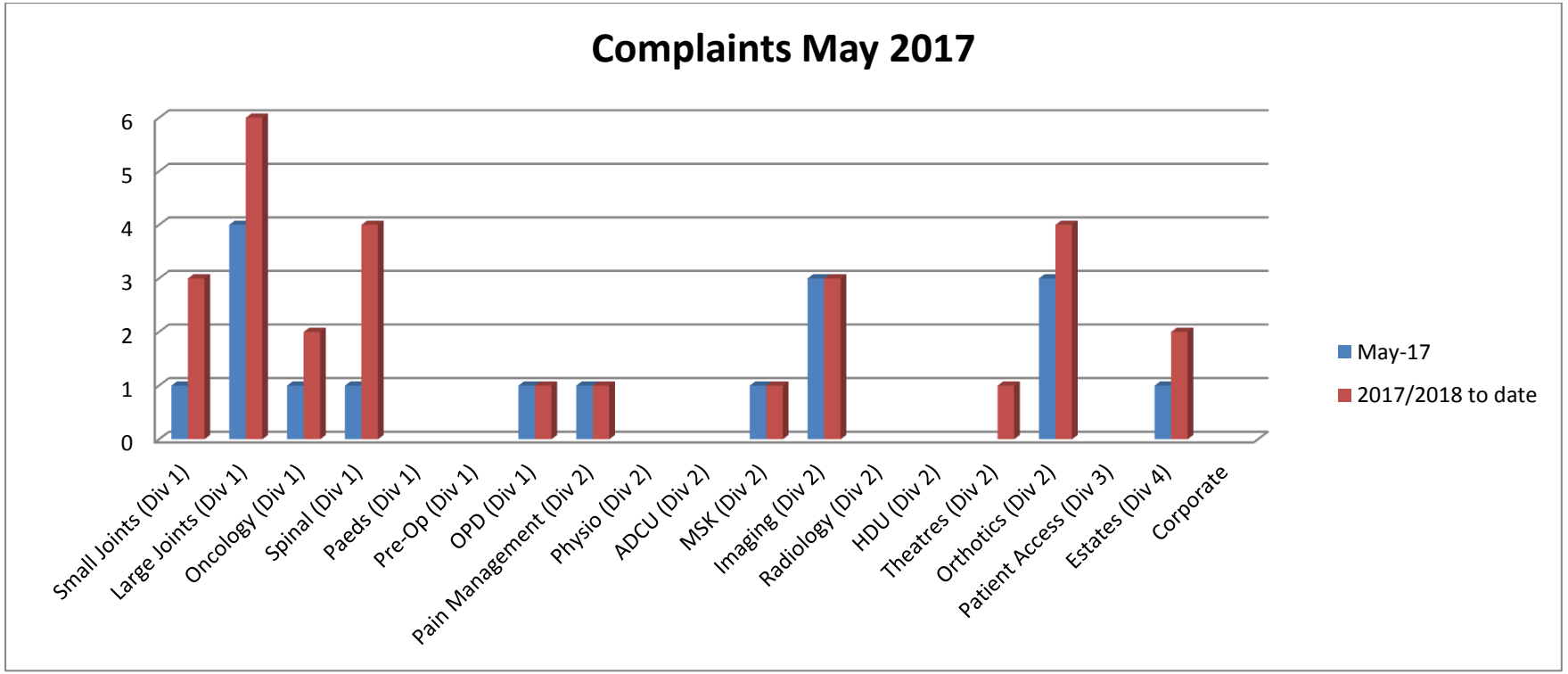
Updates:

- The 2 x Grade 3 pressure ulcers in March 2017 identified on admission under plaster casts, which were applied at The Royal Orthopaedic Hospital, have been deemed unavoidable
- The 2 x Grade 2 pressure ulcers from April, still awaiting questionnaires to establish avoidability/unavoidability.

RISKS / ISSUES

None

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.**



INFORMATION

PALS

The PALS department handled 497 contacts during May 2017 of which 141 were classified as concerns. This brings the total of PALS contact for the year to date to 1176

Compliments

There were 562 compliments recorded in May 2017, with the most being recorded for Div 1. This is higher than last month with the Pre-Operative Assessment Clinic continuing to receive a significant number of compliments. Areas have been reminded to submit their records for central recording.

All compliments are sent electronically to the Patient Experience Team who holds the records. A Compliment is recorded if there is tangible evidence such as a card, a thank you letter, a box of chocolates or an e-mail. Teams are reminded monthly to submit their compliments for central logging.

Complaints

There were 17 formal complaints made in May 2017, bringing the total to 28 for the year. 1 complaint was initially risk rated red and the remainder were risk rate amber or yellow. This is higher than the same time last year (15 complaints in May 2016)

-

ACTIONS FOR IMPROVEMENTS / LEARNING

Of the 7 complaints closed in May 2017:

- 3 were upheld
- 4 were partially upheld
- 0 were not upheld

All of the partially upheld complaints were upheld for communication issues.

Learning identified and actions taken as a result of complaints closed in May 2017 include:

- A member of staff was not interacting with patients in line with the Trust Values

  Action: Professional conversation has been undertaken

- Patient was not aware of the changes made to her medication and the reasons for this

  Action: Professional conversation has been undertaken. Complaint has been discussed at ward meeting as a facilitated learning experience for all staff

- Processes for provision of orthotic supplier outside of standard prescription were not clear

  Action: Process has been created to avoid further confusion and issues.

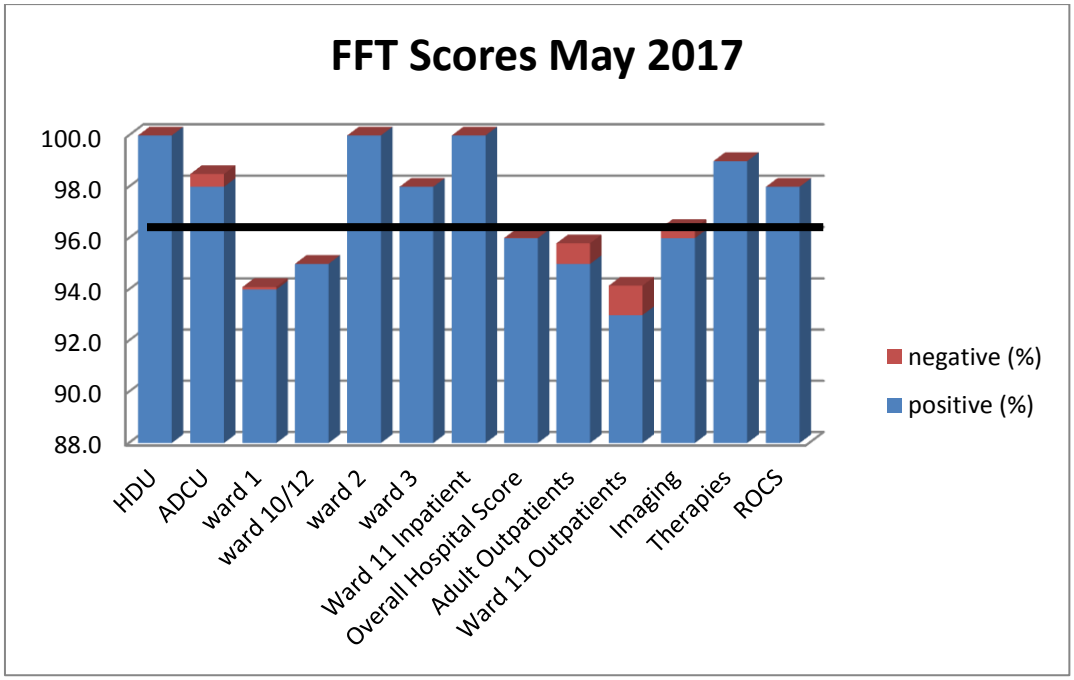
RISKS / ISSUES

None Identified.

10. Friends and Family Test Results and iwantgreatcare - 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.

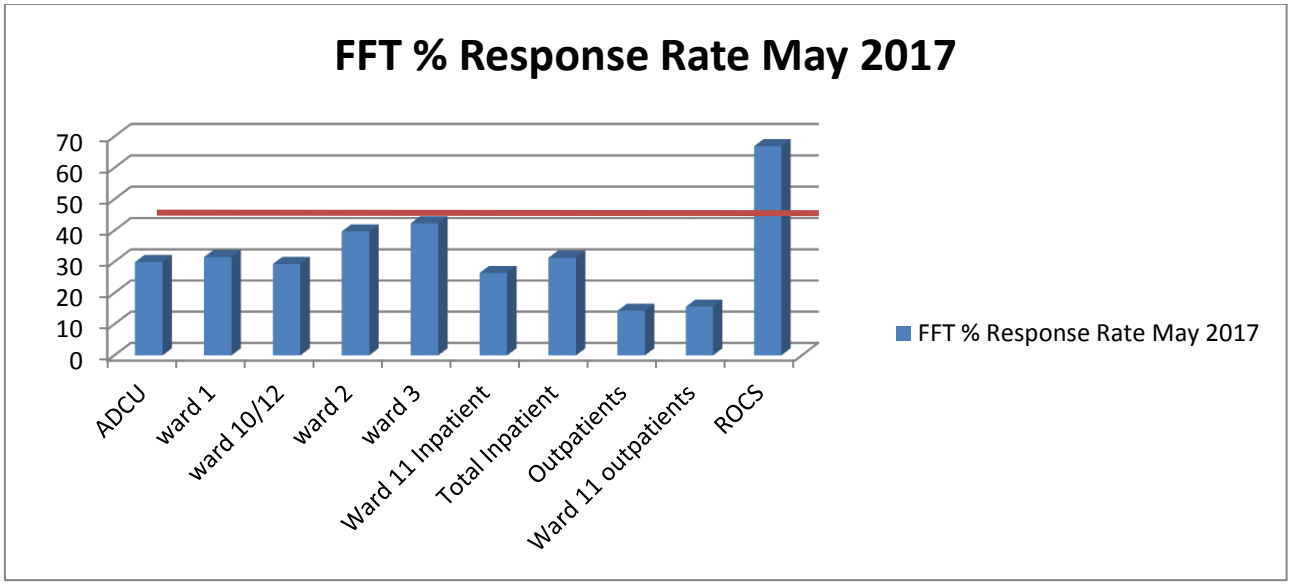
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting 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

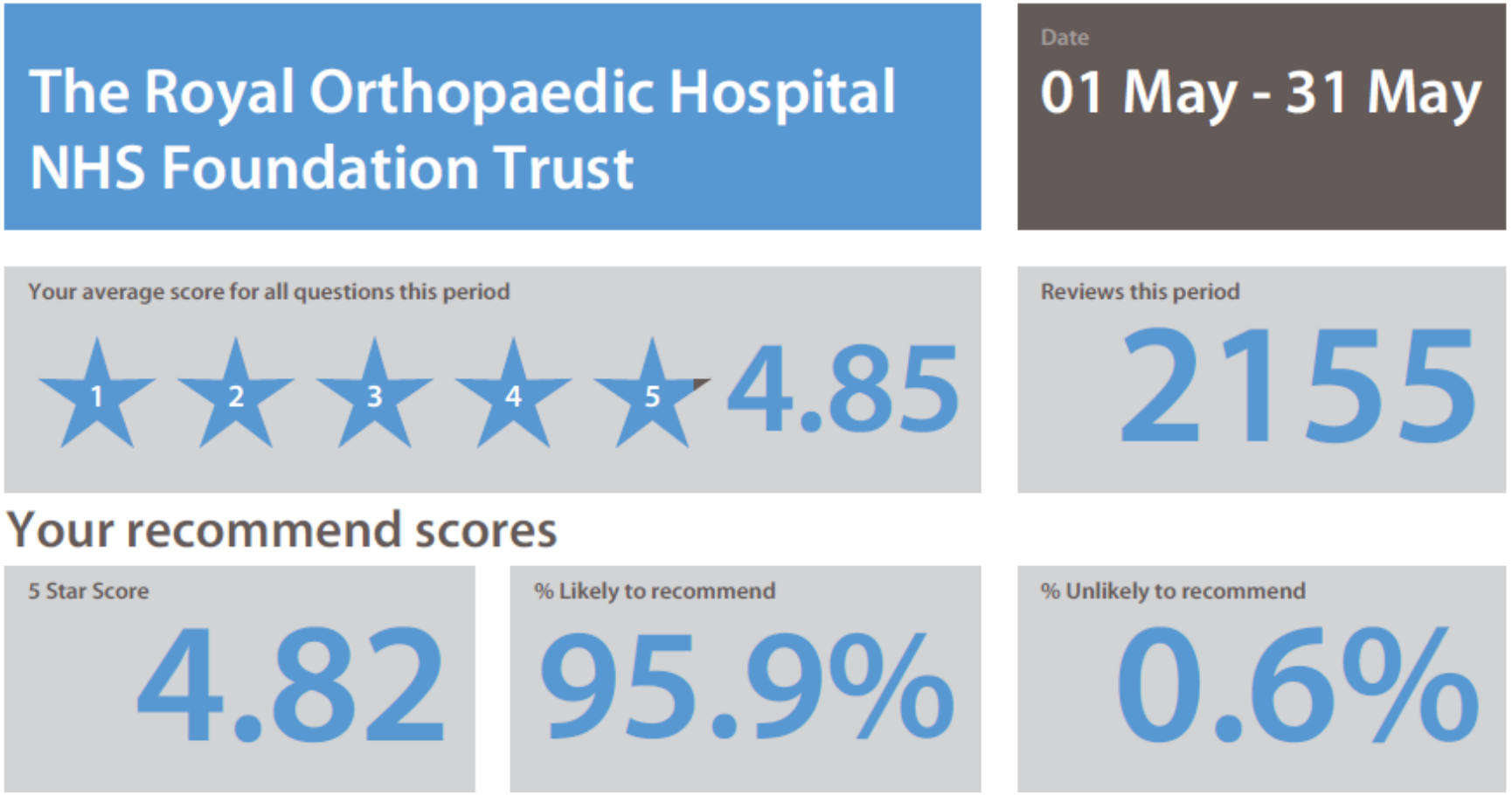
Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely / Extremely Unlikely are classified as negative.



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.

In order to attempt to address some of this imbalance, the Trust has set an internal target to reach a 40% response rate across all areas within the first quarter of 2017/18. In May 2017, Ward 3 and ROCS met this internal target.

I Want Great Care - iWantGreatCare makes it simple to collect large volumes of meaningful, detailed outcomes data direct from patients on your organisation, clinical locations and whole clinical teams. It Continuously monitor and compare performance of individual services, departments and wards and Aggregated, graphical monthly reporting meets needs of both providers and commissioners for robust, patient-centric metrics to track quality and performance.



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 24 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.

During the month of May, 4 cases are deemed to have breached Duty of Candour Regulation 20 policy. These incidents are related the 4 x Spinal Deformity patients were established as severe harm or moderate harm in the RTT Royal Orthopaedic Hospital NHS Trust harm review. Each of the severe harms (4 in total) have been recorded as a Serious Incident as agreed with the CCG. One patient has had a face to face meeting and this will be followed up in writing. The other 3 patients are in the process of being scheduled as soon as practically possible.

Duty of Candour regulation 20 stipulates that the verbal face to face contact should be as soon as practical possible but within 10 days.

The Clinical Governance Team will be completing an internal audit for added assurance.

12. Litigation

There was no new litigation to report in May 2017

13. Coroner's cases

No Coroners inquests in May 2017

14. **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 perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**

INFORMATION
No Data available due to theatre man
ACTIONS FOR IMPROVEMENTS / LEARNING
RISKS / ISSUES
The Audit Data for Who checklist is not available for May 2017 due to the migration to the new theatre man software. A new report is currently being generated that will show the WHO compliance and audit. This will be included next month

Finance and Performance Report

MAY 2017

CONTENTS

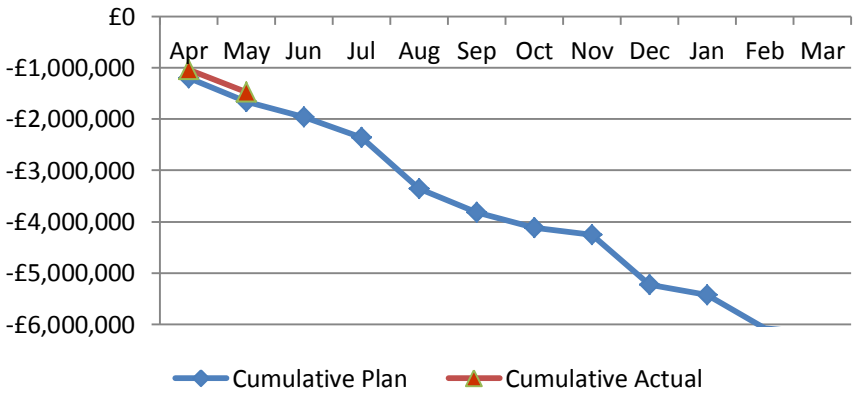
INTRODUCTION

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.

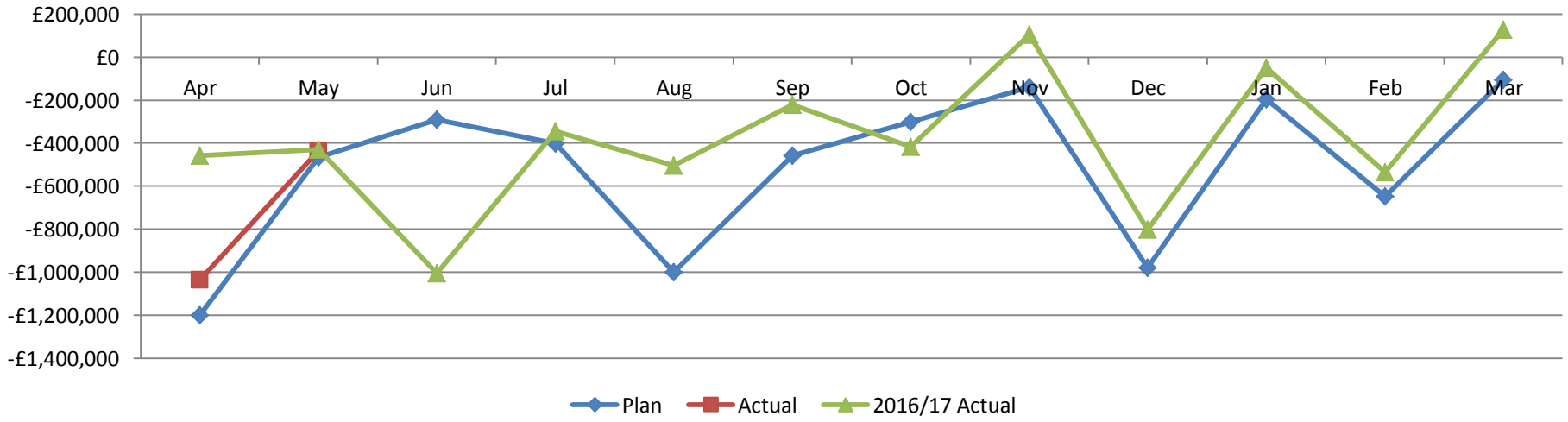
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Cumulative Deficit vs Plan



NHSI Use of Resources Rating (UOR)		
	Plan	**Actual**
Capital Service Cover	4	4
Liquidity	4	4
I&E Margin	4	4
I&E Margin – Variance against plan	1	1
Agency metric	1	1
Overall UOR	N/A	3

Monthly Surplus/Deficit Actual vs Plan



INFORMATION

The Trust has delivered a deficit of £435,000 in May against a planned deficit of £465,000, a result £30,000 ahead of plan. This brings the Trust's year to date position (on a control total basis) to £1,470,000 against a plan of £1,664,000, and is therefore ahead of plan by £194,000.

The in-month position is ahead of plan, but this is being driven by the receipt of £101,000 from the Trust's insurers in relation the December 2013 fire, which was not expected within the plan for the month. The year to date position ahead of plan is therefore as a result of this income, in addition to the prior month's control of non-pay costs. Income and expenditure performance is discussed further on the respective income and expenditure slides within this pack.

As at the end of Month 2, the Trust has recognised £276,000 of CIP savings, against a plan of £521,000. £7,000 (2%) of savings to date are non-recurrent. The in-month savings recognised were £141,000 against a target of £260,000. There has currently been insufficient engagement from Divisions 1 and 2 to fully develop the CIP schemes into achievable savings plans as a result of focus on improvement of RTT. The Director of Finance is challenging progress to ensure detailed plans are developed urgently.

With regards to the Trust's Use of Resources Risk Rating (UOR), the deficit position results in the Trust achieving ratings of 4 for Capital Service Cover, and I&E Margin. The Trust's requirement for cash support has resulted in the Trust being a 4 for liquidity. The current performance being ahead of plan, and the control of agency spend has resulted in these metrics being rated as 1s. The overall rating is a rating of 3.

ACTIONS FOR IMPROVEMENTS / LEARNING

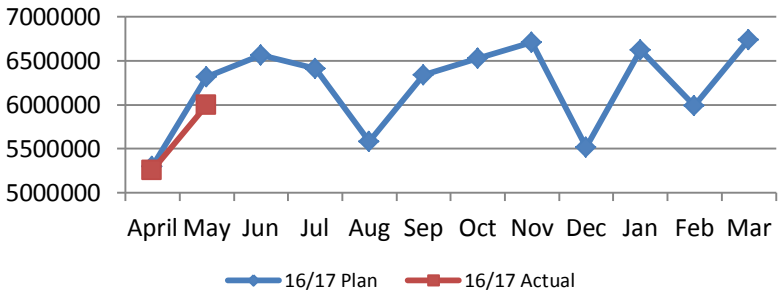
The Trust Executive are monitoring weekly progress against the action plan. Schemes such as implant rationalisation are in progress to improve the Trust's cost efficiency. Whilst the schemes are constantly being reviewed and refreshed, particular focus will be placed on ensuring the cost control plan is reconsidered and takes into account all of the coming planned CIP schemes which need particular Executive oversight.

RISKS / ISSUES

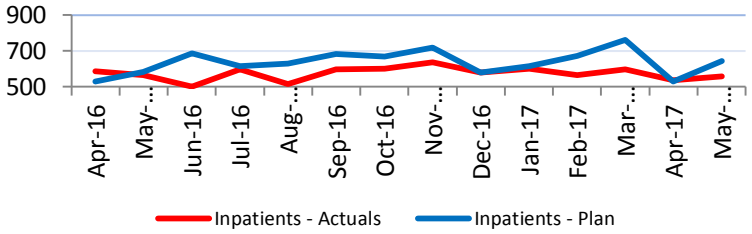
There is a risk that the focus on RTT and operational activity delivery results in CIP schemes not being implemented in a timely enough manner to ensure the required savings for 2017/18.

2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity

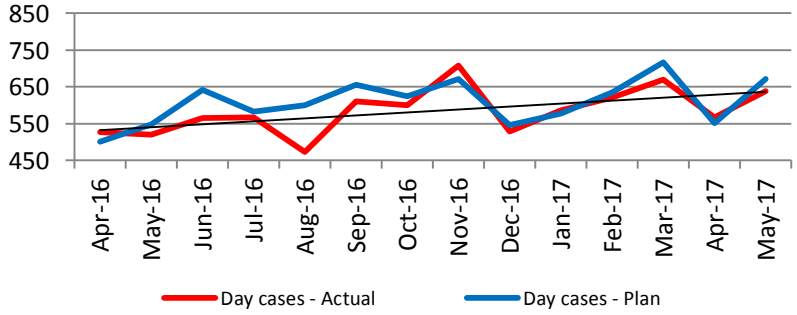
Monthly NHS Clinical Income vs Plan, £, 17/18



Inpatient Activity



Day Case Activity



NHS Clinical Income – May 2017 £'000			
	Plan	Actual	Variance
Inpatients	3,209	2,946	-263
Excess Bed Days	100	85	-15
Total Inpatients	3,309	3,031	-278
Day Cases	776	682	-94
Outpatients	620	670	50
Critical Care	249	182	-67
Therapies	203	222	19
Pass-through income	222	217	-5
Other variable income	423	473	50
Block income	518	518	0
TOTAL	6,320	5,995	-325

NHS Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	5,856	5,773	-83
Excess Bed Days	182	134	-48
Total Inpatients	6,038	5,907	-131
Day Cases	1414	1300	-114
Outpatients	1130	1112	-18
Critical Care	453	364	-89
Therapies	451	415	-36
Pass-through income	404	434	30
Other variable income	689	680	-9
Block income	1036	1036	0
TOTAL	11,615	11,248	-367

INFORMATION

NHS Clinical continued to underperform in May (by 5.1%) having underperformed by 3.1% in April. Admitted patient care performance was below plan financially and with respect to activity levels, with discharged activity 83 below target. May does have increased levels of activity compared with April which was expected. Case-mix remained steady in May. The Paediatric spinal deformity service carried out at Birmingham Children's Hospital was suspended due to issues with the sterilisation of equipment, during April and most of May 2017. The service re-started on 24th May 2017, however the loss of activity has impacted significantly on the year to date income position.

Outpatients continued to under-perform from an income point of view which is driven by the underperformance in outpatient procedures. First and follow up outpatients are over-performing year to date.

Outside of clinical income, £101,000 of insurance income was received, which related to a fire in the Trust in December 2013. This income was not expected within the plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are 4 work streams (Operations, Process, People, and Data) which have been defined with the actions required to achieve recovery of income and RTT. Continued focussed work continues with clinical service leads and consultants, with the operational managers , to create additional capacity, and using the trajectories, target individual (long waiting) patients to be booked.

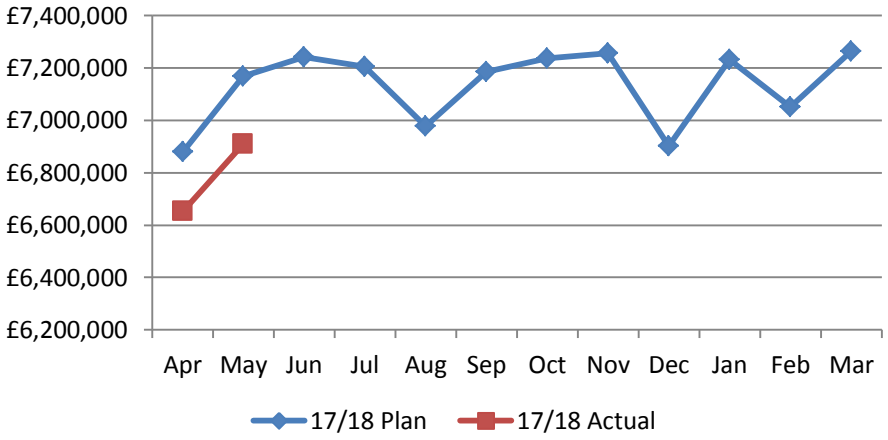
RISKS / ISSUES

Key risks are the availability of speciality teams to reutilise every fallow list, particularly during periods of high consultant leave, and to ensure that theatre productivity continues to enable fully booked lists to be delivered. There continue to be a high level of patients who cancel their operation a few days before the planned date, which then means that there are replacement patients scheduled at short notice to achieve full utilisation.

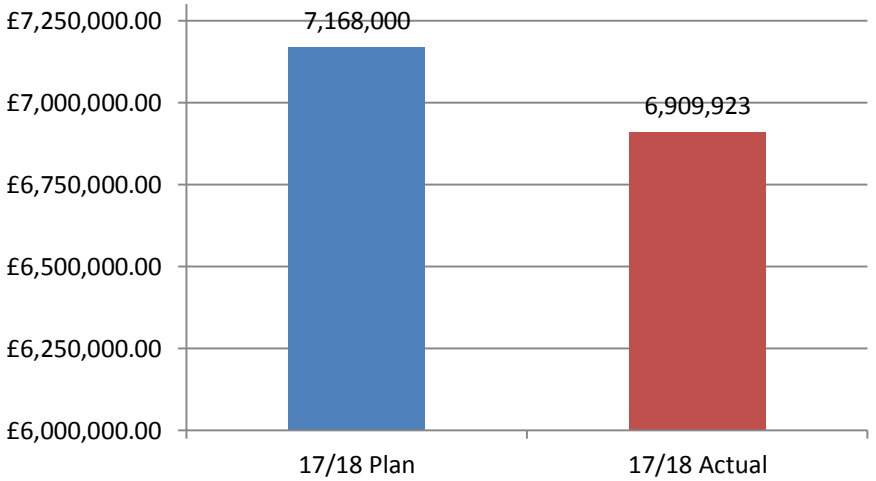
There is increasing clinical engagement in developing improvements to productivity for both operations and out patients. Some consultants have very short, with others having very long, waiting lists, and work is underway to smooth out flows across firms.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends

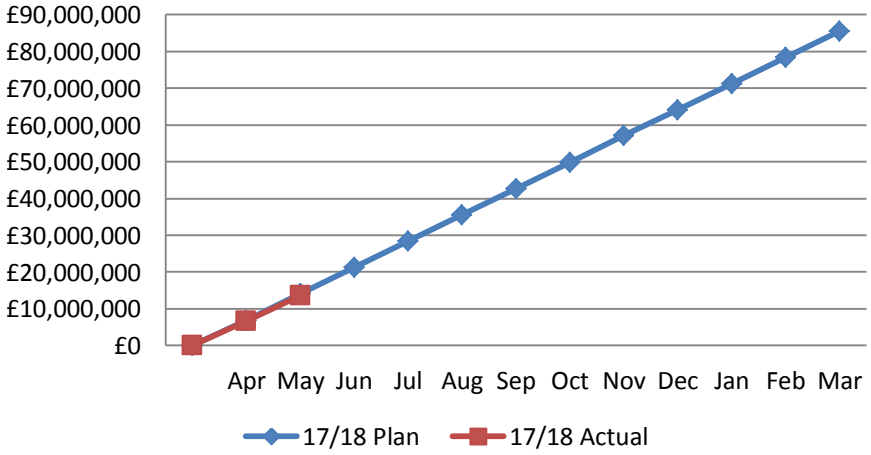
17/18 Monthly Expenditure vs Plan



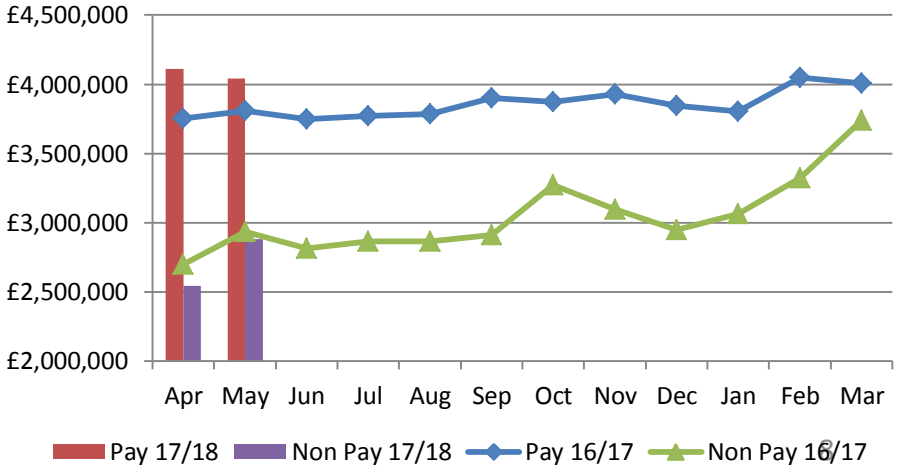
17/18 M2 Expenditure vs Plan



Cumulative Expenditure vs Plan 17/18



16/17 vs 17/18 Pay & Non Pay Spends



INFORMATION

Expenditure levels for the month were £6,910,000, £259,000 behind the in month plan of £7,168,000.

The main reason for the underspend was non-pay spend being lower than planned. Implants, orthotics and drugs for example were lower than plan as a result of activity being below plan. As noted above, the paediatric spinal deformity service suspension at Birmingham Children's Hospital has reduced the run rate of non pay spend. In addition a number of ad hoc spend areas such as utilities and legal costs were lower than expected.

Pay spend was slightly above plan. When the pay categories are reviewed individually, substantive spend was behind plan by £180,000, bank spend ahead of plan by £150,000, and agency greater than plan by £13,000 (although still lower than plan year to date). It is clear from a review of the bank plan that this was erroneously set too low in each month, with the balance being taken from substantive pay. When the plans are corrected to what they should have been set as, the spends are in line with plan. NHS Improvement have been contacted to see if a correction to the plan can be made, as this variance will otherwise be expected to be seen throughout the year. Bank spend is in line with previous months.

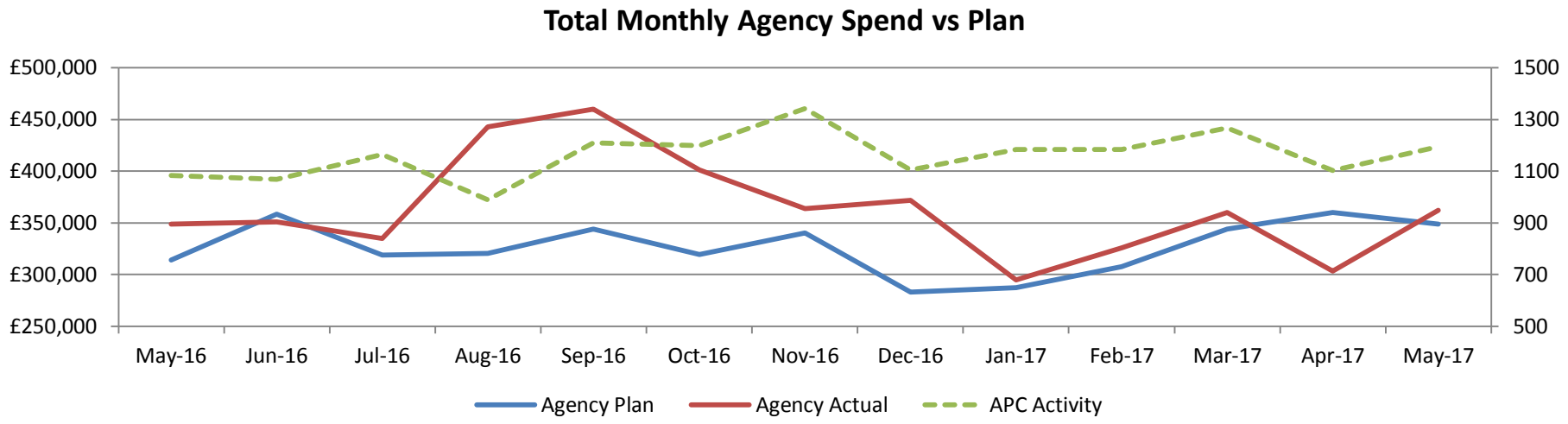
ACTIONS FOR IMPROVEMENTS / LEARNING

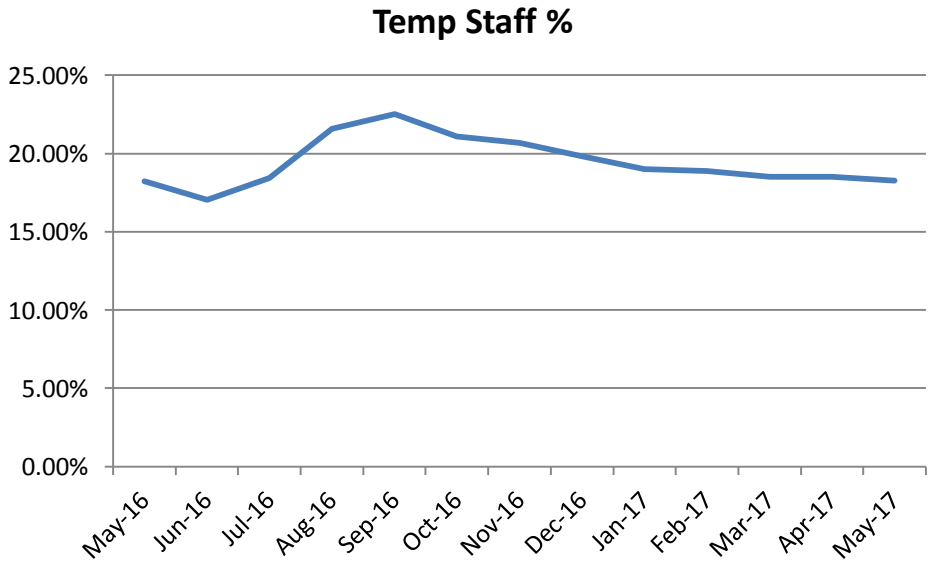
Costs will continue to be scrutinised and minimised, and the alteration of the bank spend plan will be followed up further with NHS Improvement.

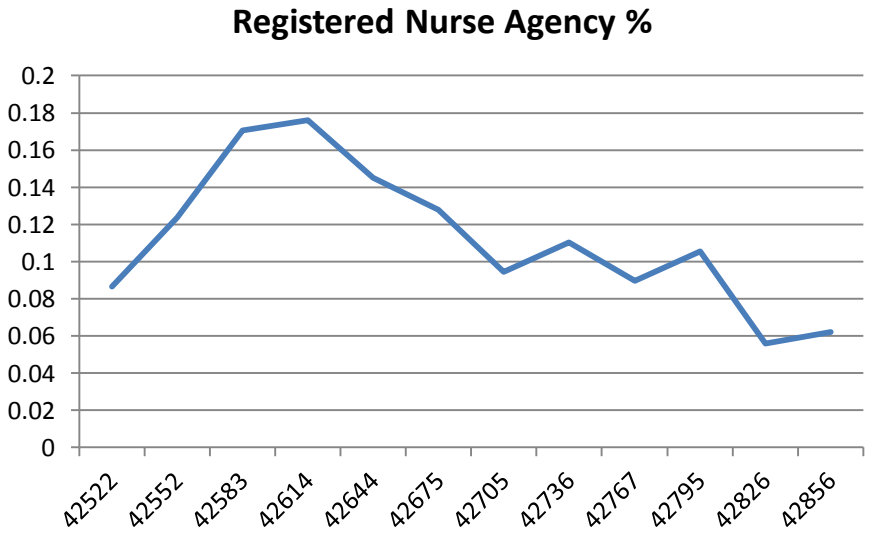
RISKS / ISSUES

Close management of the stock implant rationalisation will be required to control costs and maximise savings as described in further detail in the CIP section of this paper.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements







INFORMATION

April showed an increase in agency spend (£303k to £362k). Most agency staff categories were stable from Month 1 to Month 2, with the exception of an increase in non-clinical agency spend for additional RTT validators. May has a greater number of working days than April, and therefore a static agency spend on categories such as nursing suggest Healthroster is continuing to give better visibility of rotas and better control of nurse agency. In addition, there has been ward closures as a result of the infrastructure works, and the nursing workforce have been working effectively to group resource in these circumstances to reduce agency spend. There continues to be a pressure on Medical spend due to an under provision of GP trainees from the West Midlands Deanery, but spend is static.

ACTIONS FOR IMPROVEMENTS / LEARNING

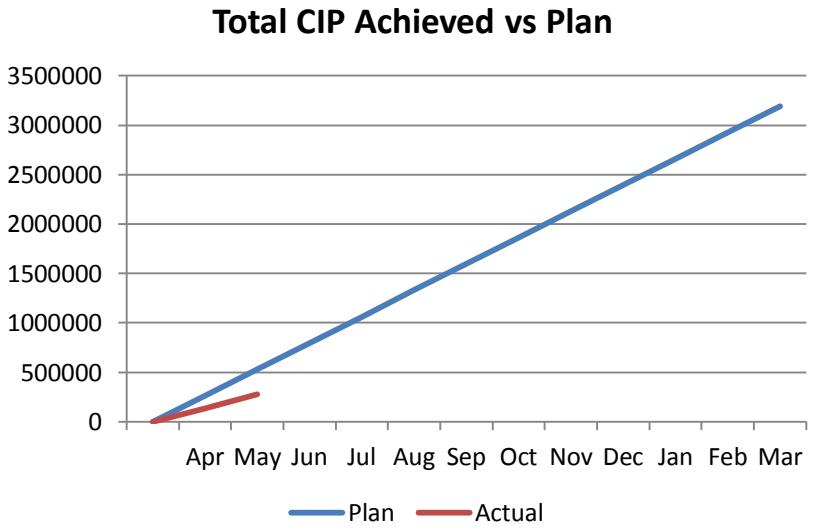
The leadership by the Nurses in addressing use of agency continues to impact positively. This has been delivered by continued and focussed review of the outputs of Healthroster.

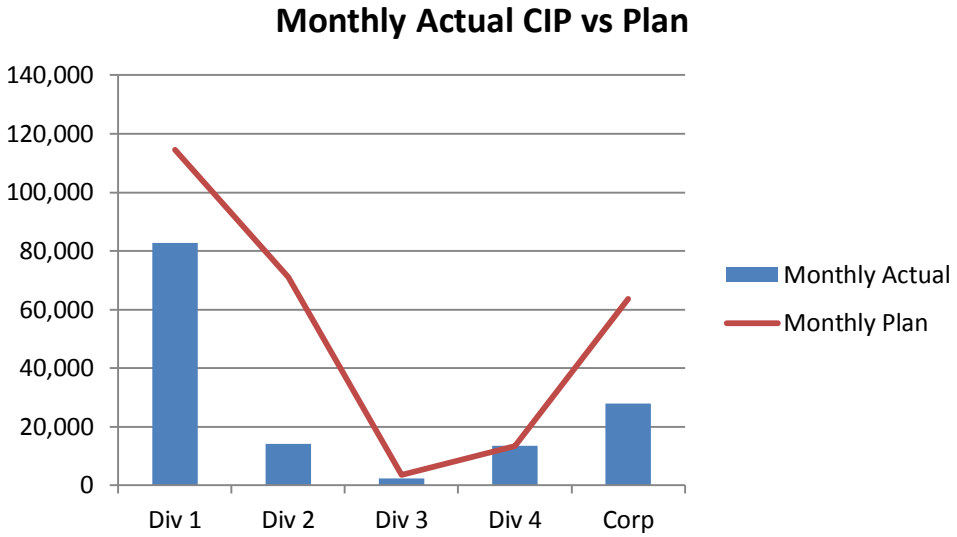
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios. The Trust is currently consulting on a change to rota working patterns as part of this process.

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. An overspend against the trajectory will have a direct impact on our regulator ratings.

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2017/18





INFORMATION

As at the end of Month 2, the Trust has recognised £276,000 of CIP savings, against a plan of £521,000. £7,000 (2%) of savings to date are non-recurrent. The in-month savings recognised were £141,000 against a target of £260,000. There has currently been insufficient engagement from Divisions 1 and 2 to fully develop the CIP schemes into achievable savings plans as a result of focus on improvement of RTT. The Director of Finance is challenging progress to ensure detailed plans are developed urgently.

The Trust continues to progress through the implementation of the non-spinal rationalisation scheme, and it will remain important to manage the process of transition closely to the new suppliers to maximise on the savings for the new rates and avoid incurring additional cost by ordering non-primary suppliers. Good progress is being made with the involvement of many teams and individuals around the Trust in the rationalisation of consumable supplies, with some notable successes on implementing alternative products following successful product trials.

Other significant schemes planned for 2017/18 include continue to implement nurse staffing improvements, in addition to embedding the operational and executive team restructures implemented from 1st April.

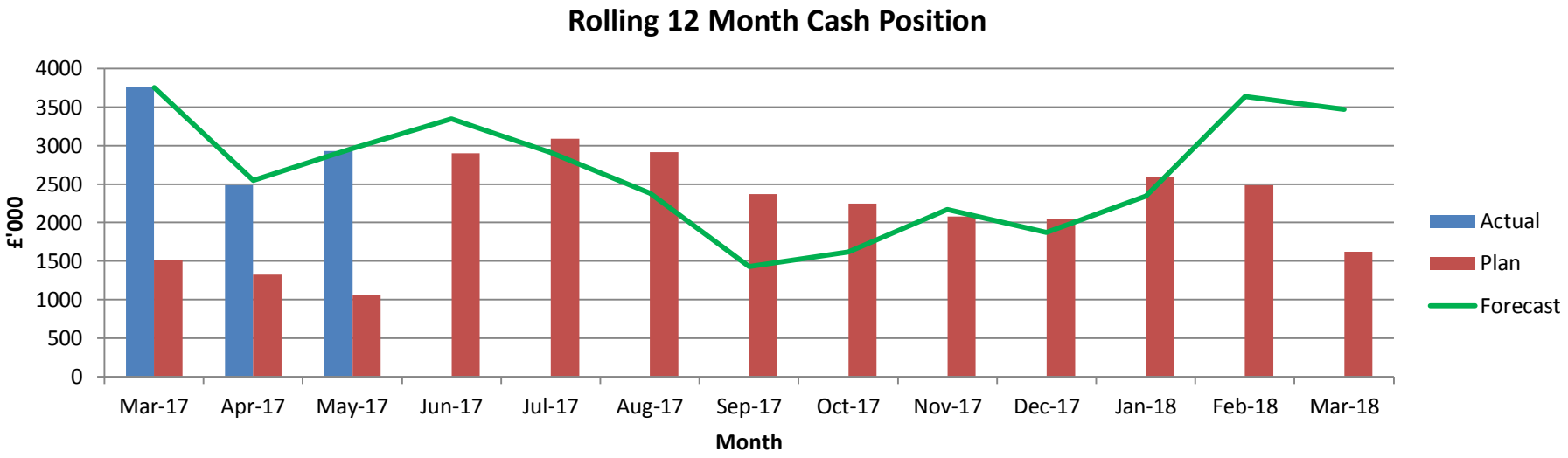
ACTIONS FOR IMPROVEMENTS / LEARNING

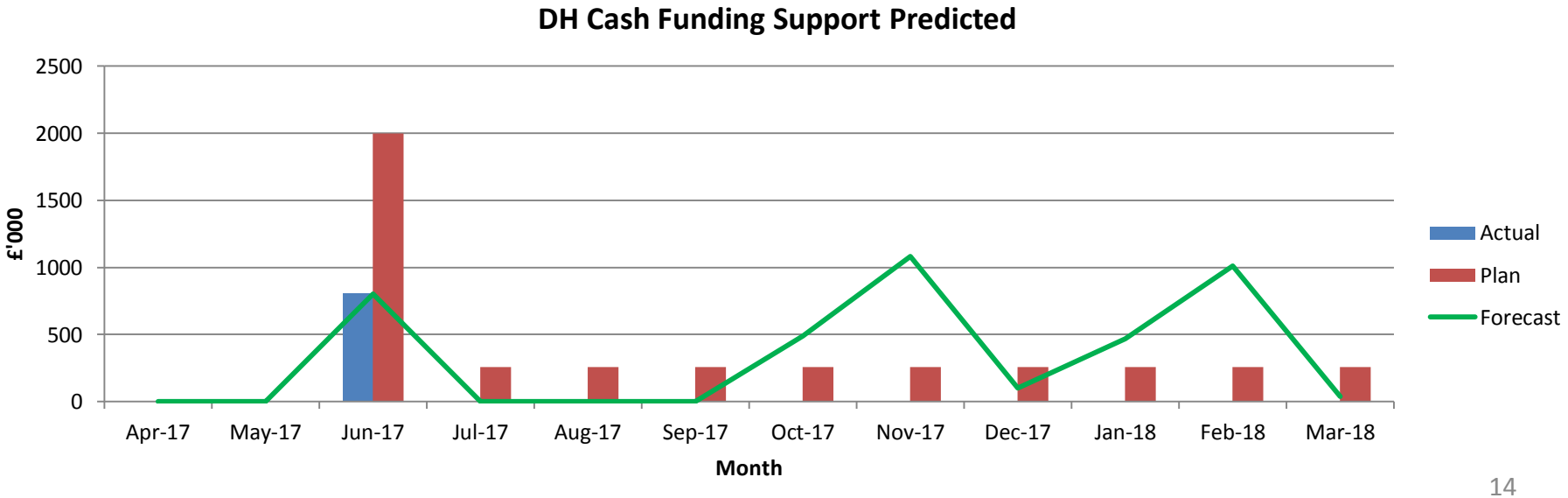
Early focus on unidentified schemes for 2017/18 is needed to ensure the CIP plans are achieved. In addition, a significant proportion of the prior year CIPs were non-recurrent. Focus on ensuring schemes are recurrently delivered will be important in the coming year.

RISKS / ISSUES

The CIP target for 2017/18 will be challenging particularly given the high level of non-recurrent CIP in 2016/17. A number of the schemes in 2017/18 are more transformational rather than traditional cost cutting schemes, and it will be vital that the required changes to working are not only implemented but thoroughly embedded to ensure savings are delivered in a consistent manner.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet in addition to expected borrowing requirements from the Department of Health





INFORMATION

Information

Cash levels are £1.9m higher than planned levels at the end of May, largely driven by cash held at the end of March being significantly higher than planned. The cash position for May is roughly in line with the Trust revised cash forecast for the month.

Despite this, due to the ongoing reduction in cash over time, liquidity levels within the Use of Resources Rating have dropped to a 4, the lowest level.

The Trust received its first cash loan from the DH on the 12th June for £804k as previously advised to the committee. Based on the current forecast funding support will not be required again until October 2017.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Head of Financial Accounting has set up a monthly cash control committee attended by the DDOF, and representatives from management accounts and the transaction team. The committee is reviewing cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications of cash from the Department of Health to be actioned.

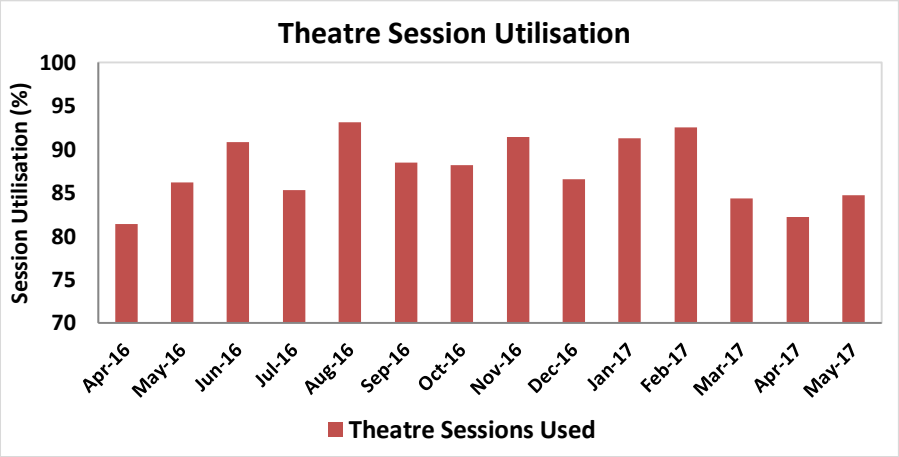
Based on the feedback from NHS Improvement the information provided to request funding was robust. The finance team are however continuing to review this and are looking to gather more information to continue to improve the Trusts management of cash.

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.

There is a risk is in relation to DH not approving a cash loan or approving a lower than requested amount, but the positive feedback to date from NHS Improvement provides assurance that this risk is relatively low.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are potentially available (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we aim to use at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis. May utilisation has improved in comparison to April, however, more work is underway to continue to improve this, to support the delivery of the RTT Action Plan.

Due to annual leave / study leave, we typically plan that surgeons will operate over 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.

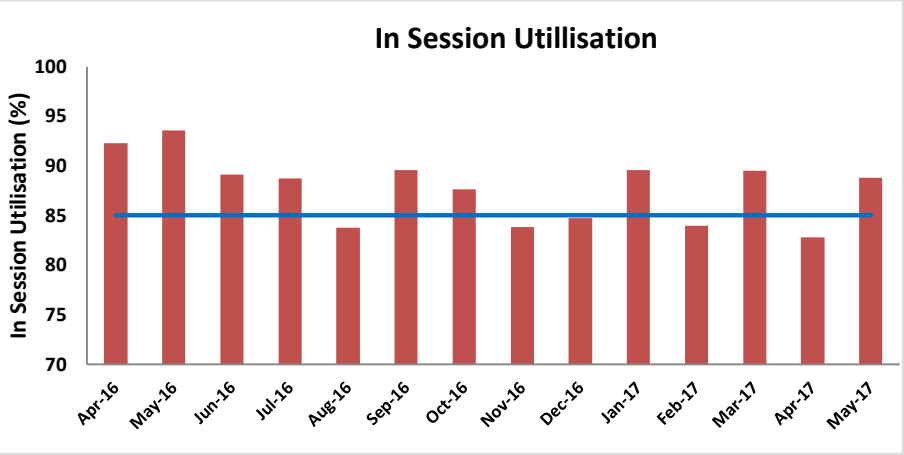
ACTIONS FOR IMPROVEMENTS / LEARNING

Job planning is building in buddy arrangements and prospective cover, as well as identifying a need for recruitment to specialities where there are vacancies or that are under pressure from an activity / RTT / 52 week perspective. Further improvements have been made to the communications to surgeons of the availability of fallow lists, enabling more effective utilisation. There are now additional 3 session days in the schedule to facilitate the 2 x scoliosis cases on a list for spinal deformity. The large joints team are exploring, a regular 3 session day list for those consultants with back log issues. In week twin theatre sessions have started in order to drive efficiency and reduce backlogs.
Some theatre lists are now being released by individual surgeons (and offered to be reutilised by other surgeons) to enable them to have additional clinics, because some surgeons who are timetabled in theatres have very short waiting lists. All reasonable efforts are made to recycle, including where it is deemed appropriate the use of sessions additional to job plan (paid ADHs.) Since theatres and anaesthetic teams are not yet fully staffed, capacity is flexed up through overtime and bank working, so where lists are not recycled, and deemed 'fallow', the theatre staffing and anaesthetic shifts are removed 1 week ahead, to reduce bank and agency costs.
The ops team are proactively monitoring surgeon annual leave up to 12 weeks in advance in order to manage the reduce the number of fallow lists and to offer appropriately to those services that are most challenged.

RISKS / ISSUES

Job planning is now completed for surgeons, with outstanding issues with only 2 surgeons; these are actively being progressed with the involvement of the Associate Medical Director, Clinical Service Manager and Clinical Service Lead.
The new theatre schedules and outpatient schedules started on 1st May 2017, to match the updated agreed job plans.
The next round of job planning is now being planned and will start by the end of Q1.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained above the target 85% in the majority of months. However, the previous measure (pre June) 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. The May performance has improved and will continues to be a focus to improve further for the coming months to enable the delivery of additional activity required to address 18 week compliance.

ACTIONS FOR IMPROVEMENTS / LEARNING

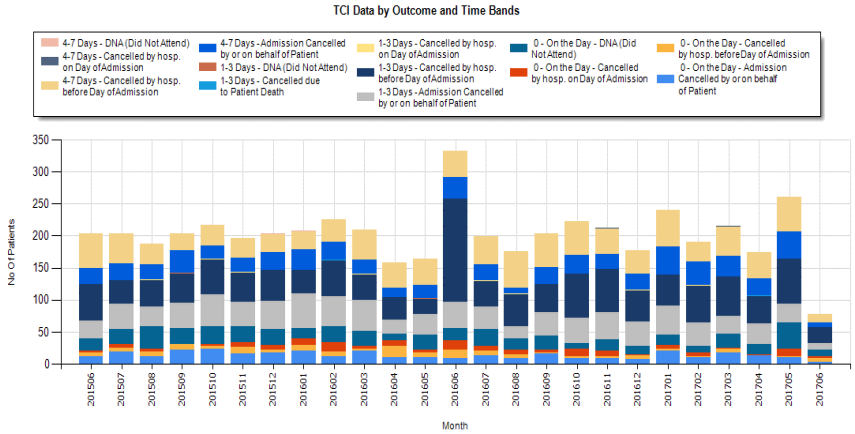
There are a range of actions being undertaken to ensure continual improvement in theatre in session utilisation, focussing on start time, turnaround, optimal list composition and the eradication of unplanned overruns. This will be led by the Head of Nursing, Division 2, working on The Productive Operating Theatre principles. The new Theatre Management System 'Theatreman' was successfully implemented on 24th May 2017, replacing ORMIS. The prescriptive nature of this software will be a further aid to ensure that lists are optimally booked based on the available time. Scrutiny and challenge is via the weekly 6-4-2 meeting, with instructions back through to the surgical teams to book lists to their maximum potential and to POAC and identify patients well in advance so that specific requirements can be planned for to reduce cancellations. Work on trajectories in the Spinal, Hands, Feet and Arthroscopy specialties has also brought to the fore some opportunities for greater efficiency and the possibility of moving some cases out of the theatre environment. Additional capacity delivery through use of non consultant staff is being explored. Detailed action plans have been completed and underpin all of the speciality trajectories, these plans include detailed monitoring of additional activity that feed into the trajectory, month by month. As the validation work continues , this will confirm an accurate picture of the waiting list and hence the level of additional activity required.

RISKS / ISSUES

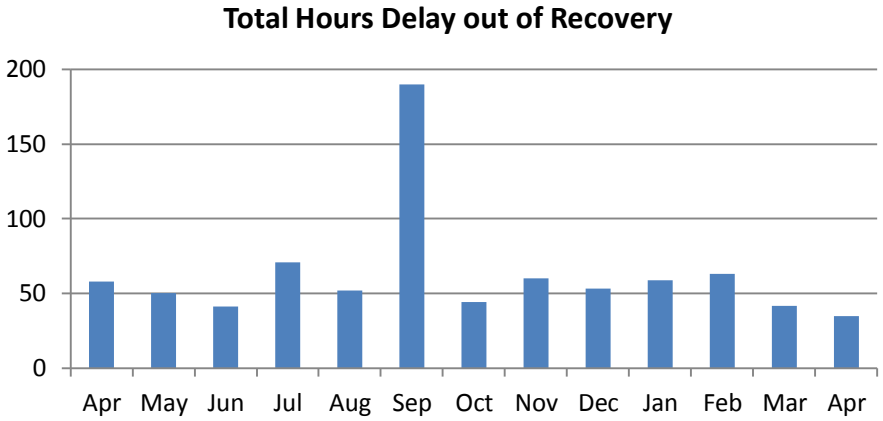
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (e.g. experience in spinal scrub) to ensure the best possible use of available operating time. Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit. Gaps in the operational structure, although recruitment is underway.

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

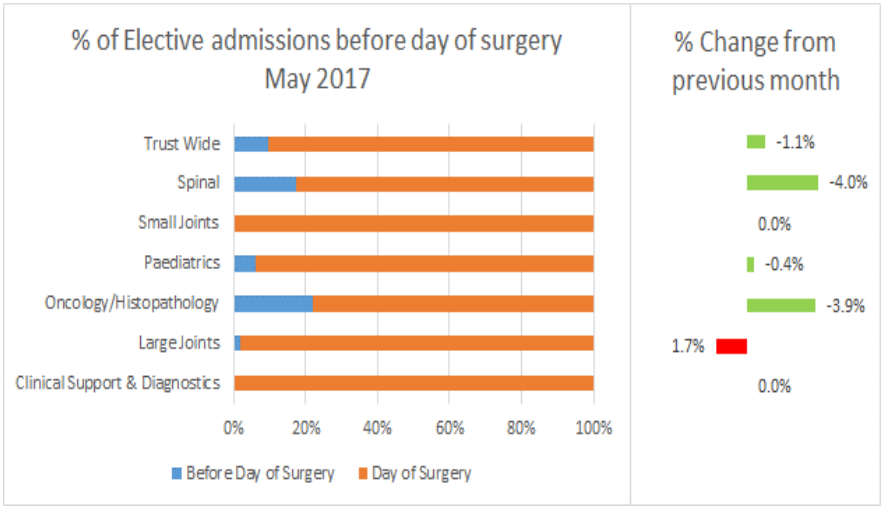
Cancellations by patient / hospital



Delays out of recovery

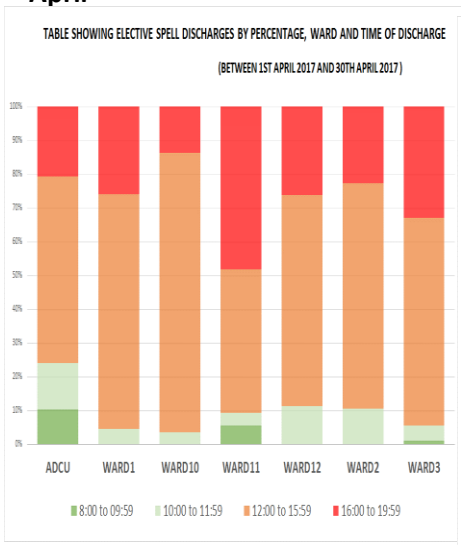


Admission the day before surgery

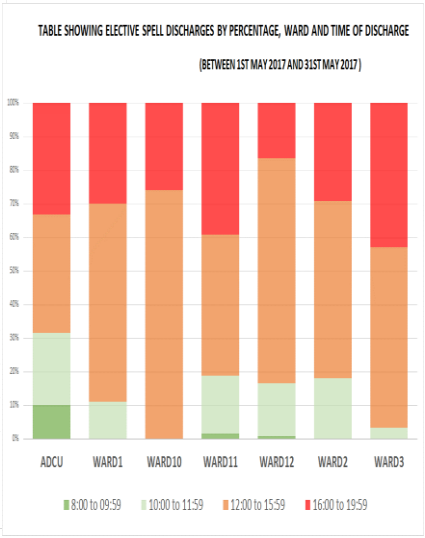


Time of day patients discharged

April



May



INFORMATION

Active management of the Patient Tracking List (PTL) , the planning for the establishment of a separate Oncology PTL weekly meeting to track the booking of individual patients, and a separate large joints PTL weekly meeting to track patients is creating a new momentum, with lists being booked several weeks ahead where previously they were being booked only days ahead.

Work on the trajectories for spinal, hands, feet and arthroscopy is identifying opportunities for streamlining referrals, reviewing the use of an operating theatre for cases being undertaken (rather than an OPD setting) and the rebalancing of waiting lists across firms. The implications of these are being worked through with Clinical Service leads and Clinical Service Managers. The validation of the waiting lists continues, as noted earlier.

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Some of the replacement patients are then booked at short notice. We are working towards booking with 3 week's notice and 2 reasonable offers as per national guidance and our Access Policy.

Now that there are Clinical Service Leads and Clinical Service Managers for each specialty, and regular team meetings, some longstanding issues relating to disparity of waiting lists across consultants, variations in theatre productivity and listing protocols are being addressed and resolved. Work is continuing, with a particular focus on Oncology. There are measurable and encouraging results from this work.

Forensic analysis of cancellations continues, with a focussed analysis by the anaesthetic lead and nursing lead for POAC of the majority cause of cancellations on the day of surgery, namely those who are medically unfit, to ascertain what process changes can be made in POAC or to the 72 hour phone call to reduce this.

ACTIONS FOR IMPROVEMENTS / LEARNING

Now that the longstanding vacancies in Medical secretaries, admin support and operational management have been filled, there is now the capacity for transacting the forward booking of patients for both preoperative assessment and surgery.

This will create a pool of patients available to be called forward earlier at short notice to fill cancellation slots.

Work is still required to agree criteria for admission the day before, to use beds more effectively and reduce length of stay.

Pre-operative assessment improvements have been delivered, so that there are now 32 slots available each day.

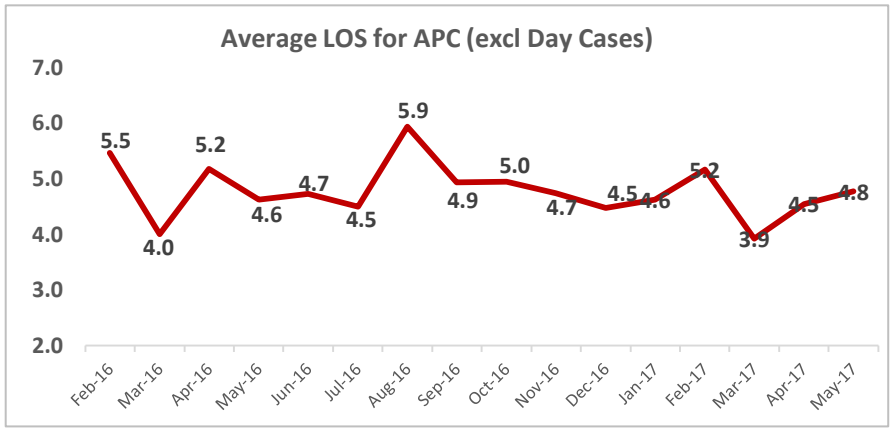
A daily update review by operational management of forward bookings has been established and the 642 and a daily 9am Operations huddle has been started. Daily statistics on beds , admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to deliver activity and patient flow.

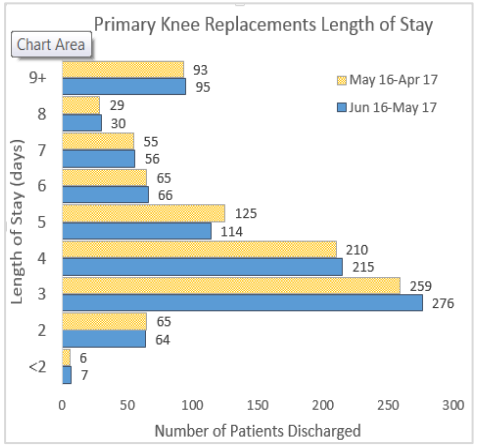
RISKS / ISSUES

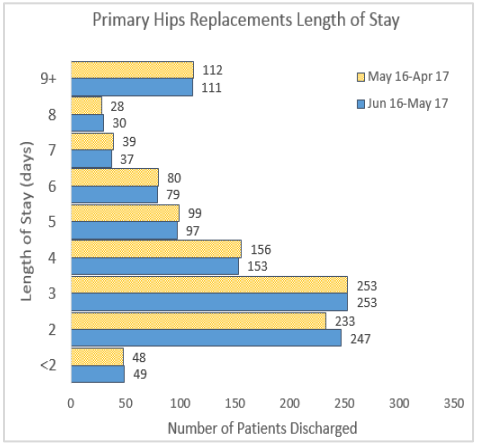
Continued focus with all staff involved to ensure that the operating lists are booked in advance, with sufficient caseloads, together with daily tracking.

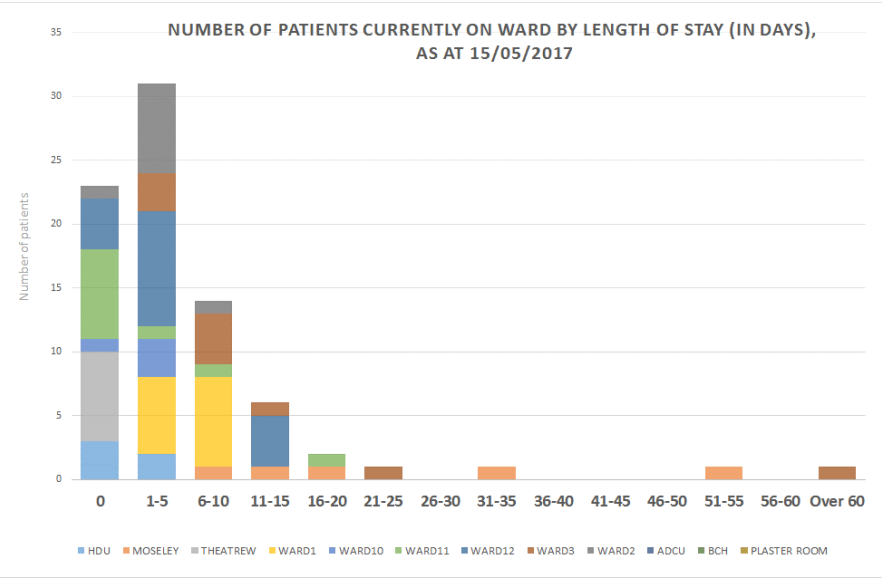
It is currently not possible to identify if the time of day patients are discharged is an accurate reflection of reality, or whether data is being entered onto the system in a delayed manner, making discharges look later in the day.

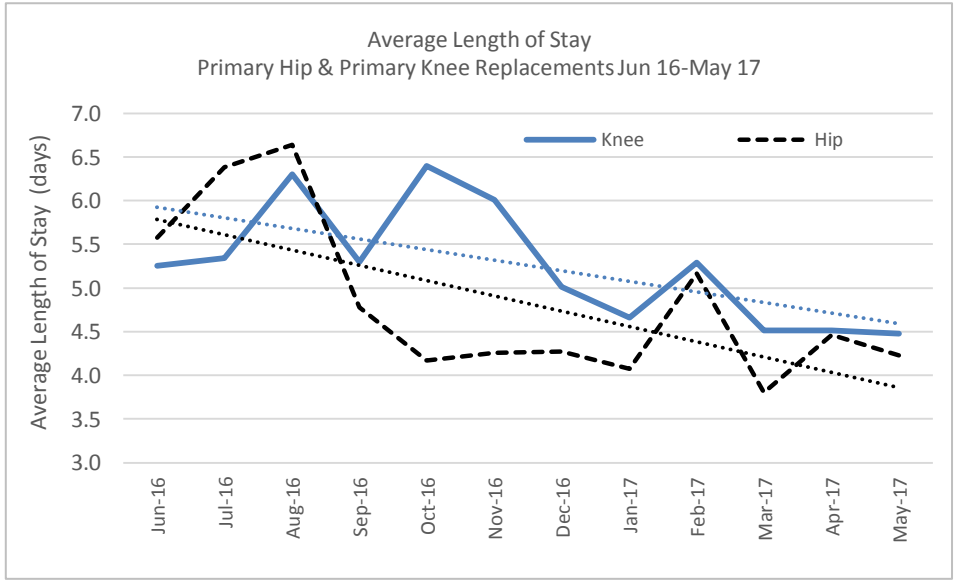
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Under the leadership of the Associate Medical Directors , Clinical Service Leads and Clinical Service Managers, work is progressing to increase activity levels to deliver 18 week compliance by creating additional capacity from within existing resources by improving flow. Length of stay reductions for primary hips and knees is key to achieving this , and an update will be brought to the next committee as to the progress of this work.

In May 2017, a 'Red/Green' process has been started to force better flow of patients hour by hour , partly to facilitate the rolling ward closures for the site infrastructure cabling installation, and mainly to improve overall patient flow.

The Home for Lunch' information campaign was launched to staff and patients during Mid February and this has also helped to reduce length of stay with the expectation setting with staff and patients about when a patient can leave the hospital, and the marshalling of resources to ensure that this occurs as early as possible in the day. This clearly sets out to all concerned that we expect that more than 80% of patients due for discharge that day will leave hospital or be off the ward and in the discharge lounge before midday.

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.

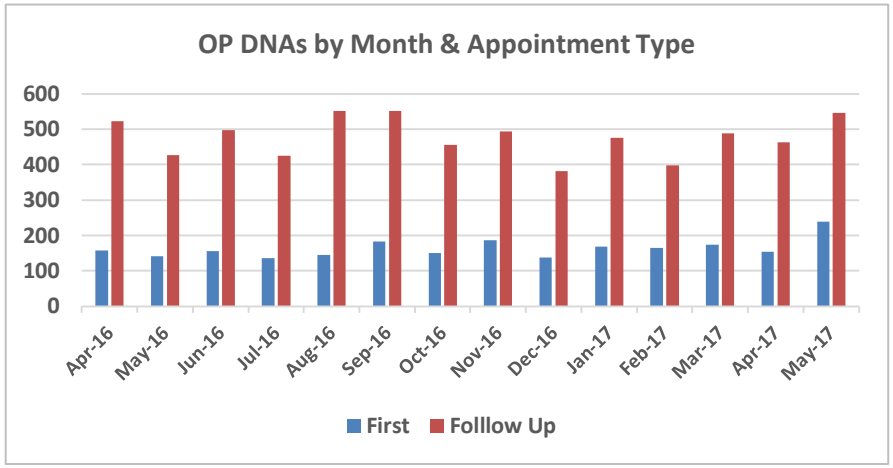
Daily senior reviews are being formalised as part of job planning, and the rising adherence to recording the Expected Date of Discharge (EDD) (now over 90%) is helping all involved in that patient's care to manage their length of stay more effectively.

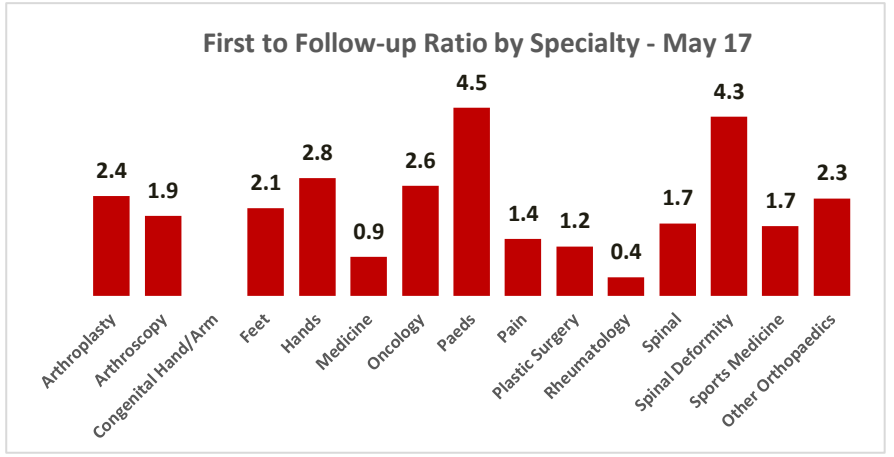
RISKS / ISSUES

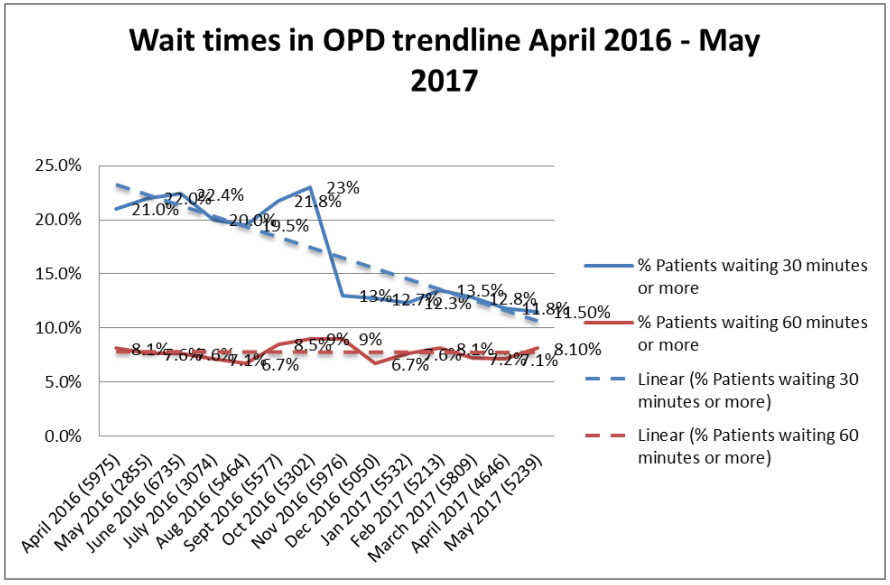
Using individual consultant information, Operational management teams and Clinical Service Leads are reviewing outlying clinical practice to help ensure that all patients are able to go home as soon as possible after their surgery.
Compliance with achieving discharge on the expected date of discharge is being monitored- When this measure was introduced, non compliance was in excess of 35% and now this is below 5%. This is being tracked through nursing and operations management to drive further improvement.

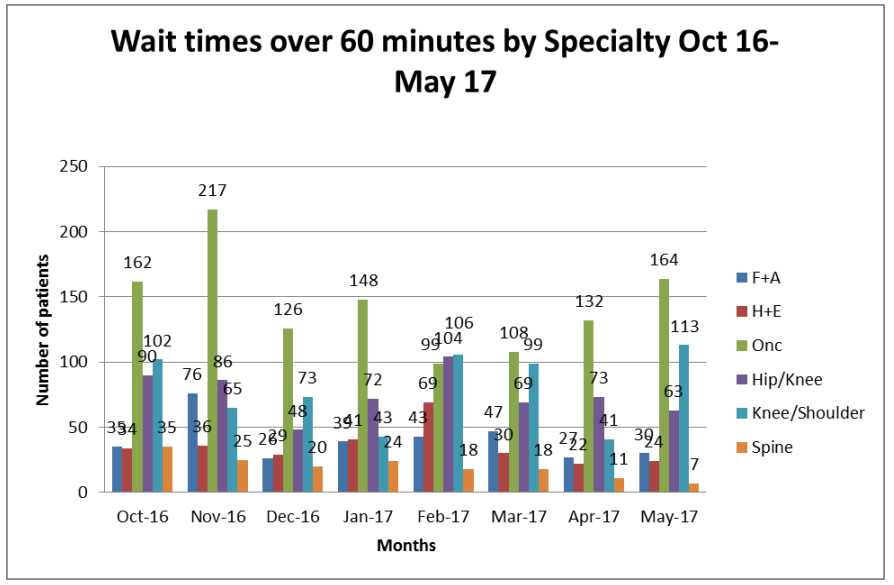
Data Quality reports are now available to show adherence to completion of 'Expected date of discharge' dates- non compliance was at over 50% and is now below 10%. This is being tracked through nursing and operations management to drive further improvement.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients









INFORMATION

Since the initial implementation of the new clinic templates in November there has been a reduction in the 30 minute wait times for patients. Since August 2016, when on average 21% of patients waited more than 30 minutes, this is now reduced to 11.5% of patients waiting in May 2017. Further work is underway, and with the introduction of the new clinic schedules on 1st May 2017, this should further reduce wait times.
There is a new standard operating procedure for any clinic running over 60 minutes late. The incident reporting system , Ulysses , has been amended to make it easier for the clinic staff to complete the incident form. An incident form is completed and a new drop down analysis is selected by the staff completing the incident . The reasons documented on the incident forms now form part of a monthly action plan and this will be shared so reasons can be addressed.
The outpatient department continue to audit its compliance against the SOP for wait time and can demonstrate 100% compliance.

The work undertaken to understand the trajectories for Hands, Feet and Arthroscopy continues and will be will be rolled out across all specialties- initial results are showing very low conversion rates from first OPD appointment to surgery, and also from second OPD appointment to surgery for some specialties.

The new Oncology clinic templates have been implemented from Monday 5th June 2017. All patients booked onto the old clinic template have been transferred across following a dedicated and controlled project management approach.

ACTIONS FOR IMPROVEMENTS / LEARNING

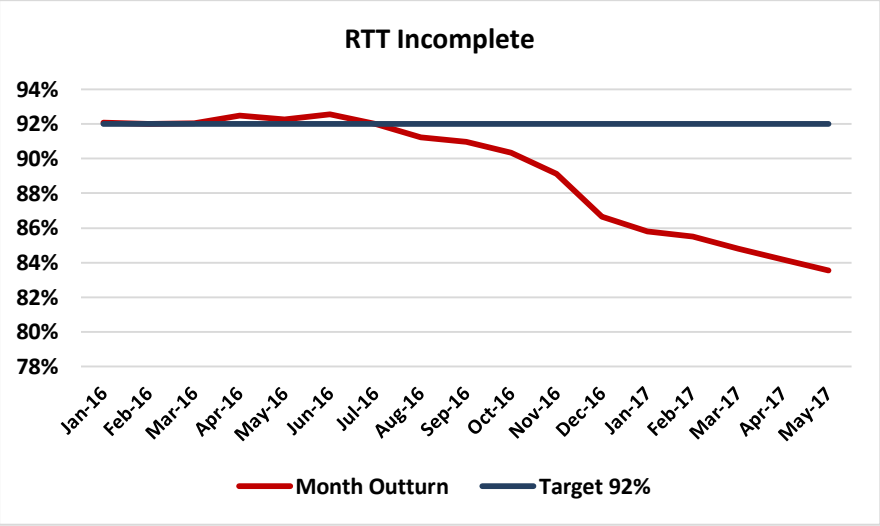
There are a range of actions as part of the CQC action plan and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

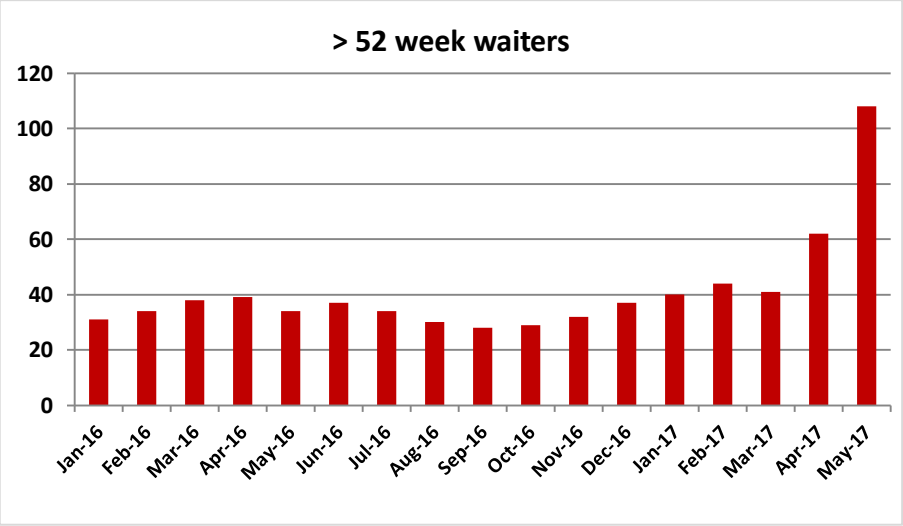
As part of the Trust's RTT recovery work, there will be a focus on out patient pathways and any patients who are in the system awaiting a follow up appointment and have become overdue, for whom a new active RTT clock should be started in line with national guidance. However, if it is found that there is a follow up appointment capacity problem, then this could worsen new to review ratios in the short term. This is being reinforced through RTT training and the clinical service managers working closely with consultants and medical secretaries to ensure that the Trust access policy is being adhered to by all involved.

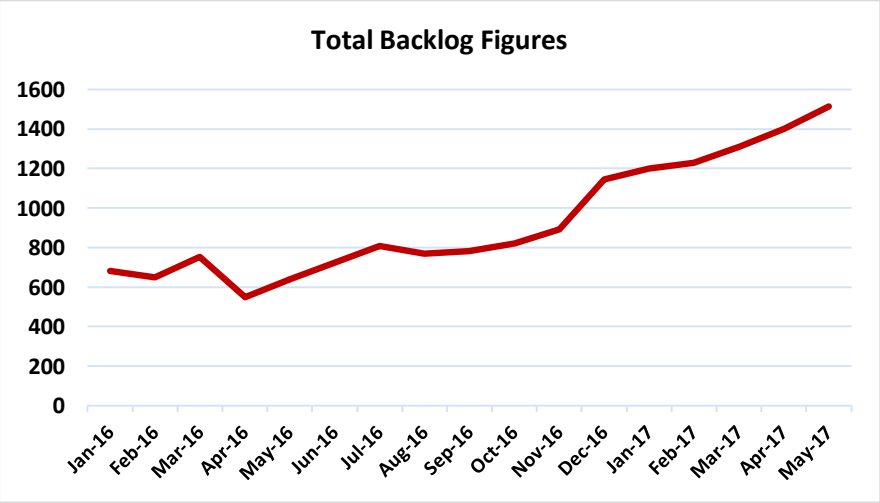
RISKS / ISSUES

Feeding back patient waiting lists to consultants weekly continues, with much focus on improving data quality arising from the validation work that is ongoing .

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets - RTT	Target / Trajectory	Actual (May 17)	Actual (YTD)
52 Weeks Waiters	-	108	108
18 Weeks Incomplete	92%	83.55%	83.86%
NHSI Performance Targets - Cancer	**Target / Trajectory**	**Actual (Apr 17)**	**Actual (YTD)**
Cancer (2 week wait)	93%	97.3%	
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	
Cancer (62 days)	85%	66.7%	

INFORMATION

RTT open pathway performance continues to cause concern. The end of May 2017 validated position is 83.55%, compared to the validated position for April 2017 of 84.17%, which was below the previous month's position of 84.79%, continuing an established pattern of month on month deterioration. This is a mixture of addressing data quality issues as they are identified as part of the ongoing validation work associated with the open pathways, and also pathways through to surgery that are not 18 week compliant for a significant number of surgeons in the majority of specialities.
As at 31st May 2017 there are a total of 1,513 patients at 18 weeks or over on the waiting list. At each milestone the number of patients at 18 weeks and over has risen since last week. Whilst these figures include both dated and undated patients, the number of patients dated 14 weeks and above is not sufficient to improve the Trust's position.
During March 2017, the Trust Chair received notification that NHSI were launching an investigation into the Trust's RTT performance. This has included the provision of various reports and data, as well as an on-site visit from 24th to 27th April 2017. An RTT Recovery Board has been established and met for the first time on 27th April 2017.

As part of our RTT recovery work, we have been accessing a range of support from stakeholders. Some of this has come via regulators, including access to NHS Improvement's Intensive Support Team, and some of this has come from other NHS organisations in the form of buddying arrangements. Through the Birmingham and Solihull STP (Sustainability & Transformation Partnership), we have now been able to access resources and expertise from University Hospitals Birmingham, who have supported RTT recovery in a range of other providers including George Elliott and Medway.

ACTIONS FOR IMPROVEMENTS / LEARNING

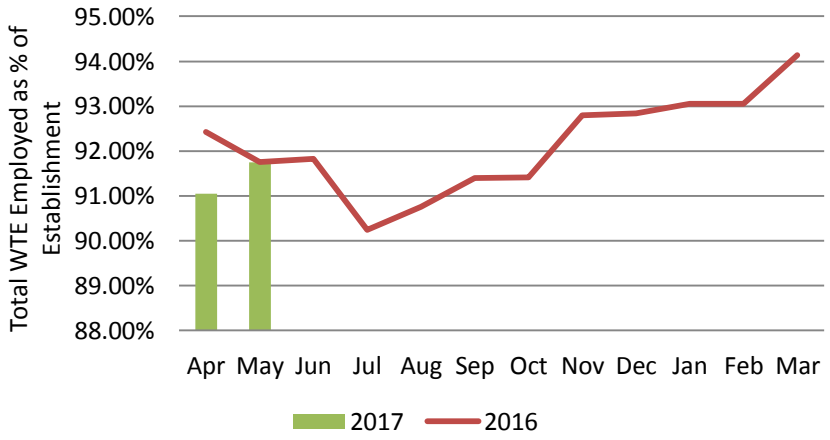
All consultants now receive an updated copy of their individual waiting list (PTL), this is sent electronically from the Operations Team every Friday to all specialities. It is expected that all medical secretaries will review their PTL with their consultant and ensure that all patients are dated in waiting time/clinical priority. From 12th June 2017 onwards, a sign off sheet is being completed by each consultant once they have reviewed their PTL.
The Operations team meet weekly to scrutinise all patients waiting over 50 weeks across all specialities to ensure all patients have definitive treatment plans and ensuring all patients requiring further validation are identified.

RISKS / ISSUES

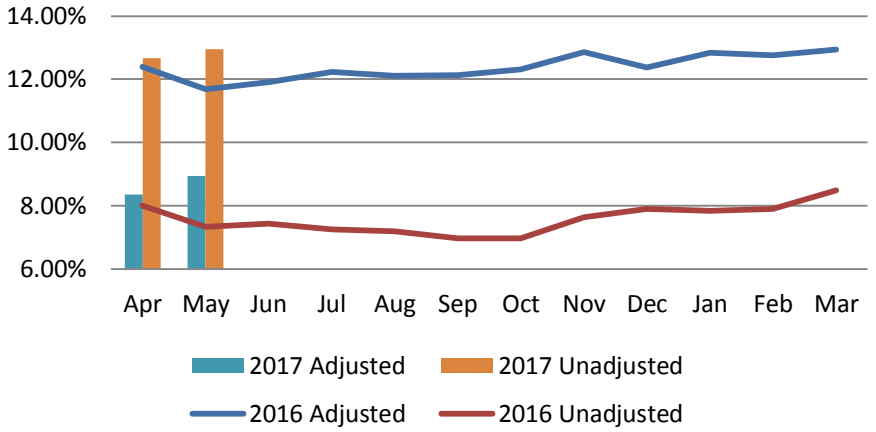
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern.
18 weeks: Significant work continues to understand the scale of the challenge with regard to open pathways, and the extent of data quality concerns. The Trust welcomes the input and expertise of NHS Improvement and the Birmingham and Solihull STP in this area.
A review is under way with regard to the robustness of cancer waiting times reporting, given the concerns with data quality around the other access targets.

15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

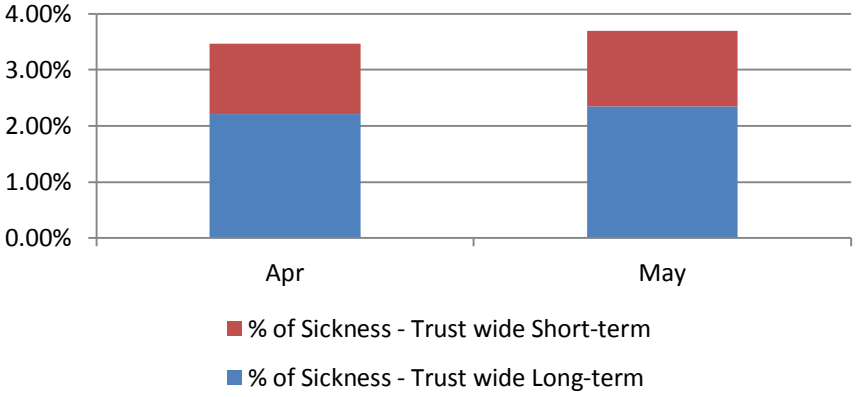
Staff in Post v Establishment



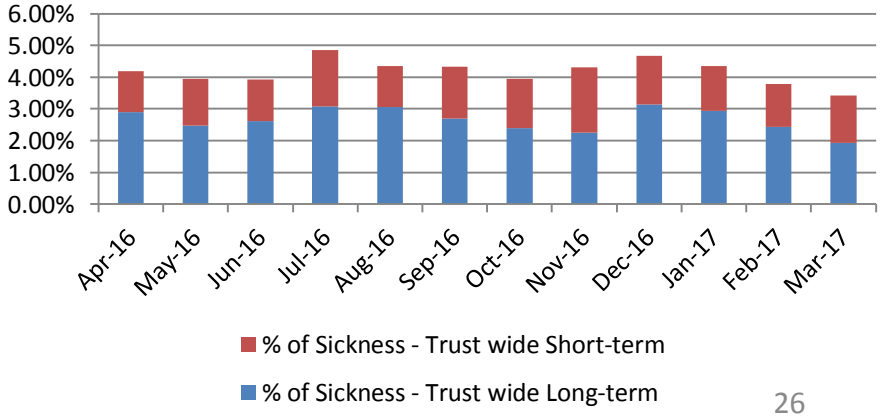
Staff Turnover



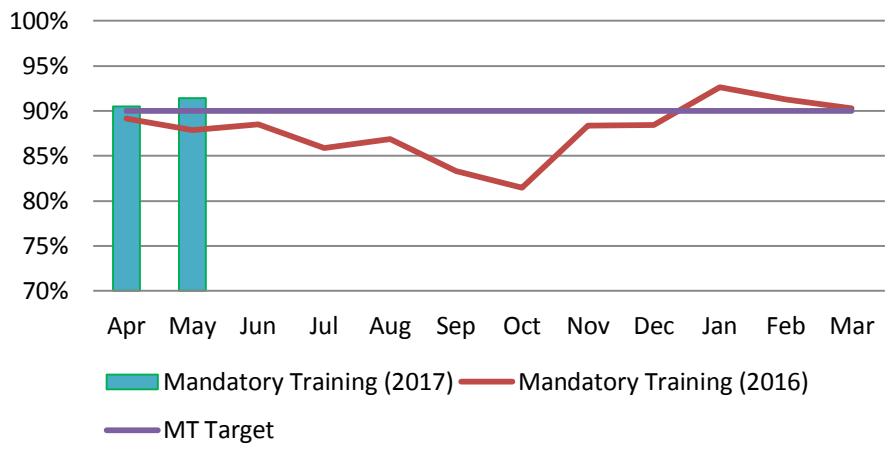
Sickness % - LT/ST (2017/18)



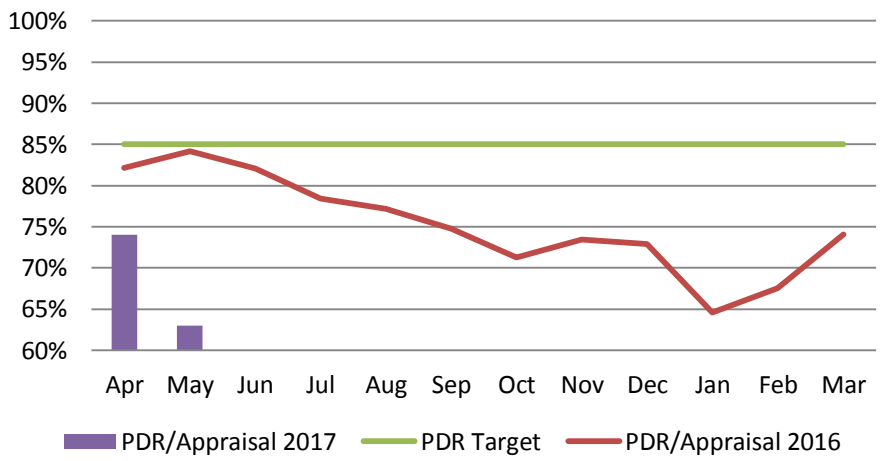
Sickness % - LT/ST (2016/17)



Mandatory Training



PDR/Appraisal



INFORMATION

In general terms, May was an encouraging one for workforce performance in sickness, vacancies and mandatory training – but appraisal is now a cause for concern.

The Trust's vacancy position improved on last month by 0.7% to 91.75%. This keeps us amber for May 2017 - but does represent progress.

May also saw a small increase (0.23%) in sickness absence, based on slight increases both in short and long term absence since the April position. At 3.69% in month, however, it represents a comparatively low figure for May (in fact, the lowest monthly May figure since 2009). This in month performance has also reduced the Trust's 12 month underlying average figure to 4.16%, turning the position "green" for the first time since June 2016.

Mandatory training was green for the fifth consecutive month. It has increased slightly this month by almost 1% and is still green at 91.46% overall. This remains an area of operational focus. Some staff are being enabled to complete modules online, which may also support compliance rates.

Performance relating to PDR/appraisals in May decreased to 62.96% (a dramatic decline of 11.03%), representing the lowest performance for almost 4 years. RTT work, harm reviews, the need to maintain statutory and mandatory training appear to have resulted in less attention being paid to appraisal than usual. Data validation work is ongoing – but this is a marked decline and needs focus.

There was slight movement in the May turnover figures. The unadjusted turnover figure (all leavers except doctors and retire/ returners) increased by 0.28% on last month with the adjusted turnover figure ("true leavers," meaning "voluntary resignations") increasing by 0.59%.

A call to action for improved appraisal performance was made via team brief in mid March2017.

Separate appraisal communications have now been issued to individual divisions in relation to their performance, asking them to validate their data, offering bespoke ESR HR support to ensure that it is correct, including training in ESR if necessary. This will also be addressed by HR Managers in their respective Divisional Board meetings.

RISKS / ISSUES

The Trust is currently has had its compliance notice from commissioners on mandatory training removed, but it will be key to manage performance in this area going forwards.

ROHTB (7/17) 005

TRUST BOARD

DOCUMENT TITLE:	**Update from the Guardian of Safe Working – Quarter 1 2017/18**
SPONSOR (EXECUTIVE DIRECTOR):	**Professor Phil Begg, Executive Director of Strategy & Delivery**
AUTHOR:	**Mr David Marks, Consultant Surgeon and Guardian of Safe Working**
DATE OF MEETING:	**5th July 2017**

EXECUTIVE SUMMARY:

The Guardian of Safe Working Hours is a senior person, independent of the management structure within the organisation (this is a separate role from, and should not be confused with, other guardian roles within the organisation, e.g. Caldicott guardian, freedom to speak up guardian), for whom the doctor in training is working and/or the organisation by whom the doctor in training is employed. The guardian is responsible for protecting the safeguards outlined in the 2016 terms and conditions of service for doctors and dentists in training. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and /or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The Trust's Guardian of Safe Working Hours for the ROH is Mr David Marks.

The Guardian is required to report routinely to the Trust Board to provide assurance that doctors in training are safely rostered and that working hours are safe and in compliance with the terms and conditions of service. The Guardian is also required to summarise for the Board any exception reports which are raised should this not be the case.

The Guardian's report this time advises that there are no exception reporting issues to advise the Board of in this quarter.

The Board is also asked to note that Mr Marks attended a national conference in London in February where it was stressed by NHS England that this vital role is supported by the Trust.

REPORT RECOMMENDATION:

Trust Board is asked to:

- Take assurance as to the safe working arrangements for doctors in training at the ROH
- Agree to accept a quarterly report to the Trust Board

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

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:
None specifically – this is a statutory role.

PREVIOUS CONSIDERATION:
None

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	28 June 2017
Guests	Mr Matthew Revell, Associate Medical Director
Presentations received	None
Major agenda items discussed	• Outcome of the West Midlands Quality Review Service (WMQRS) inspection into the Trust's arrangements for caring for the critically ill children • Quality & Patient Safety report • Harm review update • Never Event action plan • WHO checklist update • Nurse staffing updates • Quality Account priorities 2017/18 and assurance reports • Clinical Quality upward report • Children's Board upward report
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Board	• There was a significant discussion at the meeting around the letter received from the West Midlands Quality Review Service following its inspection of the Trust's arrangements concerning the services to children in the organisation and in particular out of hours cover. The response to the concerns identified have been discussed by the Trust Board in its private session. Some of the guideline and protocol concerns were reflected in the content of the Children's Board report, presented by the Executive Director of Patient Services. • Following the concerns around the level of assurance being provided by the upward reporting of the Drugs and Therapuetics Committee (DTC) described at the last Board meeting, the Executive Director of Patient services had written to the Chair of the DTC to underline the importance of attendance. In future, should he not be able to attend then a deputy would be provided. • As part of the presentation of the Quality & Patient Safety report, a number of issues and risks were raised: there had been a marked increase in the number of incidents, these largely being as a result of the ongoing 18 weeks Referral to Treatment Time pathway validation. There had been

	seven serious incidents reported during the month, some of which related to VTEs. The data for the Children's Safety Thermometer was not available due to issues between the ROH IT system and the national system. There had been two Grade 3 pressure ulcers. • It had been identified that the Trust had potentially not been compliant with the Duty of Candour regulation in some recent spinal deformity cases. The process had however been investigated and improvements made through the harm review process. • The level of appraisals being undertaken was noted to be very low at present and improvement was requested. • The Committee was very disappointed to learn that the operation on a child had been cancelled at Birmingham Children's Hospital as a result of lack of equipment. This was agreed to be an unacceptable situation and discussions are being held with BCH. • As part of the WHO checklist discussion, the Committee was advised that a review of an incident in Radiology had been undertaken. Measures had been put into place to prevent a reoccurrence, including the use of Theatreman. It was suggested that a 'Stop Before You Block' approach could be adopted in diagnostic areas. • It was reported that there was some work to do to improve the suite of Paediatric policies in the Trust and a revised timeline for the development of those outstanding was to be agreed. • Bereavement care was reported to need modernising, including the identification of better facilities for holding sensitive conversations. • There had been two incidents around the breakdown of portable x-ray machines and therefore revised business continuity arrangements needed to be identified. • It was reported that a new risk had been identified around missing patient notes – this had the potential to cause delays for patients waiting to be seen in clinic
Positive assurances and highlights of note for the Board	• The harm review process was working well and had been endorsed by the Clinical Commissioning Group and by Specialist Commissioners. The panel had sat three times to date. The pathway validation work was identifying additional patients to add into the harm review process. • Progress with the Never Event action plan was good. The action plan would be completed by January 2018. • The Committee was joined by Mr Revell, Associate Medical Director for Division 2. He reported that compliance with the WHO checklist was at 99.88% and there was anticipation that 100% compliance could be achieved in future as a result of the introduction of Theatreman.

	• Reliance on nurse agency staffing remained controlled and was below the target set. • The last meeting of the Clinical Quality Group had been a more discursive session and this had focussed on the Learning from Deaths guidance, strengthening the upward reporting into the Group and the new Serious Incident policy.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A discussion was agreed to be needed by the Trust Board around the response to the letter from the WMQRS at its next meeting • An update on the quality assurance walkabouts is to be presented at the next meeting • Administration for the DTC is to be improved and the Company Secretary will address this • Trends from the ward health check reports are to be presented to the Committee on a quarterly basis • Present the Learning from Deaths policy at a future meeting of the Trust Board or Quality & Safety Committee • Invite the Divisional General Manager for Division 3 to the next meeting to discuss the plans to address the risk around missing patient notes
Decisions made	• None beyond actions above

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

For the meeting of the Trust Board scheduled for 5 July 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	27 June 2017
Guests	Nicky Lloyd, Associate Director of Operations (in place of Jo Williams, Interim Chief Operating Officer) Alex Gilder, Deputy Director of Finance (in place of Paul Athey, Executive Director of Finance & Performance and Acting Chief Executive)
Presentations received and discussed	Procurement update
Major agenda items discussed	The meeting focussed on two major items: • Progress with the delivery of the integrated action plan for 18 weeks RTT • Finance & Performance Overview Other matters discussed were: • Application of annual leave rules for consultants • Theatreman update • Activity delivery by consultant (Service Line Reporting)
Matters presented for information or noting	• Extract of the Corporate Risk Register
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• Consultant annual leave was discussed and it was reported that in some instances the required six week notification prior to leave had not been tendered. An audit of annual leave approval was underway to check whether there was a correlation with fallow theatre lists. It was noted that the activity plan needed to be more clearly matched to the annual leave profile, particularly at times of high leave, such as February half-term and Easter. • Although the Trust was ahead of the financial plan for the month, the underlying position remained concerning. • It was reported that the Trust was behind its Cost Improvement Plan at present and some of the initial schemes planned which would now not be delivered needed to be revisited. • Theatre utilisation remained a concern, however it was hoped that the additional and new staff in theatres would assist with this position. • Cancellations were noted to remain high and the

	Committee asked for an update at the next meeting, particularly given that a significant number of cancelled operations were at the request of the patients. • Appraisal rates at present remained disappointing; some cleansing of data was planning which may improve the position however. • The Committee reviewed the service line reporting positon for each speciality; in many cases it was noted that the work undertaken was not delivering a positive contribution and there was a great variability within and between firms. A plan was being developed to address the concerns evident from the service line reporting analysis and this would be led by the Medical Director. The need for the information to be shared with clinicians was underlined. • There was significant discussion over the need for firms to own the activity targets and the Committee did not receive sufficient assurance that this was the case at present.
Positive assurances and highlights of note for the Board	**Progress with the delivery of the integrated action plan for 18 weeks RTT** • The Committee reviewed the 23-point action plan to address the 18 weeks Referral to Treatment Time target performance – this was an extract of the wider integrated action plan. • The project structure and governance around the delivery of the plan was also reviewed, which showed how the various workstreams would report into the overall project, a process that would be co-ordinated by the Programme Management Office. • The proposed templates for reporting on progress were reviewed. • The Committee agreed that further clarity was needed on reporting arrangements from the operational bodies monitoring overseeing delivery, particularly the Joint steering Forum. • Similarly, the reporting and oversight arrangements for the spinal deformity and cancer elements of the integrated plan also needed to be clarified. • It was agreed that confirmation was needed that the Programme Management Officer was adequately resourced. It was also noted that there appeared to be an over reliance on a small number of people to deliver the plan and the Committee was keen to establish that the work was given appropriate resource. Assurances were given that much of the work was already underway and there was a high confidence of delivery. • A number of the additional resources agreed by the Board to support the work were now in post or being recruited, including the new expertise from University Hospital

	Birmingham and more support for the validation process **Other matters** • The Theatreman system had gone live after significant user acceptance testing. This system was noted to be instrumental in ensuring that there was good compliance with the WHO checklist requirements. It would also more accurately record theatre sessions times as it relied on live data entry. The system would be rolled out to day case and pre-operative assessment areas before the end of July 2017. • Non-pay spend was noted to be being well controlled and agency staffing controls were working well, with some good challenge on each request made. • There was good work on length of stay and a 'Red/Green' initiative was being implemented which would ensure that there was greater focus on discharge planning. • Mandatory training rates were noted to be good. • Some significant savings would be delivered as a result of procurement work, where substitution of some items purchased with cheaper equivalent alternatives was planned. This included implants.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• An update on the audit of annual leave is to be presented at the next meeting • A demonstration of Theatreman is to be organised • Identification of evidence available to demonstrate the clinicians were owning activity targets and the service line reporting position • An update on the reasons for the increase in pay costs is to be presented at the next meeting • Cancellations update to be presented at the next meeting • Provide clarification as to the reporting arrangements for the cancer and spinal deformity action plans
Decisions made	• None – the meeting was not quorate.

Mr Tim Pile
VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 5 July 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Friday 14 July 2017

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 19th July 2017 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 1400h.

Questions for the Council of Governors should be received by the Associate Director of Governance & Company Secretary no later than 24hrs prior to the meeting by post or e-mail to Associate Director of Governance & Company Secretary, Simon Grainger-Lloyd, Trust Headquarters or via email s.grainger-lloyd@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** 19 July 2017 : 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 17 May 2017	ROHGO (5/17) 007	Chair
1410h	4	Update on actions arising from previous meeting	Verbal	SGL
1415h	5	STP update	Verbal	YB
1425h	6	Follow up to NHSI letter	Verbal	PA/TP
1440h	7	Paediatrics services update	Verbal	YB/PA
1505h	8	Complaints update	Presentation	LK
1525h	9	Update from the Board Committees: Finance & Performance Committee Major Projects & OD Committee	 Verbal ROHGO (7/17) 002 ROHGO (7/17) 002 (a)	 TP RP
1540h	10	Governor Matters: • Council of Governor membership update • Fire safety update	ROHGO (7/17) 003 ROHGO (7/17) 003 (a) Verbal	SGL SL
1555h	11	For information: • Quality & Patient Safety Report • Finance & Performance Overview	ROHGO (7/17) 004 ROHGO (7/17) 005	
	12	Any other business	Verbal	
	Date of next meeting: Thursday 5 October 2017 @ 1400h – 1600h in Trust Headquarters (followed by the Annual Members Meeting)			

MINUTES

Council of Governors v0.4

Venue Boardroom, Trust Headquarters **Date** 17 May 2017 @ 1400h

Members present

Yve Buckland	Chairman	YB
Alan Last	Lead Governor	AL
Rob Talboys	Public Governor	RT
Marion Betteridge	Public Governor	MB
Carol Cullimore	Public Governor	CC
Petro Nicolaides	Public Governor	PN
Lindsey Hughes	Public Governor	LHU
Changese Khan	Appointed Governor	CK
Paul Sabapathy	Appointed Governor	PS
Karen Hughes	Staff Governor	KH
Alex Gilder	Staff Governor	AG

In attendance

Jo Chambers	Chief Executive	JC
Paul Athey	Executive Director of Finance & Performance	PA
Garry Marsh	Executive Director of Patient Services	GM
Kathryn Sallah	Non Executive Director	KS
Tim Pile	Non Executive Director	TP
Rod Anthony	Non Executive Director	RA

Minutes	**Paper Ref**
1 Apologies and welcome	**Verbal**
Apologies were tendered from Sue Arnott, Lyn Hindley, Mel Grainger and Brian Toner.	
2 Declarations of Interest	**Verbal**

The Chairman reported that she had recently been appointed Pro Chancellor of Aston University. It was hoped that this position would strengthen the Trust's relationship with the local education providers, particularly given that Aston University was due to open a Medical School shortly.	
3 Minutes of previous meeting on 15 March 2017 and note of briefing on 12 April 2017	**ROHGO (3/17) 009** **ROHGO (4/17) 001**
The minutes of the meeting held on 15 March 2017 were approved as a true and accurate record of discussions held. It was noted that the Quality Account reported that the governor selected indicator was at green status, however as it had not been fully achieved this needed to be reconsidered.	
RESOLVED: The Council of Governors approved the minutes of the meeting held on 15 March 2017	
4 Update on actions arising from previous meeting	**Verbal**
The Associate Director of Governance & Company Secretary reported that the Complaints Manager had hoped to join the meeting to discuss the Trust's complaints situation, however due to the weight of the agenda this had been deferred to the next meeting.	
5 Update on NHS Improvement actions	**Verbal**
It was reported that NHS Improvement (NHSI) had indicated that that they were of the view that the Trust had been slow to react to the 18 weeks RTT issues, on which the Council of Governors had been previously briefed. Plans were being developed in response to these concerns and more resources were being put into the organisation in the form of validators who would review the current open pathways. A letter was expected from NHSI setting out a series of legal requirements on the Trust to rectify the position. A key area of concern for the regulators and the Board remained the absence of a fully integrated action plan, which addressed issues with 18 weeks RTT, cancer tracking and those cases where individuals had waited for treatment over 52 weeks, these being spinal deformity cases predominately. The Board would review the position and an action plan would be submitted to NHSI by the end of the week. Concerns were also expressed around capacity and capability around RTT and more resourcing would be arranged, over and above that already in place to deal with the complexity of issues and quality concerns identified by regulators and commissioners. It was reported that according to NHSI, there remained a lack of clinical ownership	

and engagement. Much better reporting systems would also be needed.

In terms of Paediatric care and 52 week waits, these cases impacted significantly on the overall 18 weeks RTT. However treatment of these was reliant on capacity being provided by Birmingham Women's and Children's Hospital NHS FT (BWC); this would be a point of challenge for NHSI.

Validators were in place in the Trust and new posts within the Operations structure were being filled. It was noted that a balance was needed to be able to react rapidly to the issues that the Trust faced, while ensuring that lessons learned from previous experiences around interims and consultants were harnessed. NHSI had indicated that they would also be sourcing some additional resources for the Trust and would consider peer review.

As part of the regulatory intervention, there would be consideration as to whether the Trust moved from Level 2 to a Level 3 under the Single Oversight Framework.

The Chief Executive provided an update on patients waiting for treatment 52 weeks or over, a number of which needed to access Paediatric Intensive Care Unit (PICU) beds at BWC. Over time, a number of influences had exacerbated the situation, including demand & capacity, particularly due to babies that were living longer with serious conditions, which needed clinical support. A process was in place to 'bid' for PICU beds, based on clinical assessment, although this often meant that the ROH patients did not rank high enough to secure the bed, particularly when this was against children who needed urgent organ replacement. It was reported that the Trust had formally asked commissioners for access to a PICU bed each Wednesday and to treat contingency patients if a PICU bed became available at any other time. This matter had been escalated and any other mechanisms to address this were being explored based on legal advice. Strategically, there were some difficult decisions to make. Alongside this, there were changes on a national level around commissioning of specialist services that were planned, including only commissioning contracts of £100m or more, which the Trust would not meet this for any aspect of its services. Therefore an alternative contract mechanism was being considered.

A staff governor commented that from a staff perspective, there was concern that there were patients waiting a long time while the wards remained partially empty, therefore there seemed a mismatch. It was acknowledged that there remained work to do to ensure that there was efficient patient flow. The Trust was on plan for activity until the beginning of May but then there had been variability since then, partially explained by the bank holidays. There were some reductions in length of stay in some specialities, such as primary hip and some diagnostic procedures which were now being handled as day cases rather than inpatient procedures. The beds were not

currently a constraining factor but restricted theatre lists and surgeon availability were an issue. Individual consultants were being provided with their own waiting list information and the move to centralised booking would reduce inefficiencies. When the change was made to even out waiting lists, this could be challenging to the staff's usual patterns of working and therefore a range of measures had been undertaken to create clinical engagement ahead of this.

There was concern as to whether retirements and staffing implications had been considered, as these had the potential to create a bigger burden on those remaining. It was reported that new spinal surgeons had been recruited, particularly with those with an interest in spinal deformity which would assist. Advertisements had been issued for additional surgeons to coincide with the offering of additional capacity from BWC from early 2018. Plans were also being discussed around those due to retire in the next few months.

In terms of theatre capacity at the ROH, it was reported that c.10% theatre slots were not filled. One theatre (Theatre 4) was only suitable for certain types of work, meaning it could be under utilised. The ability to flexibly move consultants around to the right points in the week where there was availability was a challenge. Annual leave planning also needed to improve. Some firms worked flexibly at present, with others less so, some of which was due to personal preference or due to commitments in other hospital & private practice. This was being built into the job planning, although as yet, this had not been fully harnessed. There was further work to do to even out the productivity of some consultants. There needed to be a framework set within which consultants needed to work. It was noted that currently a session started at 0800h and ran until 1700h and sometimes evening and weekend working was needed. There could also be restrictions due to availability of other professionals, equipment or additional support. A new Theatre Productivity programme sponsored by NHSI had been implemented. Start times and times between procedures was also variable and needed to be addressed from a variability point of view, drawing on best practice where possible.

There was a query as to whether the 18 weeks RTT issue had developed as a result of the Trust being overly focussed on the financial position. It was noted that RTT would not be an issue if activity was performing well. Demand for services was also high, however there was an inability to process the number of patients needing treatment within the required timeframe. The levels of theatre capacity and efficiency were the key issue. Benefit would be gained when consultants owned their specific targets; this would change attitude and behaviours. In terms of the attention on finances, there remained a keen focus on this, however this was part of the strong emphasis on activity recovery. It was reported that from the next Finance & Performance

Committee, the meetings would focus on progress against the RTT action plan. The Audit Committee also had a role to play in terms of monitoring delivery of the internal audit actions around RTT. The Non Executives were asked whether the Executive Team had a clear grip on this matter. It was reported that there was a focus on recovery, however this was a long journey. The Trust was behind where it should be in terms of an action plan on RTT and there needed to be a movement at pace to address this. This had been a strong message to the Executive from the Board.	
6 Chief Executive's update	**Verbal**
The Chief Executive reported that an external firm had been contracted to help with the Programme Management Office of the RTT improvement work; they would implement a range of systems to manage the RTT recovery and address a number of the recommendations from NHSI. Following the discussion after the last briefing of the Council of Governors, work had been undertaken to issue a joint communication between staff governors and the Chief Executive. In terms of cybersecurity, it was reported that the Trust had not been affected by the recent attack and all the necessary precautions and remedial work had been undertaken. There had been a national cascade through Chief Executives and there had been much activity over the weekend. Those managing the issues were thanked. The Paediatric services at BWC were reported to have been suspended since March on the basis of decontamination concerns, given that the wrappers for some theatre kits had been breached. A solution was awaited but a resumed date was anticipated for later in May 2017. In terms of adult services, the future arrangements in the Birmingham & Solihull areas as a result of STP development were still being considered. The possibility of having an orthopaedics workstream was being driven forward. The commercial collaborations needed for transformation change were being progressed which would support improvement in patient care. This would be developed over the summer.	
7 DRAFT Annual Report (including Quality Account) & Accounts 2017 (PRIVATE ITEM)	**ROHGO (5/17) 002 ROHGO (5/17) 002 (a) ROHGO (5/17) 002 (b) ROHGO (5/17) 002 (c)**
The press and public were excluded for this item on the basis that publicity on these could be prejudicial to the conduct of business. The annual report and accounts were also confidential until laid before parliament later in the summer.	

The Associate Director of Governance & Company Secretary reported that a special Board meeting was arranged for Tuesday 30 May to provide Board members with the final Annual Report and Accounts for their approval. The version presented to the Council was the draft version which was yet to reflect comments by all Board members and the external auditors. The detail of the annual report and accounts was presented. The final annual report and accounts and auditor's report on the accounts would be presented to the Council of Governors at the Annual Members Meeting (to include governors) on 5 October. All were invited to provide any comments on the annual report as a whole to the Associate Director of Governance & Company Secretary.	
8 18 weeks RTT recovery plan	**Verbal**
The Executive Director Patient Services joined the meeting to discuss the plan for 18 weeks recovery going forward. It was reported that there were now some clear trajectories of recovery for each speciality, which took the position to the end of the current financial year. There was good engagement by clinical service leads which would move down into discussions with individual consultants. An integrated action plan had been developed to respond to 18 weeks challenges and data quality concerns. An oncology action plan was also in place. Given that treatment of some patients had been delayed, then a harm review was now in place, with a harm committee having been established, this being chaired by the Executive Medical Director. This had sat twice, in addition to local harm fora. The regularity of the harm review panel meetings was being reviewed to ensure that there was sufficient pace behind the review. The CCG also attended the harm meetings. A cohort of patients in spinal deformity were being reviewed, with a more in depth root cause analysis being undertaken and individual patients being approached when it was necessary to apply the Duty of Candour process. Alongside this, there was a review of adolescent patients as to how they were progressing as they aged to understand those that needed priority treatment. The review of harm had evolved and prolonged pain was part of the judgement of harm when the patients were reviewed by the harm panel; distinction was made between expected pain as a result of the condition against that caused by a prolonged wait for treatment. A training programme had been developed and delivered around 18 weeks RTT management and clinical service leads & consultants were also being trained, which would be followed up by an open training session. More robust management had been seen since some of the service managers had	

come into post; more were to join in large & small joints and oncology. Work was underway with the NHSI Intensive Support Team (IST) to assist with embedding the recovery of RTT management. Locally, the information team had created more information, particularly down to consultant level, which had assisted with developing individual trajectories. The team of validators was working to plan, where at the end of June, the extent of validation expected would have been achieved. The future plans for validation were also being thought through. Further work was needed to ensure that should the rules on RTT management change in the future, this would be deployed. The governors commented that it was important to use electronic systems to support processes where possible. A move away from a decentralised system was also agreed to be needed to reduce the risk of the referrals process going awry. It was noted that there were some systems in place but more work was being done to develop the patient tracking list. The importance of the governors in challenging this process was emphasised.	
9 Data quality update	**Presentation**
The Executive Director of Finance & Performance delivered a training session on data quality. It was reported that there was more work to do to develop the data quality system, including the development of a data warehouse to harmonise solutions. Some progress was being made to understand matters linked to coding around the depth of information being collected. The Trust was better at collecting the information and ensuring that the Trust was getting properly paid for the work being done through a check and challenge perspective. Data was being used to make better decisions and to ensure that people could look at data and challenge on the robustness of this. It had been identified that improvements were needed in terms of the accuracy of the times when patients were booked into and out of wards. Where there were a number of local or subsystems for recording information, then a check back to the main systems was also being undertaken. It was suggested that the Head of Business Intelligence joined a future meeting to present further information on the Data Warehouse. It was reported that there was a data quality committee, although the main focus of this was on RTT, therefore the committee had been suspended at present to avoid duplication. In terms of the resourcing of the Business Intelligence team, there was a current vacancy which needed to be filled to provide additional support and additional skills needed were being reviewed.	

10 Complaints report	**Presentation**
It was noted that this item was deferred to the next meeting.	
11 Update from the Board Committees – Audit Committee and Finance & Performance Committee	**Verbal**

The governors considered the written update from Rod Anthony. He described the purpose and role of the Committee.

The membership was himself, Tim Pile and Kathryn Sallah. Executive directors attended, including the Executive Director of Finance and Performance who was a standard attendee and the committee was also joined by internal and external auditors.

The areas of focus for the last financial year were reported to have been:

- Financial Performance and the Going Concern principle for the Trust (and the management of cash)
- Support the Board in further improving the Board Assurance Framework
- Reviewing the effectiveness of internal and external audit functions
- Delivering improvement actions relating to:
    - The management of stock (particularly in theatres)
    - Improving compliance with agency and temporary staff targets
    - Referral to treatment recording and reporting
    - Operational performance and waiting times
- The following action areas were delegated to the Q&S committee:
    - Controlled drugs
    - Pharmacy stock
    - Duty of Candour
    - Consent procedures
    - Theatre closures

The Committee would undertake a benchmarked position in terms of its operation and the Chair of the Audit Committee would attend the Audit Committee of the Dudley Group of Hospitals NHS FT to glean any best practice. There would be additional focus on recommendation tracking and clearance of actions, given that there had been deterioration in the responses to actions raised; the trackers would be cleared by the September deadline. The auditors would be focussed in a targeted way in areas where there was anticipated additional focus needed. A further area of focus was the agreement of the Trust's risk appetite to gain consensus over the level of assurance appropriate to key operational areas. An Audit Committee workshop

would be used to discuss this. The detail of the discussions at the Audit Committee at the end of April was noted. It was noted that a dummy e-mail had been issued internally asking people to click on a link which 24 people had opened. This had prepared the organisation well ahead of the cyber attack and raised awareness of the dangers of accessing unsolicited e-mail and websites. It was noted that this was good work. It was suggested that a refresher e-mail could be issued at a later date. Tim Pile provided an update on the work of the Finance & Performance Committee. He reported that whereas there was evidence of improvement in the operations of the Trust, there remained a concern over sustainability in the longer term. Although there was good progress against the recovery workstreams, all members of the Committee had encouraged the plans to be delivered more speedily. Costs appeared to be under control and although the year end Cost Improvement target had not been met then it was still an exceptionally high levels of savings that had been achieved. Income and deficit levels were in line with year end position, however the positive April position was due to costs control rather than activity and income which remained concerning. In terms of progress, run rate was currently below £100k per month to meet the required end of year target. Cash was reported to be under pressure and external cash support was needed. Additionally, there had been improvement in DNAs and cancellations. It was reported that there would be some costs incurred to support the RTT recovery measures. In terms of agency spend, it was noted that this was elevated at a time when there was less activity and sickness absence was low, which appeared to be an anomaly. It was noted that this level of spend was reduced compared to previous months, although the recent upturn may be due to annual leave. There was also a high number of locum doctors being used, which was partially as a result of decisions from the deanery. The agency and locum working group would be reconvened to review the use of temporary staffing. The Head of HR Operations was also reviewing the policies to ensure that annual leave was being taken equitably and rules applied rigorously.	
12 Governor matters	**Verbal**
There were none.	
13 Feedback from Patient and Carers/Council	**Verbal**
Stella Noon joined the meeting and provided the key highlights of the work of the Patient & Carers' Council. There had been some concerns around car parking, which would be taken up with the Executive Director of Strategy & Delivery. The issue over the charging of community	

drivers was also to be investigated. It was suggested that the car parking services provider needed to address the machine operations and that it would be beneficial if the charges were made once the patient or visitors had finished their visit rather than at the start. Mary Higgs was thanked for her support and minute taking of the meeting.	
14 For information	**ROHGO (5/17) 005** **ROHGO (5/17) 006**
The Council of Governors received the Finance Overview and Patient Safety & Quality report for information.	
15 Any other business	**Verbal**
There was none.	
Date of next meeting: Wednesday 19 July 2017 @ 1400h – 1600h in Trust Headquarters	

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

ROHGO (7/17) 002

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Major Projects and Organisational Development Committee**
SPONSOR (EXECUTIVE DIRECTOR):	**Richard Phillips, Chair of the Major Projects & OD Committee**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**19 July 2017**

EXECUTIVE SUMMARY:

The attached outlines the purpose of the Major Projects & OD Committee, this being one of the committees of the Trust Board established in January 2017.

REPORT RECOMMENDATION:

This report is for information only.

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	x	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:

Good governance

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHGO (7/17) 002 (a)

The Royal Orthopaedic Hospital NHS Foundation Trust

MAJOR PROJECTS AND ORGANISATIONAL DEVELOPMENT COMMITTEE

Report to the Council of Governors on 19 July 2017

1 EXECUTIVE SUMMARY

1.1 Replacing the Transformation Committee, the Major Projects and Organisational Development Committee (MPODC) is one of the six formal Board committees, shown in Figure 1 below:

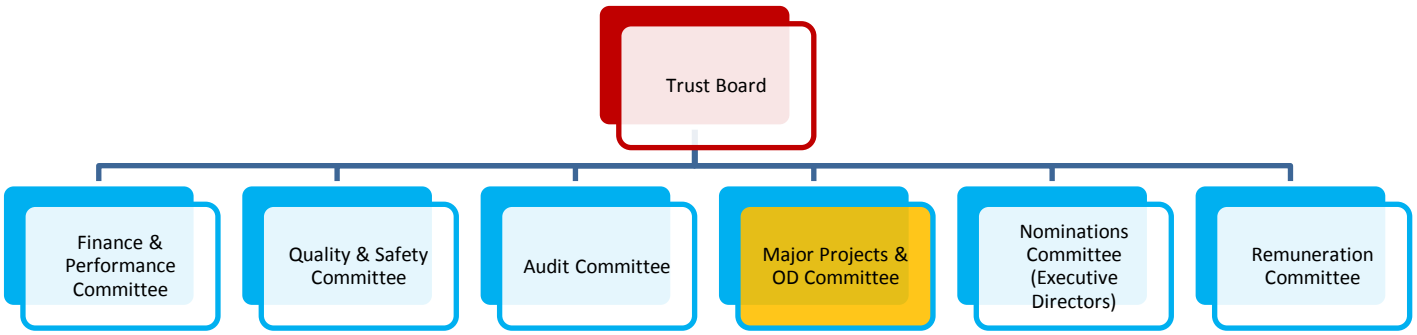


Figure 1: *Trust Board and Committee structure*

1.2 The Major Projects & OD Committee was formed in early 2017 to provide the Board with assurance concerning the arrangements for the delivery of major projects and key initiatives in support of the Trust's strategic plan. It also seeks assurance on the robustness of the plans to deliver the Trust's key strategies. The Terms of Reference were approved by the Trust board in January 2017 and adopted by the Committee at its first meeting on 5 April 2017. The Committee has met on three occasions to date, once in an extraordinary meeting.

1.3 The Committee is chaired by Richard Phillips, Non Executive Director.

2 MAJOR PROJECTS

2.1 It was agreed that the MPODC should consider strategic projects. All other operational projects will be reported by exception and/or where there are risks to completion.

2.2 Major projects currently include:

- Network Infrastructure Update
- Electronic Prescribing and Medicines Administration (ePMA)
- Regenerative Medicine Laboratory onsite at ROH

2.3 The Committee has also met with a potential strategic partner who can offer technological solutions that have the potential to improve the efficiency of operations at the Trust. This however is currently in development and therefore the exact details remain commercially confidential at present.

3 ORGANISATIONAL DEVELOPMENT

3.1 It is noted that staff engagement is one of the key Board priorities and the Committee's remit is to provide oversight of this on behalf of the Board itself.

3.2 Items for discussion within this area at the Committee have included to date:

- Staff survey
- Communication and engagement strategy including GP engagement, community involvement, membership and staff.
- Workforce strategies
- Workforce and organisational development governance structure
- OD and inclusion update
- Development of the Knowledge Hub

4 REPORTING AND ESCALATION

4.1 Various sub-groups feed into MPODC, including:

- People Committee (not yet formed but will deliver the objectives of the now defunct Workforce and Development Committee)
- Other Major Projects
- Network Infrastructure Committee

all of which have several other groups reporting to them.

The reporting arrangements are shown in Figure 2, overleaf.

4.2 MPODC meetings are held quarterly with additional meetings where necessary. The approved minutes from each Committee meeting are presented to the next private Trust Board meeting for information. The Chair of the Committee will attend to provide assurance to the Trust Board; highlighting the key points from discussions, matters of concern or risk and matters of positive assurance.

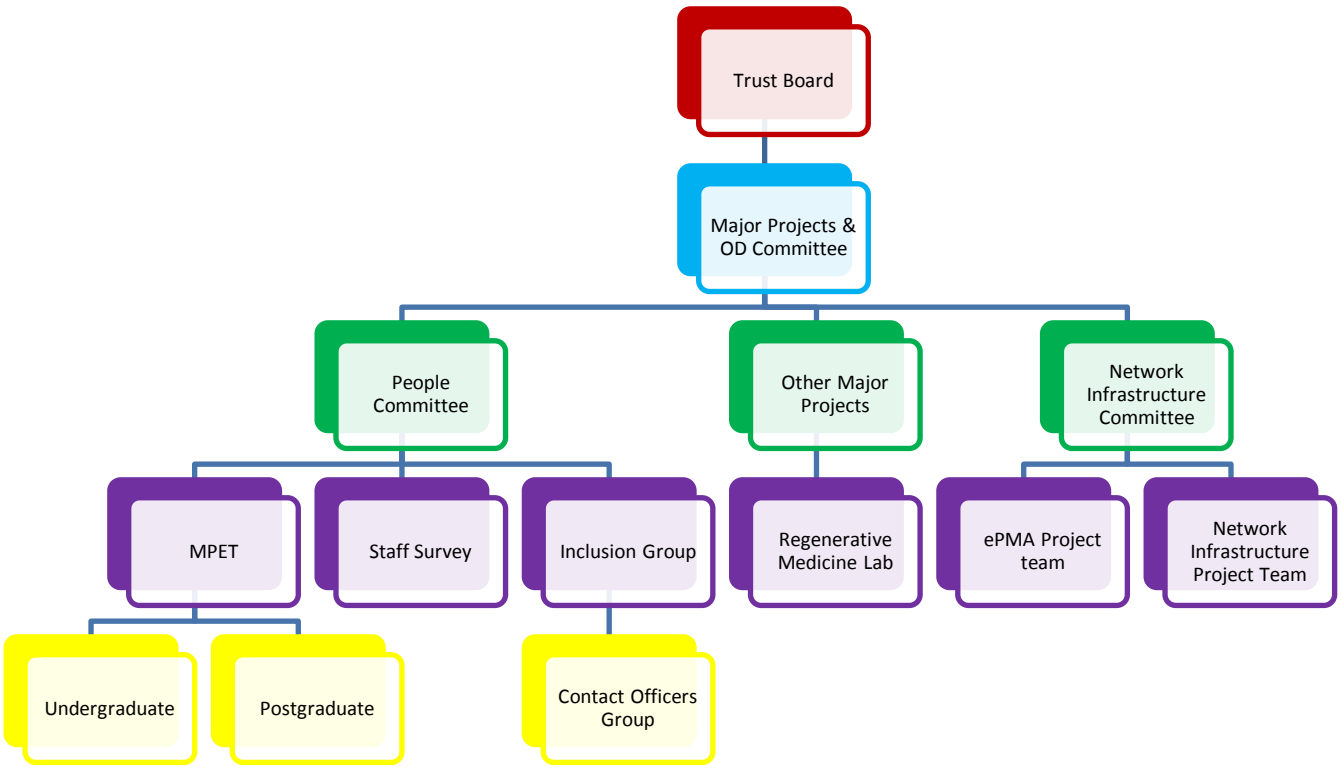


Figure 2: *Major Projects & OD Committee reporting structure and governance arrangements*

The Committee will provide an annual report to the Trust Board on the effectiveness of its work, including successful delivery of its work plan.

Richard Phillips
Non Executive Director and Chair of the Major Projects & OD Committee

11 July 2017

ROHGO (7/17) 003

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Council of Governors Membership Update**
SPONSOR:	**Dame Yve Buckland, Chairman**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**19 July 2017**

EXECUTIVE SUMMARY:

Following the resignation of a non-clinical staff governor earlier this year the process of electing a replacement has commenced.

In addition, appointed governors are required from Birmingham City University and University of Birmingham as there has been no representation from these institutes for some time.

The purpose of the paper is to update the Council on the progress of filling these vacancies.

REPORT RECOMMENDATION:

The Council is asked to note the content of 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		Environmental		Communications & Media	x
Business and market share		Legal & Policy	x	Patient Experience	x
Clinical		Equality and Diversity	x	Workforce	x

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

None specifically

PREVIOUS CONSIDERATION:

None.

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

FOR INFORMATION

The Royal Orthopaedic Hospital NHS Foundation Trust

COUNCIL OF GOVERNORS MEMBERSHIP UPDATE

Report to the Council of Governors on 19 July 2017

1 EXECUTIVE SUMMARY

1.1 Following Lyn Hindley's resignation on 22 June 2017, Electoral Reform Services (ERS) was approached to commence the process to elect a replacement non-clinical staff governor.

1.2 At the same time, Birmingham City University and University of Birmingham were approached to nominate an appointed governor as there has been no representation from these institutes for some time.

2 NON-CLINICAL STAFF GOVERNOR

2.1 It is expected that nominations for the non-clinical staff governor will open on Thursday 20 July 2017 and the process should be completed, with the declaration of results, on Friday 15 September 2017. The full timetable is shown below:

Trust to send nomination material and data to ERS	Thursday, 6 Jul 2017
Notice of Election / nomination open	Thursday, 20 Jul 2017
Nominations deadline	Friday, 4 Aug 2017
Summary of valid nominated candidates published	Monday, 7 Aug 2017
Final date for candidate withdrawal	Wednesday, 9 Aug 2017
Electoral data to be provided by Trust	Friday, 11 Aug 2017
Notice of Poll published	Wednesday, 23 Aug 2017
Voting packs despatched	Thursday, 24 Aug 2017
Close of election	Thursday, 14 Sep 2017
Declaration of results	Friday, 15 Sep 2017

3 APPOINTED GOVERNORS FROM BIRMINGHAM CITY UNIVERSITY AND UNIVERSITY OF BIRMINGHAM

3.1 Prof. Ian Blair of Birmingham City University was contacted to request a nomination for a Stakeholder Governor. This matter will be discussed at the next Faculty Executive Group meeting to be held on 18 July. An update is expected on 19 July 2017.

3.2 Prof David Adams, Dean of Medicine of University of Birmingham was contacted to request a nomination for a Stakeholder Governor. He has put forward a nomination,

which is currently still being agreed with the individual. It is likely that representation will be from the October meeting.

4 RECOMMENDATION

4.1 The Council of Governors is asked to receive and accept this update.

Simon Grainger-Lloyd
Associate Director of Governance & Company Secretary

14 July 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

June 2017

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Patient Services
AUTHOR:	Ash Tullett	Clinical Governance Manager

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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 and the CQC for routine engagement visits.

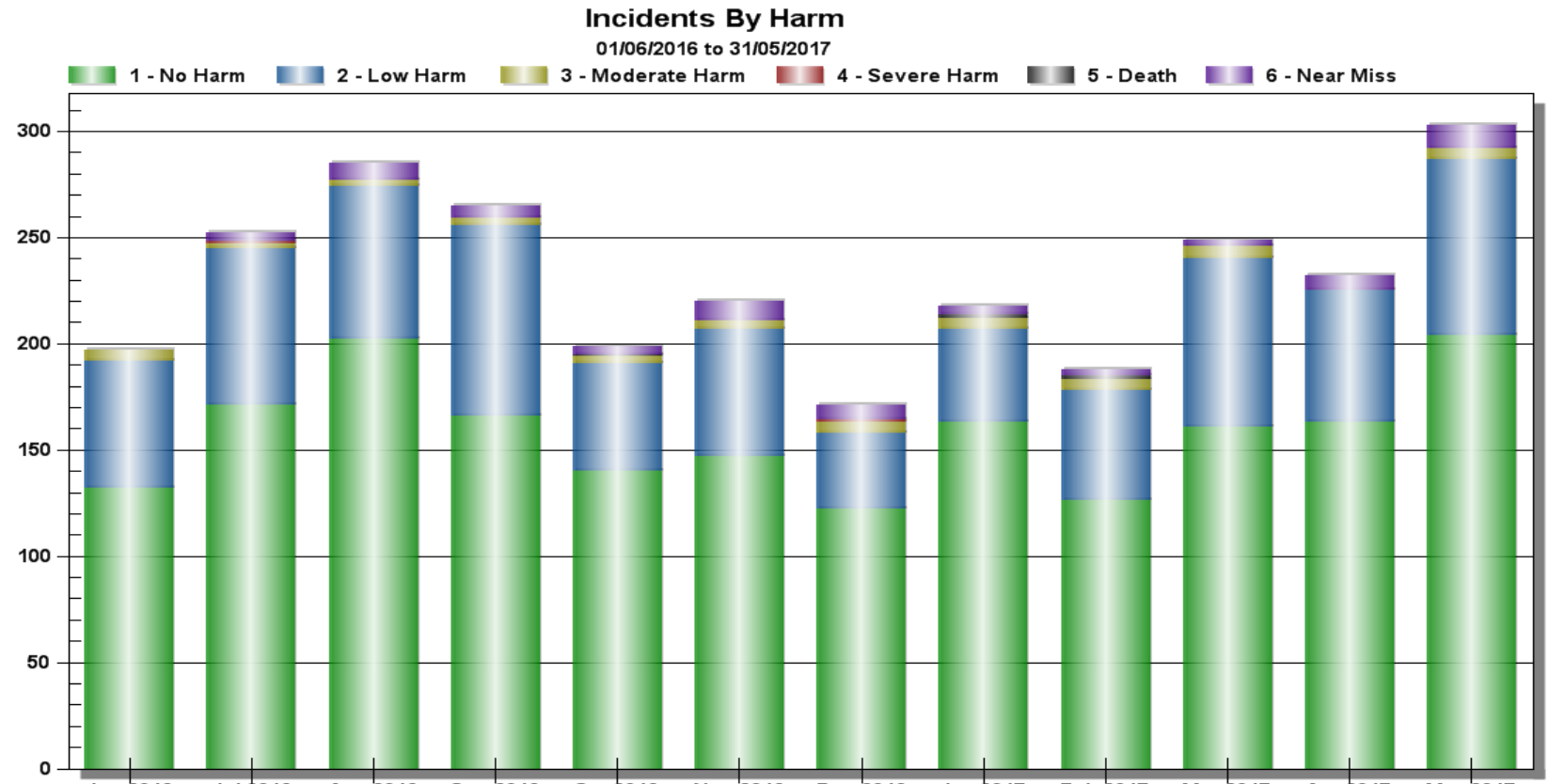
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

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.

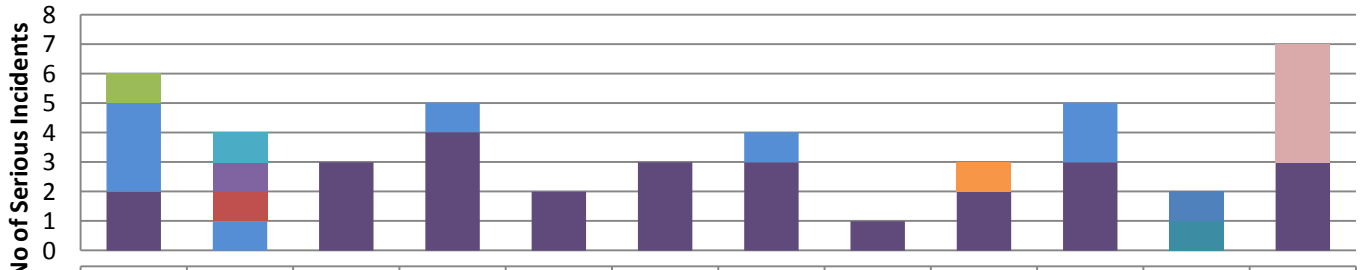


Month and Year	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017
1 - No Harm	132	171	202	166	140	147	122	163	126	161	163	204
2 - Low Harm	60	74	72	90	51	60	36	44	52	79	62	83
3 - Moderate Harm	5	2	3	3	3	4	5	5	5	6	0	5
4 - Severe Harm	0	1	0	0	0	0	1	0	0	0	0	0
5 - Death	0	0	0	0	1	0	0	2	2	0	0	0
6 - Near Miss	0	4	8	6	4	9	7	4	3	3	7	11

INFORMATION
In May 2017 there was a total of 303 Incidents reported on the Ulysses incident management system. This is an increase to the previous month. The increase is likely to be the result of the RTT revalidation work within the trust. The breakdown of those incidents is at follows 204 – No Harm 83 – Low Harm 5 – Moderate Harms 11 – Near Miss
ACTIONS FOR IMPROVEMENTS / LEARNING
As of March 2017 the new quality dashboards are in use and include all quality indicators. The Trust now has one central repository for all KPIs that can be used to populate any quality report. This includes KPIs on incidents and staffing information. This dashboard is to replace the ward health check that was previously found in the Quality report.
RISKS / ISSUES
The Trust has had issues with Managers not reviewing and updating the incidents in a timely manner. The Governance Team have developed reports that highlight those areas with open incidents and these will be discussed at the weekly Governance meetings. The first reports will go live 1st June 2017 and will be available for all areas and departments. An Agenda item is to be added to clinical quality group to address the open incidents that remain in the divisions.

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.**

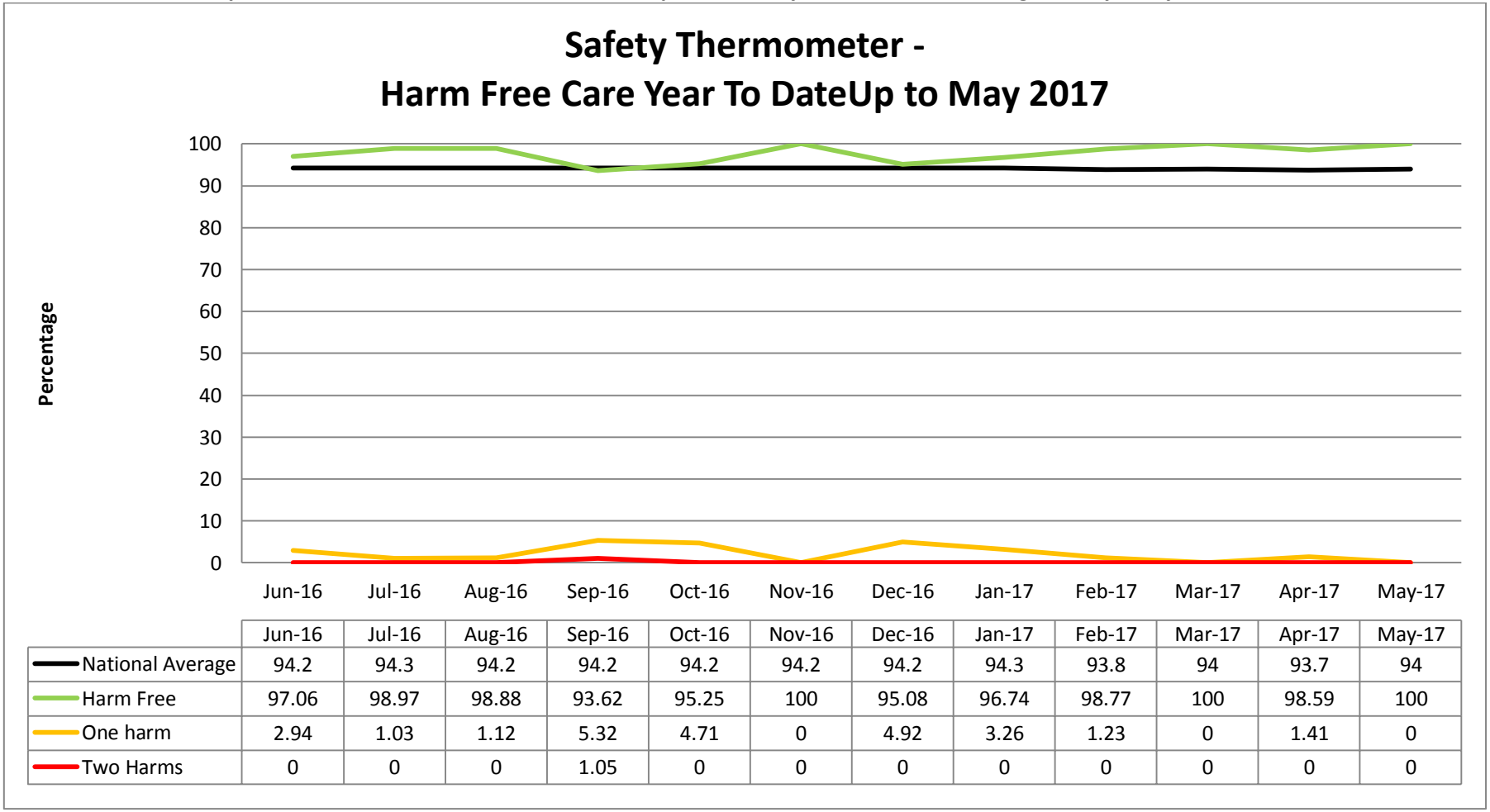
Serious Incidents Declared Year to Date to May 2017



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
RTT Harm review												4
Emergency transfer to HDU												
Exposure to hazardous substance									1			
Wrong Site Incision		1										
Wrong Implant		1										
Suspension to services	1											
RTT Data Issue											1	
Wrong side injection												
Suspension of Service (BCH Spinal)											1	
Slips, trips & falls		1										
Pressure Ulcers	3	1		1			1			2		
VTE meeting SI criteria	2	0	3	4	2	3	3	1	2	3		3

INFORMATION
There were **seven** Serious incidents declared in May 2017; These are due for submission with the Commissioners July 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
Two Serious Incident reports were submitted to the Commissioners during May 2017. The incident was reported in the February 2017 Quality report. This incident submitted was a avoidable VTE **Incident 1** **19881 – Unavoidable VTE** **Learning** With specific regards to prevention of VTE the recommendation is that ROHFT continue to practice in line with current guidance. Recommendations to further improve practice for future patients include: - Ensure 24 hour post admission risk assessment is completed, even if patient admitted on a Saturday - Ensure Recovery documentation clearly details mechanical prophylaxis. - Review weekend physiotherapy protocols to ensure these accommodate the needs of patients planned to be operated on at weekends and whether these patients can be mobilised by competent nursing staff. Staff to adhere to dosage in Trust guidelines **Incident 2** **19815 - Unavoidable VTE** **Learning** Following a thorough review of the notes the patient was risk assessed appropriately, prophylaxis prescribed. Unfortunately the patient didn't ask for help putting the support stockings back on; VTE leaflet given
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.**

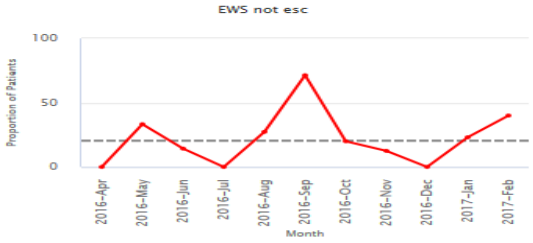


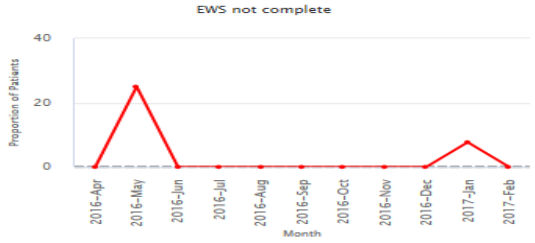
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
National Average	94.2	94.3	94.2	94.2	94.2	94.2	94.2	94.3	93.8	94	93.7	94
Harm Free	97.06	98.97	98.88	93.62	95.25	100	95.08	96.74	98.77	100	98.59	100
One harm	2.94	1.03	1.12	5.32	4.71	0	4.92	3.26	1.23	0	1.41	0
Two Harms	0	0	0	1.05	0	0	0	0	0	0	0	0

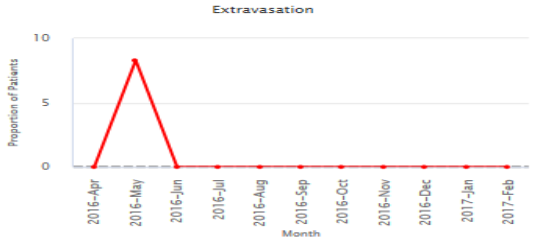
Children and Young Persons' Safety Thermometer

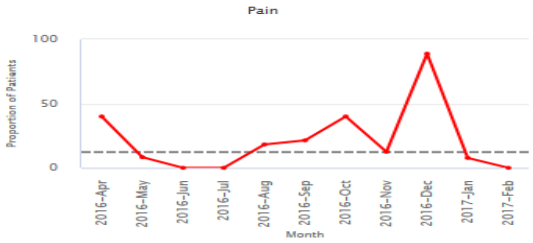
The Trust has started to submit data to the Children and Young Persons' Safety Thermometer. The Trust uploads data from ward 11 and HDU and has been reporting data since April 2016. The table below illustrates the data that is recorded.

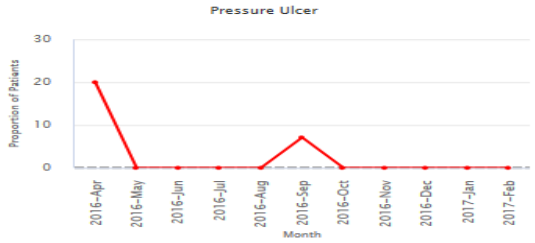
The Children & Young People's Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in children and young people's services. As a point of care survey it integrates measurement for improvement into daily routines and supports improvement in patient care. Data are collected on a single day each month and enables wards, teams and organisations to understand the burden of harm to children and young people. Data can be used as a baseline to direct improvement efforts and then to measure improvement over time.

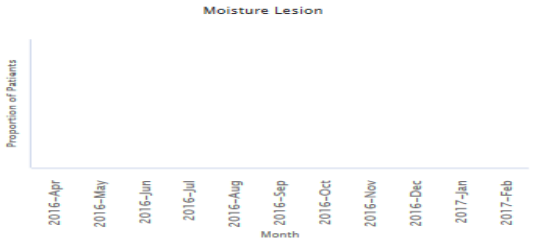


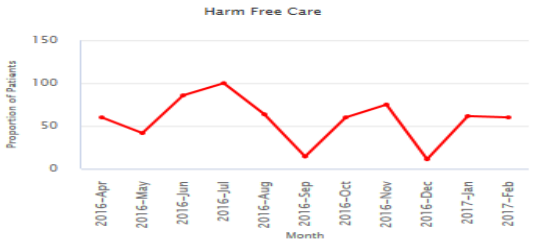












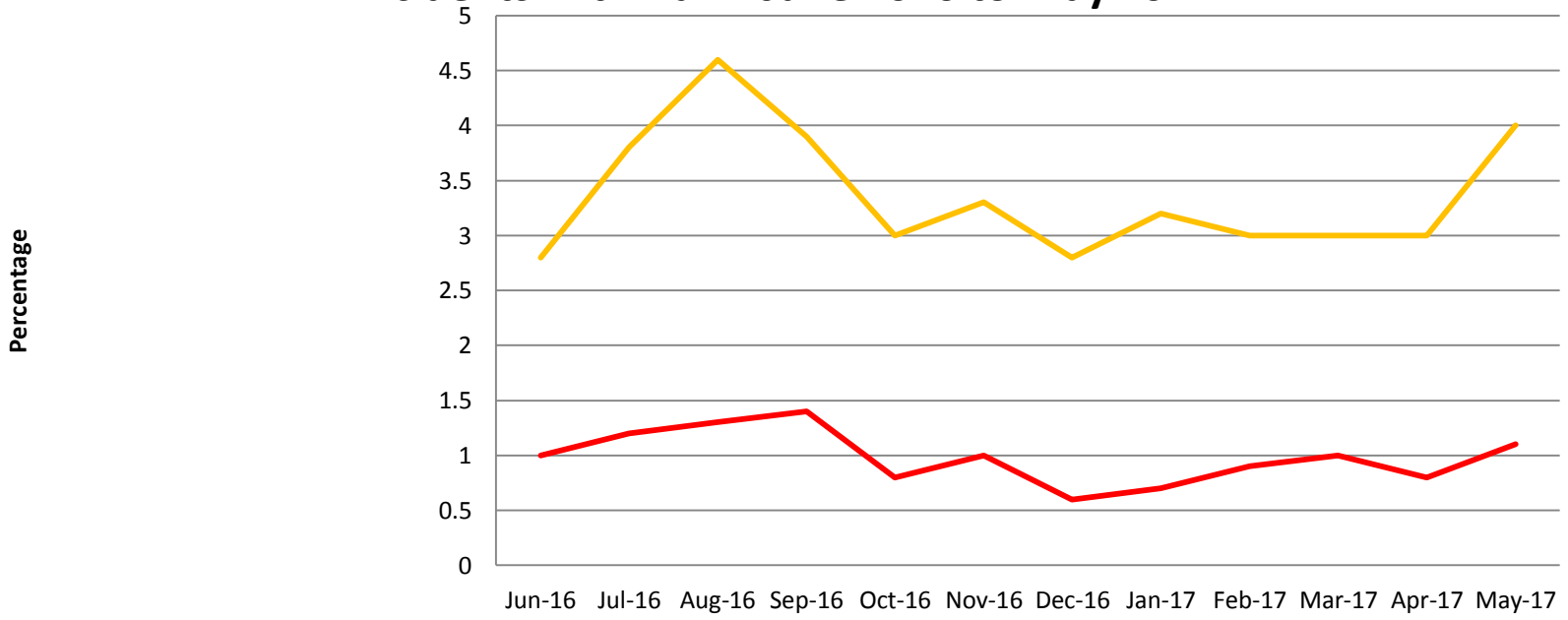
According to the national database, this has not been updated since February 2017. The Matron for Children's and Young Person's and the Trusts informatics team are currently investigating why this hasn't been updated.

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 2017 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
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
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794
Feb-17	52	5	0	2	59	188	6429
Mar-17	80	6	0	0	86	250	7326
Apr-17	62	0	0	0	62	232	7328
May-17	83	5	0	0	83	303	6918

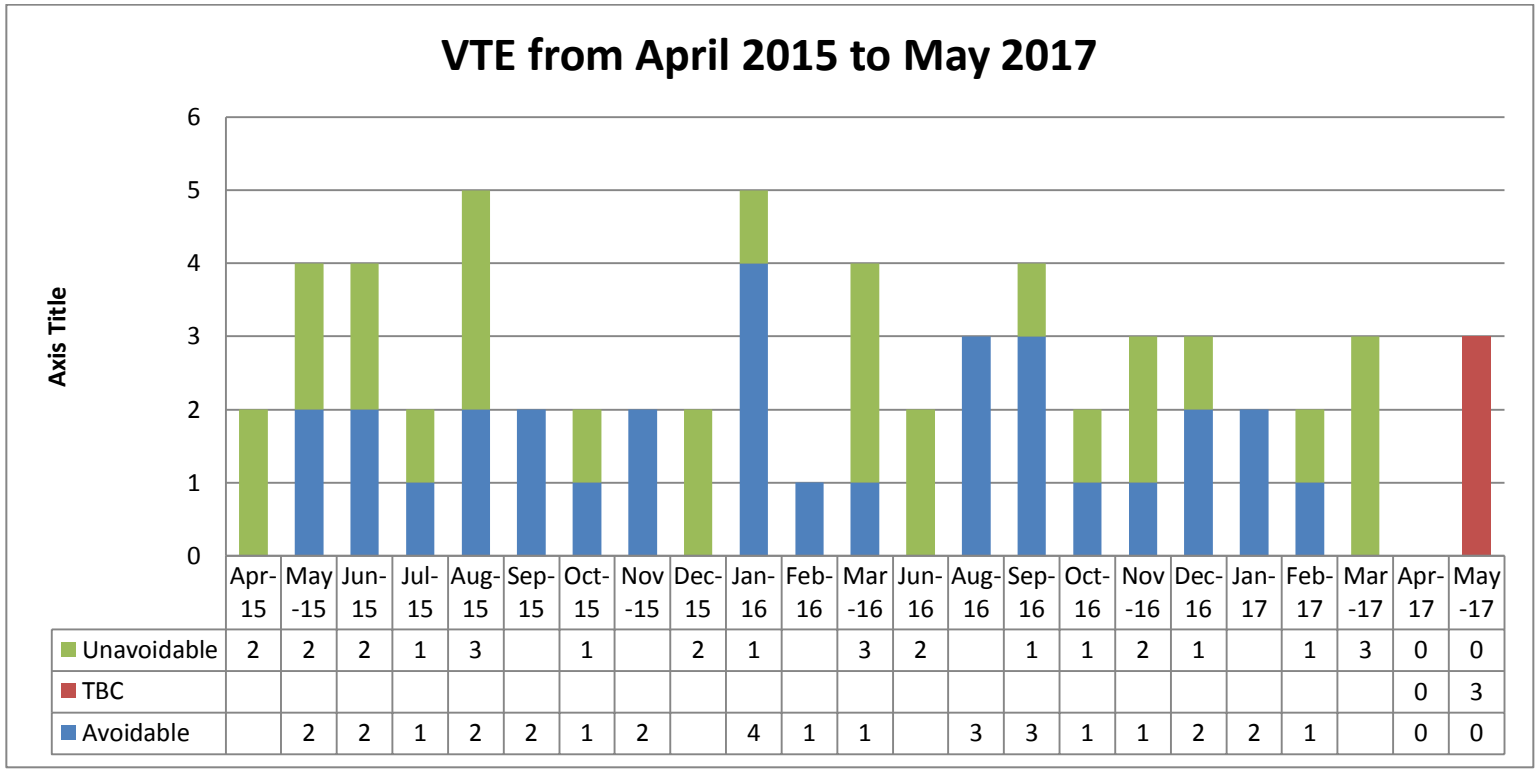
In May 2017, there were a total of 6918 patient contacts. There were 303 incidents reported which is 4 percent of the total patient contacts resulting in an incident. Of those 303 reported incidents, 62 incidents resulted in harm which is 1.1 percent of the total patient contact.

% of Patient Contact Compared to Number of Incidents and Incidents with Harm June 2016 to May 2017



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
% of Patient Contacts with Incidents Causing Harm	1	1.2	1.3	1.4	0.8	1	0.6	0.7	0.9	1	0.8	1.1
% of Patient Contact With All Incidents Reported	2.8	3.8	4.6	3.9	3	3.3	2.8	3.2	3	3	3	4

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).**



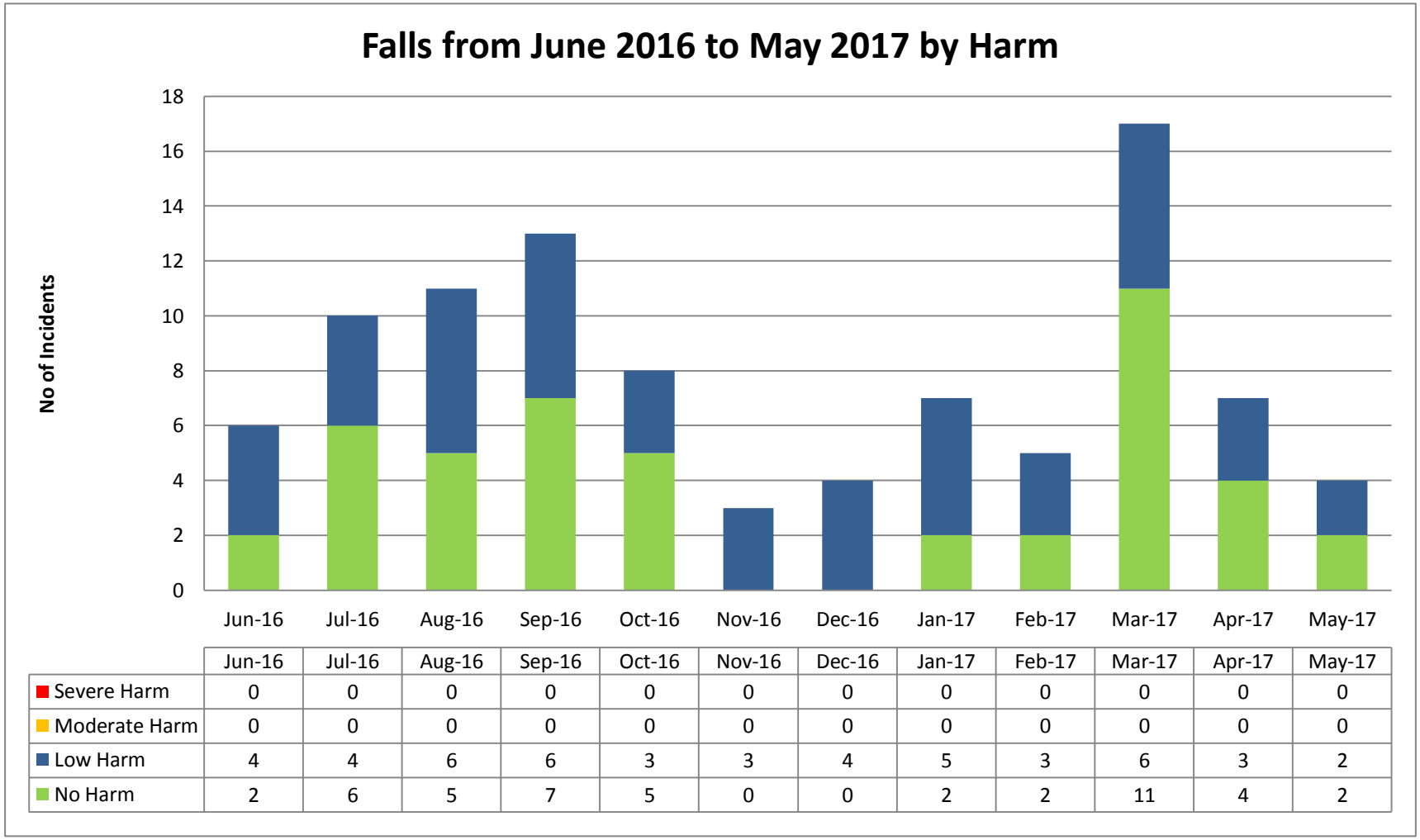
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Jun-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Unavoidable	2	2	2	1	3		1		2	1		3	2		1	1	2	1		1	3	0	0
TBC																						0	3
Avoidable		2	2	1	2	2	1	2		4	1	1		3	3	1	1	2	2	1		0	0

12

total		Avoidable
15/16	35	18
16/17	27	13
17/18	3	0

INFORMATION
There were three VTEs declared in May 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
All commissioner KPIs /audits have been completed and continue to be consistently achieved VTE training continues for Student nurses, training for registered and non-registered staff (clinical update days) was suspended in Q4 but will re-commence in April 2017. 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. Now that the VTE guidelines have been finalised and approved the requirements for meeting exemplar site status are met which has enabled application to be completed in Quarter 4.
RISKS / ISSUES
None

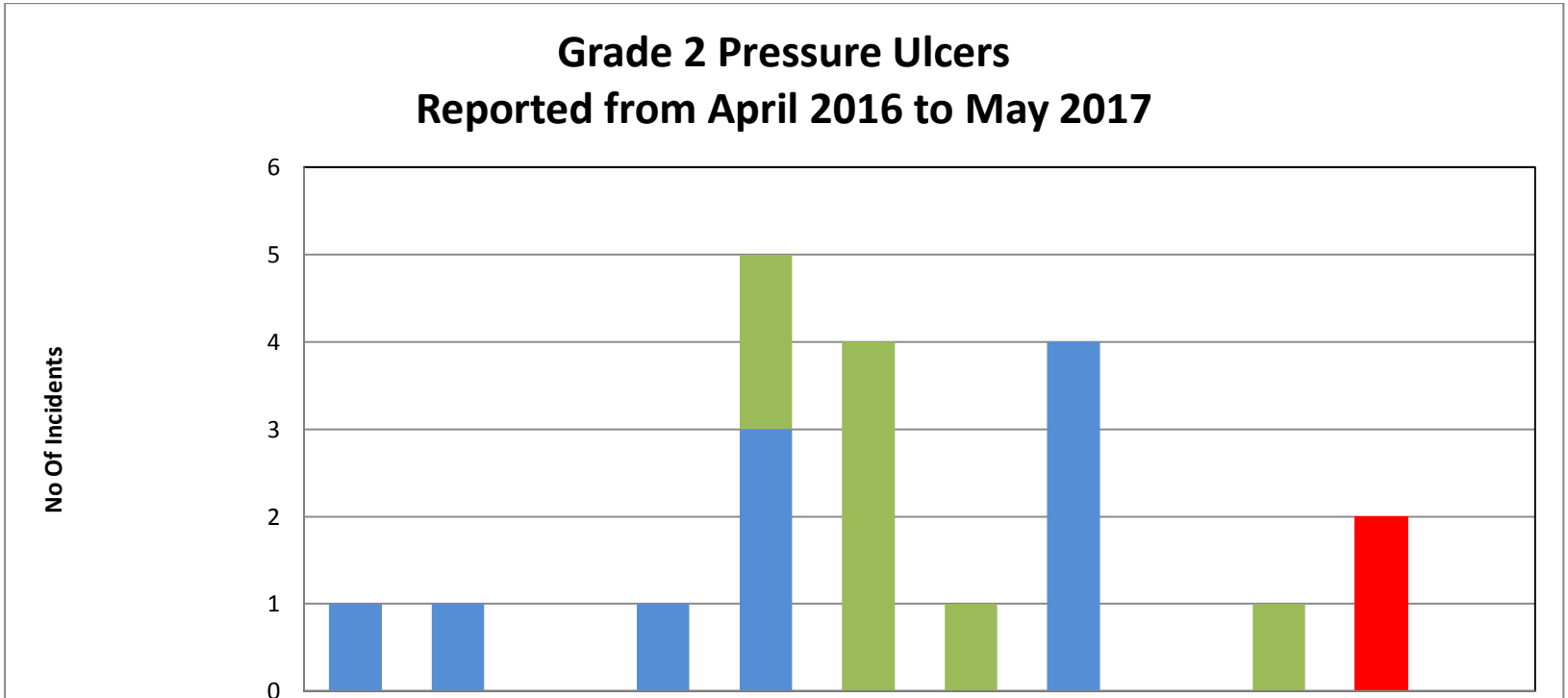
7. Falls – are incidents that are reported when a patient slips, trips or falls. The data is presented by month and each month is broken down by the level of actual harm that was caused by each falls incident.



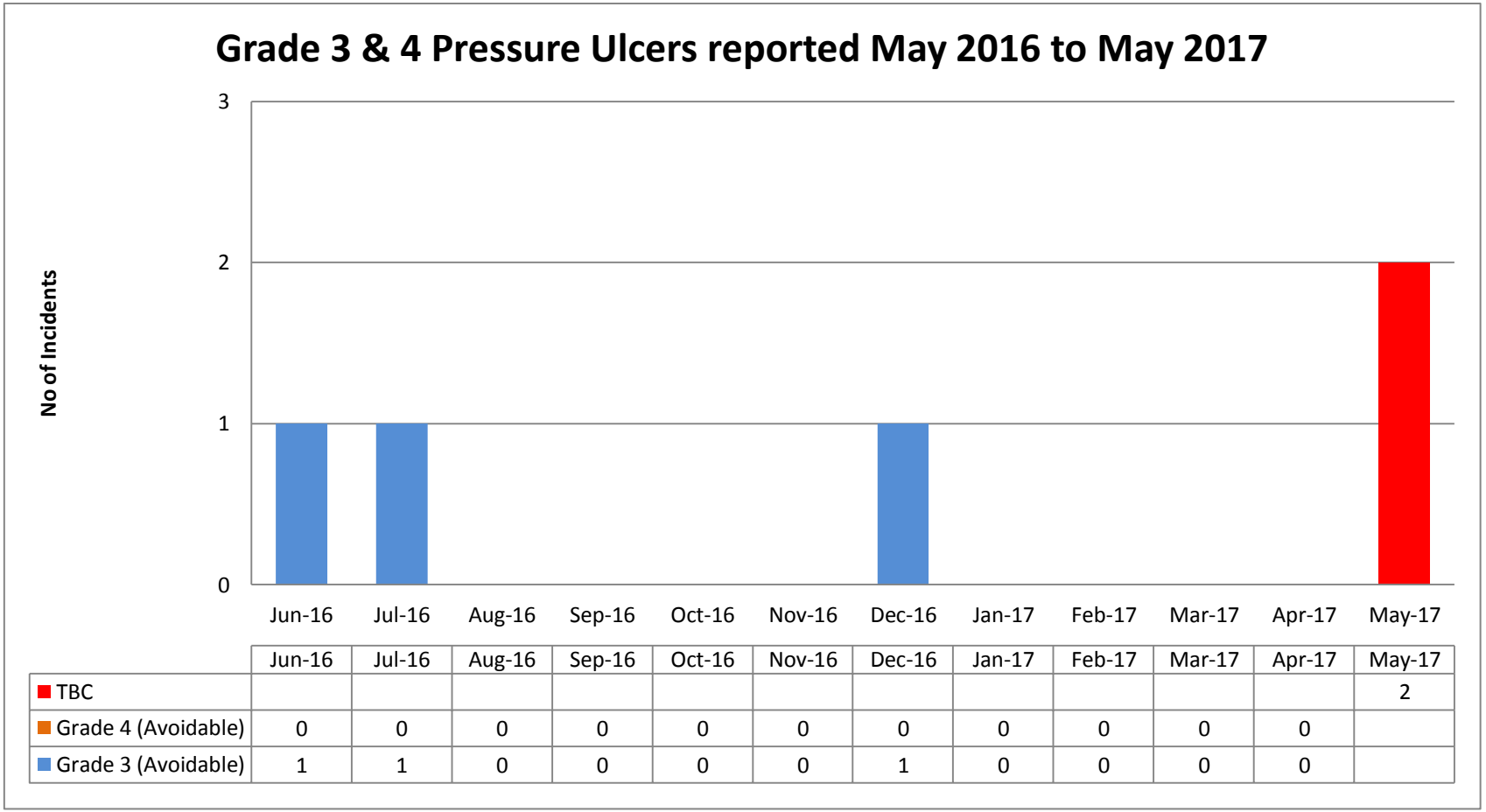
	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	0	0	0	0	0	0	0
Low Harm	4	4	6	6	3	3	4	5	3	6	3	2
No Harm	2	6	5	7	5	0	0	2	2	11	4	2

INFORMATION
Overall seven fall related incidents were reported across the Trust in May 2017. Four of these related to adult inpatient falls, with three falls being reported as Staff falls. Each in-patient incident has been subject to a post-fall notes review by the ward manager or deputy and a falls questionnaire has been completed for each fall. The inpatient falls are all reported to CQG via the Divisional Condition reports from the Heads of Nursing. All wards reported that they were fully staffed at the time of the patient falling and all risk assessments had been completed on admission and the post falls reviews had been completed for all patients.
ACTIONS FOR IMPROVEMENTS / LEARNING
• The Falls Working Group (FWG) meetings recommenced in December 2016 and are scheduled bi-monthly after the January 2017 meeting. • Through the FWG the work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller is in progress. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care. • The Throne project was discussed at the Falls Steering Group meeting in May 2017 and it was agreed that Therapies would repeat this audit to: ➢ See if the actions from the audit in 2015 had been carried out ➢ To re-audit to highlight any areas for improvement. This will be reported back to the Falls Steering Group meeting in July 2017 (12th July). Trend analysis identified that patients fall in the bathroom/toilet. • Falls information boards are to be standardised across all ward areas, with the information being agreed at the FWG meeting. 'Walking stick' visual information to be produced on a monthly basis for all ward areas for cascading of information regarding the number of falls per ward, per month to all staff.
RISKS / ISSUES
Reassessment of risk assessments need to be completed more consistently.

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-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
Unavoidable	0	0	0	0	2	4	1	0	0	1	0	0
Avoidable	1	1	0	1	3	0	0	4	0	0	0	
Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	2	0



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
TBC												2
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	
Grade 3 (Avoidable)	1	1	0	0	0	0	1	0	0	0	0	

INFORMATION

There have been 6 reported pressure ulcer incidents for May

- Three Grade 2 pressure ulcers were present on admission.
- There were Two x Grade 3 device related hospital acquired pressure ulcers relating to the same patient these are currently under investigation to establish avoidability.

In total, from 1st May 2017 the Trust has reported the following avoidable pressure ulcers:
0 avoidable Non Device Related Grade 2 pressure Ulcers against a limit (target) of 12. (Two Grade 2 Pressure Ulcers currently awaiting RCA to establish avoidability and are therefore not included in these figures)

0 avoidable Device Related Grade 2 pressure Ulcers against a limit (target) of 12.

0 avoidable Grade 3 pressure Ulcers against a limit of 0. (Two Grade 3 Pressure Ulcer currently awaiting RCA to establish avoidability and are therefore not included in these figures)

ACTIONS FOR IMPROVEMENTS / LEARNING

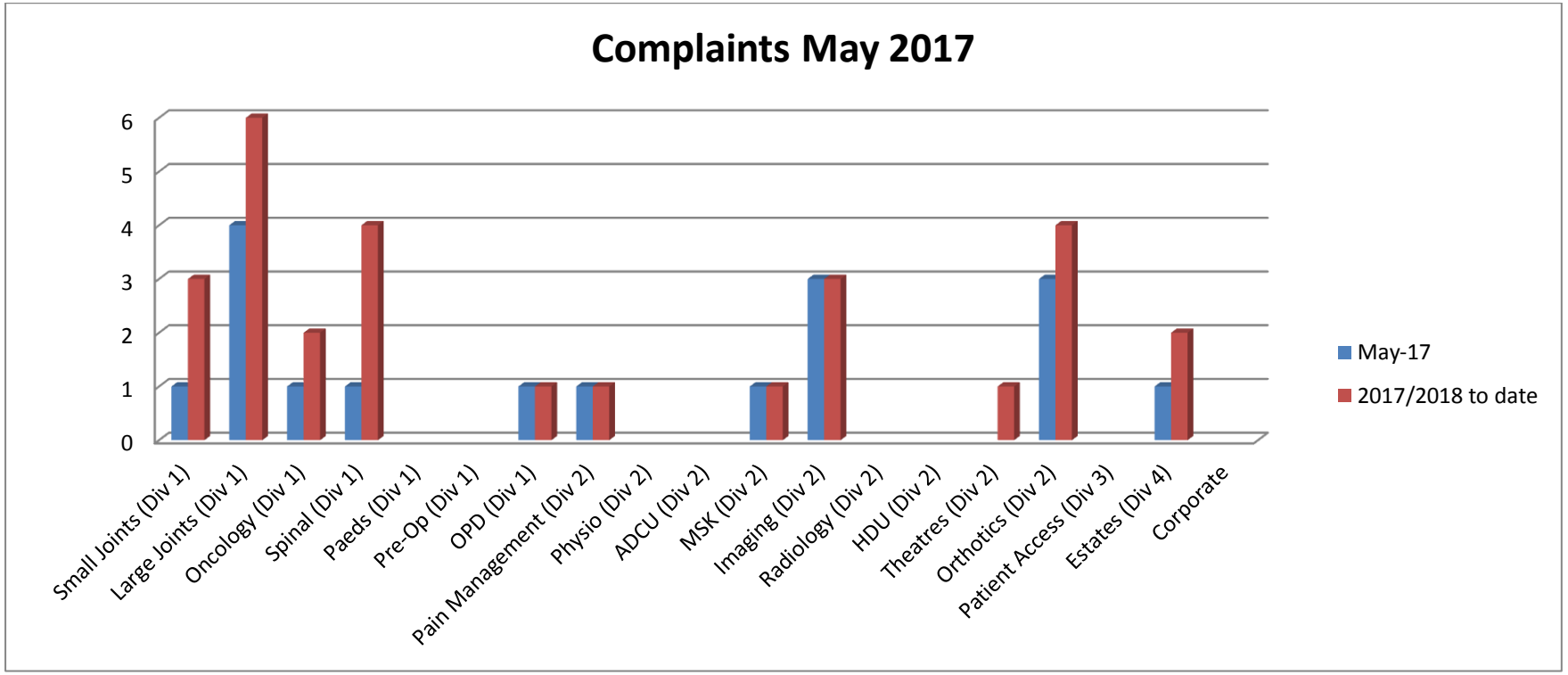
Updates:

- The 2 x Grade 3 pressure ulcers in March 2017 identified on admission under plaster casts, which were applied at The Royal Orthopaedic Hospital, have been deemed unavoidable
- The 2 x Grade 2 pressure ulcers from April, still awaiting questionnaires to establish avoidability/unavoidability.

RISKS / ISSUES

None

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.



INFORMATION

PALS

The PALS department handled 497 contacts during May 2017 of which 141 were classified as concerns. This brings the total of PALS contact for the year to date to 1176

Compliments

There were 562 compliments recorded in May 2017, with the most being recorded for Div 1. This is higher than last month with the Pre-Operative Assessment Clinic continuing to receive a significant number of compliments. Areas have been reminded to submit their records for central recording.

All compliments are sent electronically to the Patient Experience Team who holds the records. A Compliment is recorded if there is tangible evidence such as a card, a thank you letter, a box of chocolates or an e-mail. Teams are reminded monthly to submit their compliments for central logging.

Complaints

There were 17 formal complaints made in May 2017, bringing the total to 28 for the year. 1 complaint was initially risk rated red and the remainder were risk rate amber or yellow. This is higher than the same time last year (15 complaints in May 2016)

-

ACTIONS FOR IMPROVEMENTS / LEARNING

Of the 7 complaints closed in May 2017:

- 3 were upheld
- 4 were partially upheld
- 0 were not upheld

All of the partially upheld complaints were upheld for communication issues.

Learning identified and actions taken as a result of complaints closed in May 2017 include:

- A member of staff was not interacting with patients in line with the Trust Values

  Action: Professional conversation has been undertaken

- Patient was not aware of the changes made to her medication and the reasons for this

  Action: Professional conversation has been undertaken. Complaint has been discussed at ward meeting as a facilitated learning experience for all staff

- Processes for provision of orthotic supplier outside of standard prescription were not clear

  Action: Process has been created to avoid further confusion and issues.

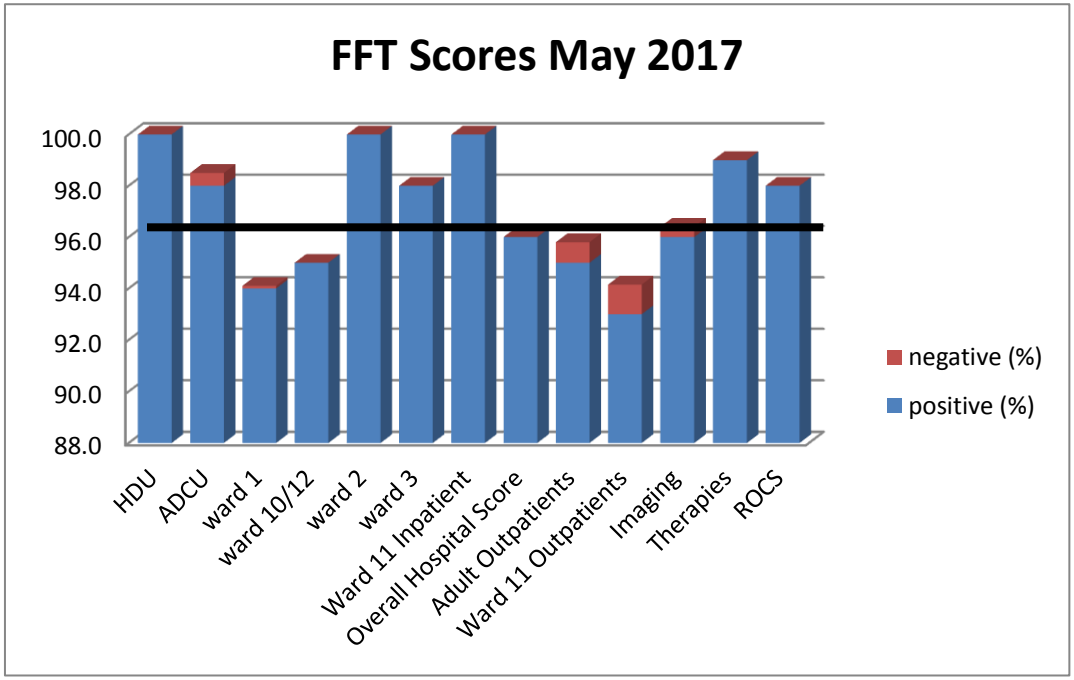
RISKS / ISSUES

None Identified.

10. Friends and Family Test Results and iwantgreatcare - 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.

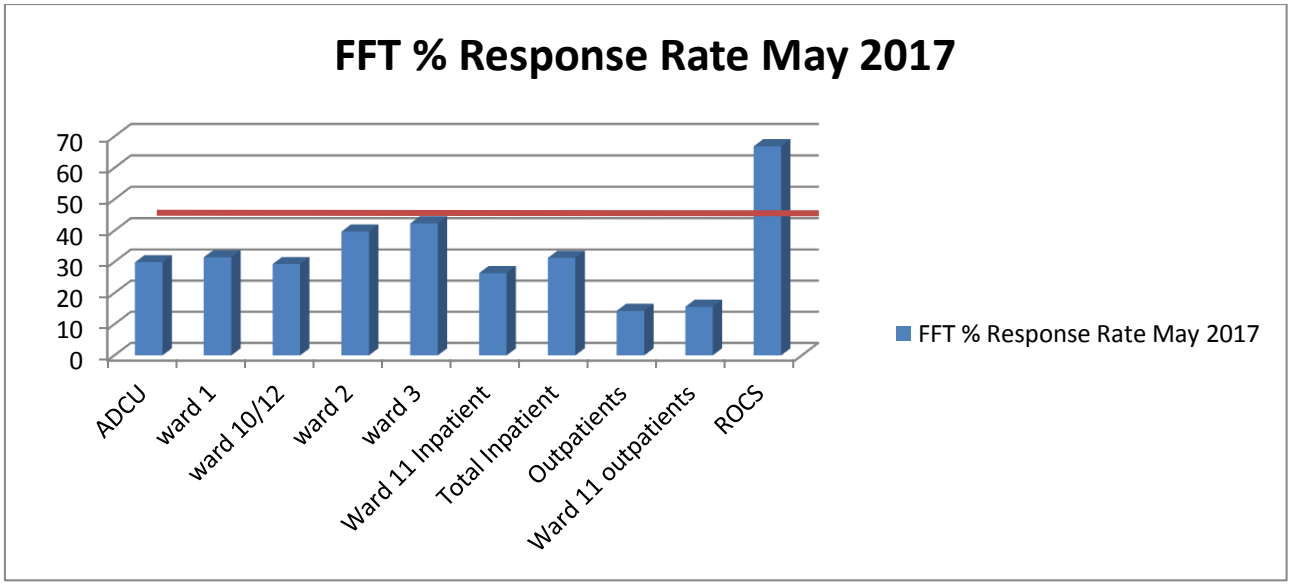
It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming the services and supporting 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

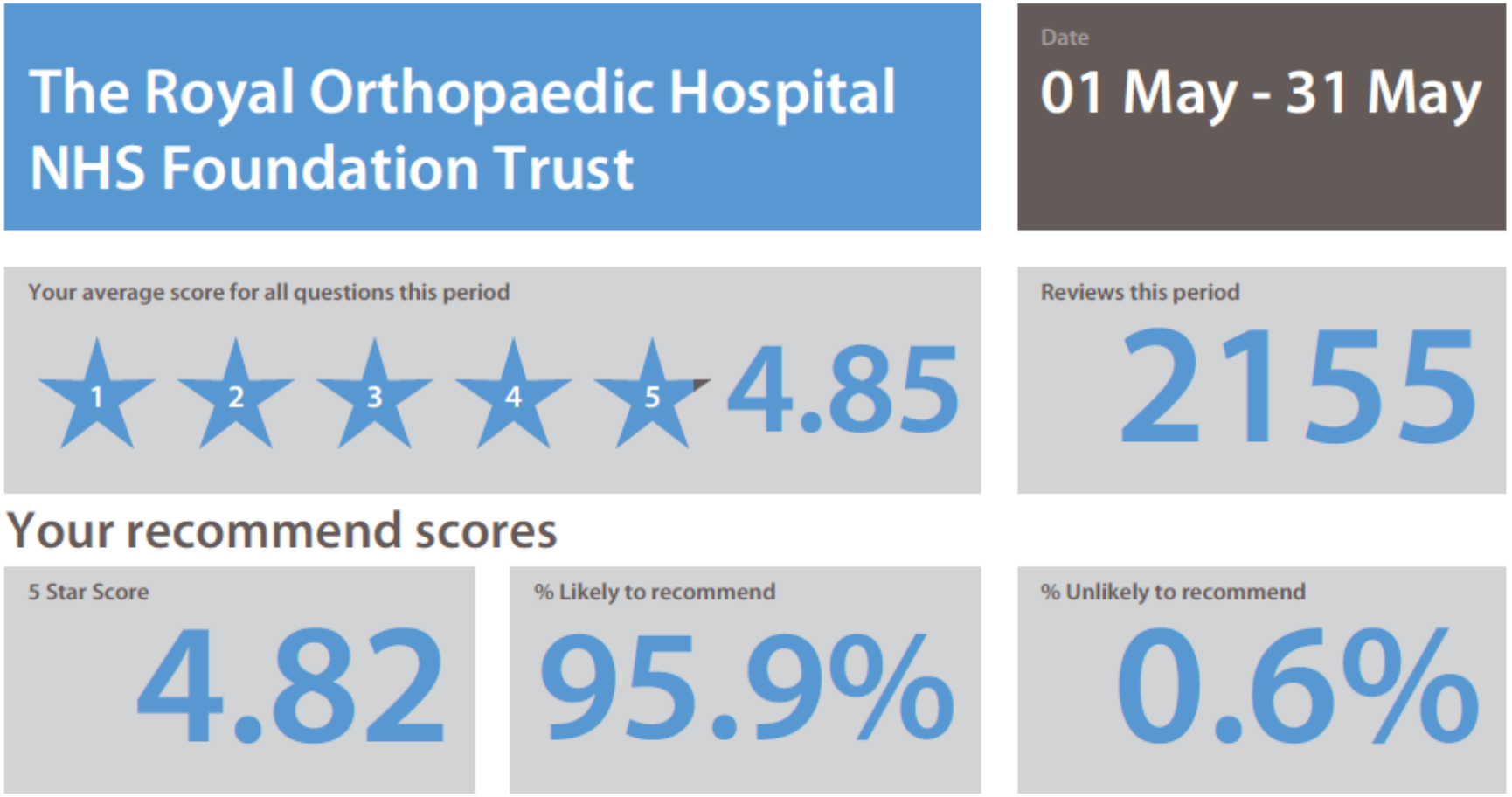
Promoters. Any patients answering the question as neither likely nor unlikely / don't know are classified as passive. Any patients answering the question as Unlikely / Extremely Unlikely are classified as negative.



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.

In order to attempt to address some of this imbalance, the Trust has set an internal target to reach a 40% response rate across all areas within the first quarter of 2017/18. In May 2017, Ward 3 and ROCS met this internal target.

I Want Great Care - iWantGreatCare makes it simple to collect large volumes of meaningful, detailed outcomes data direct from patients on your organisation, clinical locations and whole clinical teams. It Continuously monitor and compare performance of individual services, departments and wards and Aggregated, graphical monthly reporting meets needs of both providers and commissioners for robust, patient-centric metrics to track quality and performance.



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 24 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.

During the month of May, 4 cases are deemed to have breached Duty of Candour Regulation 20 policy. These incidents are related the 4 x Spinal Deformity patients were established as severe harm or moderate harm in the RTT Royal Orthopaedic Hospital NHS Trust harm review. Each of the severe harms (4 in total) have been recorded as a Serious Incident as agreed with the CCG. One patient has had a face to face meeting and this will be followed up in writing. The other 3 patients are in the process of being scheduled as soon as practically possible.

Duty of Candour regulation 20 stipulates that the verbal face to face contact should be as soon as practical possible but within 10 days.

The Clinical Governance Team will be completing an internal audit for added assurance.

12. Litigation

There was no new litigation to report in May 2017

13. Coroner's cases

No Coroners inquests in May 2017

14. **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 perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**

INFORMATION
No Data available due to theatre man
ACTIONS FOR IMPROVEMENTS / LEARNING
RISKS / ISSUES
The Audit Data for Who checklist is not available for May 2017 due to the migration to the new theatre man software. A new report is currently being generated that will show the WHO compliance and audit. This will be included next month

Finance and Performance Report

MAY 2017

CONTENTS

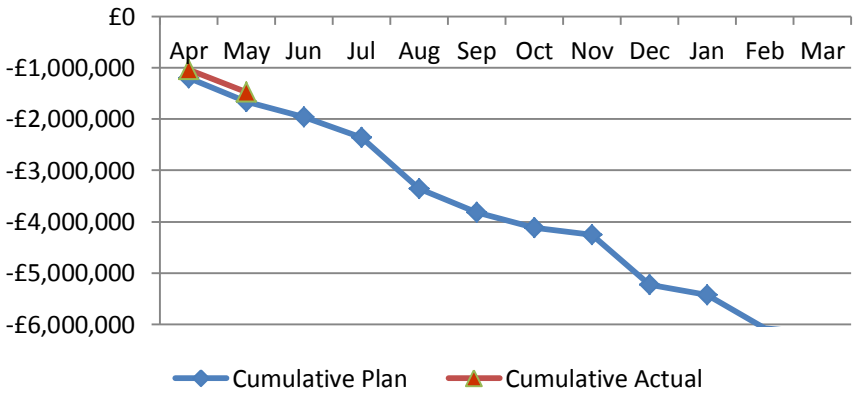
INTRODUCTION

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.

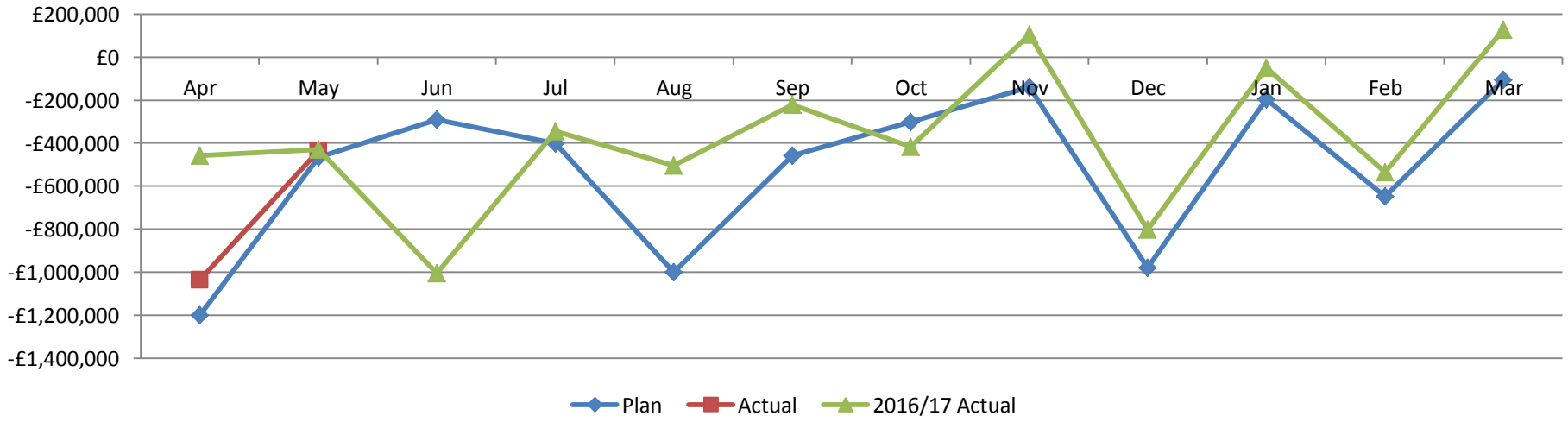
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Cumulative Deficit vs Plan



NHSI Use of Resources Rating (UOR)		
	Plan	**Actual**
Capital Service Cover	4	4
Liquidity	4	4
I&E Margin	4	4
I&E Margin – Variance against plan	1	1
Agency metric	1	1
Overall UOR	N/A	3

Monthly Surplus/Deficit Actual vs Plan



INFORMATION

The Trust has delivered a deficit of £435,000 in May against a planned deficit of £465,000, a result £30,000 ahead of plan. This brings the Trust's year to date position (on a control total basis) to £1,470,000 against a plan of £1,664,000, and is therefore ahead of plan by £194,000.

The in-month position is ahead of plan, but this is being driven by the receipt of £101,000 from the Trust's insurers in relation the December 2013 fire, which was not expected within the plan for the month. The year to date position ahead of plan is therefore as a result of this income, in addition to the prior month's control of non-pay costs. Income and expenditure performance is discussed further on the respective income and expenditure slides within this pack.

As at the end of Month 2, the Trust has recognised £276,000 of CIP savings, against a plan of £521,000. £7,000 (2%) of savings to date are non-recurrent. The in-month savings recognised were £141,000 against a target of £260,000. There has currently been insufficient engagement from Divisions 1 and 2 to fully develop the CIP schemes into achievable savings plans as a result of focus on improvement of RTT. The Director of Finance is challenging progress to ensure detailed plans are developed urgently.

With regards to the Trust's Use of Resources Risk Rating (UOR), the deficit position results in the Trust achieving ratings of 4 for Capital Service Cover, and I&E Margin. The Trust's requirement for cash support has resulted in the Trust being a 4 for liquidity. The current performance being ahead of plan, and the control of agency spend has resulted in these metrics being rated as 1s. The overall rating is a rating of 3.

ACTIONS FOR IMPROVEMENTS / LEARNING

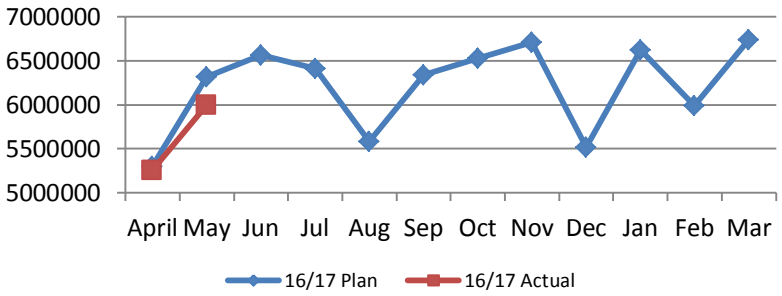
The Trust Executive are monitoring weekly progress against the action plan. Schemes such as implant rationalisation are in progress to improve the Trust's cost efficiency. Whilst the schemes are constantly being reviewed and refreshed, particular focus will be placed on ensuring the cost control plan is reconsidered and takes into account all of the coming planned CIP schemes which need particular Executive oversight.

RISKS / ISSUES

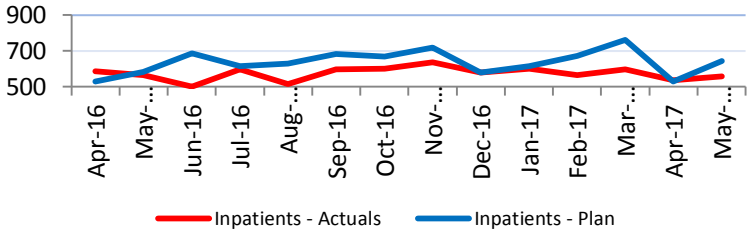
There is a risk that the focus on RTT and operational activity delivery results in CIP schemes not being implemented in a timely enough manner to ensure the required savings for 2017/18.

2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity

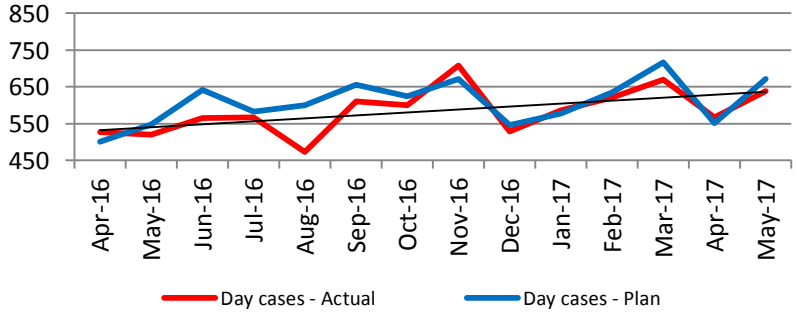
Monthly NHS Clinical Income vs Plan, £, 17/18



Inpatient Activity



Day Case Activity



NHS Clinical Income – May 2017 £'000			
	Plan	Actual	Variance
Inpatients	3,209	2,946	-263
Excess Bed Days	100	85	-15
Total Inpatients	3,309	3,031	-278
Day Cases	776	682	-94
Outpatients	620	670	50
Critical Care	249	182	-67
Therapies	203	222	19
Pass-through income	222	217	-5
Other variable income	423	473	50
Block income	518	518	0
TOTAL	6,320	5,995	-325

NHS Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	5,856	5,773	-83
Excess Bed Days	182	134	-48
Total Inpatients	6,038	5,907	-131
Day Cases	1414	1300	-114
Outpatients	1130	1112	-18
Critical Care	453	364	-89
Therapies	451	415	-36
Pass-through income	404	434	30
Other variable income	689	680	-9
Block income	1036	1036	0
TOTAL	11,615	11,248	-367

INFORMATION

NHS Clinical continued to underperform in May (by 5.1%) having underperformed by 3.1% in April. Admitted patient care performance was below plan financially and with respect to activity levels, with discharged activity 83 below target. May does have increased levels of activity compared with April which was expected. Case-mix remained steady in May. The Paediatric spinal deformity service carried out at Birmingham Children's Hospital was suspended due to issues with the sterilisation of equipment, during April and most of May 2017. The service re-started on 24th May 2017, however the loss of activity has impacted significantly on the year to date income position.

Outpatients continued to under-perform from an income point of view which is driven by the underperformance in outpatient procedures. First and follow up outpatients are over-performing year to date.

Outside of clinical income, £101,000 of insurance income was received, which related to a fire in the Trust in December 2013. This income was not expected within the plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

There are 4 work streams (Operations, Process, People, and Data) which have been defined with the actions required to achieve recovery of income and RTT. Continued focussed work continues with clinical service leads and consultants, with the operational managers , to create additional capacity, and using the trajectories, target individual (long waiting) patients to be booked.

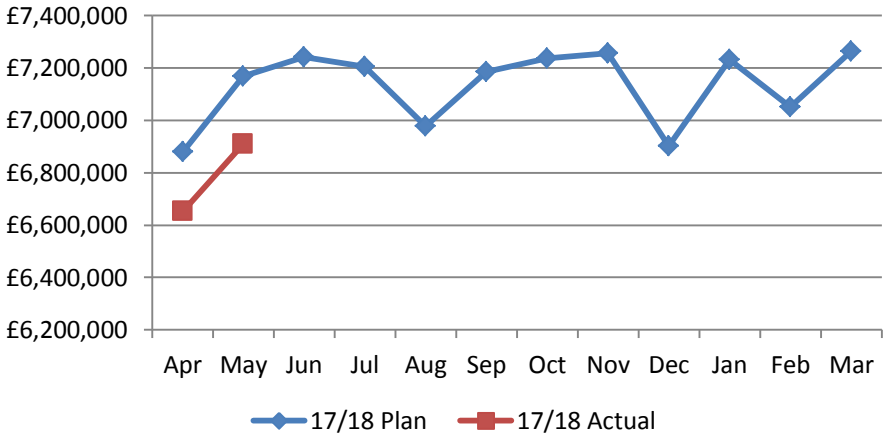
RISKS / ISSUES

Key risks are the availability of speciality teams to reutilise every fallow list, particularly during periods of high consultant leave, and to ensure that theatre productivity continues to enable fully booked lists to be delivered. There continue to be a high level of patients who cancel their operation a few days before the planned date, which then means that there are replacement patients scheduled at short notice to achieve full utilisation.

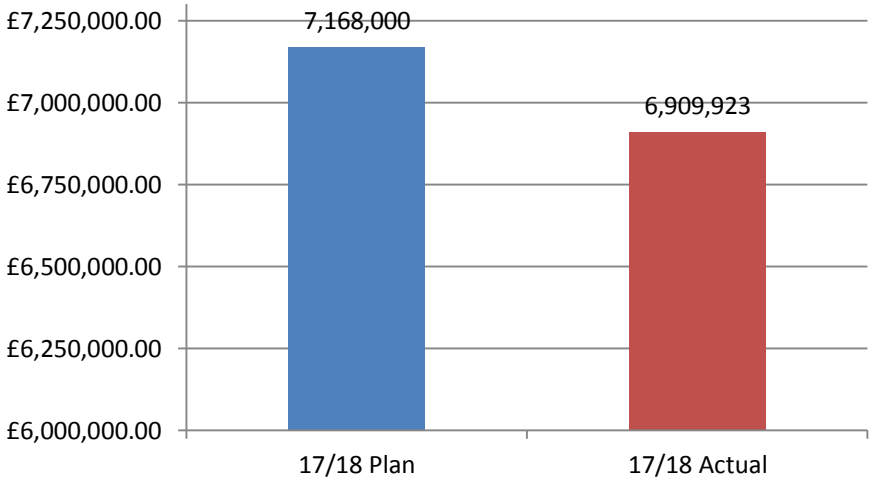
There is increasing clinical engagement in developing improvements to productivity for both operations and out patients. Some consultants have very short, with others having very long, waiting lists, and work is underway to smooth out flows across firms.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends

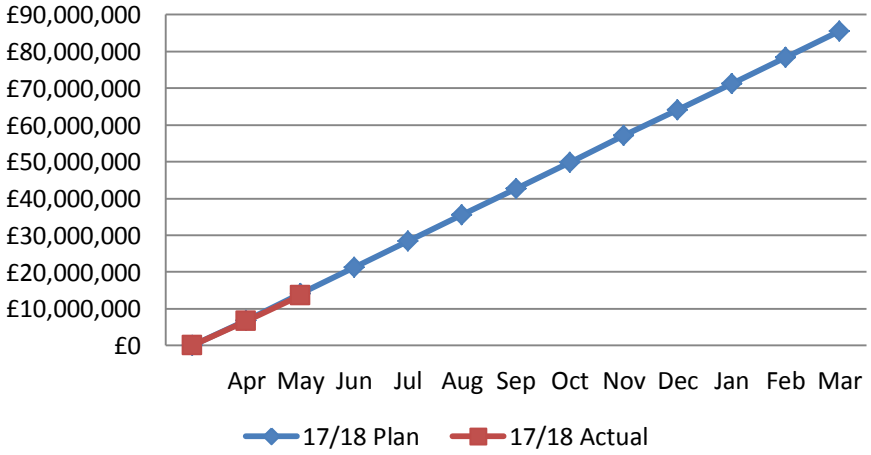
17/18 Monthly Expenditure vs Plan



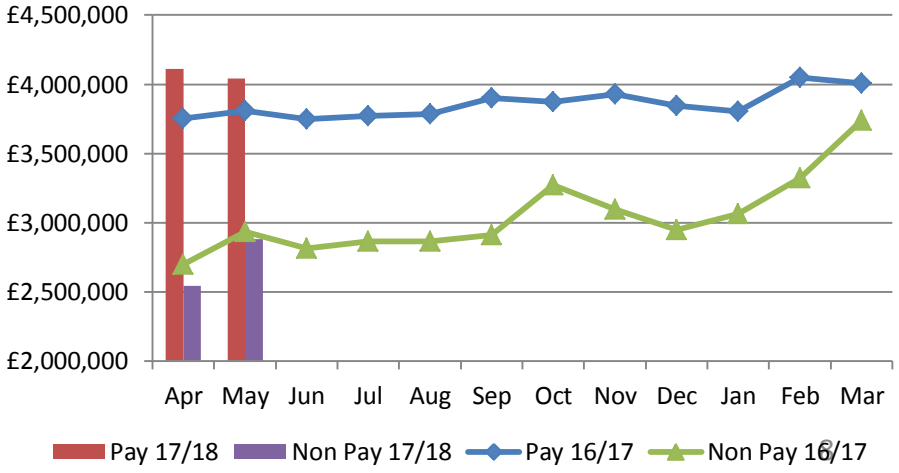
17/18 M2 Expenditure vs Plan



Cumulative Expenditure vs Plan 17/18



16/17 vs 17/18 Pay & Non Pay Spends



INFORMATION

Expenditure levels for the month were £6,910,000, £259,000 behind the in month plan of £7,168,000.

The main reason for the underspend was non-pay spend being lower than planned. Implants, orthotics and drugs for example were lower than plan as a result of activity being below plan. As noted above, the paediatric spinal deformity service suspension at Birmingham Children's Hospital has reduced the run rate of non pay spend. In addition a number of ad hoc spend areas such as utilities and legal costs were lower than expected.

Pay spend was slightly above plan. When the pay categories are reviewed individually, substantive spend was behind plan by £180,000, bank spend ahead of plan by £150,000, and agency greater than plan by £13,000 (although still lower than plan year to date). It is clear from a review of the bank plan that this was erroneously set too low in each month, with the balance being taken from substantive pay. When the plans are corrected to what they should have been set as, the spends are in line with plan. NHS Improvement have been contacted to see if a correction to the plan can be made, as this variance will otherwise be expected to be seen throughout the year. Bank spend is in line with previous months.

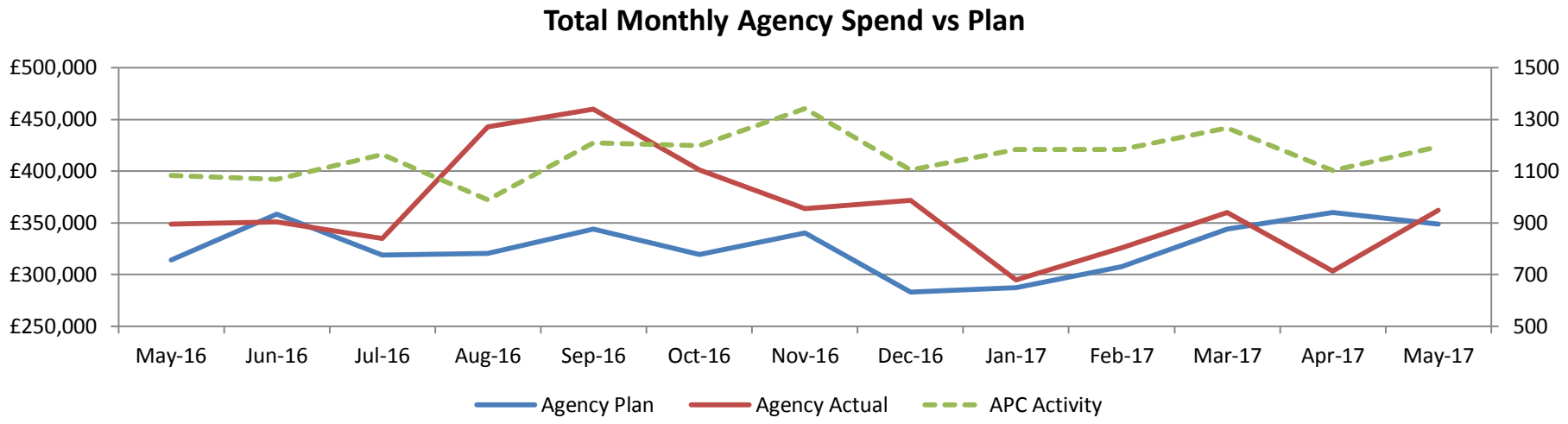
ACTIONS FOR IMPROVEMENTS / LEARNING

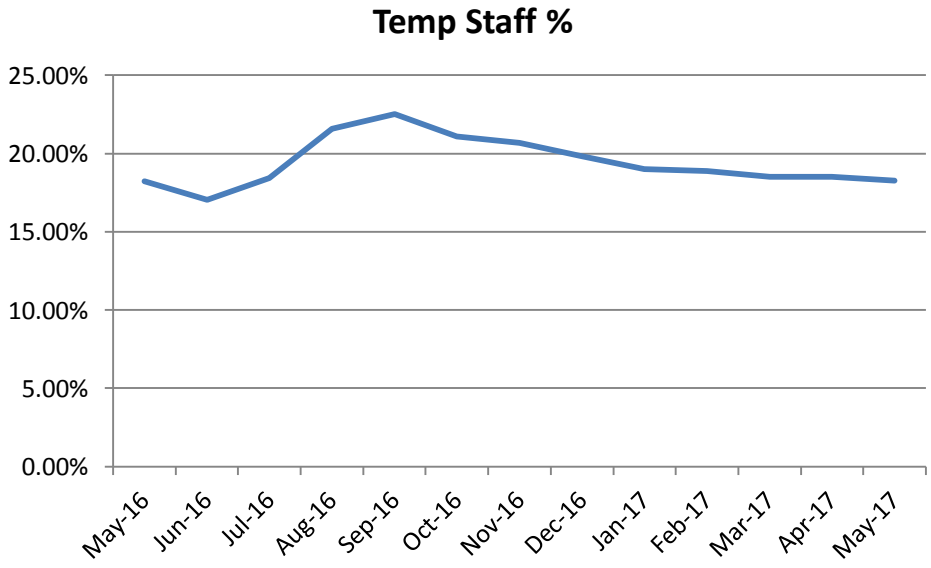
Costs will continue to be scrutinised and minimised, and the alteration of the bank spend plan will be followed up further with NHS Improvement.

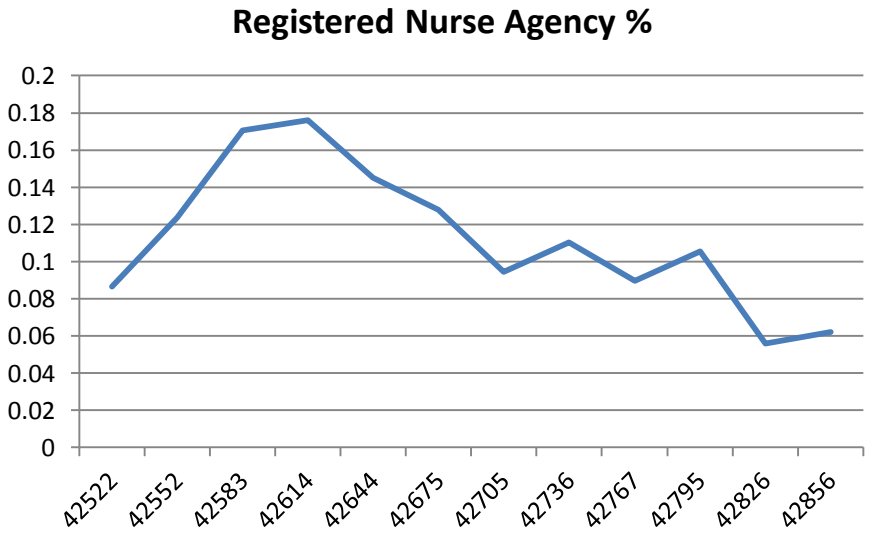
RISKS / ISSUES

Close management of the stock implant rationalisation will be required to control costs and maximise savings as described in further detail in the CIP section of this paper.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements







INFORMATION

April showed an increase in agency spend (£303k to £362k). Most agency staff categories were stable from Month 1 to Month 2, with the exception of an increase in non-clinical agency spend for additional RTT validators. May has a greater number of working days than April, and therefore a static agency spend on categories such as nursing suggest Healthroster is continuing to give better visibility of rotas and better control of nurse agency. In addition, there has been ward closures as a result of the infrastructure works, and the nursing workforce have been working effectively to group resource in these circumstances to reduce agency spend. There continues to be a pressure on Medical spend due to an under provision of GP trainees from the West Midlands Deanery, but spend is static.

ACTIONS FOR IMPROVEMENTS / LEARNING

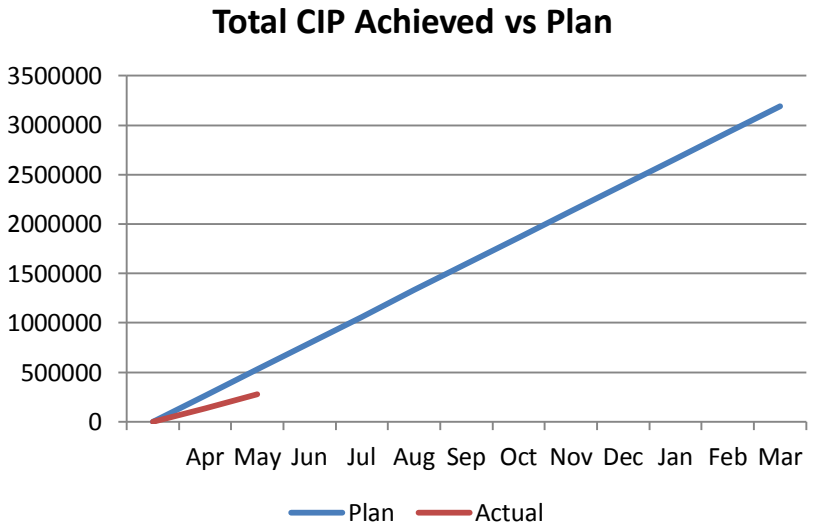
The leadership by the Nurses in addressing use of agency continues to impact positively. This has been delivered by continued and focussed review of the outputs of Healthroster.

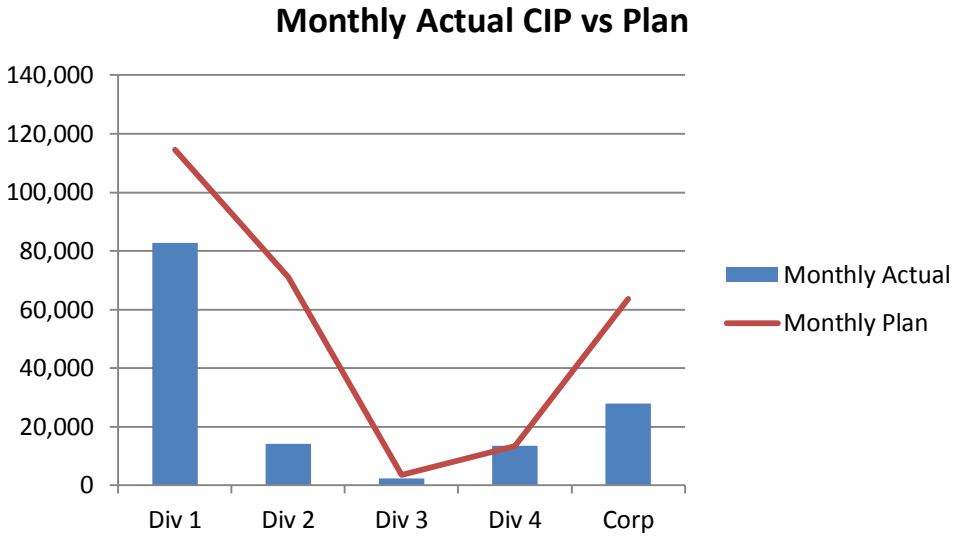
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios. The Trust is currently consulting on a change to rota working patterns as part of this process.

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. An overspend against the trajectory will have a direct impact on our regulator ratings.

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2017/18





INFORMATION

As at the end of Month 2, the Trust has recognised £276,000 of CIP savings, against a plan of £521,000. £7,000 (2%) of savings to date are non-recurrent. The in-month savings recognised were £141,000 against a target of £260,000. There has currently been insufficient engagement from Divisions 1 and 2 to fully develop the CIP schemes into achievable savings plans as a result of focus on improvement of RTT. The Director of Finance is challenging progress to ensure detailed plans are developed urgently.

The Trust continues to progress through the implementation of the non-spinal rationalisation scheme, and it will remain important to manage the process of transition closely to the new suppliers to maximise on the savings for the new rates and avoid incurring additional cost by ordering non-primary suppliers. Good progress is being made with the involvement of many teams and individuals around the Trust in the rationalisation of consumable supplies, with some notable successes on implementing alternative products following successful product trials.

Other significant schemes planned for 2017/18 include continue to implement nurse staffing improvements, in addition to embedding the operational and executive team restructures implemented from 1st April.

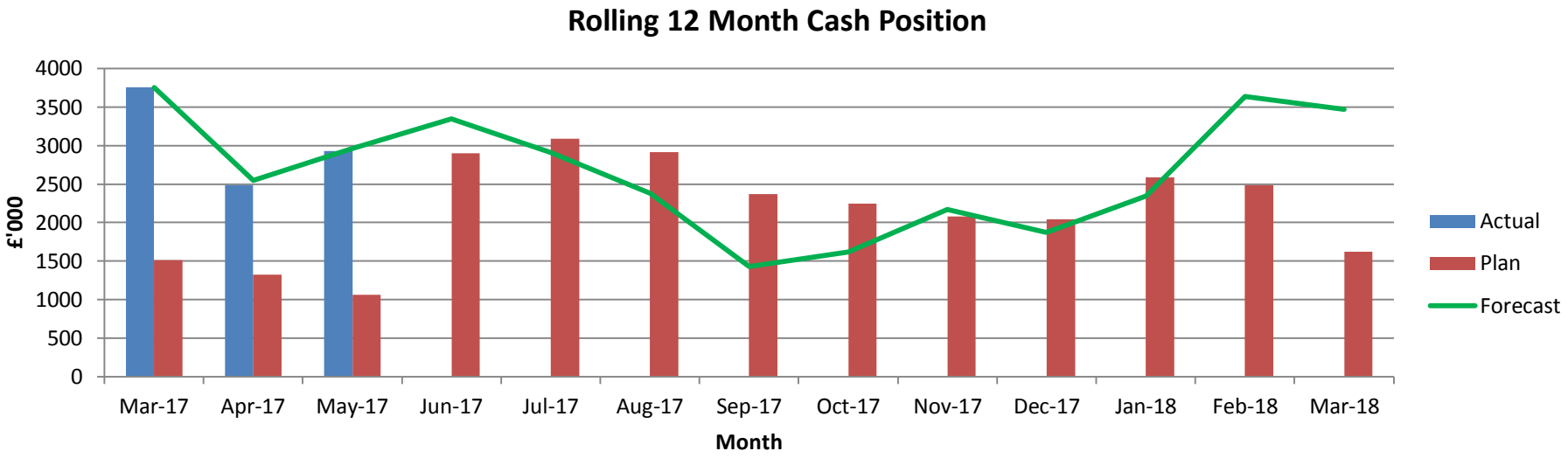
ACTIONS FOR IMPROVEMENTS / LEARNING

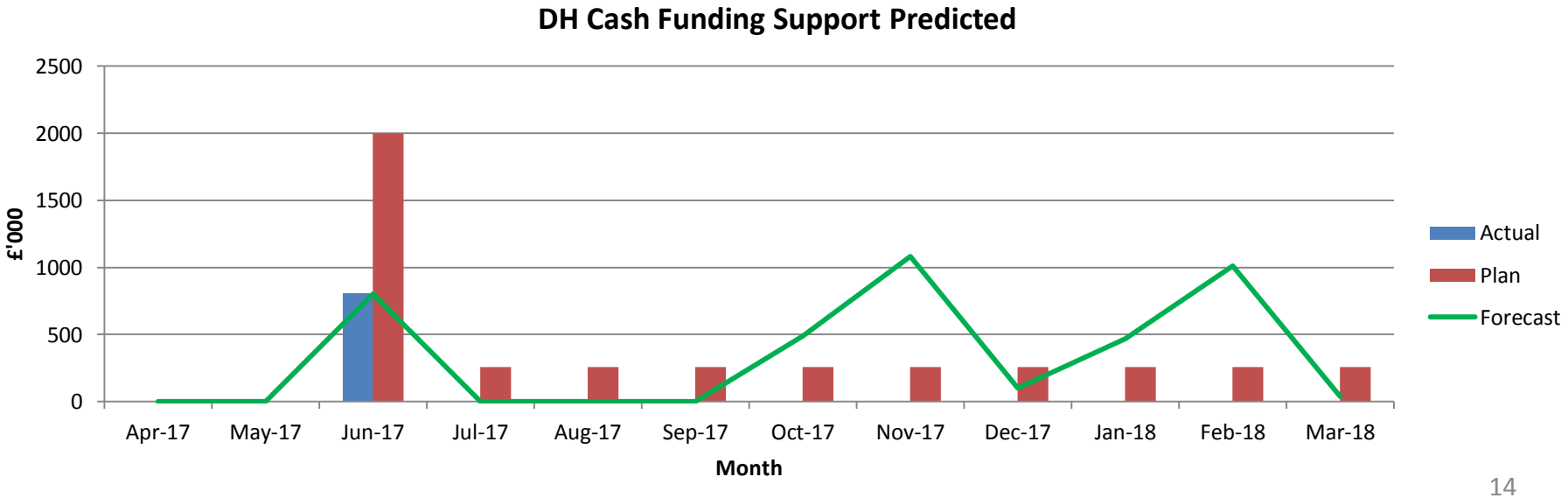
Early focus on unidentified schemes for 2017/18 is needed to ensure the CIP plans are achieved. In addition, a significant proportion of the prior year CIPs were non-recurrent. Focus on ensuring schemes are recurrently delivered will be important in the coming year.

RISKS / ISSUES

The CIP target for 2017/18 will be challenging particularly given the high level of non-recurrent CIP in 2016/17. A number of the schemes in 2017/18 are more transformational rather than traditional cost cutting schemes, and it will be vital that the required changes to working are not only implemented but thoroughly embedded to ensure savings are delivered in a consistent manner.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet in addition to expected borrowing requirements from the Department of Health





INFORMATION

Information

Cash levels are £1.9m higher than planned levels at the end of May, largely driven by cash held at the end of March being significantly higher than planned. The cash position for May is roughly in line with the Trust revised cash forecast for the month.

Despite this, due to the ongoing reduction in cash over time, liquidity levels within the Use of Resources Rating have dropped to a 4, the lowest level.

The Trust received its first cash loan from the DH on the 12th June for £804k as previously advised to the committee. Based on the current forecast funding support will not be required again until October 2017.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Head of Financial Accounting has set up a monthly cash control committee attended by the DDOF, and representatives from management accounts and the transaction team. The committee is reviewing cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications of cash from the Department of Health to be actioned.

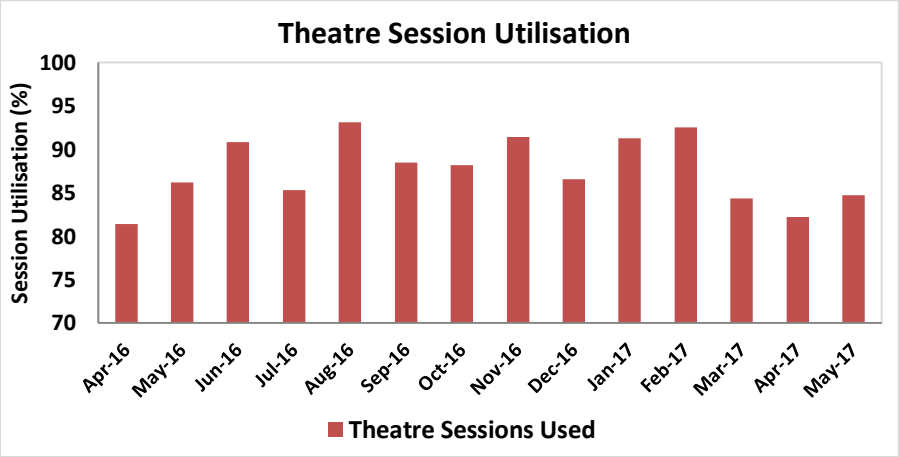
Based on the feedback from NHS Improvement the information provided to request funding was robust. The finance team are however continuing to review this and are looking to gather more information to continue to improve the Trusts management of cash.

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.

There is a risk is in relation to DH not approving a cash loan or approving a lower than requested amount, but the positive feedback to date from NHS Improvement provides assurance that this risk is relatively low.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are potentially available (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we aim to use at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis. May utilisation has improved in comparison to April, however, more work is underway to continue to improve this, to support the delivery of the RTT Action Plan.

Due to annual leave / study leave, we typically plan that surgeons will operate over 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.

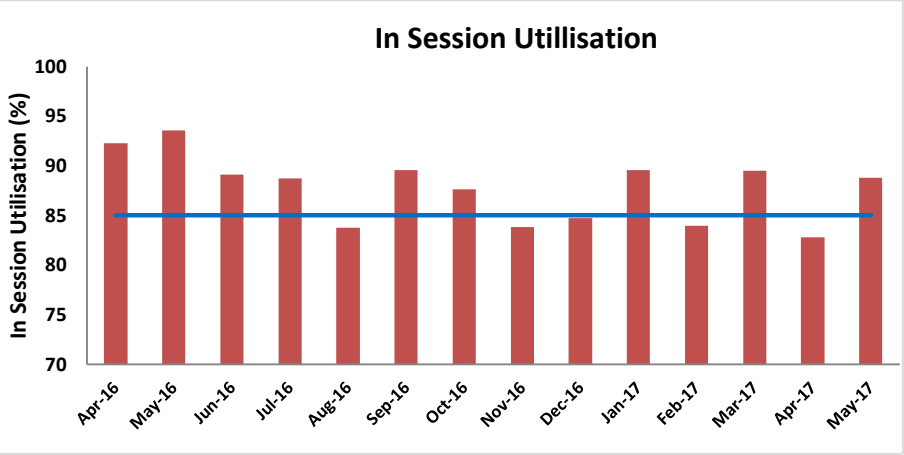
ACTIONS FOR IMPROVEMENTS / LEARNING

Job planning is building in buddy arrangements and prospective cover, as well as identifying a need for recruitment to specialities where there are vacancies or that are under pressure from an activity / RTT / 52 week perspective. Further improvements have been made to the communications to surgeons of the availability of fallow lists, enabling more effective utilisation. There are now additional 3 session days in the schedule to facilitate the 2 x scoliosis cases on a list for spinal deformity. The large joints team are exploring, a regular 3 session day list for those consultants with back log issues. In week twin theatre sessions have started in order to drive efficiency and reduce backlogs.
Some theatre lists are now being released by individual surgeons (and offered to be reutilised by other surgeons) to enable them to have additional clinics, because some surgeons who are timetabled in theatres have very short waiting lists. All reasonable efforts are made to recycle, including where it is deemed appropriate the use of sessions additional to job plan (paid ADHs.) Since theatres and anaesthetic teams are not yet fully staffed, capacity is flexed up through overtime and bank working, so where lists are not recycled, and deemed 'fallow', the theatre staffing and anaesthetic shifts are removed 1 week ahead, to reduce bank and agency costs.
The ops team are proactively monitoring surgeon annual leave up to 12 weeks in advance in order to manage the reduce the number of fallow lists and to offer appropriately to those services that are most challenged.

RISKS / ISSUES

Job planning is now completed for surgeons, with outstanding issues with only 2 surgeons; these are actively being progressed with the involvement of the Associate Medical Director, Clinical Service Manager and Clinical Service Lead.
The new theatre schedules and outpatient schedules started on 1st May 2017, to match the updated agreed job plans.
The next round of job planning is now being planned and will start by the end of Q1.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained above the target 85% in the majority of months. However, the previous measure (pre June) 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. The May performance has improved and will continues to be a focus to improve further for the coming months to enable the delivery of additional activity required to address 18 week compliance.

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. This will be led by the Head of Nursing, Division 2, working on The Productive Operating Theatre principles. The new Theatre Management System 'Theatreman' was successfully implemented on 24th May 2017, replacing ORMIS. The prescriptive nature of this software will be a further aid to ensure that lists are optimally booked based on the available time. Scrutiny and challenge is via the weekly 6-4-2 meeting, with instructions back through to the surgical teams to book lists to their maximum potential and to POAC and identify patients well in advance so that specific requirements can be planned for to reduce cancellations. Work on trajectories in the Spinal, Hands, Feet and Arthroscopy specialties has also brought to the fore some opportunities for greater efficiency and the possibility of moving some cases out of the theatre environment. Additional capacity delivery through use of non consultant staff is being explored. Detailed action plans have been completed and underpin all of the speciality trajectories, these plans include detailed monitoring of additional activity that feed into the trajectory, month by month. As the validation work continues , this will confirm an accurate picture of the waiting list and hence the level of additional activity required.

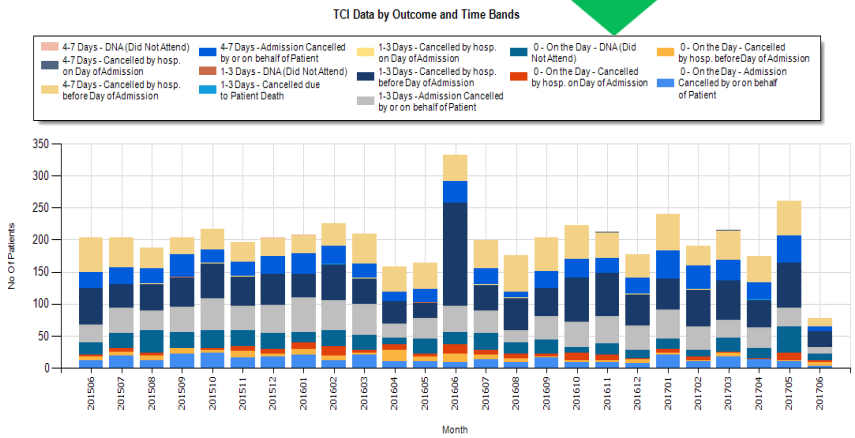
RISKS / ISSUES

Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (e.g. experience in spinal scrub) to ensure the best possible use of available operating time. Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit. Gaps in the operational structure, although recruitment is underway.

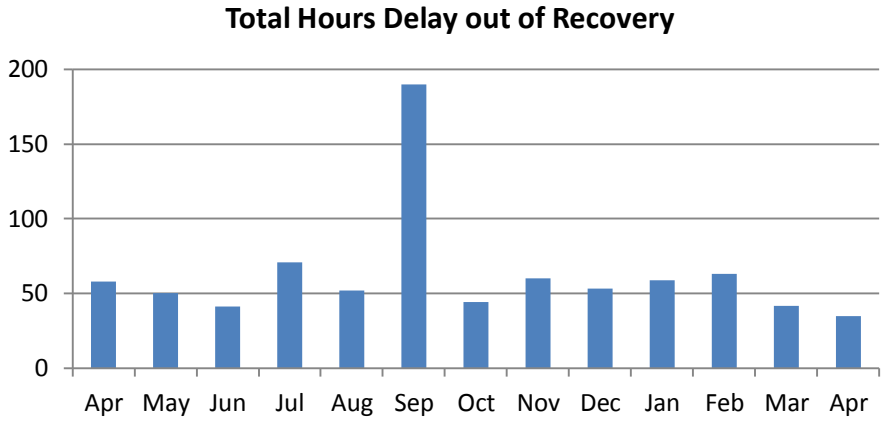
Governor indicator

11. Process & Flow efficiencies – This illustra sful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient ma

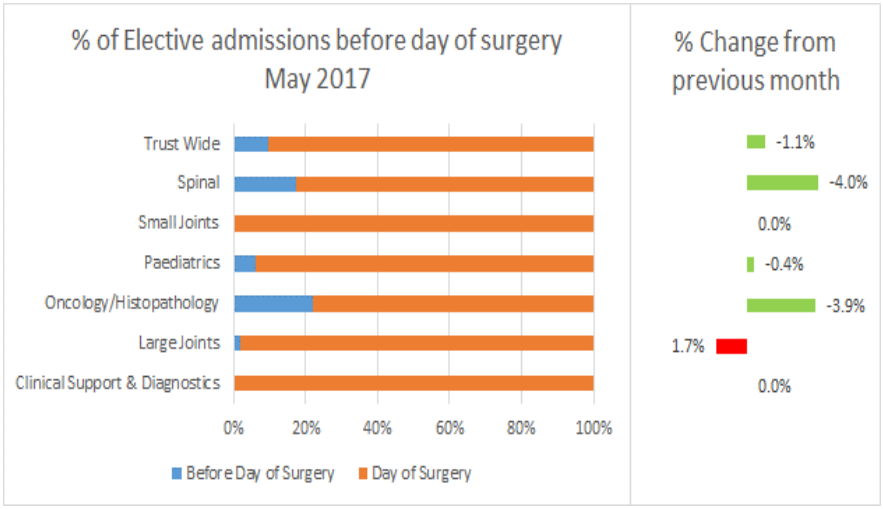
Cancellations by patient / hospital



Delays out of recovery

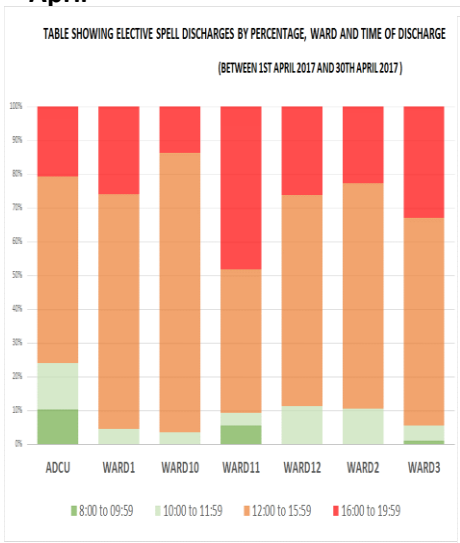


Admission the day before surgery

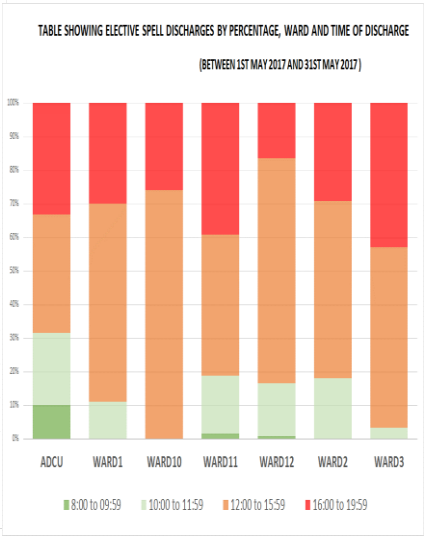


Time of day patients discharged

April



May



INFORMATION

Active management of the Patient Tracking List (PTL) , the planning for the establishment of a separate Oncology PTL weekly meeting to track the booking of individual patients, and a separate large joints PTL weekly meeting to track patients is creating a new momentum, with lists being booked several weeks ahead where previously they were being booked only days ahead.

Work on the trajectories for spinal, hands, feet and arthroscopy is identifying opportunities for streamlining referrals, reviewing the use of an operating theatre for cases being undertaken (rather than an OPD setting) and the rebalancing of waiting lists across firms. The implications of these are being worked through with Clinical Service leads and Clinical Service Managers. The validation of the waiting lists continues, as noted earlier.

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Some of the replacement patients are then booked at short notice. We are working towards booking with 3 week's notice and 2 reasonable offers as per national guidance and our Access Policy.

Now that there are Clinical Service Leads and Clinical Service Managers for each specialty, and regular team meetings, some longstanding issues relating to disparity of waiting lists across consultants, variations in theatre productivity and listing protocols are being addressed and resolved. Work is continuing, with a particular focus on Oncology. There are measurable and encouraging results from this work.

Forensic analysis of cancellations continues, with a focussed analysis by the anaesthetic lead and nursing lead for POAC of the majority cause of cancellations on the day of surgery, namely those who are medically unfit, to ascertain what process changes can be made in POAC or to the 72 hour phone call to reduce this.

ACTIONS FOR IMPROVEMENTS / LEARNING

Now that the longstanding vacancies in Medical secretaries, admin support and operational management have been filled, there is now the capacity for transacting the forward booking of patients for both preoperative assessment and surgery.

This will create a pool of patients available to be called forward earlier at short notice to fill cancellation slots.

Work is still required to agree criteria for admission the day before, to use beds more effectively and reduce length of stay.

Pre-operative assessment improvements have been delivered, so that there are now 32 slots available each day.

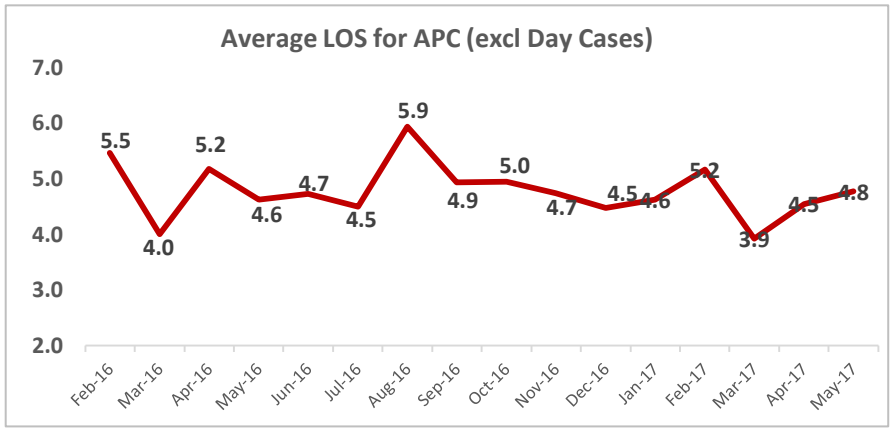
A daily update review by operational management of forward bookings has been established and the 642 and a daily 9am Operations huddle has been started. Daily statistics on beds , admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to deliver activity and patient flow.

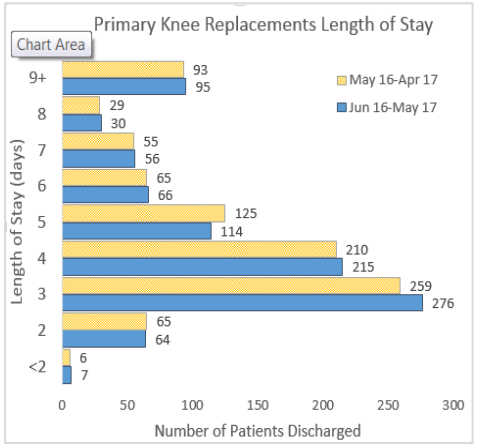
RISKS / ISSUES

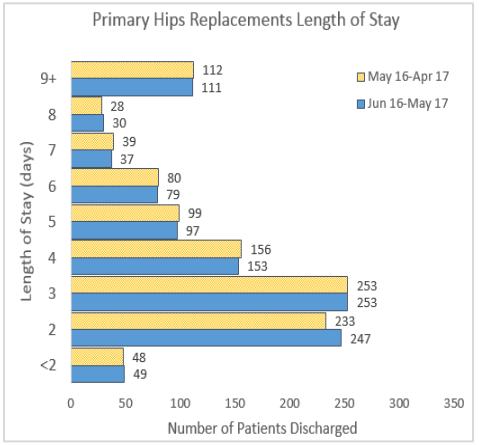
Continued focus with all staff involved to ensure that the operating lists are booked in advance, with sufficient caseloads, together with daily tracking.

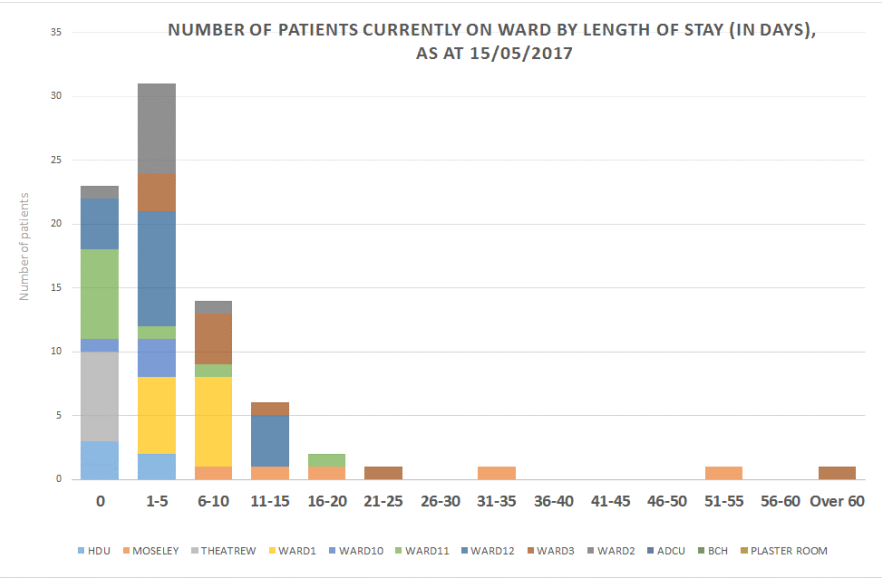
It is currently not possible to identify if the time of day patients are discharged is an accurate reflection of reality, or whether data is being entered onto the system in a delayed manner, making discharges look later in the day.

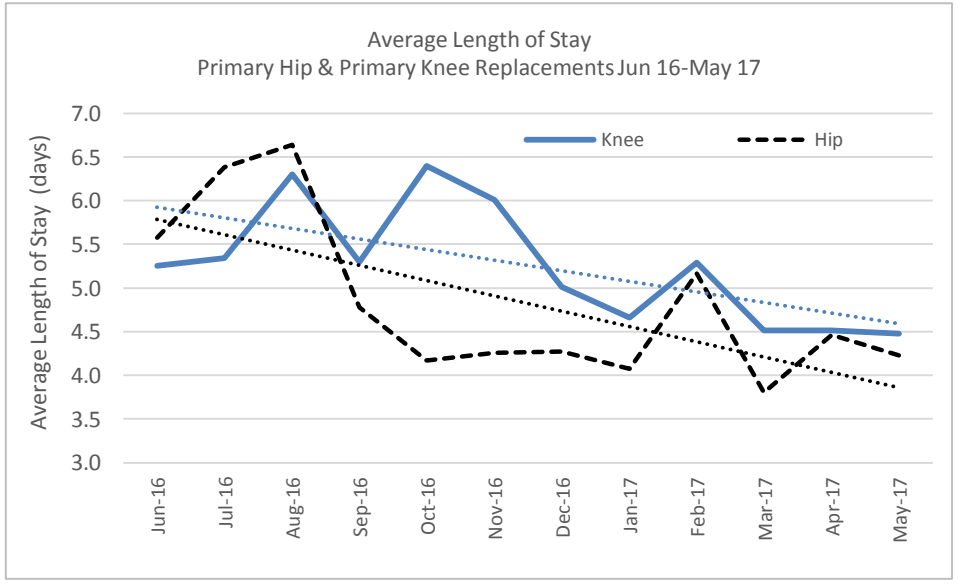
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Under the leadership of the Associate Medical Directors , Clinical Service Leads and Clinical Service Managers, work is progressing to increase activity levels to deliver 18 week compliance by creating additional capacity from within existing resources by improving flow. Length of stay reductions for primary hips and knees is key to achieving this , and an update will be brought to the next committee as to the progress of this work.

In May 2017, a 'Red/Green' process has been started to force better flow of patients hour by hour , partly to facilitate the rolling ward closures for the site infrastructure cabling installation, and mainly to improve overall patient flow.

The Home for Lunch' information campaign was launched to staff and patients during Mid February and this has also helped to reduce length of stay with the expectation setting with staff and patients about when a patient can leave the hospital, and the marshalling of resources to ensure that this occurs as early as possible in the day. This clearly sets out to all concerned that we expect that more than 80% of patients due for discharge that day will leave hospital or be off the ward and in the discharge lounge before midday.

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.

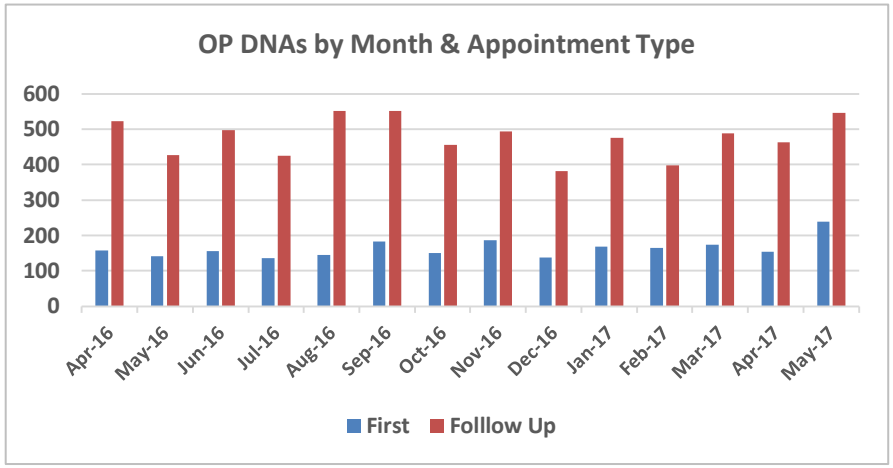
Daily senior reviews are being formalised as part of job planning, and the rising adherence to recording the Expected Date of Discharge (EDD) (now over 90%) is helping all involved in that patient's care to manage their length of stay more effectively.

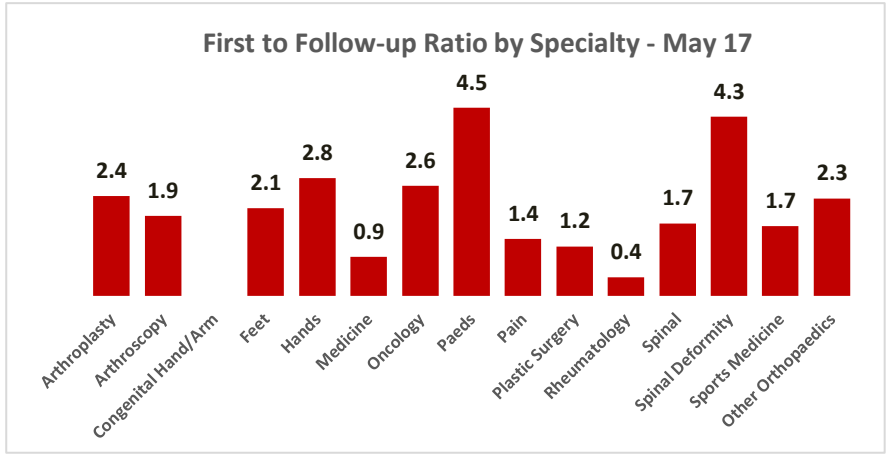
RISKS / ISSUES

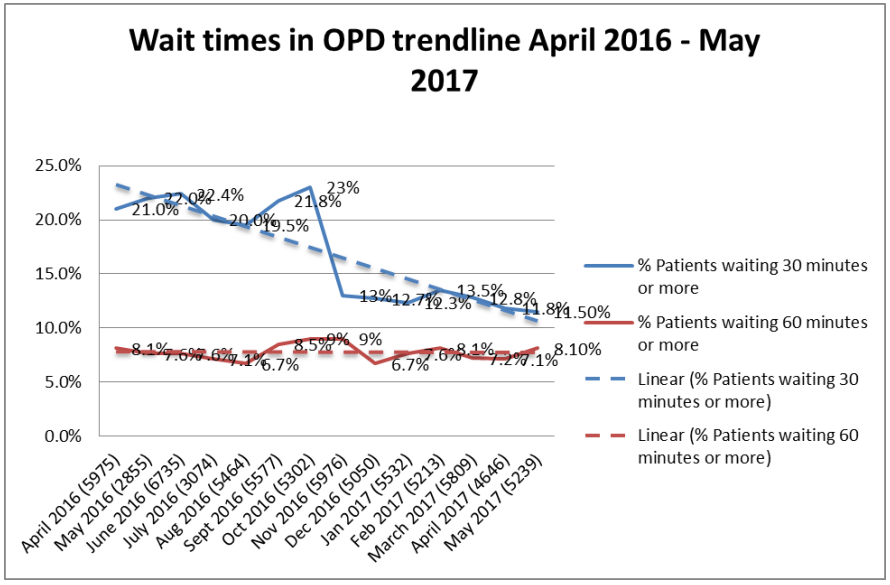
Using individual consultant information, Operational management teams and Clinical Service Leads are reviewing outlying clinical practice to help ensure that all patients are able to go home as soon as possible after their surgery.
Compliance with achieving discharge on the expected date of discharge is being monitored- When this measure was introduced, non compliance was in excess of 35% and now this is below 5%. This is being tracked through nursing and operations management to drive further improvement.

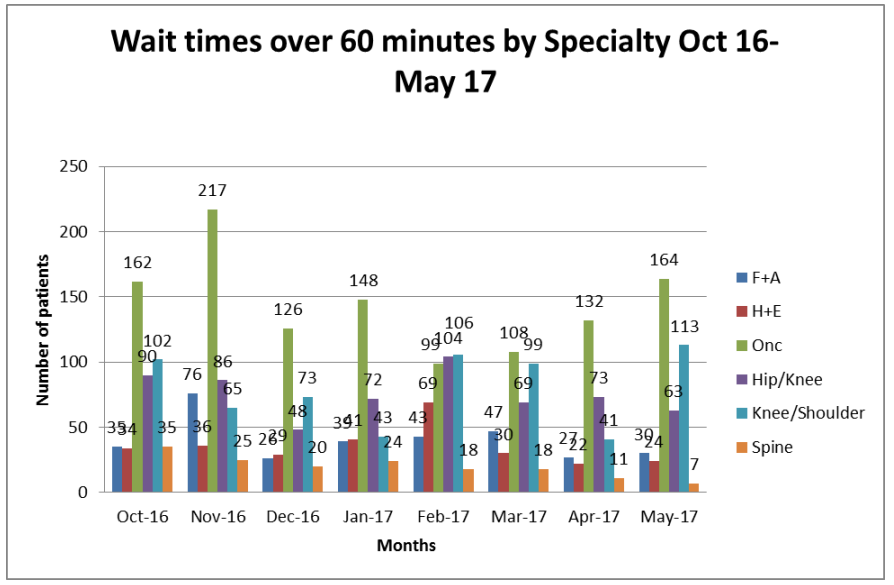
Data Quality reports are now available to show adherence to completion of 'Expected date of discharge' dates- non compliance was at over 50% and is now below 10%. This is being tracked through nursing and operations management to drive further improvement.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients









INFORMATION

Since the initial implementation of the new clinic templates in November there has been a reduction in the 30 minute wait times for patients. Since August 2016, when on average 21% of patients waited more than 30 minutes, this is now reduced to 11.5% of patients waiting in May 2017. Further work is underway, and with the introduction of the new clinic schedules on 1st May 2017, this should further reduce wait times.
There is a new standard operating procedure for any clinic running over 60 minutes late. The incident reporting system , Ulysses , has been amended to make it easier for the clinic staff to complete the incident form. An incident form is completed and a new drop down analysis is selected by the staff completing the incident . The reasons documented on the incident forms now form part of a monthly action plan and this will be shared so reasons can be addressed.
The outpatient department continue to audit its compliance against the SOP for wait time and can demonstrate 100% compliance.

The work undertaken to understand the trajectories for Hands, Feet and Arthroscopy continues and will be will be rolled out across all specialties- initial results are showing very low conversion rates from first OPD appointment to surgery, and also from second OPD appointment to surgery for some specialties.

The new Oncology clinic templates have been implemented from Monday 5th June 2017. All patients booked onto the old clinic template have been transferred across following a dedicated and controlled project management approach.

ACTIONS FOR IMPROVEMENTS / LEARNING

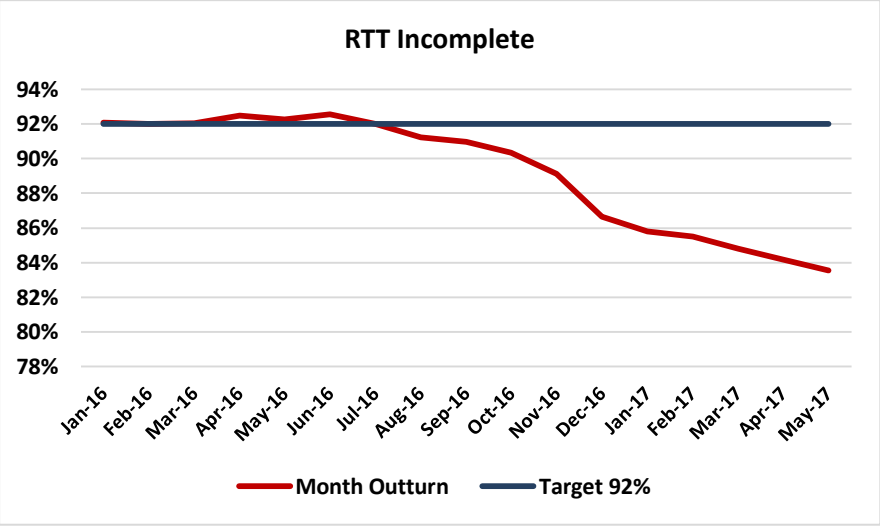
There are a range of actions as part of the CQC action plan and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

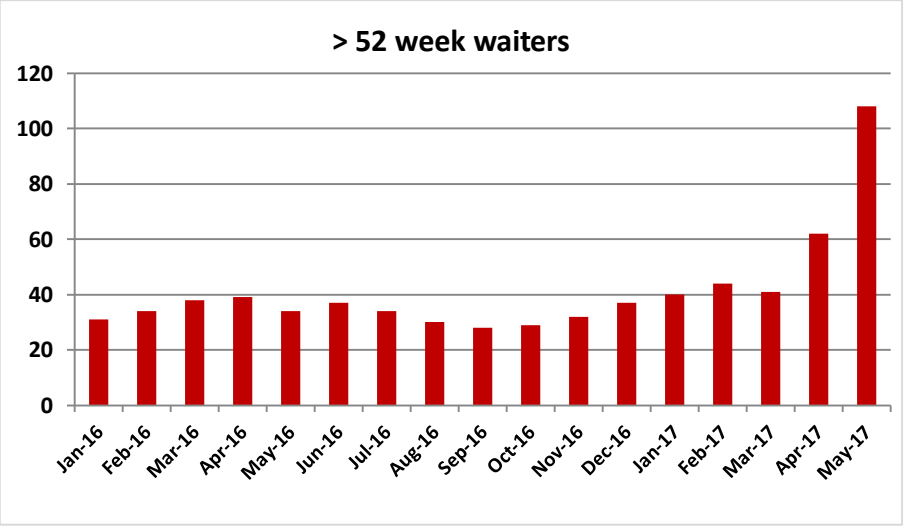
As part of the Trust's RTT recovery work, there will be a focus on out patient pathways and any patients who are in the system awaiting a follow up appointment and have become overdue, for whom a new active RTT clock should be started in line with national guidance. However, if it is found that there is a follow up appointment capacity problem, then this could worsen new to review ratios in the short term. This is being reinforced through RTT training and the clinical service managers working closely with consultants and medical secretaries to ensure that the Trust access policy is being adhered to by all involved.

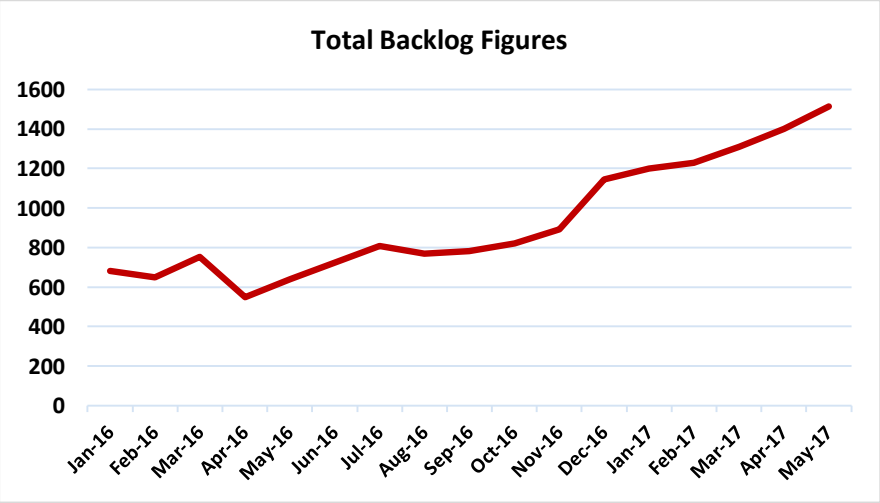
RISKS / ISSUES

Feeding back patient waiting lists to consultants weekly continues, with much focus on improving data quality arising from the validation work that is ongoing .

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets - RTT	Target / Trajectory	Actual (May 17)	Actual (YTD)
52 Weeks Waiters	-	108	108
18 Weeks Incomplete	92%	83.55%	83.86%
NHSI Performance Targets - Cancer	**Target / Trajectory**	**Actual (Apr 17)**	**Actual (YTD)**
Cancer (2 week wait)	93%	97.3%	
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	
Cancer (62 days)	85%	66.7%	

INFORMATION

RTT open pathway performance continues to cause concern. The end of May 2017 validated position is 83.55%, compared to the validated position for April 2017 of 84.17%, which was below the previous month's position of 84.79%, continuing an established pattern of month on month deterioration. This is a mixture of addressing data quality issues as they are identified as part of the ongoing validation work associated with the open pathways, and also pathways through to surgery that are not 18 week compliant for a significant number of surgeons in the majority of specialities.
As at 31st May 2017 there are a total of 1,513 patients at 18 weeks or over on the waiting list. At each milestone the number of patients at 18 weeks and over has risen since last week. Whilst these figures include both dated and undated patients, the number of patients dated 14 weeks and above is not sufficient to improve the Trust's position.
During March 2017, the Trust Chair received notification that NHSI were launching an investigation into the Trust's RTT performance. This has included the provision of various reports and data, as well as an on-site visit from 24th to 27th April 2017. An RTT Recovery Board has been established and met for the first time on 27th April 2017.

As part of our RTT recovery work, we have been accessing a range of support from stakeholders. Some of this has come via regulators, including access to NHS Improvement's Intensive Support Team, and some of this has come from other NHS organisations in the form of buddying arrangements. Through the Birmingham and Solihull STP (Sustainability & Transformation Partnership), we have now been able to access resources and expertise from University Hospitals Birmingham, who have supported RTT recovery in a range of other providers including George Elliott and Medway.

ACTIONS FOR IMPROVEMENTS / LEARNING

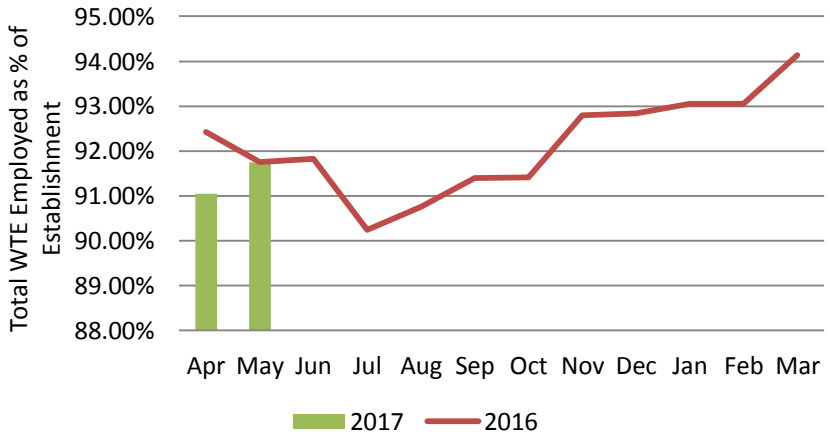
All consultants now receive an updated copy of their individual waiting list (PTL), this is sent electronically from the Operations Team every Friday to all specialities. It is expected that all medical secretaries will review their PTL with their consultant and ensure that all patients are dated in waiting time/clinical priority. From 12th June 2017 onwards, a sign off sheet is being completed by each consultant once they have reviewed their PTL.
The Operations team meet weekly to scrutinise all patients waiting over 50 weeks across all specialities to ensure all patients have definitive treatment plans and ensuring all patients requiring further validation are identified.

RISKS / ISSUES

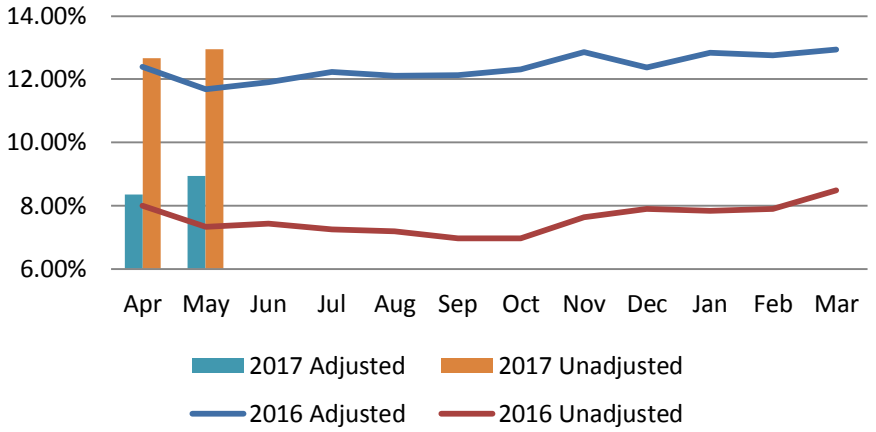
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern.
18 weeks: Significant work continues to understand the scale of the challenge with regard to open pathways, and the extent of data quality concerns. The Trust welcomes the input and expertise of NHS Improvement and the Birmingham and Solihull STP in this area.
A review is under way with regard to the robustness of cancer waiting times reporting, given the concerns with data quality around the other access targets.

15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

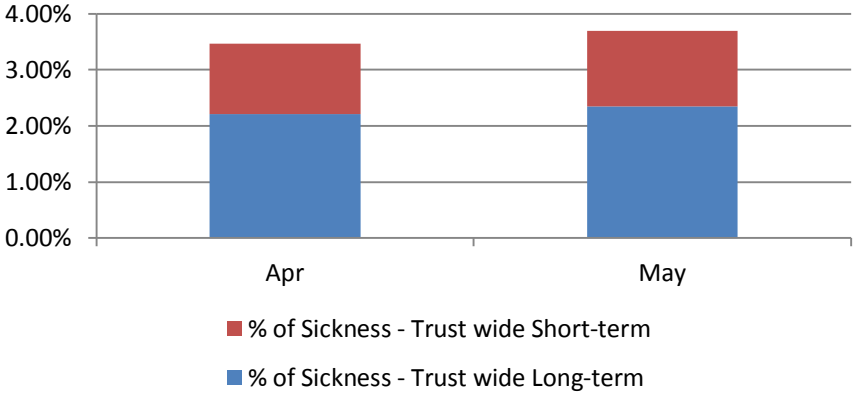
Staff in Post v Establishment



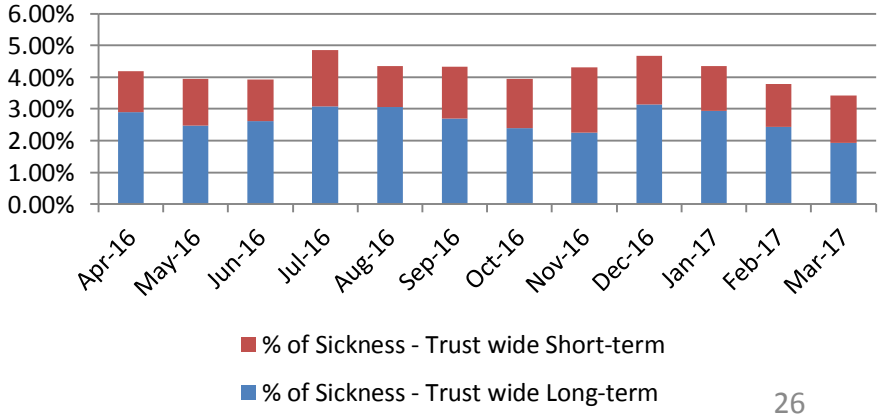
Staff Turnover



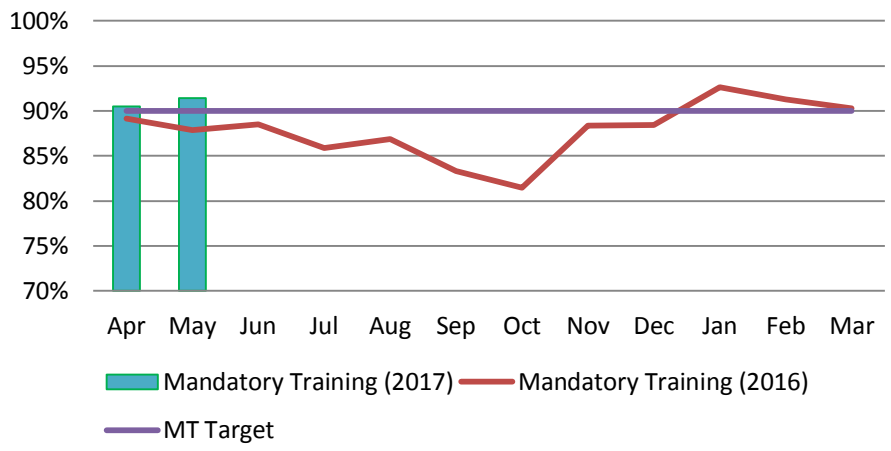
Sickness % - LT/ST (2017/18)



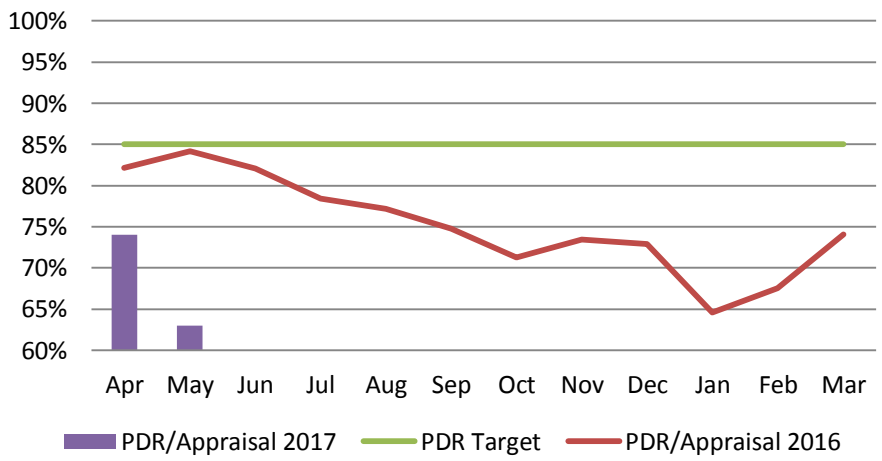
Sickness % - LT/ST (2016/17)



Mandatory Training



PDR/Appraisal



INFORMATION

In general terms, May was an encouraging one for workforce performance in sickness, vacancies and mandatory training – but appraisal is now a cause for concern.

The Trust's vacancy position improved on last month by 0.7% to 91.75%. This keeps us amber for May 2017 - but does represent progress.

May also saw a small increase (0.23%) in sickness absence, based on slight increases both in short and long term absence since the April position. At 3.69% in month, however, it represents a comparatively low figure for May (in fact, the lowest monthly May figure since 2009). This in month performance has also reduced the Trust's 12 month underlying average figure to 4.16%, turning the position "green" for the first time since June 2016.

Mandatory training was green for the fifth consecutive month. It has increased slightly this month by almost 1% and is still green at 91.46% overall. This remains an area of operational focus. Some staff are being enabled to complete modules online, which may also support compliance rates.

Performance relating to PDR/appraisals in May decreased to 62.96% (a dramatic decline of 11.03%), representing the lowest performance for almost 4 years. RTT work, harm reviews, the need to maintain statutory and mandatory training appear to have resulted in less attention being paid to appraisal than usual. Data validation work is ongoing – but this is a marked decline and needs focus.

There was slight movement in the May turnover figures. The unadjusted turnover figure (all leavers except doctors and retire/ returners) increased by 0.28% on last month with the adjusted turnover figure ("true leavers," meaning "voluntary resignations") increasing by 0.59%.

A call to action for improved appraisal performance was made via team brief in mid March2017.

Separate appraisal communications have now been issued to individual divisions in relation to their performance, asking them to validate their data, offering bespoke ESR HR support to ensure that it is correct, including training in ESR if necessary. This will also be addressed by HR Managers in their respective Divisional Board meetings.

RISKS / ISSUES

The Trust is currently has had its compliance notice from commissioners on mandatory training removed, but it will be key to manage performance in this area going forwards.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 6 September 2017

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 6 September 2017 commencing at **1130h** 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, Claire Kettle at the Management Offices or via email claire.kettle@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** 6 September 2017: 1130h – 1315h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Rod Anthony	Non Executive Director	(RA)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Acting Chief Executive	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Guests

Ms Alicia Stanton	Senior Physiotherapist	(AS)	[Item 3]

TIME	ITEM	TITLE	PAPER	LEAD
1130h	1	Apologies - Tim Pile	Verbal	Chair
1132h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1135h	3	Patient story – Rapid Recovery	Presentation	AS
1155h	4	Minutes of Public Board Meeting held on the 5 July 2017: *for approval*	ROHTB (7/17) 014	Chair
1200h	5	Trust Board action points: *for assurance*	ROHTB (7/17) 014 (a)	SGL
1205h	6	Designation of Acting Accounting Officer: *for approval*	ROHTB (9/17) 012	YB
1210h	7	Chairman's and Chief Executive's update, including update on planned changes to regulatory guidance: *for information and assurance*	ROHTB (9/17) 001	YB/PA
		QUALITY & PATIENT SAFETY		
1220h	8	Patient Safety & Quality report: *for assurance*	ROHTB (9/17) 002	GM

1230h	9	Safe nurse staffing: *for assurance*	ROHTB (9/17) 004 ROHTB (9/17) 004 (a)	GM
1240h	10	Learning from Deaths policy: *for approval*	ROHTB (9/17) 005 ROHTB (9/17) 005 (a)	AP
FINANCE AND PERFORMANCE				
1245h	11	Finance & Performance overview: *for assurance*	ROHTB (9/17) 006	PA
GOVERNANCE, RISK AND COMPLIANCE				
1255h	12	Emergency Preparedness and Resilience Reponse: *for approval*	ROHTB (9/17) 007 ROHTB (9/17) 007 (a)	PB
1300h	13	Board Assurance Framework: *for assurance*	ROHTB (9/17) 008 ROHTB (9/17) 008 (a)	SGL
UPDATES FROM THE BOARD COMMITTEES				
1310h	14	Quality & Safety Committee – assurance report and Terms of Reference: *for assurance & approval*	ROHTB (9/17) 009 ROHTB (9/17) 009 (a)	KS
	15	Finance & Performance Committee – assurance report and Terms of Reference: *for assurance & approval*	ROHTB (9/17) 010 ROHTB (9/17) 010 (a)	RA
	16	Major Projects & OD Committee	ROHTB (9/17) 011	RP
MATTERS FOR INFORMATION				
1315h	17	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 4th October 2017 at 1100h, Board Room, Trust Headquarters				

Notes

Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 5 July 2017: 1200h – 1315h

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)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Richard Phillips	Non Executive Director	(RP)
Mr Paul Athey	Acting Chief Executive and Director of Finance & Performance	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Nicky Lloyd	Associate Director of Operations	(NL)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Jo Chambers and Jo Williams.	
2 Declarations of interest	**Verbal**
There were none.	
3 Minutes of Public Board Meeting held on 6 June 2017	**ROHTB (6/17) 031**
The minutes of the Trust Board meeting held on 6 June 2017 were accepted as a true and accurate record of discussions.	
4 Trust Board action points	**ROHTB (6/17) 031 (a)**

The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern. It was noted that some of the actions arising from the staff survey would be disseminated across the Trust and included in the ward dashboards when prepared.	
5 Chairman's & Chief Executive's update	**Verbal** **ROHTB (7/17) 002**
The Acting Chief Executive reported that the Board had been selected as a provider to help with the national orthopaedic tariff work and the development of a more accurate set of prices for these procedures. Initiation meetings would commence shortly. The Medical Director reported that in terms of the Medicines and Healthcare products Regulatory Agency (MHRA) alert concerning metal on metal hip replacements that had recently received some press attention, this was a refresh of the previous recommendation in 2012. There was already a requirement for trusts to offer all patients with this type of implant and resurfacing to have an annual review of blood metal ion levels and a scan. A robust process was in place at the ROH to comply with this. The latest advice had come on the back of a further report on metal on metal implants, with the latest view being that there was a small additional cohort of patients who would have symptoms that may be silent and therefore these patients also needed to be offered a review appointment. The impact on the ROH was that in addition to current patients being reviewed, an additional 2000 patients over a three year period would need to be seen. This would be built into the current metal on metal review process but it may present a resource issue. There was also a risk that insurance companies may refuse to fund some of the private reviews and therefore they would be referred into the NHS processes. There would also be an impact on around surgeons' private practice. Further information would be available later. The Board noted this guidance was being challenged professionally. It was noted that following recent speculation by staff, the Trust was not being taken over by University Hospitals Birmingham NHS FT and the STP was being used to provide expertise and additional capacity. The Board was advised that a letter from the Secretary of State for Health had been received, congratulating the Trust on its achievement of 100% in the Friends and Family Test. The Board was asked to note some changes to the existing Well Led Framework. It was proposed that this would be used to drive some changes across the organisation rather than handling this as a major initiative at the time, however a	

formal assessment would be needed at some point. It was noted that as many of the requirements of the framework related to Organisational Development, these would be picked up by the Head of OD & Inclusion.	
6 Patient Safety & Quality Report	**ROHTB (7/17) 003**
It was noted that the report had been previously considered by the Quality & Safety Committee. It was reported that the number of incidents had increased, largely as a result of the ongoing validation of the open pathways and the harm review process. There had been seven Serious Incidents reported during the month. There had been three Grade 3 pressure ulcers reported in May; there appeared to be a set of cast-related ulcers. There had been an audit of Duty of Candour and some non-compliances around the process for those spinal deformity patients who had been identified as experiencing harm as a result of the long waiting times had been identified. Meetings had now been held with two of the patients and one has not been met with as surgery had been brought forward. It was observed that there was a big disparity between the staff friends and family test results and the patients' friends and family test results. It was noted that this was a common position, however the timing of the survey impacted this year significantly.	
7 Finance & Performance overview	**ROHTB (7/17) 004**
The Chair of Finance & Performance Committee advised that the report had been considered by his committee which had met recently. The underlying financial position was noted to be worse than expected, although the month's figure was above plan due to the impact of an insurance payment. The activity position was noted to be very poor and was expected to be worse for June. This would jeopardise the achievement of the quarter's control total. Revised staffing arrangements in theatres were planned. For many of the weeks there had been an absence of theatre senior leadership. These vacancies had now largely been addressed however. A new forum which would look back at the issues during the previous week was being introduced. Through the 6-4-2 meeting, all were reminded of the delivery of tasks by firm; this would be monitored daily. There were a number of three session days planned. Professor Gourevitch encouraged a review of these arrangements as in his view, it was rare that the full three sessions were utilised. There had been little weekend working. A process of re-letting lists had been introduced and other	

measures had been put into place to achieve better in session utilisation. It was agreed that a list of standby patients was needed, these have been pre-operatively assessed. Mrs Sallah noted that lengths of stay were concerning and suggested that this might reflect the complexity of cases. Equipment availability for those needing rehabilitation at home also impacted. It was noted that the position was frustrating, especially as the issues were those which the Board had discussed on many occasions previously. The Chairman was not assured that the reasons for the activity were understood. It was suggested that a patient journey needed to be walked through to understand the reasons for the inefficiencies. There needed to be a prioritised list of actions to deliver improvement. Staff were not skilled in quality improvement however, although this approach was needed, so process maps needed to be developed. It was agreed that this needed to be considered by the Finance & Performance Committee. Cancellations were noted to be high. In terms of expenditure, the agency position was under control overall, however there was a slight overspend on costs such as those associated with validators. Delivery of Cost Improvement schemes was behind and it noted that it would be challenging to recover this at present. New schemes needed to be identified. It was reported that the Finance & Performance Committee had considered information on service level reporting. This needed to be shared with clinicians. It was suggested that activity targets needed to be owned by the consultants and rectification plans needed to be provided. In terms of Theatreman, the Board was advised that the system went live in May. This forced live data entry and data capture. Care plans would also be included on the system and this also assisted with compliance against the WHO checklist. The feedback from medical secretaries has been positive.	
8 Guardian of Safe Working Hours update	**ROHTB (7/17) 005**
In Mr Marks' absence the Executive Director of Strategy & Delivery reported that there was a requirement for doctors in training to be protected in terms of their working hours and the Guardian of Safe Working Hours was required to report to the Board quarterly any exceptions. On this occasion, there were no issues to report.	
9 Fire safety	**Verbal**

The Executive Director of Strategy & Delivery reported that following the Grenfell Tower disaster, the NHS had reacted to undertake some urgent work and submissions were needed from all organisations regarding any risks as a result of the cladding used on their estates. Additionally, precautionary measures were taken to review all properties and provide assurance jointly with West Midlands Fire Service. The Group Commander held a meeting on 27 June and provided a brief on the national risks. There were 38 buildings in the NHS that were categorised as high priority. Nine of which had cladding similar to Grenfell Tower, none of them being in the West Midlands however. The ROH was categorised as low rise and it had a small amount of aluminium cladding but this was in non-inpatient areas and there was no cladding similar to that in Grenfell Tower. Further national work would continue. Annual reviews would also continue. All were thanked for working over the weekend. It was agreed that the Council of Governors needed to be appraised.	
ACTION: **SGL to arrange for the Council of Governors to be appraised of fire safety in the context of the Grenfell Tower disaster**	
10 Quality & Safety Committee	**ROHTB (7/17) 006**
The Board was advised that the Quality & Safety Committee had discussed the letter received following the review of Paediatric care by the West Midlands Quality Review Service (WMQRS). There Committee was concerned over the robustness of assurance provided by the Drugs & Therapeutics Committee (DTC). In particular, the minutes of the DTC needed to be improved. There had been a discussion around bereavement support services and there were improvements planned.	
11 Finance & Performance Committee	**ROHTB (7/17) 007**
It was noted that the discussions at the Finance & Performance Committee had been covered elsewhere. It was noted that the meeting had not been quorate.	
12 Any Other Business	**Verbal**
It was noted that the Trust's summer fete was planned for Saturday 8 July and all were encouraged to attend if possible. The Board was advised of a risk around missing patient notes in readiness for clinic. This was an ongoing issue but was a frustration of consultants. The addition of Lordswood clinic and Oncology clinics had impacted to some degree. There was sickness in the medical records area which was also impacting. Incidents were	

being raised when records were not available for clinic. It was reported that the Divisional General Manager for Division 3 was focussed on resolving this and a report back was planned to Executive Team. It was suggested that a clinical portal was needed, however this was dependent on some IT enabling works.	
Details of next meeting	**Verbal**
The next meeting is planned for 6 September 2017 at 1100h in the Boardroom, Trust HQ.	

PUBLIC SESSION

Next Meeting: 6 September 2017, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

5 July 2017, Boardroom @ Trust Headquarters

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 036	Patient Story - Rapid Recovery	Video	01/03/2017	Update on progress to be brought to a future meeting.	SGL	06-Sep-17	Included on the agenda of the September Trust Board meeting	
ROHTBACT. 037	Patient Safety & Quality Report	ROHTB (6/17) 003	07/06/2017	Arrange for the Throne Project to be used as a patient story at a future meeting	GM	04-Oct-17	ACTION NOT YET DUE	
ROHTBACT. 038	Staff Survey and Analysis	ROHTB (6/17) 006 ROHTB (6/17) 006 (a) ROHTB (6/17) 006 (b)	07/06/2017	Schedule a further update on the delivery of the staff survey action plan	SGL	04-Oct-17	ACTION NOT YET DUE	
ROHTBACT. 040	Fire safety	Verbal	05/07/2017	Arrange for the Council of Governors to be appraised of fire safety in the context of the Grenfell Tower disaster	SGL	19-Jul-17	Head of Estates provided an update the July meeting of the Council of Governors	

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

ROHTB (9/17) 012

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Appointment of acting Accounting Officer**
SPONSOR (EXECUTIVE DIRECTOR):	**Dame Yve Buckland, Trust Chairman**
AUTHOR:	**Mr Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**6 September 2017**

EXECUTIVE SUMMARY:

The NHS Act 2006 designates the Chief Executive of an NHS foundation trust as the accounting officer.

The Act specifies that the accounting officer has a duty to prepare the accounts in accordance with the Act. An accounting officer has the personal duty of signing the NHS foundation trust's accounts.

The accounting officer also has a further set of general and specific responsibilities which are detailed in the NHS foundation trust accounting officer memorandum.

In a period of absence of the substantive Chief Executive of a foundation trust, the Board is required to appoint an Acting accounting officer.

REPORT RECOMMENDATION:

The Trust Board is asked to agree the designation of Paul Athey as Acting accounting officer, this being in line with his current responsibilities as Acting Chief 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	x	Environmental		Communications & Media	
Business and market share		Legal & Policy	x	Patient Experience	
Clinical		Equality and Diversity		Workforce	

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

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

None specifically

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (9/17) 001

The Royal Orthopaedic Hospital NHS Foundation Trust

Proposed Changes to the Single Oversight Framework and the introduction of the Use of Resources Framework

Report to Trust Board on 6 September 2017

1 Background

1.1 The first version of the ***Single Oversight Framework*** (SOF) was published in September 2016. As the first SOF constituted a new approach to oversight of both NHS trusts and NHS foundation trusts, NHS Improvement was clear when it was published that it was anticipating that there would be learning from the first year of operation that it would want to feed into future iterations of the framework. In line with this, NHS Improvement has reviewed the current SOF and identified a set of proposed changes to be introduced later in 2017, which reflect changes in national policy & standards, data quality and other regulatory frameworks, as well as its own learning.

1.2 NHS Improvement and the CQC have also published the final ***Use of Resources (UoR) framework***. Use of Resources assessments will be introduced, alongside the CQC's new inspection approach from autumn 2017.

2 Summary

2.1 As the SOF has been in place for less than a year, NHS Improvement is not proposing to change the underlying framework itself, this being the five themes under which performance is assessed, the approach to monitoring, identifying and responding to support needs and the segmentation of providers.

2.2 The changes are mainly minor and relate to information and metrics used to assess providers' performance under each theme and the indicators that trigger consideration of potential support needed.

3 Changes proposed to the Single Oversight Framework

3.1 In addition to the changes to the information and metrics used to assess performance, the structure and presentation of the SOF document has also been amended to clarify certain processes and definitions and to correct some working and figures where discrepancies have been identified.

3.2 It has been made explicit that providers are expected to notify NHS Improvement of significant actual or prospective changes in performance or risk outside routine

monitoring. It has also been noted under all themes that in addition to specific triggers, other material concerns arising from intelligence gathered by or provided to NHS Improvement could trigger consideration of a support need.

3.3 There are several changes proposed to the Quality of Care theme, these being:

- *Amended*: current trigger of a CQC rating of 'inadequate' or 'requires improvement' against any of the safe, effective, caring or responsive key questions changed to a CQC rating of 'inadequate' or 'requires improvement' in the overall rating
- *Removed*: 'aggressive cost reduction plans' from the metrics list, referring instead to it in the main narrative
- *Removed*: Hospital Standardised Mortality Ratio-Weekend (DFI) metric. A new indicator is being developed to replace this.
- *Added*: new *E.coli* bacteraemia bloodstream infection (BSI) metric, in line with the national target to reduce health care associated gram-negative bloodstream infections (GNBSI) by 50% by March 2021

3.4 There are no changes proposed to how the finance score is calculated. The existing SOF term 'finance and use of resources score' will be amended to 'finance score' to make a clear distinction from the ratings under the new Use of Resources framework.

The revised SOF contains an explanation of how NHS Improvement will use the new UoR framework and rating, alongside the finance score, to inform consideration of the provider's support needs under this theme.

It was originally proposed that two additional metrics around capital controls and change in cost per weighted activity unit would be introduced in shadow format in 2016/17. These were not implemented and will not be used to inform the finance score in 2017/18.

3.5 NHS Improvement has added or revised several aspects of the operational performance metrics, however the impact of these is confined to acute and mental health providers only. Notably, however, the metric around 62-day wait for first treatment from NHS cancer screening service has been removed to align with Sustainability & Transformation Fund performance improvement trajectories.

3.6 NHS Improvement will consider the assessment of system-wide leadership under the recently published STP ratings, along with broader intelligence, when considering providers' performance under this theme.

3.7 The leadership and improvement capability theme has been amended to reflect the new, joint Well Led Framework on which the Board has been previously briefed.

3.8 The changes proposed are subject to a consultation exercise, which closes on 13 September, with a view to publishing the updated SOF in October 2017, with changes introduced during Quarter 3 (October – December 2017).

4 Segmentation change

4.1 The overall judgement of a provider's performance under the Single Oversight Framework, categorises trusts into one of four segments according to the level of support each trust needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability.

4.2 When the SOF was first introduced, the ROH was placed into Segment 2, this being described as being for 'providers triggering concerns in relation to one or more of the themes. Targeted support that the provider can access has been identified to address these concerns, but which they are not obliged to take up. For some providers in Segment 2, more evidence may need to be gathered to identify appropriate support.'

4.3 Following the regulatory concerns identified by NHS Improvement in Spring 2017 and the subsequent letter of undertakings to rectify the breaches to the Trust's licence, it was understood that the Trust would be moved to a lower segment in due course. When the quarterly provider segmentation was published in July 2017, this confirmed that the Trust had been moved from Segment 2 to Segment 3.

4.4 Segment 3 is described as being for 'providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.' The Board will be familiar with the efforts being made and work being delivered to address the shortcoming in the operation of the Trust that have resulted in this change.

5 Use of Resources framework

5.1 The final Use of Resources (UoR) framework has been published, following a period of consultation and a series of pilots undertaken to refine the assessment methodology.

5.2 The table below, sets out the metrics that NHS Improvement will use to inform the assessment, along with local intelligence gathered during NHS Improvement's day to day interactions with the Trust and qualitative evidence gathered through an on-site assessment visit.

Use of Resources area	Initial metrics
Clinical services	• Pre-procedure non-elective bed days • Pre-procedure elective bed days • Emergency readmissions (30 days) • Did Not Attend rate
People	• Staff retention rate • Sickness absence rate • Pay cost per weighted activity unit (WAU)

	• Doctors cost per WAU • Nurses cost per WAU • Allied Health Professional cost per WAU (community adjusted)
Clinical support services	• Top 10 medicines - %age delivery of savings target • Overall cost per test
Corporate services, procurement, estates and facilities	• Non-pay cost per WAU • Finance cost per £100 million turnover • Human resources cost per £100 million turnover • Procurement Process Efficiency and Price Performance Score • Estates cost per square metre
Finance	• Capital service capacity • Liquidity (days) • Income and expenditure margin • Distance from financial plan • Agency spend

5.3 The framework also contains ratings characteristics which describe what 'outstanding', 'good', 'requires improvement' and 'inadequate' use of resources looks like.

5.4 Until a provider has undergone a Use of Resources assessment, NHS Improvement will use the Finance Score under the SOF, alongside other evidence of whether a provider is making optimal use of its resources, to identify potential support needs under this theme.

5.5 Once a provider has undergone a Use of Resources assessment and been given a proposed rating, the draft report and proposed rating will be used alongside the Finance Score to inform NHS Improvement's consideration of the provider's support needs at that point in time.

5.6 NHS Improvement will continue to monitor a trust's finances and operational productivity – and associated support needs – between UoR assessments, using the Finance Score and metrics available through the Model Hospital alongside other relevant evidence.

5.7 Changes in the monthly Finance Score and other indicators of financial performance and operational productivity will be considered in the context of the last UoR assessment when considering support needs.

5.8 The Use of Resources framework will initially applied to acute trusts only, with specialist acute, ambulance, mental health and community trusts being included after April 2019, once appropriate metrics have been developed.

6.0 Recommendation

6.1 The Trust Board is asked to receive and note the updates to the Single Oversight Framework and the future plans for the Trust to be assessed against the new Use of Resources framework

Simon Grainger-Lloyd
Associate Director of Governance/Company Secretary

31 August 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

August 2017

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Patient Services
AUTHOR:	Ash Tullett	Clinical Governance Manager

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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 and the CQC for routine engagement visits.

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 report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: 0121 685 4000 (ext. 55641)

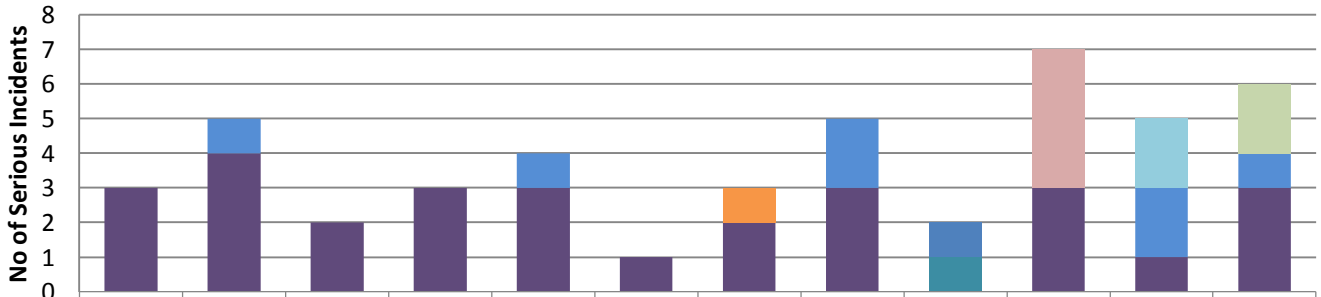
2. Incidents Reported – This illustrates all incidents that have been reported at ROH on Ulysses by members of staff during the previous 12 months. The data is presented by month and each month is broken down by the level of actual harm that was caused by each incident.

Month and Year	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017
1 - No Harm	202	166	140	147	122	163	126	161	165	206	232	178
2 - Low Harm	72	90	51	60	36	44	52	79	60	82	178	82
3 - Moderate Harm	3	3	3	4	5	5	5	6	0	6	4	4
4 - Severe Harm	0	0	0	0	1	0	0	0	0	0	0	0
5 - Death	0	0	1	0	0	2	2	0	0	0	0	0
6 - Near Miss	8	6	4	9	7	4	3	3	7	11	0	9

INFORMATION
In July 2017 there was a total of 273 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is at follows; 178 – No Harm 82 – Low Harm 4 – Moderate Harms 9 – Near Miss
ACTIONS FOR IMPROVEMENTS / LEARNING
An Agenda item at Clinical Quality group discussed the open incidents currently within the trust. A report of all open incidents was circulated and the divisions are to review the incidents and clear the backlog. It was agreed that the incident data will be included on the quality dashboards.
RISKS / ISSUES
There are approximately 9000 Incidents that remain open on the Ulysses incident reporting system. The Ulysses reporting system was first implemented into the Trust in 2006. The system was used as a incident reporting system only rather than the incident management it is used for today. As a result, there are 6000 incidents that remain open on the system that were never intended to be managed. Since 2011 The system has been used as an incident management system and there are approximately 3000 incidents that remain open. A more detailed report on the Trusts backlog of incidents will be presented to the Quality and Safety Committee in September 2017. The report will include the number of incident that remain open and a methodology of closing these incidents

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 .

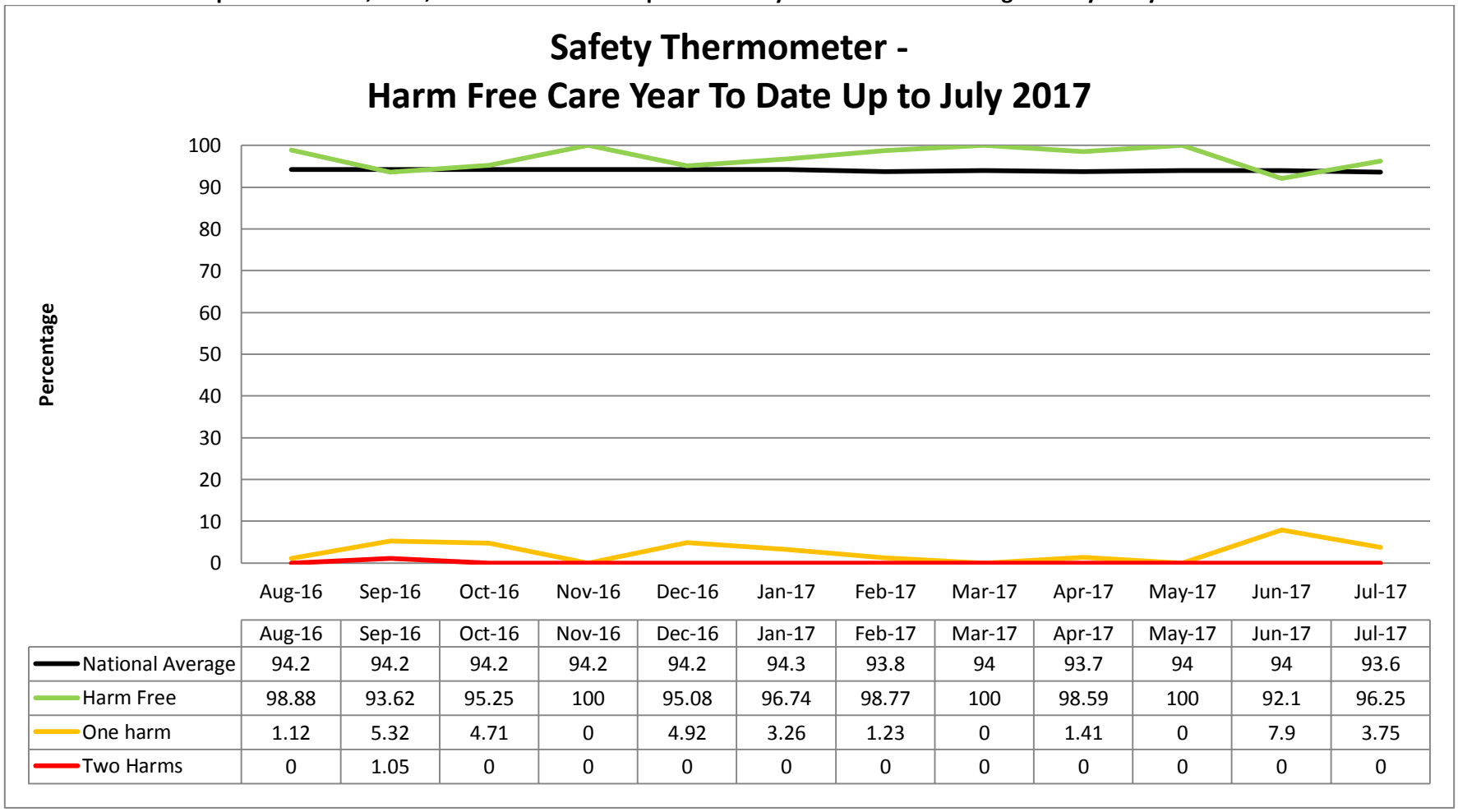
Serious Incidents Declared Year to Date to July 2017



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	July
Unexpected Injury												2
RTT Harm review										4		
Emergency transfer to HDU												
Exposure to hazardous substance							1					
Wrong Site Incision												
Wrong Implant												
Suspension to services												
RTT Data Issue									1			
Wrong side injection											2	
Suspension of Service (BCH Spinal)									1			
Slips, trips & falls												
Pressure Ulcers		1			1			2			2	1
VTE meeting SI criteria	3	4	2	3	3	1	2	3		3	1	3

INFORMATION
There were **Six Serious Incidents Declared in July 2017;**
ACTIONS FOR IMPROVEMENTS / LEARNING
One Serious Incident report was submitted to the Commissioners during July 2017. The incidents were reported in the May 2017 Quality report. These were; **Incident 1** **20800 – Wrong Side block – Non Never Event**- We have not classified this as a never event as discussions have led to the conclusion that this was a pain control procedure. **Conclusions** This was an operator error on the day of the procedure. It was noted following concerns and following the review of the notes and round table meeting that there was; Poor standard of documentation Breach of consent policy / not marked in line with Safe Surgery policy. Unknown level of supervision of a trainee. Procedure consent was not in the patient file when notes retrieved (now repatriated).
RISKS / ISSUES
None.

3. **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.**



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
National Average	94.2	94.2	94.2	94.2	94.2	94.3	93.8	94	93.7	94	94	93.6
Harm Free	98.88	93.62	95.25	100	95.08	96.74	98.77	100	98.59	100	92.1	96.25
One harm	1.12	5.32	4.71	0	4.92	3.26	1.23	0	1.41	0	7.9	3.75
Two Harms	0	1.05	0	0	0	0	0	0	0	0	0	0

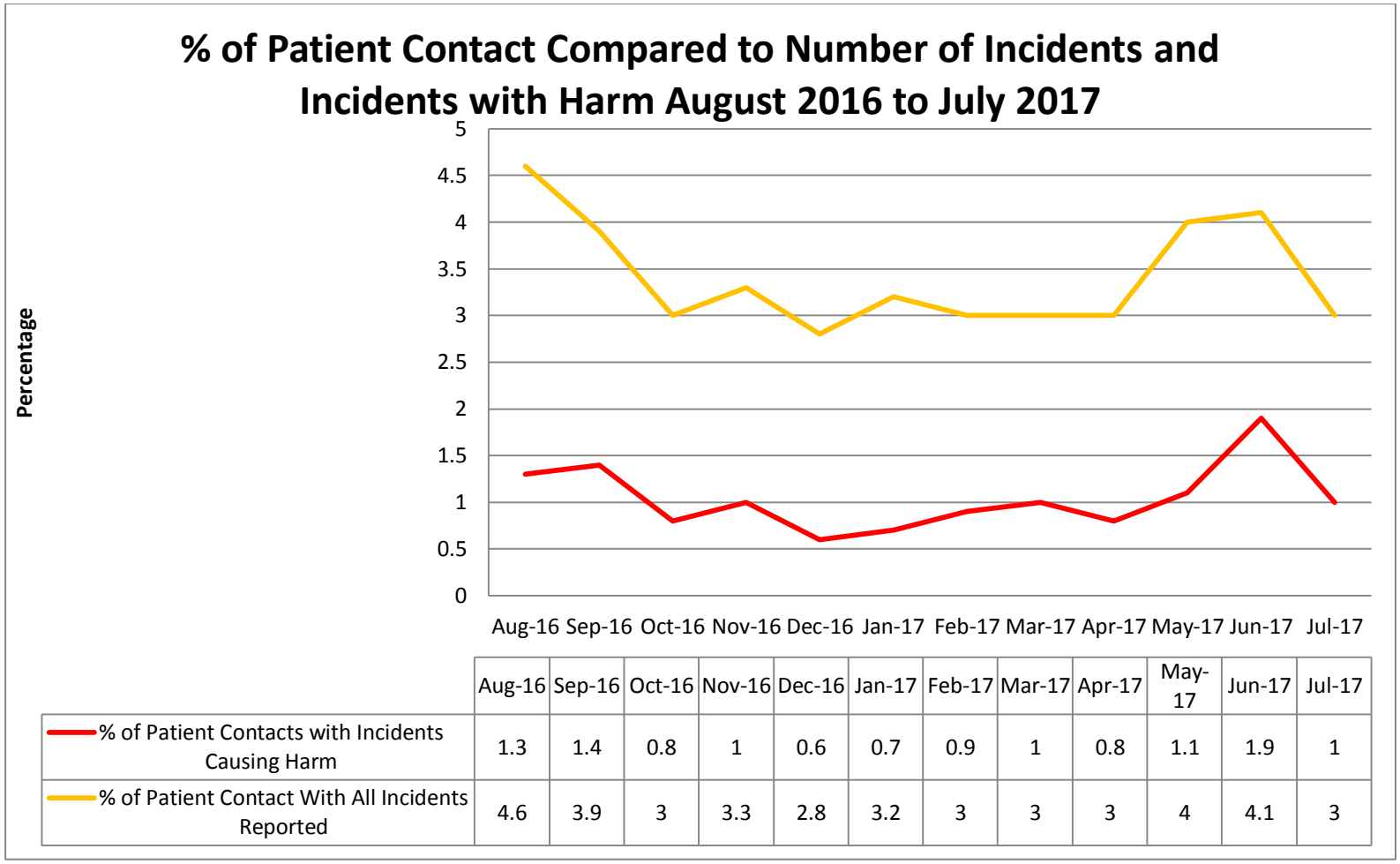
The harms highlighted on the safety thermometer were;

1 new Pressure Ulcer on Ward 2 and 2 old Pressure Ulcer's on Ward 1 and HDU

4. **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 July 2017 compared to all incidents reported and incidents resulting in harm. Harm includes low harm, moderate harm, severe harm and deaths.**

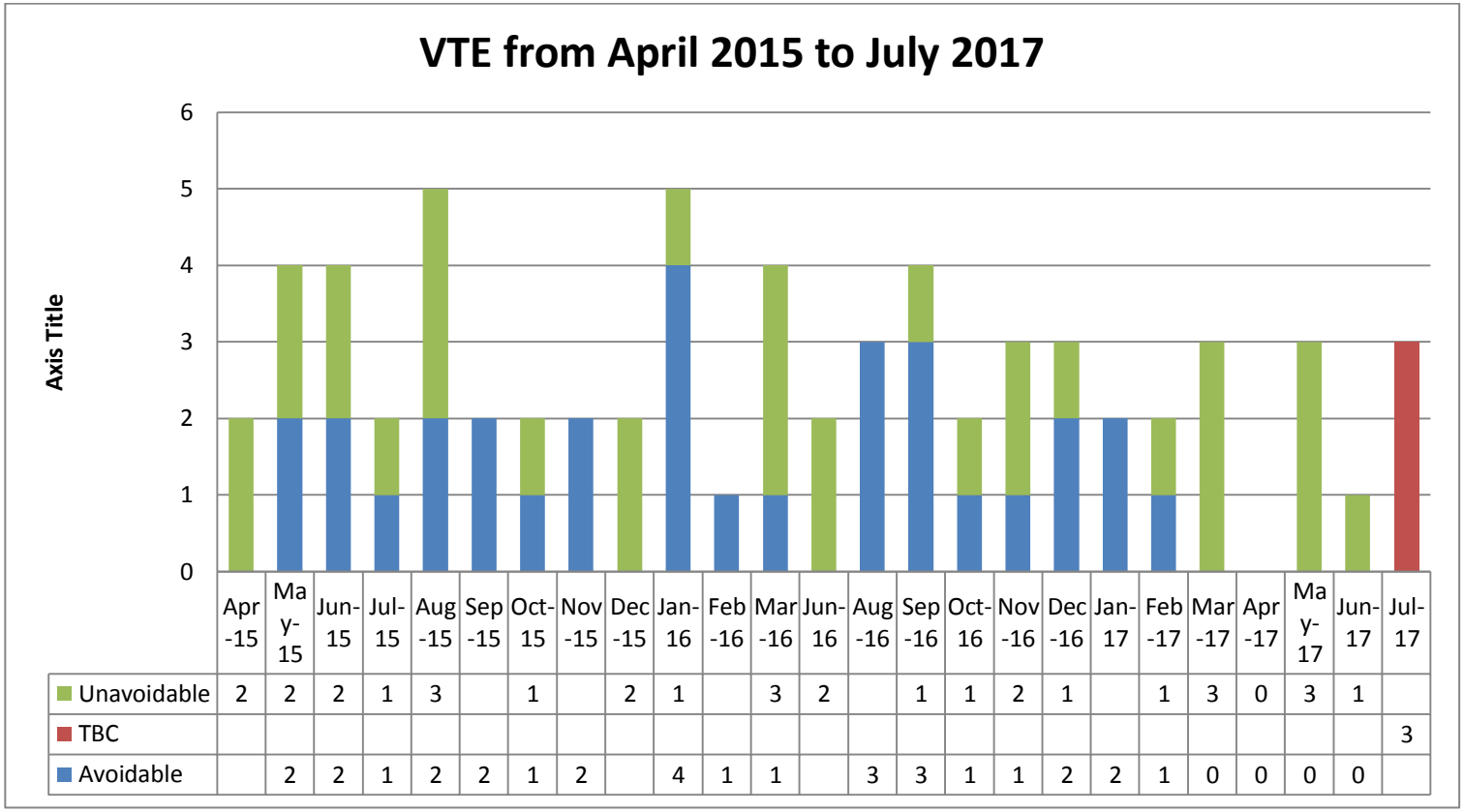
	Low Harm	Moderate Harm	Severe Harm	Death	Total Incident with Harm	All Incidents Total	Total Patient Contacts
Jun-16	58	7	2	0	67	197	7037
Jul-16	73	4	1	1	79	248	6426
Aug-16	77	3	0	0	80	286	6274
Sep-16	97	5	0	0	102	268	6823
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794
Feb-17	52	5	0	2	59	188	6429
Mar-17	80	6	0	0	86	250	7326
Apr-17	62	0	0	0	62	232	7328
May-17	83	5	0	0	83	303	6918
Jun-17	178	4	0	0	182	414	9162
Jul-17	82	4	0	0	86	273	8743

In July 2017, there were a total of 8743 patient contacts. There were 273 incidents reported which is 3.1 percent of the total patient contacts resulting in an incident. Of those 273 reported incidents, 86 incidents resulted in harm which is 1 percent of the total patient contact.



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
% of Patient Contacts with Incidents Causing Harm	1.3	1.4	0.8	1	0.6	0.7	0.9	1	0.8	1.1	1.9	1
% of Patient Contact With All Incidents Reported	4.6	3.9	3	3.3	2.8	3.2	3	3	3	4	4.1	3

5. **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).**



	Apr -15	May-15	Jun-15	Jul-15	Aug -15	Sep -15	Oct-15	Nov -15	Dec -15	Jan-16	Feb -16	Mar -16	Jun-16	Aug -16	Sep -16	Oct-16	Nov -16	Dec -16	Jan-17	Feb -17	Mar -17	Apr -17	May-17	Jun-17	Jul-17
Unavoidable	2	2	2	1	3		1		2	1		3	2		1	1	2	1		1	3	0	3	1	
TBC																									3
Avoidable		2	2	1	2	2	1	2		4	1	1		3	3	1	1	2	2	1	0	0	0	0	

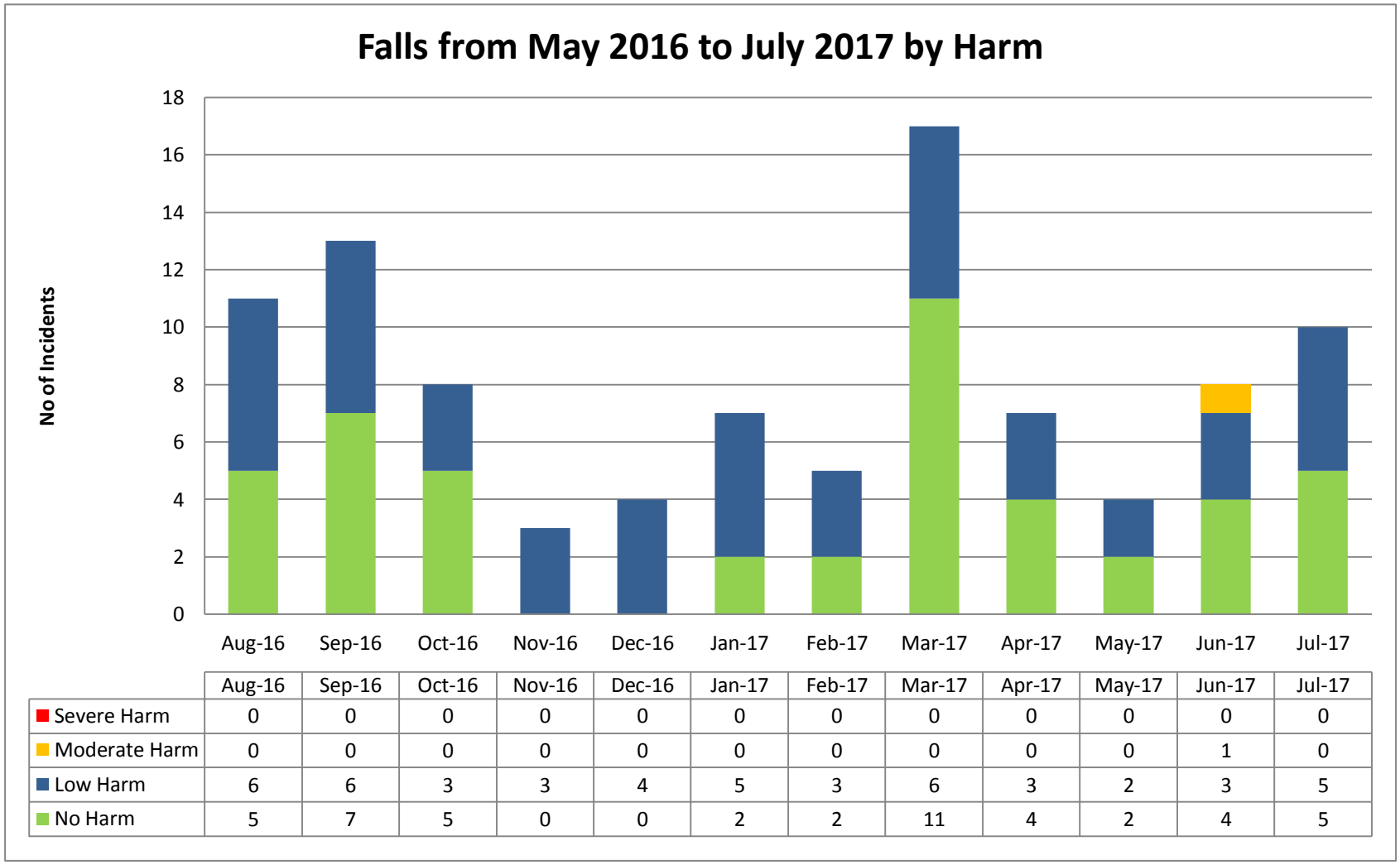
11

total		Avoidable
15/16	35	18
16/17	27	13
17/18	7	0*

***not classified**

INFORMATION
There was three VTE's declared in July 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
All commissioner KPI's /audits have been completed and continue to be consistently achieved VTE training continues for Student nurses, training for registered and non-registered staff (clinical update days) was suspended in Q4 but will re-commence in April 2017. It is mandatory for clinical staffs 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. Now that the VTE guidelines have been finalised and approved the requirements for meeting exemplar site status are met which has enabled application to be completed in Quarter 4.
RISKS / ISSUES
On-going learning and management in relation to non-compliance with 24 hour re-assessment by medical staff and Advanced Nurse Practitioners is required. Once the electronic system is implemented this will enforce completion.

6. **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-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Moderate Harm	0	0	0	0	0	0	0	0	0	0	1	0
Low Harm	6	6	3	3	4	5	3	6	3	2	3	5
No Harm	5	7	5	0	0	2	2	11	4	2	4	5

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

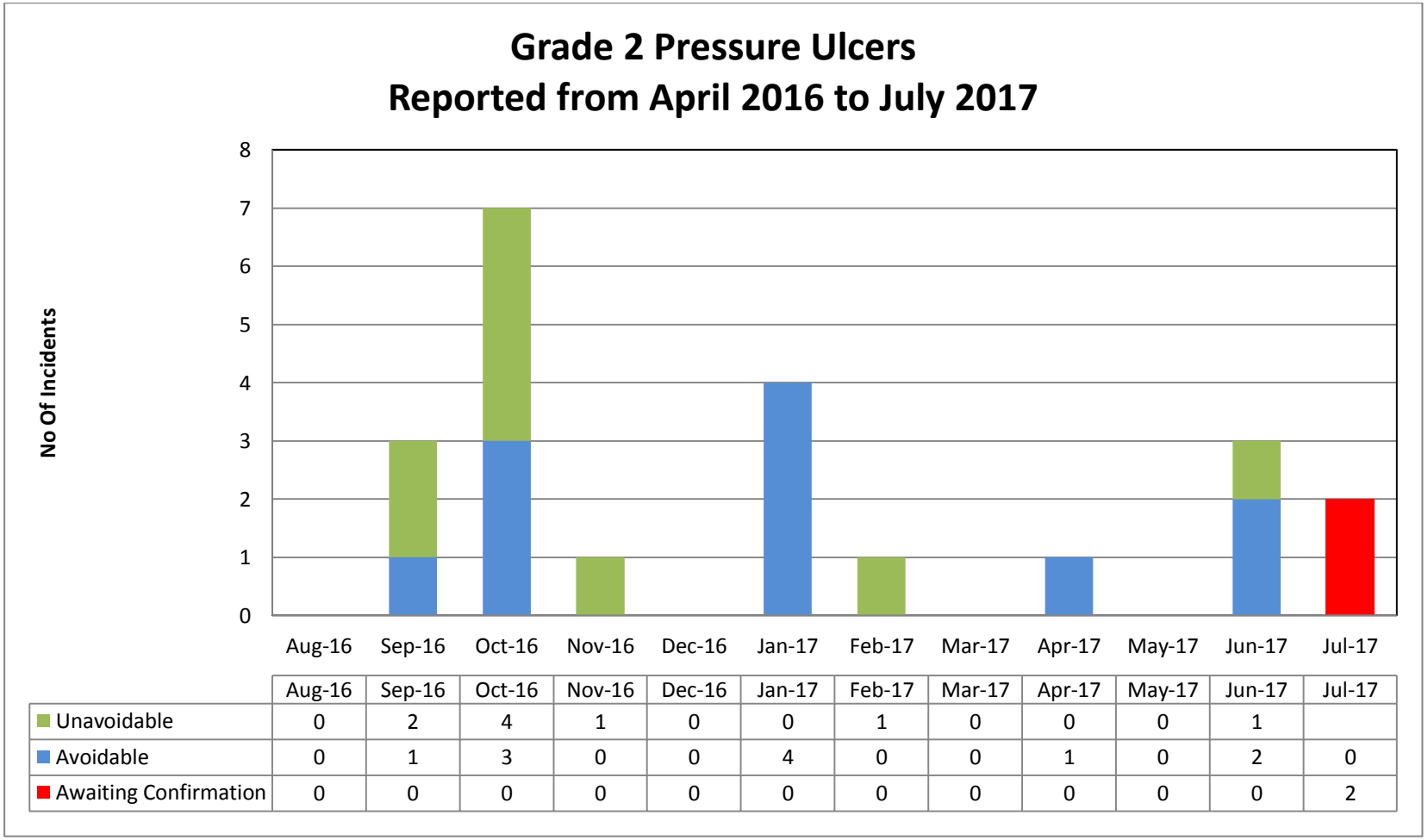
First choice for orthopaedic care

INFORMATION
Overall twelve fall related incidents were reported across the Trust in July 2017. Ten of these related to adult inpatient falls, with one fall being reported from a patient's home by the ROCS team and one staff fall. Each in-patient incident has been subject to a post-fall notes review by the ward manager or deputy and a falls questionnaire has been completed for each fall. The inpatient falls are all reported to CQG via the Divisional Condition reports from the Heads of Nursing and are reported in the Monthly Quality Report.

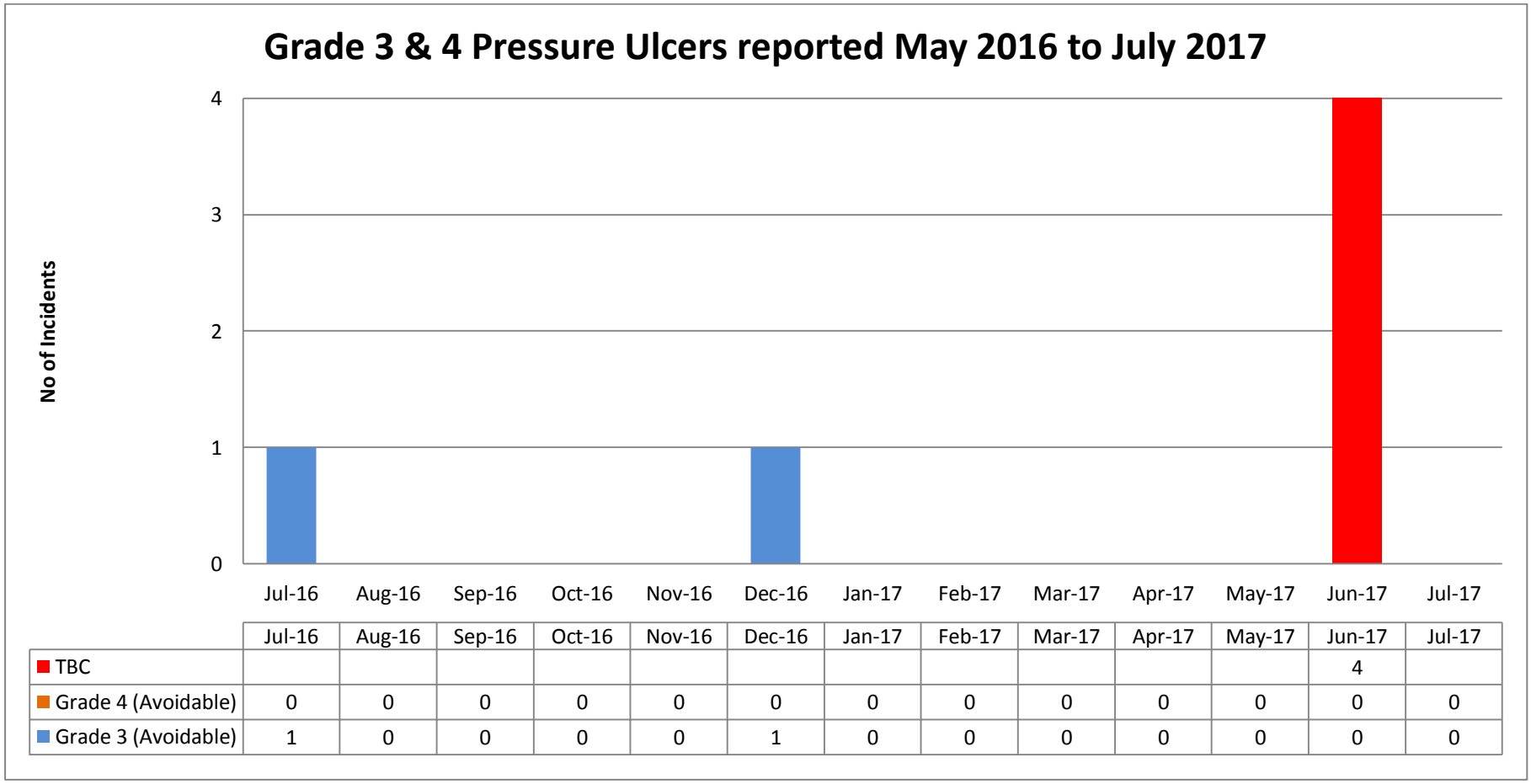
ACTIONS FOR IMPROVEMENTS / LEARNING
• The Falls Working Group (FWG) meetings recommenced in December 2016 and are scheduled bi-monthly after the January 2017 meeting. • Through the FWG the work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller is in progress. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care. • Falls information boards are to be standardised across all ward areas, with the information being agreed at the FWG meeting. 'Walking stick' visual information to be produced on a monthly basis for all ward areas for cascading of information regarding the number of falls per ward, per month to all staff. • Recommendations from the Throne Project will be overseen by the Falls Group on a Bi-monthly basis. • A review of the falls assessment and care plan documentation to take place, to include development of a post falls medical review template report, which is with the Documentation task and finish group currently. • Monthly reporting via the Ward Quality Dashboards to continue.

RISKS / ISSUES
None

7. **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-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
Unavoidable	0	2	4	1	0	0	1	0	0	0	1	
Avoidable	0	1	3	0	0	4	0	0	1	0	2	0
Awaiting Confirmation	0	0	0	0	0	0	0	0	0	0	0	2



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17
TBC												4	
Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0	0	0	0
Grade 3 (Avoidable)	1	0	0	0	0	1	0	0	0	0	0	0	0

Confirmed avoidable Pressure ulcers Device/Non Device related April 2017 to July 2017

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Non Device Grade 3												
Device Grade 3												
Non Device Grade 2	1		1									
Device Grade 2			1									

INFORMATION

In July 2017 there has been;

2 new Pressure Ulcer incidents
(Both pending RCA investigations)

In total, from 1st April 2017 the Trust has reported the following avoidable pressure ulcers:

1 avoidable Non Device Related Grade 2 pressure Ulcers against a limit (target) of 12. (1 x Grade 2 Pressure Ulcer currently awaiting RCA to establish avoidability and are therefore not included in these figures)

1 avoidable Device Related Grade 2 pressure Ulcers against a limit (target) of 12.

0 avoidable Grade 3 pressure Ulcers against a limit of 0. (Two Grade 3 Pressure Ulcer currently awaiting RCA to establish avoidability and are therefore not included in these figures)

ACTIONS FOR IMPROVEMENTS / LEARNING

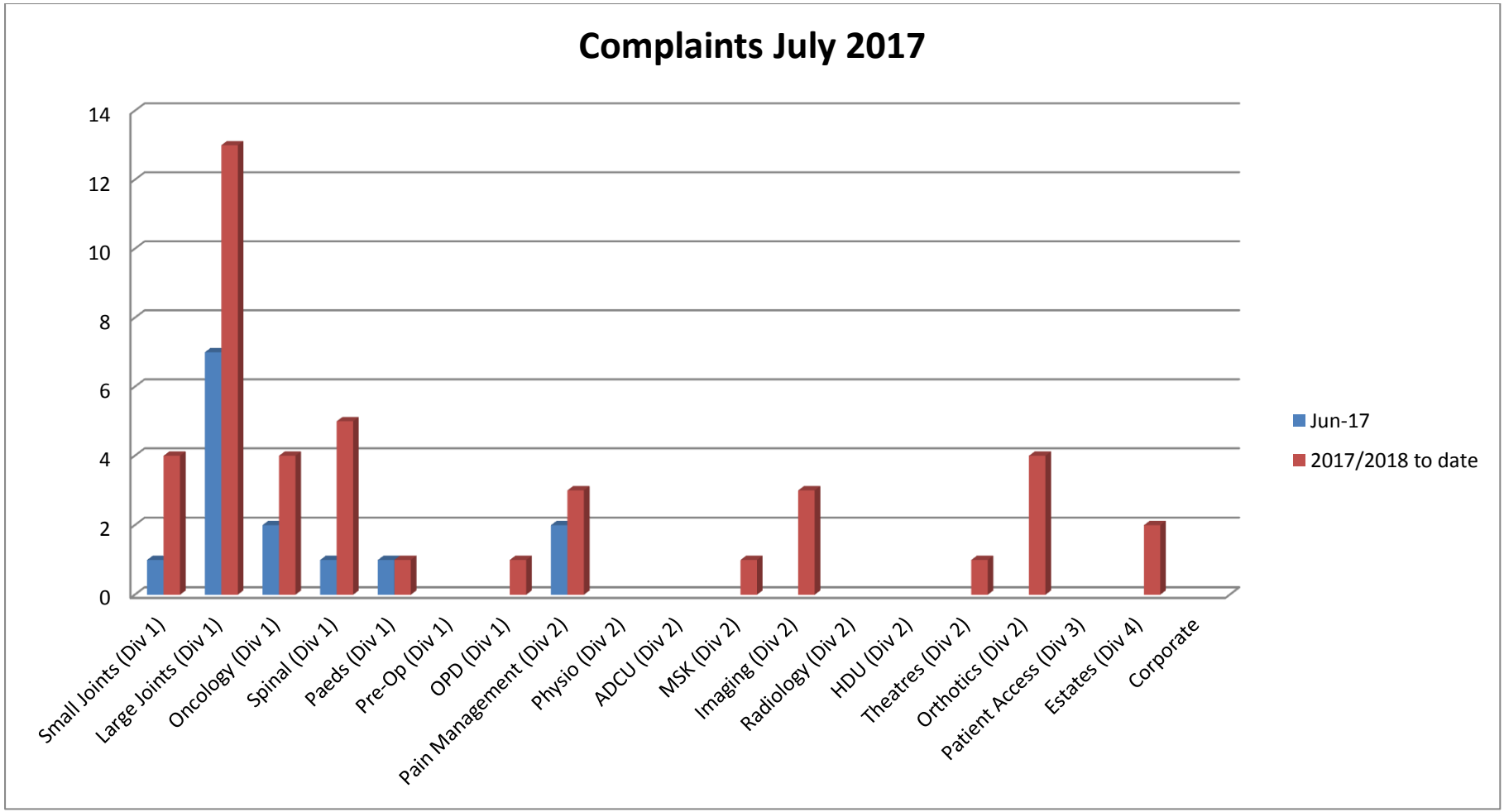
Updates from June:

- **1 x Grade 2** post RCA Completion: **UNAVOIDABLE.**
- **1 x Grade 3** and **1 x Grade 4** (relating to same patient) device related pressure ulcers Currently under investigation to establish avoidability /unavoidability.
- **1 x Grade 3** device related pressure ulcers currently under investigation
- **1 x Grade 3** hospital acquired pressure ulcers under investigation.

RISKS / ISSUES

None

8. 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.



INFORMATION

PALS

The PALS department handled 374 contacts during July 2017 of which 123 were classified as concerns. This brings the total of PALS contact for the year to date to 1993 (458 concerns) This represents a much higher figure than at the same point last year (1241 PALS contacts)

Compliments

There were 435 compliments recorded in July 2017, with the most being recorded for Div 1. This is slightly higher than last month with the Pre-Operative Assessment Clinic continuing to receive a significant number of compliments. Areas have been reminded to submit their records for central recording.

All compliments are sent electronically to the Patient Experience Team who holds the records. A Compliment is recorded if there is tangible evidence such as a card, a thank you letter, a box of chocolates or an e-mail. Teams are reminded monthly to submit their compliments for central logging.

Complaints

The subjects of this month's complaints were:

Initially Risk Rated Red:

- Cancellation of spinal deformity operation (Div. 1, Spinal)

Initially Risk Rated Amber:

- Progression of treatment; referral for further opinion (Div. 2, MSK)
- Nursing Care from ward and Discharge Process from different ward (Div. 1, Spinal)
- Failure to provide adjustable brace after surgery (Div. 2, OT)
- Delay to transfer from QE for complex operation (Div.1, Oncology)
- Approach of Staff; unnecessary delay to biopsy (Div. 1, Spinal)
- Nursing Care on 2 wards (Div. 1, Small Joints)
- Poor care provided by some members of staff (Div.1, Spinal)

Initially Risk Rated Yellow:

- Treatment options and approach of Registrar (Div. 1, Large Joints)
- Complications following anaesthetic (Div. 1, Paeds)
- Late notice cancellation of apt; marked as DNA (Div. 1, Large Joints)
- Care provided on ward; allegation of discrimination (Div.1 , Oncology).

ACTIONS FOR IMPROVEMENTS / LEARNING

Complaints closed in July 2017

There were 10 complaints closed in July 2017, all of which were closed within the agreed timescales. This gives a 100% completion on time rate and meets the KPI for the month. Of the 10 complaints closed in July 2017:

- 5 were upheld
- 3 were partially upheld
- 2 were not upheld

Learning identified and actions taken as a result of complaints closed in July 2017 include:

- Blistering after surgery

  Action: Incident form completed; investigation in process

- Member of Staff not acting within Trust Values and Expected Behaviours

  Action: Additional training and support undertaken/professional conversation

- Pressure wound not identified early enough

  Action: Staff have received refreshed tissue viability training

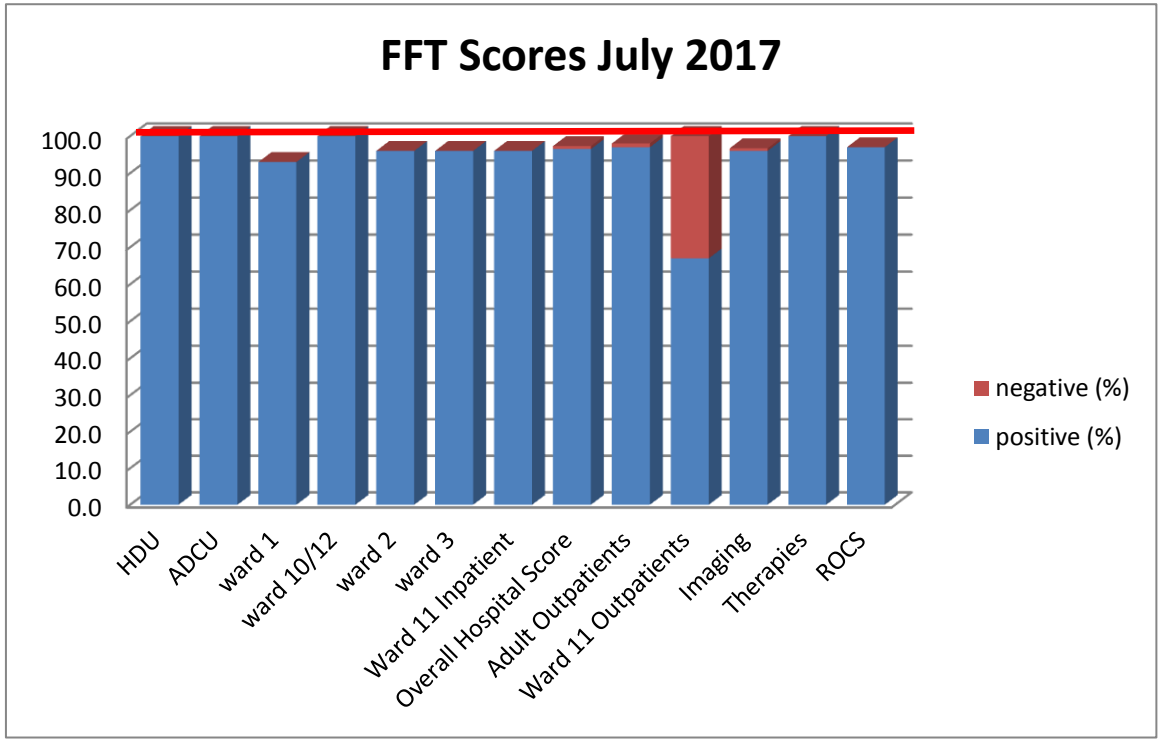
RISKS / ISSUES

None Identified.

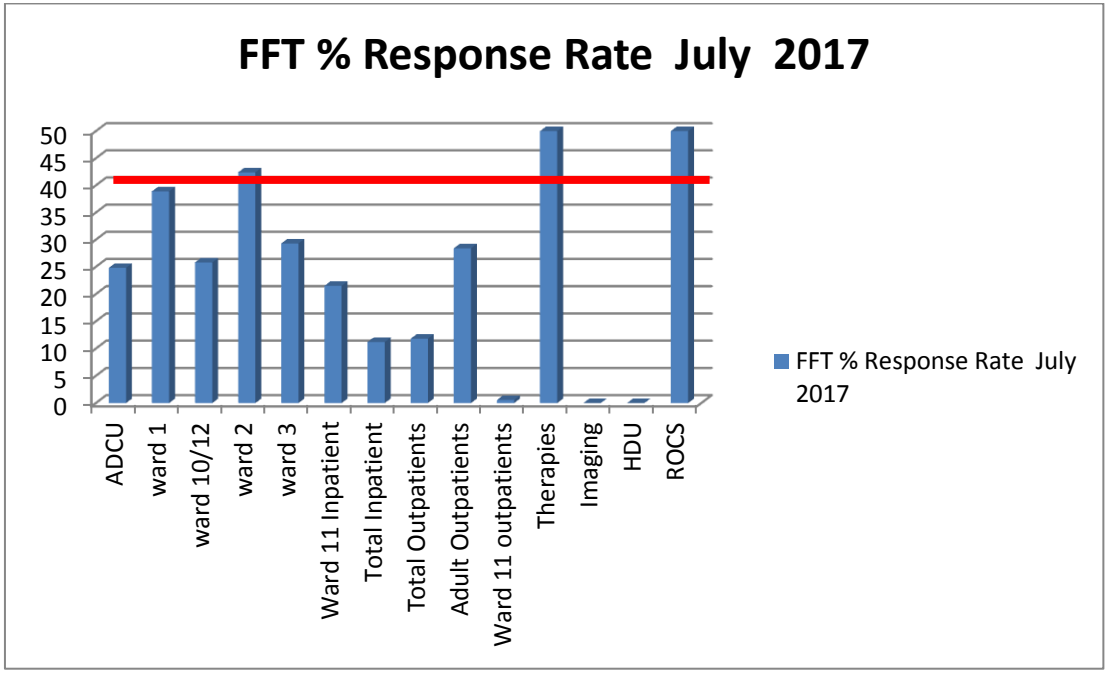
10. Friends and Family Test Results and iwantgreatcare - The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

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.



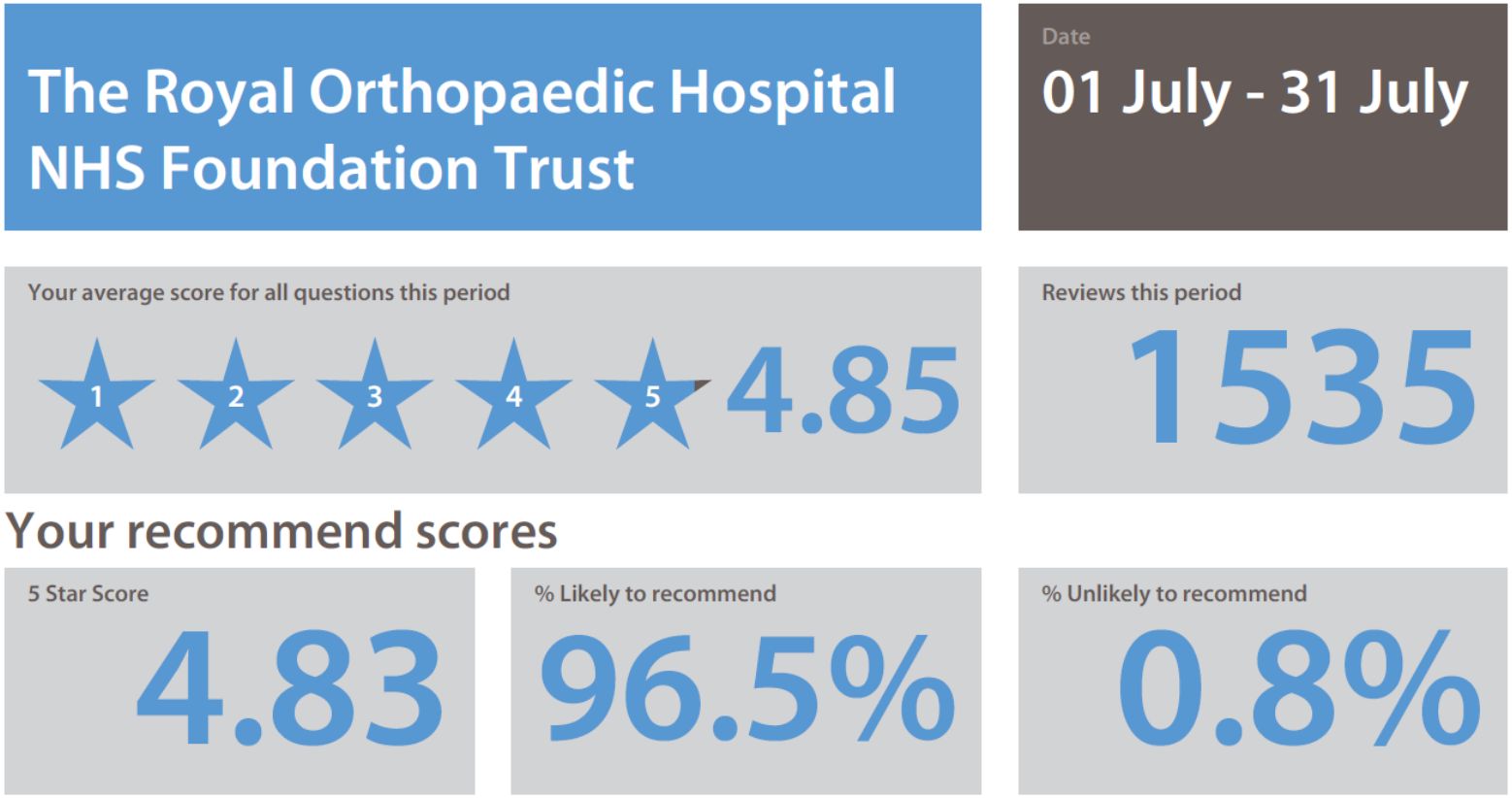
The Scores for Friends and Family are calculated using a straightforward percentage response to the question 'How likely are you to recommend this area to friends or family if they require similar care or treatment?' Any patients answering the question as Extremely Likely / Likely are classified as Promoters. 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.



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.

In order to attempt to address some of this imbalance, the Trust has set an internal target to reach a 40% response rate across all areas within the first quarter of 2017/18.

I Want Great Care - iWantGreatCare makes it simple to collect large volumes of meaningful, detailed outcomes data direct from patients on your organisation, clinical locations and whole clinical teams. It Continuously monitor and compare performance of individual services, departments and wards and Aggregated, graphical monthly reporting meets needs of both providers and commissioners for robust, patient-centric metrics to track quality and performance.



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 21 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

There was no new litigation to report in July 2017.

13. Coroner's

There was one Coroners Case in July 2017

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 perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.

INFORMATION
No Data available due to theatre man
ACTIONS FOR IMPROVEMENTS / LEARNING
The Clinical Standards Lead and Theatres Manager are discussing the development of a new report to ensure that we give an accurate reporting and provide the correct assurances.
RISKS / ISSUES
The Audit Data for WHO checklist is not available for May/June/July 2017 due to the migration to the new theatre man software. A new report is currently being generated that will show the WHO compliance and audit. This will be included next month

ROHTB (9/17) 004

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Safe nurse staffing**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Patient Services**
AUTHOR:	**Jo Wakeman, Deputy Director of Nursing & Clinical Governance**
DATE OF MEETING:	**6th September 2017**

EXECUTIVE SUMMARY:

The attached paper presents the following:

- The outcome of the safe staffing reviews undertaken in July 2015 and July 2017
- The assurance regarding actions already underway and actions planned to ensure staffing levels are safe, effectively monitored in line with the National Quality Board standards (2016) and NICE Guidance.
- A review against the National Quality Board (NQB) 2016 standards and expectations 1,2 & 3.

The paper provides evidence that the number of nurses on duty within the Royal Orthopaedic Hospital (ROH):

- Is safely staffed to meet the needs of our patients.
- Provides detail of the external data that has been reported.
- Provides an update on current vacancies.
- Details the utilisation of bank and agency nurses across the Trust

REPORT RECOMMENDATION:

The Trust Board is asked to:

- Note the contents of the paper as outlined in expectation 1 of the NQB, 2016. In addition to NICE, 2014 guidance.

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	
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:

Safe, efficient processes that are patient centred.

Failure to provide safe staffing levels in all ward areas has a direct impact on the quality of patient care.

The development of 'red flag shift' reports will strengthen the level of assurance provided to the Trust Board about the safety of nurse staffing levels in in-patient areas across the Trust.
PREVIOUS CONSIDERATION:
None

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

SAFE NURSE STAFFING UPDATE

REPORT TO THE TRUST BOARD ON 6 SEPTEMBER 2017

1.0 UNIFY Upload

The Trust submits safe staffing data to NHS England each month via the UNIFY data set. This data is also presented within the Safe Staffing report submitted each month to the Quality and Safety Committee. The report triangulates data with any clinical incidents relating to staffing, the ward healthcheck data and the newly developed ward quality dashboards.

Appendix 1 provides examples of the UNIFY data for the months of June and July 2017, this shows the planned nursing levels versus the actual nursing levels. During the months of June and July 2017 ROH was undertaking IT works across the Trust. This required some wards to be closed or partially closed; consequently staffs were redeployed to other areas. There were two ambers highlighted against day fill rates for registered nurses these have been triangulated against CHPPD (Care hours per patient bed day) and 'red flag' incidences to access if patients had come to harm. The data (reported monthly to Quality and Safety Committee) states either no harm or low harm as detailed within section 6 of this report. CHPPD indicates that each ward remains within the agreed variation of 6.3 and 16.8 CHPPD.

2.0 Nurse Vacancy Levels

Human Resources provide the Executive Director of Patient Services with ward vacancies each month. Details of these vacancies and plans to appoint are detailed within this section.

2.1 Registered Nurse Vacancies

At the end of July 2017 there were 15.62 permanent whole time equivalent (WTE) Band 5 Registered Nurse Vacancies across the Trust (excluding Theatres). The Trust has adopted a 'one stop' approach to interviewing potential candidates. This approach has enabled ROH to successfully recruit a further 9.6 WTE leaving a vacancy position of 6 WTE. This is not dissimilar to figures produced in July 2015 where there were 4 WTE vacancies. This demonstrates the Trust's sustainability and reputation as an employer of choice. The Trust Band 5 vacancies are shown in Table 1 below (the numbers in brackets detail staff recruited to the Trust waiting start dates):

Ward	Number of Vacancies
HDU	3.8 paediatric
1	3.23 (2.6)
2	4.87 (2)
3	1.72 (2)
11	2 (3)
12/10	0 vacancies

2.2 Theatre Recruitment

Theatre recruitment remains challenging with 17wte Band 5 posts vacant with 3 staff recently recruited awaiting start dates. There is a marginal improvement based on 2015 figures of 18 WTE. During 2017 Theatres had particular workforce challenges with more senior posts which resulted in a gap within key leadership roles. The Trust has now successfully recruited into all vacant Band 7 posts in addition to the newly appointed Head of Nursing. This will certainly strengthen the clinical leadership within Theatres to support ongoing efficiencies and quality improvements. We are aiming to strengthen the nursing leaderships within theatres and are in the process of appointing a Matron.

3.0 Safer Nurse Staffing Tool

The Safer Nursing Care Tool (SNCT) is a nationally developed and validated acuity/dependency tool to measure nursing workload and estimate staffing requirements. The tool is widely used across the NHS. It has been used to assess the dependency and/or acuity of patients across the adult in-patient wards at ROH.

To further enhance monitoring of safe staffing on a daily basis ROH has commenced a roll out of E rostering which began in October 2016. In addition Safecare has been introduced to enable ongoing monitoring of acuity and dependency versus staffing and skill mix. All ward areas have been set up on E roster and Safecare.

A review of July 2015 and July 2017 using the Shelford tool confirms that the number of nursing staff on duty within ROH is sufficient to meet the requirements of our patients. Following the implementation of Safecare within our wards ROH have the capability to review staffing levels in relation to acuity and dependency every 24 hrs.

4.0 Bank & Agency Usage

Wards managers are permitted to utilise bank against agreed planned hours. Authorisation of agency shifts is approved by the Heads of Nursing. The agreed and embedded controls around bank and agency usage have contributed to the reduction in pay expenditure during 2017.

Table 2 below provides a comparator of bank and agency usage by ward during July 15 and July 2017. In 2015 the Director of Patient Services made a recommendation to the Board to increase staffing levels from 2 registered nurses to 3 registered nurses at night, this was in direct response to patient feedback and safety concerns. The data below shows a positive sustainable trend with

a 13.39% increase in substantive staff, 7.16% reduction in bank usage and a 6.27% reduction in agency usage. This is evidence of the effectiveness of the controls put in place to manage bank and agency usage. One of the key enables was the purchasing of Allocate in providing oversight and standardisation of E-rostering practices. Overall in 2017 ROH utilise significantly more substantive/ bank staff on our wards positively impacting on the quality and standard of care to our patients.

Table 2: Bank and agency use in June 2015 and June 2017

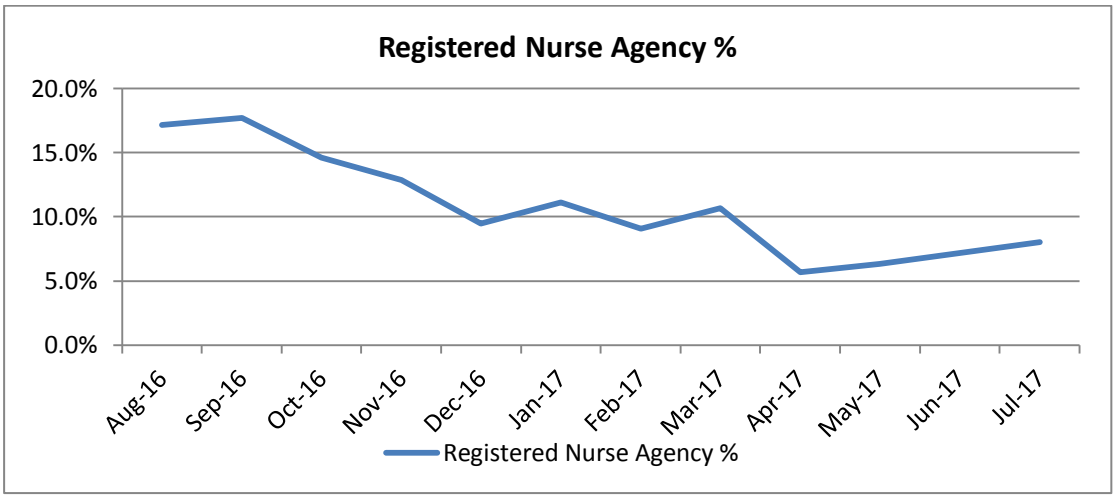
July 15	Permanent	Bank	Agency
Ward 1	65.4%	26.1%	2.34%
Ward 2	72.9%	18%	2.78%
Ward 3	70.8%	22.5%	2.44%
Ward 11	86.3%	12.3%	9.04%
Ward 12 & 10	58.3%	31%	1.79%
HDU	80.6%	8.7%	16.77%
Total	**70.5%**	**20.1%**	**9.4%**

[redacted]

ALL STAFF

July-17	Permanent	Bank	Agency
Ward 1	82.56%	16.14%	1.3%
Ward 2	83.85%	14.1%	2.05%
Ward 3	82.39%	14.49%	3.12%
Ward 11	72.78%	23.74%	3.48%
Ward 12 & 10	97.78%	1.84%	0.38%
HDU	84.12%	7.38%	8.5%
Total	**83.89%**	**12.94%**	**3.13%**

Table 4: Agency use over time (all wards)



It can be seen that there has been a significant improvement from March 2017 in the overall use of bank and agency staff. This is despite challenges to provide 1-1 nurse patient ratio within our paediatric HDU area. The reduced target of 10% agency usage has been achieved for the 4th month running and continues to date.

5.0 Establishment Review

The Executive Director of Patient Services is in the process of reviewing all clinical areas staffing levels in conjunction with the ward managers, Matron and Head of Nursing. The process for agreeing future nursing establishments at ROH will take into account three key components which include professional judgement, Safecare and quality indicators as detailed within the required expectations of the NQB, 2016.

6.0 NICE Safe Staffing Guidelines

The NICE (2014) safe staffing for nursing in adult in-patient wards in acute hospitals describes 'red flag shifts' and state that '*hospitals need to have a system in place for nursing red flag events to be reported by any member of the nursing team, patients, relatives or carers to the registered nurse in charge of the ward or shift'.*

Red Flag Shifts are defined as:

- Unplanned omission in providing patient medications.
- Delay of more than 30 minutes in providing pain relief.
- Patient vital signs not assessed or recorded as outlined in the care plan.
- Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan.
- A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For

example, if a shift requires 40 hours of registered nurse time, a red flag event would occur if less than 32 hours of registered nurse time is available for that shift.

- Less than 2 registered nurses present on a ward during any shift.

ROH continue to review all 'red flag' staffing incidents, narrative is included in the monthly staffing report to the Quality and Safety Committee.

7.0 A full review against the NQB 2016 standards has been undertaken

Measure and Improve – **Patient outcomes, people productivity and financial sustainability.** **Report investigate and act on incidents (including red flags)** **Patient, carer and staff feedback**	**Compliant**
Implementation Care Hours per Patient Day (CHPPD) **Develop local quality dashboards for safe sustainable staffing.**	**Compliant**
Expectation 1 Right Staff	**Compliant**
Expectation 2 Right Skills	**Partially compliant**
Expectation 3 Right Place and time	**Compliant**

8.0 Conclusion

This paper has given an update of the monthly nurse staffing position to Trust Board within ROH for the data periods July 2015 and July 2017.

This paper gives detail of ROH externally reported information (UNIFY return) demonstrating that the registered nurse shift fill rate is monitored and triangulated with aquity data, clinical incidents and 'red flags' each month. Upwardly reporting on a monthly basis to the Quality and Saferty Committee providing oversight and scrutany of safe staffing levels within ROH.

Use of the Safer Nursing Care Tool demonstrates that the number of nurses on duty within our wards is sufficient to meet the needs of our patients.

This paper shows that there has been an increase in sunstantive staff with a significant reduction in the uese of temporary staffing, when comparing July 2015 to July 2017.

A full review of the Safe Sustainable and Productive Staffing – National Quality Board 2016 standards have been undertaken.

9.0 Recommendation

The Trust Board is asked to:

- Note the contents of the paper as outlined in expectation 1 of the NQB, 2016. In addition to NICE, 2014 guidance.

APPENDIX 1 UNIFY UPLOAD

July 2017 – Fill rates

	Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Ward 1	90.3%	109.9%	97.8%	119.4%
Ward 2	91.4%	101.8%	100%	103.3%
Ward 3	84.4%	167.3%	96%	129.5%
Ward 12/10	103.8%	104%	100%	140%
Ward 11	99.2%	64.2%	97.2%	-
HDU	102.3%	100.7%	102.3 %	-

July 2017 – Care Hours per Patient day

	Care Hours Per Patient Day (CHPPD)			
	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Ward 1	540	4.3	2.7	7.0
Ward 2	565	4.2	2.3	6.4
Ward 3	523	4.5	2.8	7.3
Ward 10 & 12	328	7.1	4.4	11.5
Ward 11	201	10.7	1.6	12.3
HDU	218	15.9	1.0	16.9

June 2017 – Fill rates

	Day		Night	
	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)
Ward 1	96%	119.6%	101.4%	135.7%
Ward 2	100%	123.4%	102.6%	111.0%
Ward 3	96%	124.8%	105.6%	104.4%
Ward 12/10	90.3%	78%	97.4%	106.7%
Ward 11	85.0%	66.0%	94.4%	-
HDU	102.8%	110.7%	101.5 %	-

June 2017 – Care Hours per Patient day

	Care Hours Per Patient Day (CHPPD)			
	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
Ward 1	532	4.2	2.7	6.9
Ward 2	481	4.4	2.7	7.0
Ward 3	383	5.1	3.1	8.2
Ward 10 & 12	410	4.5	3.1	7.7
Ward 11	148	14.6	2.2	16.9
HDU	216	15.6	0.9	16.5

Appendix 2 - Safe Sustainable and productive staffing
National Quality Board (2016)

Introduction

In 2016 the National Quality Board (NQB) provided an updated set of expectations for nursing and midwifery. The new guidance encompasses the findings from the Carter Report (2016) aiming to reduce unwarranted variation within healthcare. From May 2016 CHPPD (Care hours per patient day) is the principle measure of nursing and healthcare support worker deployment. Detailed below provides the update guidance which focuses on triangulating data taking into account patient needs, acuity and risks thus allowing appropriate judgements about delivering safe, sustainable and productive staffing. Historically NHS Trusts have been criticised for making judgements solely based on numbers or ratio of staff to patients.

In Sections 1, 2 and 3, represent an updated version of the 2013 NQB guidance by combining findings from the Carter report. Aiming at setting out key principles and tools that are used to measure and improve the use of staffing resources to ensure safe, sustainable and productive services.

Section 3, identifies three updated NQB expectations that form a 'triangulated' approach ('Right Staff, Right Skills, Right Place and Time') to staffing decisions. An approach to deciding staffing levels based on patients' needs, acuity and risks, which can be monitored from 'ward to board', that will enable trusts to make appropriate judgements about delivering safe, sustainable and productive staffing. The report (NQB, 2016) states that the CQC supports this triangulated approach to staffing decisions, rather than making judgements based solely on numbers or ratios of staff to patients.

Safe, Effective, Caring, Responsive and Well-Led Care

Measure and Improve

- patient outcomes, people productivity and financial sustainability -
- report investigate and act on incidents (including red flags) -
- patient, carer and staff feedback -

- Implementation Care Hours per Patient Day (CHPPD) -
- develop local quality dashboard for safe sustainable staffing -

Expectation 1	Expectation 2	Expectation 3
Right Staff	**Right Skills**	**Right Place and Time**
➢ Evidence-based workforce planning ➢ Professional judgement ➢ Compare staffing with peers	➢ Mandatory training, development and education ➢ Working as a multi-professional team ➢ Recruitment and retention	➢ Productive working and eliminating waste ➢ Efficient deployment and flexibility ➢ Efficient employment and minimising agency

Section 1: Safe Sustainable and productive staffing: measurement and improvement

	Rationale	Progress	Assessment of compliance
Patient and carer feedback	Patient and carer feedback provides insight into the quality of their own care, and often extends into observations of the wider care environment and staff capacity	FFT reported monthly 'I want great Care' has been introduced to allow timely feedback at ward level. National patient survey. Local complaints & compliments data presented at Clinical Quality Group.	Compliant
Staff feedback	Staff feedback provides insight into their own and their colleagues' capacity, capability and morale, and of their perception of the quality of care	Staff FFT *(place to be treated/place to work)* National Staff Survey *(place to be treated/ place to work and questions related to workload)* Monitoring of staffing incidents monthly reported to Quality and Safety Committee. GMC trainee survey GEST training survey	Compliant

Access to care	While staffing capacity will never be the sole factor, lack of staff capacity will affect access to care; for example, operations will be cancelled if any key staff in theatre or ward are unavailable	Systems in place to capture and monitor - Cancelled elective operations – proportion of last minute cancellations Those not treated within 28 days of a last minute cancellation Monitoring of OPD waiting times across all specialities.	Compliant Cancellations on the day and OPD waiting times monitored as part of quality account priorities for 17/18.
Completion of key clinical processes	Clinical process measures provide a very early indication of changes in the quality of care delivery, so action can be taken before outcomes are affected Processes are often the responsibility of a specific staff group, and so can help pinpoint staffing capacity issues for that group	Medication omitted for non-clinical reasons (registered nursing staff) Observations/Early Warning Scores not taken/calculated as planned (nursing staff) MRSA screening/decolonisation completion rates VTE risk assessment completion (medical staff) Reviewing 7 days services Sepsis CQuIN 17/18. Monitoring of quality Metrix via the ward healthcheck and quality dashboards. Safety Thermometer Daily huddles to assess/ manage staff levels.	Compliant

NQB recommendations for monitoring the impact of staffing on quality in acute			
	Rationale for using as a quality	**Progress**	**Compliance/action**
Harm during healthcare	While a wide range of measures need to ensure the system of care supports staff to do the right thing, some types of harm are particularly likely to be affected by staff capacity Pressure ulcer prevention typically requires constant nursing intervention in terms of skin care and position changes, and therefore monitoring of pressure ulcers can help pinpoint staffing capacity issues for that staff group Effective inpatient falls prevention relies on identifying underlying medical causes, medication review, early mobilisation, and nursing observation. Therefore monitoring falls can help pinpoint staffing capacity issues across medical, pharmacy, AHP and nursing staff	Robust incident reporting systems. SI policy updated. Monitoring of pressure sores with timely avoidable/unavoidable reviews. Monitoring of falls with timely avoidable/unavoidable reviews. Established Duty of Candour process. Freedom to speak up guardians in place. Harm Review process in place for all cases breaching 52 weeks. Ward Healthcheck data Quality Dashboards Use of 'red flags' monitoring. Monitoring of hospital associated infections.	Compliant

Section 2: Care hours per patient day (CHPPD) – ROH Compliant

ROH continues to submit CHPPD to NHSI on a monthly basis. This data is also scrutinised as part of the Safe Staffing report submitted to Quality and Safety Committee. This data is triangulated against any incidents that may impact on quality of care. The use of the Red Flag system (defined below) is in place at ROH however, it is reliant on staff to recognise the criteria for a 'red flag'. Some general communication has been put out to remind staff.

- Any unplanned omissions or delay in providing patient medications
- Delay of more than 30 minutes in providing pain relief
- Any potential vital signs not assessed as detailed within the patients care plan
- Intentional rounding / fundamental care needs not completed as detailed within the patients care plan.
- Shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time.
- Less than two registered nurses present.

One of the criticisms of CHPPD is that it looks at patient count at midnight and did not take into capture daily flow and the activity on ward areas. As part of the ROH implementation for E roster the Trust purchased a Safecare tool which takes into account patient dependency and acuity at three points across a 24 hr period. The reports from Health Roster allows for a 24 hr view of staffing required providing the right level of care. The wards have gone through a transitional phase to improve standardisation against the Shelford scoring tool. Monthly reports are produced and sent out to the senior nurses detailing CHPPD required versus actual hours available. All ward areas including paediatrics submit to Safecare. Unfortunately High Dependency Unit sit outside the Shelford model as they use CCMDS (Critical Care Minimum Data Set) to capture acuity in terms of organ support. This is a national issue across the region.

Section 3: Expectation 1, 2 & 3 (1 & 3 compliant 2 partially compliant)

Expectation 1	Expectation 2	Expectation 3
Right Staff ➢ Evidence-based workforce planning ➢ Professional judgement ➢ Compare staffing with peers	**Right Skills** ➢ Mandatory training, development and education ➢ Working as a multi-professional team ➢ Recruitment and retention	**Right Place and Time** ➢ Productive working and eliminating waste ➢ Efficient deployment and flexibility ➢ Efficient employment and minimising agency

Expectation 1 – Right staff	Evidence	Action	Compliance
Evidenced based workforce planning	Recent consultation with ward nursing staff to implement 12 hr shifts. Minimum safe staffing on each ward area 3 RN to improve pain control requirements of our patients. (local target) Staffing levels compliant with NICE guidance. Safe staffing paper submitted to Quality and Safety and CQC each month. Monthly CQC meetings, triangulating staffing and quality.	Recent establishment review underway by the Executive Director of Patient Services. SafeCare implemented across all ward areas with the ability to monitor CHPPD. Further analysis required against theatre staffing establishment, at present compliant with national standards.	Compliant

Professional Judgement	ROH have introduced Health Roster across all ward/clinical areas. This provides a visual oversight of the Trust aiding decisions for deployment of staff. There is in place a Duty Manager for escalations in/out of hours. A Quality report is produced and submitted monthly to the Clinical Quality Group and an upward report to the Quality and Safety Committee. This triangulates quality of care, incidents, risks and user feedback.	No action	Compliant
Compare Staffing with Peers	As a specialised Orthopaedic Hospital comparison with peers is difficult. However, ROH benchmark CHPPD range with the nation standard each month to provide some assurance. In July 2015 a benchmarking visit was undertaken with The Royal Orthopaedic Hospital in Stanmore l Split trained /untrained 65/35 compliant – Executive Director of Patient Services increased trained nurse cover at night to improve quality of care.	No Action	Compliant

Expectation 2 – Right Skills	Evidence	Action	Compliance
Mandatory training, development and education	A weighting of 21 % is applied to the qualified nurse baseline establishment. Ward Managers are rostered as fully supervisory to support education and development of staff. . Introduction of KPIs for the role of the supervisory ward manager this includes the development of staff within clinical areas. Clinical Tutor developing an education strategy for the Trust. Preceptorship Competency booklet in place	Need to remove 'ring in' and appoint substantively to mitigate bank and agency usage and improve quality of care.	Partially
Recruitment and retention	Successful recruitment campaign over the last 6 months particularly paediatric nurses. Band 6 nursing staffed have had a change in uniform to navy as one of the strategies to strengthen clinical leadership. All shift co-ordinators wear a nurse in charge badge . Care certificate program for substantive and bank staff.	On going	Compliant

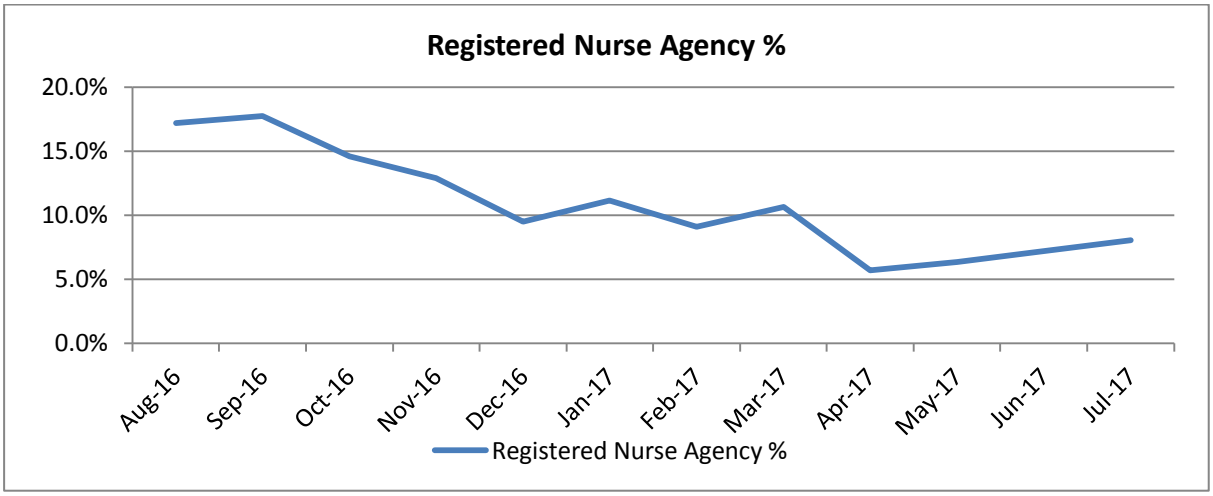
	Nursing Strategy has been developed with engagement from frontline staff. EIA completed for all CIPs and policies. Flexible working policy in place.		
Expectation 3 – Right Place right time	Evidence	Action	Compliance
Productive working and eliminating waste	Productive theatres methodology to be introduced, Theatreman introduced 2017. Rapid Recovery models for Knees and Hips. Twice daily huddles introduced to improve patient flow and monitor staffing levels. Any staffing issues reported through the duty manager and reported through the clinical incident reporting system to access impact on quality of care. Quality report submitted to Quality and Safety to monitor management of risk. Redeployment of staff during periods of reduced demand. Agency usage less than 10% target	No action	Compliant

Efficient deployment and flexibility	E-rostering system in place across all clinical areas. Twice daily huddles to access appropriate staffing levels to meet patient demand. Safe staffing report submitted to Quality and Safety Committee	No action	Compliant
Efficient employment and minimising agency	Significant progress has been made this year in recruiting to vacancies. All paediatric nurses have been appointed into (CQC action) This year has also seen a significant reduction in agency usage with an increase usage of bank . Theatre vacancies remain high in comparison to other areas a monthly workforce meeting has been set up to review.	Further work to be carried out to reduce the reliance of bank and agency within theatres	Compliant

Bank/Agency Usage 16/17

Detailed below is the percentage of pay relating to agency spend as a proportion of the total pay budget. A trajectory to reduce agency spend was agreed by the Trust Board of 10 %. This was achieved initially in December 16 with a further significant fall in April 17. This achievement has been achieved due to:

- Improved recruitment- 'one stop recruitment days', recruitment days at weekend.
- Clear controls around authorisation of bank and agency
- Implementation of E roster and safecare



E roster update

The roll out E roster commenced on in October 2016, there has been some delays against plan. Detailed below is the progress to date. In addition Safecare has been introduced across all ward areas this allows us to review acuity and dependency 24 hours per day and compare staffing levels required per ward. Care hours per patient day is the methodology used to report safe staffing metrics each month to the Quality and Safety Committee.

Ward	Live on Heath Roster	Plan to go live on Health roster
Ward 1	Live	
Ward 2	Live	
Ward 3	Live	
Ward 11	Live	
Ward 11 clinic	Live	
Ward 12	Live	
Discharge Lounge	Live	
HDU	Live	
Infection Prevention and Control	Live	
ADCU	Live	
POAC	Live	
Outpatients	Live	
Theatres Main	Live- Live to payroll for September (1st October 2017)	
Theatres Recovery Physiotherapy	Live- Live to payroll for September (1st October 2017) Set up done and ready. Implementation to be organised.	

Challenges over the next six months;

- The reconfiguration of paediatric services.
- Financial viability and sustainability as an adult provider of Orthopaedic care.
- Trade-offs to meet financial demands
    - Recruitment & Retention- Preceptorship training
    - Annual updates stopped
    - Impact on PDR and MT for our frontline staff
    - Tighter controls on B & A usage (higher level of resource)
- NHS Five Year forward view- To make changes we need to invest in the workforce and deliver high-quality timely care within available finances

- Difficulty engaging frontline staff
- National demands the same irrespective of size of the Trust
- Future impact of the supply of nurses - bursary versus loans

ROHTB (9/17) 005

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

POLICY TITLE:	Policy for Reporting, Investigation and Learning from Deaths in Care
ACCOUNTABLE EXECUTIVE LEAD:	Mr Andrew Pearson, Executive Medical Director
POLICY AUTHOR:	Mrs Jo Wakeman, Deputy Director of Nursing & Clinical Governance
DATE OF MEETING:	6 September 2017

POLICY STATUS:

NEW POLICY	**x**	**AMENDED EXISTING POLICY**	

SUMMARY OF KEY POINTS/CHANGES:

Earlier in the year, the Royal College of Physicians released a set of guidance around how organisations should learn from deaths. In summary, the guidance requires the Trust to:

- Report all deaths publicly by Quarter 3 2017/18.
- Ensure that a case review is carried out with standard methodology
- Ensure families are included and updated with any investigations particularly any Serious Incident.
- Demonstrate that we can describe lessons learned

The Trust is also required to have a Board approved policy that sets out its approach to Learning from Deaths.

The Policy for Reporting, Investigation and Learning from Deaths in Care is presented for approval.

The key points of the policy are:

1. Organisations should be able to identify when deaths have occurred through a failure of processes and systems.

2. Requirement for organisations to have a forum which has oversight of patient deaths where discussion occurs and learning points are identified and addressed.

3. Numbers of deaths must be presented at Public Trust Board by the executive lead which would ordinarily be the Medical Director from Quarter 3 2017 onwards.

4. Cumulative numbers to be presented in the Annual Quality Accounts.

5. Clinicians identified who have undergone the appropriate training to allow them to undertake a case *Structured Judgement Review* (see appendix 4) and complete the required assessment of cause and avoidability making this available to the Clinical Audit and Effectiveness Committee which is charged with ensuring organizational learning occurs.

The Trust Board is requested to approve the policy, together with the proposed implementation plan.

The length of the policy is 38 pages, this being necessary to incorporate all national guidance on this topic.

CONSULTATION:

This policy has been reviewed by the Medical Director as chair for the Clinical Audit and Effectiveness Committee with oversight by the Quality and Safety Committee a committee of the Trust Board.

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

EQUALITY IMPACT ASSESSMENT:

The development of the policy has involved an equality impact assessment and an initial impact assessment has been completed by the Executive Medical Director.

ROHTB (9/17) 005 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Policy for Reporting, Investigation and Learning from Deaths in Care

Policy author	Deputy Director of Nursing
Accountable Executive Lead	Mr A Pearson – Medical Director
Approving body	Trust Board
Policy reference	ROH/XXX/NNN [Assigned by Governance Team]

ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:

1 – Medical workforce

2 –Governance Team

3. All other staff AHP, Nursing

POLICY APPROVAL DATE:
August 2017

POLICY IMPLEMENTATION DATE:
August 2017

DATE POLICY TO BE REVIEWED:

August 2020

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	6-09-2017	Sep-2017	Aug-2020	New policy

Reporting, Investigating and Learning from Deaths in Care Policy

KEY POINTS

1. Organisations should be able to identify when deaths have occurred through a failure of processes and systems.

2. Requirement for organisations to have a forum which has oversight of patient deaths where discussion occurs and learning points are identified and addressed.

3. Numbers of deaths must be presented at Public Trust Board by the executive lead which would ordinarily be the Medical Director from Quarter 3 2017 onwards.

4. Cumulative numbers to be presented in the Annual Quality Accounts.

5. Clinicians identified who have undergone the appropriate training to allow them to undertake a case *Structured Judgement Review* (see appendix 4) and complete the required assessment of cause and avoidability making this available to the Clinical Audit and Effectiveness Committee which is charged with ensuring organizational learning occurs.

Reporting, Investigation and Learning from Deaths in Care

1.0 INTRODUCTION

1.1 As an NHS Organisation we are required to put in place a framework that provides assurance and demonstrates we are learning from deaths that are deemed 'avoidable'. Avoidable has been defined as 'death due to a problem in care' (NQB, 2017) This policy aims to describe the steps required for The Royal Orthopaedic Hospital NHS Foundation Trust (ROHFT) to meet the required standards as laid out within 'A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting ,Investigating and Learning from Deaths in Care (NQB, 2017).Professor Keogh at a conference in March 2017 stated that the aim of the policy is to focus on process driven avoidable mortality he further clarifies this by adding:

'Something that we did that we shouldn't have done or something that we should have done but didn't '

2.0 SCOPE

2.1 The principles of identifying, reporting, investigating and learning from Deaths in care applies to all persons working within The Royal Orthopaedic NHS Foundation Trust including locums, GPs with specialist interest, agency staff (medical and nursing) and volunteers.

Categories and selection of deaths in scope for case record review:

2.2 The Royal Orthopaedic NHS Foundation Trust will focus reviews on in-patient deaths in line with the criteria detailed below. The rationale for the scope selected by the Trust will need to be published and presented at the Public Board quarterly.

- All deaths where bereaved families and carers, or staff, have raised a **significant concern about the quality of care provision.**

- The National Quality Board suggests that, Trusts should include cases of people who had been an in-patient but had **died within 30 days of leaving hospital**

- All in-patient and out-patient deaths of those with **learning disabilities** (the LeDeR review process outlined in app 1 should be adopted in those regions where the programme is available otherwise Structured Judgement Review or another robust and evidence-based methodology should be used) and with severe mental illness.

- All deaths in a **service specialty, particular diagnosis or treatment group where an 'alarm' has been raised** with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator).

- All deaths in areas where people are **not expected to die.**

- Deaths where **learning will inform the provider's existing or planned improvement work**, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically.

- **A further sample of other deaths** that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

2.3 The above minimum requirements are additional to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths, such as deaths of patients detained under the Mental Health Act 1983 (App 2).

2.4 Providers should consider a case record review following any linked inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths" in order to examine the effectiveness of their own review process.

2.5 Guidance relating to deaths in children and young adults is referred to in appendix 3.

3.0 OTHER POLICIES TO WHICH THIS POLICY RELATES

- Serious Incident Policy
- Incident Reporting Policy
- Duty of Candor Policy

4.0 GLOSSARY AND DEFINITIONS

4.1 **Case record review:** The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians.

4.2 **Investigation:** The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

4.3 **Death due to a problem in care:** A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

5.0 PRINCIPLES

5.1 Context

In December 2016, the Care Quality Commission (CQC) published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England.* The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

The Secretary of State for Health accepted the report's recommendations and in a Parliamentary statement4 made a range of commitments to improve how Trusts learn from reviewing the care provided to patients who die. This includes regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information in Quality Accounts from June 2018.

5.2 Accountability

Mortality governance should be a key priority for Trust boards. Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

This *National Guidance on Learning from Deaths* should be read alongside the *Serious Incident Framework*. Trust boards are accountable for ensuring compliance with both these frameworks. They should work towards achieving the highest standards in mortality governance. However, different organisations will have different starting points in relation to this agenda and it will take time for all Trusts to meet such standards. Over time this guidance is likely to be updated to include wider providers of NHS care and whole healthcare systems.

5.3 Responding to Deaths

Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under its management and care. The standards expected of Trusts are set out in the appendicies.

Boards should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This will allow them to identify any areas of failure of clinical care and ensure the delivery of safe care. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership, regular mortality reporting to the Board at the public section of the meeting with data suitably anonymised, and outputs of the mortality governance process including investigations of deaths being communicated to frontline clinical staff.

6.0 ROLES AND RESPONSIBILITIES

6.1 Chief Executive

The Chief Executive is responsible for ensuring the infrastructure is in place to report and manage the requirements of Identifying, Reporting, Investigating and Learning from Deaths in Care (NCB, 2017). The Chief Executive delegates responsibility for the Trust's governance arrangements to the Director of Patient Services.

6.2 Trust Board

The board should ensure that their organisation:

- Has an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda and an existing non-executive director to take oversight of progress.
- Pays particular attention to the care of patients with a learning disability or mental health needs.
- Has a systematic approach to identifying those deaths requiring review and selecting other patients whose care they will review.
- Adopts a robust and effective methodology for case record reviews of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented.
- Ensures case record reviews and investigations are carried out to a high quality,

acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur.

- Ensures that mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised.

- Ensures that learning from reviews and investigations is acted on to sustainably change clinical and organisational practice and improve care, and reported in annual Quality Accounts.

- Shares relevant learning across the organisation and with other services where the insight gained could be useful.

- Ensures sufficient numbers of nominated staff have appropriate skills through specialist training and protected time as part of their contracted hours to review and investigate deaths.

- Offers timely, compassionate and meaningful engagement with bereaved families and carers in relation to all stages of responding to a death.

- Acknowledges that an independent investigation (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved.

- Works with commissioners to review and improve their respective local approaches following the death of people receiving care from their services.

- Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.

6.3 **Non-Executive Directors**

- The boards of directors at the Royal Orthopaedic NHS Foundation Trust are collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, taking into consideration the views of the board of governors.

- Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced. Commissioners are accountable for quality assuring the robustness of providers' systems so that providers develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

6.4 **Quality and Safety Committee**

The Quality and Safety Committee is the designated sub- committee of the Trust Board with responsibility for overseeing all governance and learning from deaths activity within the Trust. The committee will oversee the activity of the Clinical Audit and Effectiveness Committee. The Quality and Safety Committee will be responsible for:

- To provide assurance and upward report to the Trust Board
- Ensuring appropriate policies are in place for the identification, reporting, investigating and learning from deaths in Care and those carers and families are included within the process
- Receive monthly reports providing a synopsis of any deaths and that any patient that has been reported as a serious incident or unexpected death as a detailed case review and lessons learnt clearly actioned and communicated internally and externally to the organisation.

6.5 **Clinical Audit and Effectiveness Committee**

It is the responsibility of the Clinical Audit and Effectiveness Committee to ensure that all deaths are reviewed.

- An assessment has been made to establish that the categories and selection of deaths in scope for case record review has robustly been applied
- Those lessons are learnt from any deaths resulting in a case record review and communicated internally and externally to the Trust
- Ensure that carers and families are involved in the investigations of investigations into deaths that require a case record review.
- To provide a quarterly report into any deaths to the Quality and Safety Committee. This should include: total number of in-patient deaths and the number of those deaths that are subject to a case record review and the number of deaths judged to have been due to problems in the care provided.

6.6 **Medical Director (Executive lead)**

The Medical Director is responsible to the Trust Board and Chief Executive and has a pivotal role in supporting the Trust to deliver and embed the structural approach to learning from deaths through a process of investigation and case note reviews.

- To provide a paper and agenda item to the public Board meeting each quarter
- To oversee the establishment of a case record review process using evidenced based methodology for reviewing the quality of care provided to those patients who die
- The National Quality Board (2017) recommends the Structured Judgement Review (SJR) as the methodology. The Medical Director is responsible for ensuring that Consultants have the necessary training to carry out case record reviews

- To ensure that the quarterly reports are available in the public domain on the Trust website

- To ensure that a summarised account of learning and action taken as a result is provided in the Quality Accounts for 18/19 report

6.7 **Executive Director of Patient Services**

The Executive Director of Patient Services is responsible to the Trust Board and Chief Executive in providing a governance framework is in place and act upon any clinical risk and safety information.

6.8 **Governance Manager**

It is the responsibility of the Governance Manager to**:**

- To ensure that robust system for reporting, investigating and analysis is in place

- Provide advice on incident reporting and investigations to staff

- Ensure appropriate external reporting of incidents

- Provide advice and guidance to staff in the contractual application of Duty of Candour and in being open with carers and families when errors have occurred or patients have been harmed

6.9 **Responsible Consultant for the patient**

It is the responsibility of the Responsible Consultant to:

- Undertake a review of any death of patient within their care to establish if the death meets the criteria for further investigation and a SJR

- Ensure that families and carers are involved within any investigations

- Consider and report to the Medical Director and the Governance Manager any deaths that full into the category of a serious incident

- Where indicated ensure that a comprehensive investigation and that a SJR is completed within four weeks of the patients death

- Any serious concerns during the investigation to be escalated to the Medical Director and Governance Manager with a completed clinical incident form marked red.

6.10 **All staff**

All staff are required to:

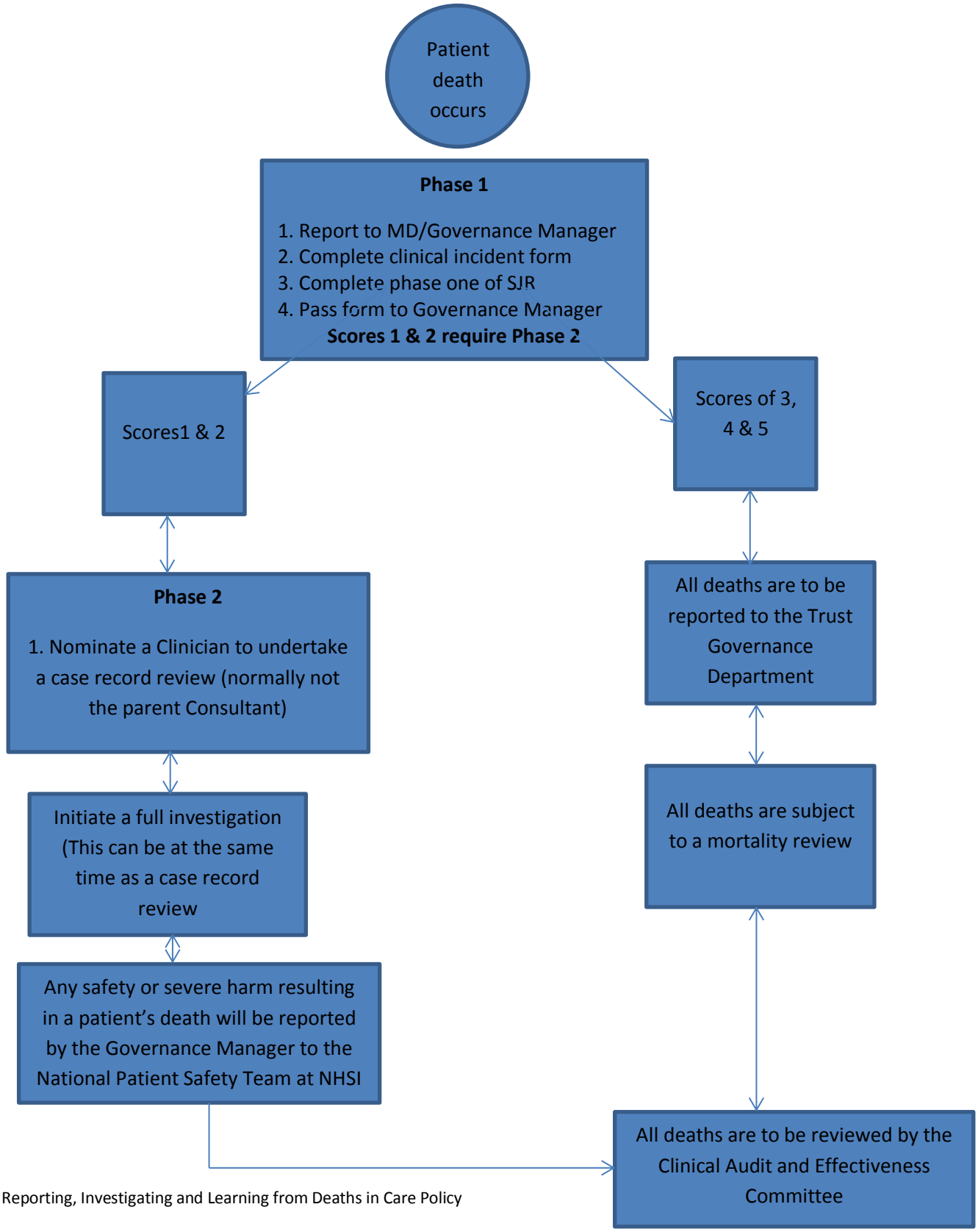
- Report any concerns they may have relating to the death of a patient immediately to their line manager

- Report any concern through the Trust clinical incident reporting system

- To assist and co-operate in any investigation process

- Report accurate factual details only regarding the circumstances surrounding an incident
- For all incidents relevant clinical records, documentation, equipment etc. should be secured. Staff are required to ensure that these remain as they were when the incident occurred

7.0 PROCEDURE (refer to appendix 4) –
N.B. Use of the Structured Judgement Review Template (appendix 5) is mandated



8.0 CONSULTATION

8.1 This policy has been reviewed by the Medical Director as chair for the Clinical Audit and Effectiveness Committee with oversight by the Quality and Safety Committee a committee of the Trust Board.

8.2 An initial draft of this policy was shared with the Executive Team, key clinical and corporate leads and stakeholders for comment and input. Amendments based on feedback received have been included where possible and deemed appropriate.

Individuals whose feedback is ESSENTIAL (role names)	Feedback received (Y/N)	Comments made (where applicable) including nil returns
Medical Director	Y	
Executive Team	Y	Minor comments on process
Deputy Director of Nursing & Clinical Governance	Y	Minor comments on process
Clinical Quality Group	Y	Open discussion and were supported over carers' involvement in the decision making and study days would be needed for medical workforce
Paediatric matron	Y	Minor comments on process
Paediatric Associate Medical Director	Y	Minor comments on process
Individuals whose feedback is DESIRABLE (role names)	**Feedback received (Y/N)**	**Comments made (where applicable) including nil returns**

9.0 AUDITABLE STANDARDS/PROCESS FOR MONITORING EFFECTIVENESS

9.1 This policy will be monitored through the Clinical Audit and Effectiveness Committee, with quarterly reports submitted to the Quality and Safety Committee. In addition the Trust is required to make available the quarterly reports within the public domain.

10.0 TRAINING AND AWARENESS

10.1 It will be identified which Consultants require further training in Structured Judgment Review methodology and this will be provided by the Trust.

11.0 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 appropriate to their needs. 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.

12.0 REVIEW

12.1 This policy will be reviewed after three years or sooner if significant new information deems it necessary to do so.

13.0 REFERENCE DOCUMENTS AND BIBLIOGRAPHY

1. Royal College of Physicians. National Mortality Case Record Review Programme. Oct 2016. Available at: https://www.rcplondon.ac.uk/projects/national-mortality-case-record-review-programme

2. Care Quality Commission. Learning, candour and accountability. 2016. Available at:https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

3. National Guidance on Learning from Deaths – A framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting and investigating and learning from deaths in care, National Quality Board (2017).

14.0 APPENDICES

APPENDIX 1 – Guidance for providers for deaths that occur with patients with learning disabilities

Key points to note are:

- All deaths of people with learning disabilities aged four years and older are subject to review using LeDeR methodology

- The LeDeR programme is currently being rolled out across England. Full coverage is anticipated in all Regions by the end of 2017. If there is a death of a person with learning disabilities in an acute setting in an area that is not yet covered by the LeDeR programme, Trusts are recommended to use the SJR process or a methodology of equivalent quality that meets the requirements for the data that must be collected as an interim measure

- If a Trust wishes to complete its own internal mortality review, it is recommended that it uses the LeDeR initial review process and documentation available at: http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf The provider can then submit that as an attachment to the LeDeR notification web-based platform once their internal review is completed

- If a Trust wishes to complete its own internal mortality review, it is recommended that it uses the LeDeR initial review process and documentation available at: http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf The provider can then submit that as an attachment to the LeDeR notification web-based platform once their internal review is completed

- Once the LeDeR review has been completed, a copy will be sent to the relevant governance body at the Trust where the death occurred

- Trusts are encouraged to identify appropriate personnel to undertake LeDeR training and review processes. Reviewers would be expected to conduct reviews independent of the Trust in which they work

APPENDIX 2 - Deaths in patients with Mental Health Issues

1. Physical and mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people. In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems.

2. Reporting and reviewing of any death of a patient with mental health problems should consider these factors i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

Inpatients detained under Mental Health Act

1. Regulations require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay. In 2015, the Care Quality Commission reported concern that providers were failing to make this notification in 45% of cases. The Commission has since updated its notifications protocols to ensure that providers ensure they report in a timely way.

2. Under the Coroners and Justice Act 2009, Coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983).

3. In circumstances where there is reason to believe the death may have been due, or in part due to, to problems in care - including suspected self-inflicted death - then the death must be reported to the provider's commissioner(s) as a serious incident and investigated appropriately. Consideration should also be given to commissioning an independent investigation as detailed in the *Serious Incident Framework*.

APPENDIX 3 - Children and Young People

1. Infant and Child Mortality

Over the last 20 years, the UK has gone from having one of the lowest mortality rates for 0 to 14 year olds in Europe to one of the highest. In 2014, 4, 419 children and young people aged 0 to 18 years old died in England and Wales. 24% of deaths in children and young people are thought to be preventable. In the year ending March 2016, 68% of all deaths occurred in hospital, 22% in the home, 4% in a public place, and 4% in a hospice. In the year ending March 2016, 32% of all deaths occurred following a perinatal or neonatal event, 26% in children with chromosomal, genetic and congenital anomalies, 8% in children with 'sudden unexpected and unexplained' death, 7% in children with malignancy, 6% in children with acute medical or surgical illnesses, 6% in children with infection, 5% in children suffering trauma, 3% in young people taking their life, and 2% following deliberately inflicted injury, abuse or neglect.

In child mortality review, professionals have moved away from defining 'avoidability' to instead using the language of 'a preventable death' where the latter is defined as a death in which 'modifiable factors may have contributed to the death and which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths'. In the year ending March 2016, 54% of deaths in hospital and 31% of death in the home were identified as having modifiable factors. Most modifiable factors are found in children dying from perinatal/neonatal events, followed by trauma, followed by those with chromosomal, genetic and congenital anomalies.

2. Children (1-9 years)

The main factors that contribute to death during childhood are different to those that contribute to death during infancy or adolescence. The common causes of death amongst 1 to 9 year-olds are cancer, injuries and poisonings, congenital conditions and neurological and developmental disorders. Injuries and poisonings from external causes are the leading cause of death in boys aged one to four years, whilst cancer is the leading cause of death leading cause of death in girls of the same age. For both girls and boys five to nine years of age, cancer is the leading cause of death. Very early life also still has an impact on mortality in later childhood; children who were born preterm remain more likely to die before age 10 years compared to children born at term.

In the period 2012-2014, the mortality rate in children aged 1-9 years in the U.K. was 12.1 per 100,000 population. Although the mortality rate has declined across the UK since the 1970s, the UK's recent progress has been significantly lower than in other wealthy European countries, and concerningly the incidence of death due to diseases such as asthma and diabetes is higher than equivalent high-income countries. The scale of difference between the UK child mortality rate and the average suggests there are around 130 excess deaths of 1- to 9-year-olds each year in the UK.

Many childhood deaths are preventable. As with infants there is a strong association between deprivation, social inequality, and mortality. Causes amenable to interventions include environmental and social factors as well as health service factors and key actions include the following:

- creating safe environments, including access to information and safety equipment schemes to promote safety in the home

- reduce road speed limits in built-up areas to 20mph

- ensuring that clinical teams looking after children with long-term conditions such as asthma, epilepsy and diabetes deliver care to the highest standards, incorporating good communication, open access for patients and families, use of established tools such as the epilepsy passport and asthma plan, adherence to the components prevalent in the best practice tariff for diabetes, and address early the optimal conditions for safe transition to adult services. Implicit in this is teaching self- management and ownership of the condition

- Increasing the provision of high-quality end-of-life care and access to appropriate palliative care; delivering integrated health systems across primary and secondary care; whilst providing the optimal configuration of specialist services for children with complex conditions needing tertiary care, such as cardiac, renal conditions and children's cancer

3. Young People (10-19 years)

After the first year of life, adolescence is the life stage when children are most likely to die. The factors leading to death in adolescence are different to those in earlier childhood, and differ between males and females. The most common causes of death in this age group are injuries, violence and suicide, followed by cancer, substance misuse disorders and nervous system and developmental disorders.

Although the mortality rate in young people has decreased across the UK since the 1970s, progress recently has been slower than that seen in other wealthy countries. The UK's 'average' adolescent overall mortality today is a mixed picture. Whilst our injury mortality rate is amongst the lowest, we have a higher rate of deaths due to 'non- communicable diseases' such as asthma than other equivalent wealthy countries. Social inequalities are important since injury and illness are associated with poor environmental conditions and hazards such as smoking, alcohol, and drug use.

Many deaths are preventable and key actions include:

- reducing deaths from traffic injuries through the introduction of graduated licensing schemes
- improving adolescent mental health services
- improving services for children with long term conditions, and especially those transitioning to adult care
- increasing the involvement of young people and their families with rare and common long-term conditions in developing guidelines, measuring outcomes, service design and research trials

Underpinning all efforts to reduce child mortality in England lies an urgent need to collect high-quality data to better understand the reasons why children die, to allow accurate international comparisons, and to inform health policy. This requires a national system for the analysis of child mortality data, as well as improved child death review processes.

Historical Background to the Process of Child Mortality Review

Since 1 April 2008, Local Safeguarding Children's Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The relevant legislation underpinning such

responsibility is enshrined in the Children's Act 2004 and applies to all children under 18 years of age. The processes to be followed when a child dies are described in Chapter 5 of the statutory guidance document, *Working Together to Safeguard Children*. The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children, and to prevent future deaths. *Working Together* describes two interrelated processes:

1. a "Rapid Response" multi-professional investigation of an individual unexpected death

2. a Child Death Overview Panel (CDOP) review of all deaths in a defined geographical area. The purpose of the CDOP is to establish the exact cause of death, identify patterns of death in community and remedial factors, and to contribute to improved forensic intelligence in suspicious deaths. The family should be kept central to the process.

Drivers for Change including new legislation

The review of child deaths has been, to date, far more comprehensive than that for adults. However the following drivers for change exist:

1. **Variation in process.** There is significant variation across the system in how child deaths are reviewed, which deaths are reviewed, and the quality of the review.

   Specifically:

- 'unexpected' deaths in the community are generally reviewed as per the Sudden Unexpected Deaths in Infancy (SUDI) process. However there is variation in when a death is considered "unexpected" and in the timing of triggering investigations

- hospital deaths are usually reviewed at a Mortality and Morbidity (M&M) meeting. However there is wide variation, across the NHS, in how these meetings are convened, no standardisation on terminology, and a confused array of investigations (root cause analysis, serious incident inquiry, and mortality review) that follow certain types of deaths

- there is wide variation in CDOP processes (size, structure and functioning) an CDOP panels are dislocated from governance processes within their local children's hospital.

2. **The Wood Review**. In 2016, Alan Wood recommended that national responsibility for child death reviews should move from the Department for Education to the Department of Health, that DH should re-consider how CDOPs should best be supported within the new arrangements of the NHS, and that DH should determine how CDOPs might be better configured on a regional basis with sub-regional structures to promote learning. He also recommended that child deaths be reviewed over a population size that allowed a sufficient number of deaths to be analysed for patterns and themes. He went further to recommend that the NHS consider the role CDOPs should play in the process for achieving a common national standard for high quality serious incident investigations. Finally, he supported the intention to introduce a national child mortality database, and urged DH to expedite its introduction.

3. **The National Adult Case Review** programme. This programme uses a very different structured judgment review (SJR) methodology to that used in child mortality review. It focuses on problems in health care processes within an organisation rather than trying to understand the cause of death. Cases in which care is judged to be poor are scored according to an 'Avoidability of Death' scale. It is important to recognise that many 16 and 17 year olds die in adult ITU's and therefore it is important to understand what processes should take precedence in the review of such

patients.

4. **Medical Examiner** *process*. The Medical Examiner will be introduced across England. This appointee will link with bereaved families as well as the Coroner and their involvement will affect all mortality review processes.

5. **CQC report: Learning, Candour, and Accountability**. This report identified inconsistencies in: the involvement of families and carers; the process of identifying and reporting the death; how decisions to review or investigate a death was made; variation in the quality of reviews and investigations; and variation in the governance around processes and questionable demonstration of learning and actions.

6. **Legislative change (*Children and Social Work Bill 2017)*.** The Wood Review recommendation that national responsibility for child death reviews should move from the Department for Education to the Department of Health is being enacted through the Children and Social Work Bill 2017. Under the new legislation, local authorities and clinical commissioning groups are named as 'child death review partners' and must make arrangements for the review of each death of a child normally resident in the local authority area. They may also, if they consider it appropriate, make arrangements for the review of a death in their area of a child not normally resident there. The proposed legislation also states that the 'child death review partners' must make arrangements for the analysis of information about deaths reviewed and identify any matters relating to the death or deaths in that area a) relevant to the welfare of children in the area or to public health and safety and b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified.

National Child Mortality Programme

NHS England is undertaking a national review of child mortality review processes both in the hospital and community. A key aim is to make the process easier for families to navigate at a very difficult time in their life. Central to the programme is the creation of a National Child Mortality Database, which is currently being commissioned. The effective functioning of the national database requires high-quality, standardised data arising from simplified and standardised local mortality and CDOP review processes. NHS England have therefore established 3 work streams:

- the simplification and standardisation of mortality review processes in the community and hospital;
- a review of the governance arrangements and standardisation of CDOP processes;
- the creation of the national child mortality database.

The goals of the NHS England's child mortality review programme are to:

- establish, as far as possible, the cause or causes of each child's death
- identify any potential contributory or modifiable factors
- provide on-going support to the family
- ensure that all statutory obligations are met
- learn lessons in order to reduce the risk of future child deaths

- establish a robust evidence base to inform national policy across government to reduce avoidable child mortality across the UK nations

NHS England, the Department of Health and the Department for Education are working together to produce new statutory guidance for child death review. This guidance will cover the processes which should take place following the death of a child, and in particular how the death should be reviewed at local mortality meeting and child death overview panel. This new guidance will be published in late 2017.

Reporting

The definitions used within the adult Case Review programme for record review and to identify problems in care are not recognised within *Working Together*. NHS England's work programme intends to identify best practice and standardise processes across deaths in hospital and the community, to improve the experience of families and professionals. The deaths of children who are treated in acute, mental health and community NHS Trusts should be included by Trusts in quarterly reporting from April 2017. The information should come from child death review processes, and should include reporting problems related to service delivery.

APPENDIX 4

Structured Judgement Review

Background to the method and its strengths

In order to provide the benefits to patient care that are commensurate with the effort put into case note review, methods need to be standardised, yet not rigid, and usable across services, teams and specialists.

Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase and to score care for each phase[1]. The result is a relatively short but rich set of information about each case in a format that can also be aggregated to produce knowledge about clinical services and systems of care.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.

In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management and the outcomes of interventions.

Structured judgement case note review can be used for a wide range of hospital-based safety and quality review across services and specialities and not only for those cases where people die in hospital. For example, it has been used to assess the care provided for people who have had a cardiac arrest in hospital, to review safety and quality of care prior to and during non-elective admission to intensive care settings and to review the care provided for people admitted at different times of the week.

An important feature of the method is that the quality and safety of care is judged and recorded whatever the outcome of the case, and good care is judged and recorded in the same detail as care that has been judged to be problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care.

How the Structured judgement review method works

1. Who does what and when?

There are two stages to the review process. The first stage is mainly the domain of what might be called ‘front line’ reviewers, who are trained in the method and who undertake reviews within their own services or directorates, sometimes as mortality and morbidity (M&M) reviews, sometimes as part of a team looking at the care of groups of cases. This is where the bulk of the reviewing is done and most of the reviews are completed at this point.

A second-stage review is recommended where care problems have been identified by a first-stage reviewer and an overall care score of 1 or 2 has been used to rate care as very poor or poor. This second-stage review is usually undertaken within the hospital governance process and normally uses the same review method. At this stage the hospitals may also choose to assess the potential avoidability of a death where harms due to care have been identified (see Section 4 below and A *clinical governance guide* (RCP 2016) associated with the review guide).

2. Phases of Care – the 'structure' part of the method

The phase of care structure provides a generalised framework for the review and also allows for comparisons among groups of cases at different stages of care. The principal phase descriptors are shown in Box 1. However the use of the phase structure depends on the type of care and service being reviewed – not all phase of care headings will be used for any particular case. Thus the procedure-based review section may only be required in a few medical cases (e.g. a lumbar puncture, a chest drain or non-invasive ventilation) but are likely to be used in many surgical cases. It is up to the reviewer to judge which phase of care forms are appropriate in a particular case.

Box 1 Phase of care headings

- Admission and initial care – first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/procedure care
- End-of-life care (or discharge care)*
- Assessment of care overall

*Note that discharge care is included because this method is just as applicable for the review of care for people who do not die during an admission

3. Explicit judgement comments – the core of the method

The purpose of the review is to provide information from which teams or the organisation can learn. Explicit judgement commentaries serve two main purposes. First, they allow the reviewer to concisely describe how and why they assess the safety and quality of care provided. Second, they provide a commentary that other health professionals can readily understand if they subsequently look at the completed review.

When asked to write comments on the quality and safety of care, clinical staff often tend to write a resume of the notes or make an *implicit* critique of care. This is not helpful when others try to understand the reviewer's real meaning. So the central part of the review process comprises short, written, *explicit* judgement statements about the perceived safety and quality of care that is provided in each care phase.

This review guide does not include a glossary of explicit terms that reviewers might choose from, because this approach would inevitably be constraining or would fail to cover all eventualities in the complexities of clinical practice. Instead, reviewers are asked to use their own words in a way that explicitly states their assessment of an aspect of care and gives a short justification for why they have made the assessment.

Explicit statements use judgement words and phrases such as 'good', 'unsatisfactory', 'failure' or 'best practice'. See Box 2 and Box 3 for examples.

Box 2 Examples of phase of care structured judgement comments

- Continued omission to provide oxygen and respiratory support – poor care.
- Team still failed to discuss potential diagnosis with patient – unsatisfactory.
- Referral to intensive treatment unit (ITU) was too late
- There was some evidence of good management by the overnight team, with prompt review and intervention.
- Although patient discussed with a consultant once and a specialist registrar (SpR) once, for 3 days they were only seen by junior doctors – this is completely unsatisfactory.
- Very good care – rapid triage and identification of diabetic ketoacidosis with appropriate treatment.

Additionally, these judgement words are accompanied by short statements that provide an explicit reason why a judgement is made – e.g. 'unsatisfactory because, etc.' and 'for example, resuscitation and ceiling of treatment decisions made far too late in course of admission – poor care'. The purpose here is not to write long sentences but to encapsulate the clinical process in a few explicit statements.

Judgement comments should be made on anything the reviewer thinks is important for a particular case. Among other things, this will include the appropriateness of management plans and subsequent implementation together with the extent to which, and how, care meets good practice. In some cases, there may be care in a phase that has both good and poor aspects. Both should be commented on.

Commentary on holistic care is just as important as commentary on technical care, particularly where complex ceiling of treatment and end-of-life care discussions might be held. Judgements should be made on how the teams have managed end-of-life decision making and to what extent patients and their relatives have been involved. Thus, for example, a judgement comment might be couched as 'end-of-life care met recommended practice, good ceiling of treatment discussions with patient and family'. Similar approaches and levels of detail are required when care is thought not to have gone well, or where aspects of care are judges to be only just acceptable. Then words such as 'unsatisfactory', 'poor' or 'doesn't meet good practice standards' might be necessary.

Sometimes it is just not clear what has been happening during part of the process of care, where there appears to be a lack of decision making or guidance. Here, judgement words such as 'delay', 'poor planning' and 'lack of clarity is due to the level of documentation, comments such as 'inadequate record keeping' may apply.

Overall, phase of care comments are intended to bring a focus to the review by asking for an explicit, clear judgement on what the reviewer thinks of the whole care episode, taking all aspects into consideration. It is not necessary to repeat all of what has been commented on before, although it is sometimes useful to repeat some key messages – that is a reviewer's choice. Again, however, it is important to make clear and explicit what the overall judgement is and why. Examples are given in Box 3.

Box 3 Examples of overall care structured judgement comments

- Overall, a fundamental failure to recognise the severity of this patient's respiratory failure.
- Good multidisciplinary team involvement.
- On the whole, good documentation of clinical findings, investigation results, management plan and discussion with other teams.
- Poor practice not to be aware of the do not attempt resuscitation (DNAR) status of the patient, especially when it has been discussed with family, clearly documented when first put in place and reviewed later on.

Cause of death information should form part of the review framework. If, on review, the certified cause of death causes the reviewer some concern, this should be explicitly stated, because there may be a clinical governance question involved.

So the overall message about review language is that it should be explicit and clear, in order that you, the reviewer, feel you have made the points clearly and that others who read the review will be able to understand what you have said and why.

4. Giving phase of care scores

Box 4 Phase of care scores

1	Very poor care
2	Poor care
3	Adequate care
4	Good care
5	Excellent care

Care scores are recorded after the judgement comments have been written, and the score is in itself the result of a judgement by the reviewer. Only one score is given per phase of care: it is not necessary to score each judgement statement.

Scores range from 'Excellent' (score 5) to 'Very poor' (score 1) – see Box 4 – and are given for each phase of care that is commented on and for care overall.

These scores have a number of uses. For the individual reviewer, scores help them to come to a rounded judgement on the phase of care, particularly when there may be a mix of good and unsatisfactory care within a phase. The reviewer must judge what their overall decision is about the care provided for each phase and for care overall. Scoring makes this very explicit.

Overall care scores are particularly important in the review process. A score of 1 or 2 is given when the reviewer decides that care has been very poor or poor. Research evidence suggests that this might happen in upwards of 10% of cases in some circumstances, but less in others. A score at this level should trigger a second-stage review through the hospital clinical governance process (see Section 4).

5. Judging whether problems in care have caused harm

Problems in care take many forms and may have a range of impacts, some of which are potential rather than actual. Some of these events cause harms, but many do not.

The first-stage reviewer has an important role here in assisting the hospital to identify both actual and potential threats to patient safety. Using the assessment sheet at Appendix 1, reviewers are asked three questions in relation to problems identified in care. These are in the following format.

A. Were there one or more problems in care during this admission? Yes or no
B. If so, in which area(s) of the care process did this/these occur?
C. And for each of these problems, did any cause harm?

While the results of this assessment will be of importance in clarifying the issues in each review, it is the information aggregated across reviews that may pick up more fundamental care process issues that require attention.

6. Judging the quality of recording in the case notes

Case note review of course depends critically on the content and the legibility of the records. Safety of care also depends to some extent on good record keeping. Therefore, as part of the overall care assessment, the reviewer is also asked to record their judgement on the quality and legibility of the records, again using a score of 1-5.

7. The review in practice

Case note review takes up expensive clinical resource so that the time spent on establishing the purpose and desired outcome of the review is important.

In some hospitals, the majority of mortality reviews take place in an M&M context and so they are often already being considered to be potentially problematic cases. Structured judgement review has been found to be of value in providing a reproducible process for M&Ms.

However the challenge for hospitals has often been the gathering together of the material from the reviews so that it can be used to examine care processes. Data from M&M cases should be entered into the hospital reviews database. Aggregated information is more powerful in the longer term than the data from individual cases.

Screening deaths for possible problem is another means of indicating where focused reviews are necessary. Valuable information about specific issues can be gained in this way, although generalising messages from complex cases can produce 'solutions' that may themselves have unintended consequences.

Another approach is to evaluate care for all or some patients who come to a particular service, or to explore the care provided for the majority of people who die in hospital over a particular time period in particular services; for example, all elective surgery deaths or people who die from acute kidney injury might require review. This aspect is covered in some detail in the *governance guidance* which forms part of the overall guidance materials.

Given the constraints on reviewer availability and the need to produce usable information from the reviews, the principle of 'less is more' applies.

A simple time-based longitudinal sample of around 40-50 cases will produce a rich source of quantitative and qualitative information on what goes right and what is not working properly. Timely review, rather than review after a delay, provides better information.

Time spent on the analysis and information presentation outweighs the benefit of adding a few more cases to the sample. The textual information allows for themes to be developed that then allows a focus for the next improvement steps. Such an approach also has the benefit of enabling individuals to learn from, and celebrate, the cases where care has gone well.

8. Second-stage review

In the context of the National Mortality Case Record Review Programme, second-stage review takes place within the hospital governance framework when the first-stage 'front line' reviewer judges care overall to be very poor (score 1) or poor (score 2), or when harms have been identified, or if concerns have been raised about a case.

Second-stage review is also undertaken using the structured judgement method and is effectively a process of validation of the first reviewer's concerns. If the second-stage reviewer broadly agrees with the initial case review (with poor or very poor overall scores and/or where actual harm(s) is judged to have occurred), the hospital governance group may decide on an additional assessment concerning the potential avoidability of the patient's death.

Judging the level of the avoidability of a death is a complex assessment that can be challenging to undertake. This is because the assessment goes beyond judging safety and quality of care by also taking account of such issues as comorbidities and estimated life expectancy. Recent evidence suggests the levels of agreement can be very low when assessing potential avoidability of death.

The judgement is framed by a six-point scale (6 – no evidence of avoidability, to 1 – definitely avoidable). This scale has been used in a number of recent national mortality review studies in Canada, the Netherlands and England [2]. Additionally, the national review process, the second-stage reviewer supports the score choice with an explicit judgement comment justifying why the score decision was made.

The avoidability scale is shown in Box 5, together with an example of an 'avoidability of death' judgement comment. A score of 1, 2 or 3 on the avoidability scale would indicate a governance 'cause for concern'

Box 5 'Avoidability of death' scale

Score 1	Definitely avoidable
Score 2	Strong evidence of avoidability
Score 3	Probably avoidable (more than 50:50)
Score 4	Possibly avoidable, but not very likely (less than 50:50)
Score 5	Slight evidence of avoidability
Score 6	Definitely not avoidable

Example structured judgement commentary

Non-invasive ventilation management was sub-optimal, but ultimately it was the patient's wish not to continue treatment. There may have been an alternative cause of breathlessness that was not fully explored or treated, which is why there may have been some avoidability.

Score 5 – slight evidence of avoidability

Appendix 1 – Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick) No ☐

(please stop here) Yes ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)***:** Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)***:** Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

4. **Problem with infection control:** Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

5. **Problem related to operation/invasive procedure** (*other than infection control)***:** Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)***:** Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))***:** Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

8. **Problem of any other type not fitting the categories above:** Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239

Editorial note

This document has been adapted with permission from: Hutchinson A, McCooe M, Ryland E. *A guide to safety, quality and mortality review using the structured judgement case note review method*. Bradford: The Yorkshire and the Humber Improvement Academy, 2015. (Copyright The Yorkshire and the Humber Improvement Academy.)

The case note review methods discussed in this guide were primarily developed in a research study published as: Hutchinson A, Coster JE, Cooper KL, McIntosh A, Walters SJ, Bath PA *et al*. Comparison of case note review methods for evaluating quality and safety in health care. *Health Technol Assess* 2010; 14(10):1-165.

All clinical examples and structured judgement comments in this document are taken from hypothetical scenarios.

Please note that this guide is subject to change following conclusion of the pilot phase of the programme.

References

1. Hutchinson A, Coster JE, Cooper KL, Pearson M, McIntosh A, Bath PA. A structured judgement method to enhance mortality case note review: development and evaluation. *BMJ Quality and Safety* 2013;22:1032– 1040. DOI: 10.1136/bmjqs-2013-001839.
2. Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239.
3. Royal College of Physicians. *Using the structured judgement review method – a clinical governance guide to mortality case record reviews*. London: RCP, 2016.

APPENDIX 5

ROH STRUCTURED JUDGEMENT REVIEW

(to be completed with reference to appendix 4 of *Policy for Reporting, Investigating and Learning form Deaths in Care*)

Hospital Number:
Reviewer:

STAGE ONE (Front Line Review)

a) Phase of Care

Phase of Care	Care Score
Administration & initial care in first 24 hours	
Ongoing care	
Care during a procedure	
Perioperative/procedure care	
End-of-life/Discharge care	
Assessment of overall care	
TOTAL SCORE	

b) Explicit Judgement Statement(s):

Level of Care	Score
Very Poor	1
Poor	2
Adequate	3
Good	4
Excellent	5

c) Overall Care Structured Judgement Comments:

d) Was harm caused through problems in care? **YES / NO**

e) Were there one or more problems in care during this admission? **YES / NO**
(use questions in appendix 1 to make this judgement)

f) If so, in which area(s) of the care process did this/these occur? Complete in table below

g) For each problem did any cause harm?

Problem	Harm Caused	
	Yes	No

h) Judging recording in the case notes – quality and legibility

Quality of Medical Records	Score	Tick
Very poor	1	
Poor	2	
Adequate	3	
Good	4	
Excellent	5	

Do you consider that:

1) **Care overall was very poor (score 1) or poor (score 2)** **YES / NO**
2) **Harm has been identified** **YES / NO**
3) **Concerns raised** **YES / NO**

If the answer to any of these 3 questions is YES, a SECOND-STAGE review is required by the Trust Governance Manager

i) Avoidability of Death

Avoidability	Score	Tick
Definitely avoidable	1	
Strong evidence of avoidability	2	
Probable avoidability (more than 50:50)	3	
Possible avoidability (less than 50:50)	4	
Slight evidence of avoidability	5	
Definitely not avoidable	6	

PLEASE PASS TO TRUST GOVERNANCE MANAGER ONCE COMPLETED

Appendix 1 : Assessment of Problems in Healthcare

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here) Yes ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

9. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)***:** Yes ☐

   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

10. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)***:** Yes ☐

    Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

11. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)*: Yes ☐

    Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

12. **Problem with infection control:** Yes ☐

    Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

13. **Problem related to operation/invasive procedure** (*other than infection control)***:** Yes ☐

    Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

14. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)***:** Yes ☐

    Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

15. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))***:** Yes ☐

    Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

16. **Problem of any other type not fitting the categories above (state problem):** Yes ☐

    Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

APPENDIX 6

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:	**Division 1 & 2**
Speciality/Service Area	**Clinical**
Executive Lead (name and designation):	**A Pearson – Executive Medical Director**
Title of Policy:	**Reporting, Investigating and Learning from Deaths in Care Policy**

Q1) What is the aim of your Policy?

Ensure a culture of learning from deaths is embedded in the Trust

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

Safe patient care

Q3) Who benefits from your Policy?

Patients and Staff

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

Yes	No
☐ Please complete below.	X 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	☐	X	☐
Disability	☐	X	☐
Race	☐	X	☐
Sex	☐	X	☐
Gender Reassignment	☐	X	☐
Sexual Orientation	☐	X	☐
Religion or belief	☐	X	☐
Pregnancy & Maternity	☐	X	☐
Marriage & Civil Partnership	☐	X	☐

Other socially excluded groups	☐	x	☐

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

Q6) Who was involved in the EIA and how?

Medical Director

Deputy Director of Nursing & Governance

How were they involved?

☐ Surveys

☐ Team Meeting

☐ Group Review

X Other

Please specify: Corporate leads for NHS Improvement required action

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

No	X	yes	☐

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

There is no discriminatory impact of applying the principles of learning from deaths to assess if avoidable

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:	A M Pearson
Designation:	Medical Director
Date:	22.08.17
Contact number:	0121 685 4166

This EIA has been approved:

Name:	
Designation:	
Date:	
Contact number:	

APPENDIX 7

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

POLICY IMPLEMENTATION PLAN

POLICY TITLE:	Reporting, Investigating and Learning from Deaths in Care
ACCOUNTABLE EXECUTIVE LEAD:	Andrew Pearson – Medical Director
POLICY AUTHOR:	Andrew Pearson
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

Policy Implementation Plan

Monitoring body (Internal and/or External):	Trust Board/ NHS Improvement
Reason for action plan:	NHS Improvement request
Date of action plan approval:	6 September 2017
Executive Sponsor:	Mr Pearson, Executive Medical Director
Operational Lead:	Mrs Jo Wakeman, Deputy Director of Nursing & Clinical Governance
Frequency of review:	Monthly
Date of last review:	Not applicable
Expected completion of action plan:	October 2017

REF	ACTION	SENIOR/EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
1	**The NQB launched its Learning From Deaths policy in March 2017. The policy set out several key requirements including:**						
	From April 2017, trusts must collect new quarterly information on deaths including: the total number of patient deaths; the number of deaths subject to case record review; the number investigated as SIs; an estimate of the number	AP	JW			Completed	

REF	ACTION	SENIOR/EXEC LEAD	OPS LEAD	COMPLETION DATE	RISKS TO DELIVERY OF ACTION	PROGRESS UPDATE	STATUS
	thought more likely than not to have been caused by problems in care; the main themes and trends emerging from review and investigation; and what the trust is doing to address those themes and trends in order to improve care.						
	By September 2017, trusts should publish an updated policy on how they respond to and learn from the deaths of patients in their care.	AP	JW	Sept 17		Completed	
	From Q3 2017 onwards they must publish information on deaths, reviews and investigations quarterly via an agenda item and paper to their public board meetings.	AP	JW	Dec 17		Structure in place monitored through CAEC .	
	From June 2018, trusts must publish an annual summary of this data in their quarterly accounts.	AP	JW	18/19		Monitored as part of the quarterly updates through CQG. One of the key deliverables for 16/17 quality Accounts.	
	Publish a Learning from Deaths policy	AP	JW	Sept 17		Completed	
	Ensure that the web address for the policy is communicated to NHS Improvement	AP	SGL				
	Trust Board meeting considers the first published data required by the Learning from Death policy	AP		6 September 17		28th June 2017 – Q & S Executive sign off 22 August 2017	

Key to initials of leads

AP	Andrew Pearson, Executive Medical Director
JW	Jo Wakeman, Deputy Director of Nursing & Clinical Governance
SGL	Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary

Finance and Performance Report

JULY 2017

CONTENTS

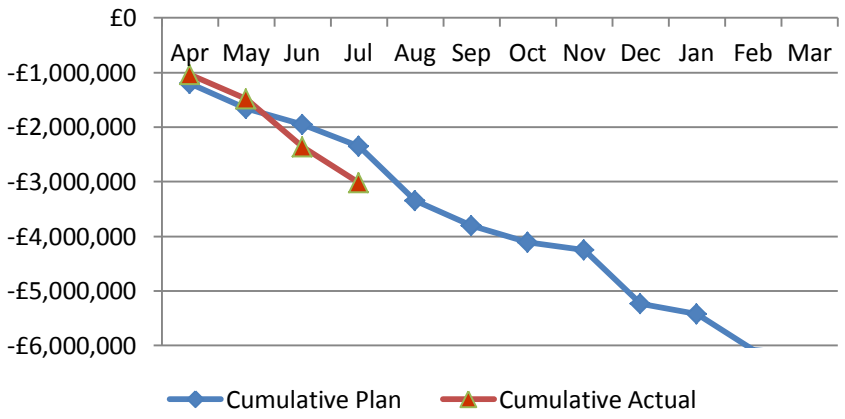
INTRODUCTION

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.

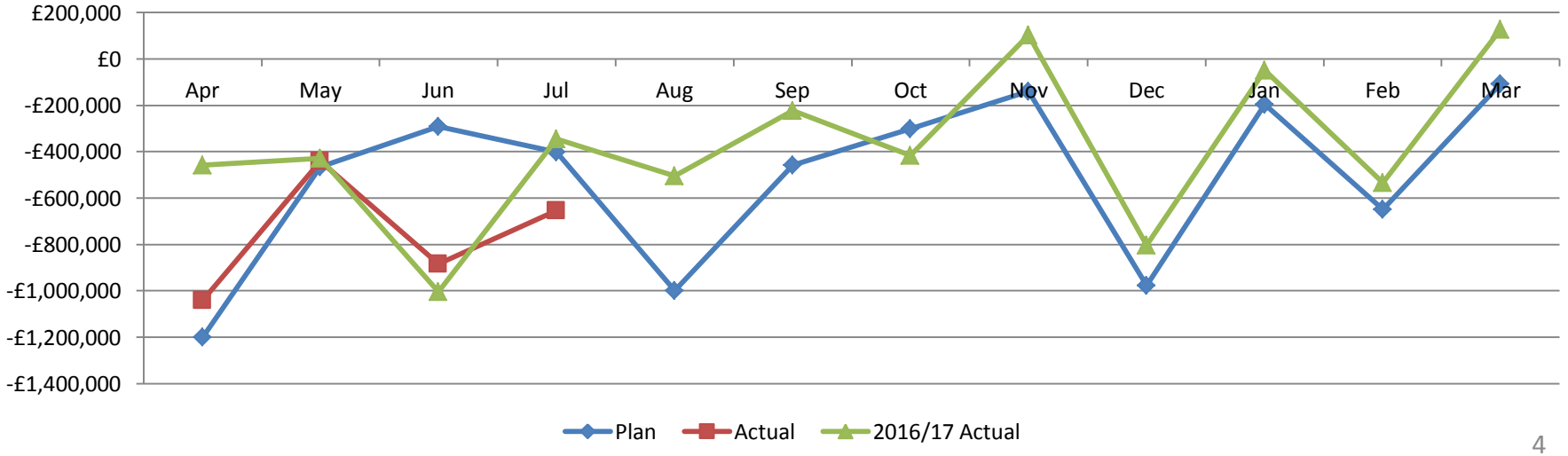
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Cumulative Deficit vs Plan



NHSI Use of Resources Rating (UOR)		
	Plan	**Actual**
Capital Service Cover	4	4
Liquidity	4	4
I&E Margin	4	4
I&E Margin – Variance against plan	1	4
Agency metric	1	2
Overall UOR	N/A	4

Monthly Surplus/Deficit Actual vs Plan



INFORMATION

The Trust has delivered a deficit of £655,000 in July against a planned deficit of £405,000, a result £250,000 behind plan. This brings the Trust's year to date position (on a control total basis) to £2,997,000 against a plan of £2,450,000, £547,000 behind plan.

The in-month position is therefore significantly behind plan again in July, although much improved on June's performance. Part of the variance year to date is the spend on RTT resources, including consultancy and agency. This alone results in c.£400,000 of cost pressure against the original plan. This in itself does not explain the variance however; the quarterly result includes a positive variance of £101,000 as a result of an unexpected insurance income receipt in relation to the 2013 onsite fire. The remaining variance is as a result of poor activity performance, particularly in June as discussed in prior month. In month performance will be discussed further in the slides to follow.

As at the end of Quarter 1, the Trust has recognised £565,000 of CIP savings, against a plan of £1,042,000. £17,000 (3%) of savings to date are non-recurrent. The in-month savings recognised were £141,000 against a target of £260,000. Divisions 1 and 2 have further considered their CIP plans for the year during July and August, but they currently remain poorly defined in some areas due to a focus on improvement of RTT and activity delivery. The Executive has challenged CIP progress urgently as part of the Divisional Performance Reviews.

With regards to the Trust's Use of Resources Risk Rating (UOR), the deficit position against plan results in the Trust reporting ratings of 4 for Capital Service Cover, I&E Margin and I&E Margin variance. The negative variance from plan has also resulted in a 4 for I&E Margin Variance. The Trust's requirement for cash support has resulted in the Trust being a 4 for liquidity. The use of RTT agency means that despite significant control of other agency in month, there was an overspend on agency costs, resulting in an Agency rating of 2. As a result, the overall rating for July remains at a 4.

ACTIONS FOR IMPROVEMENTS / LEARNING

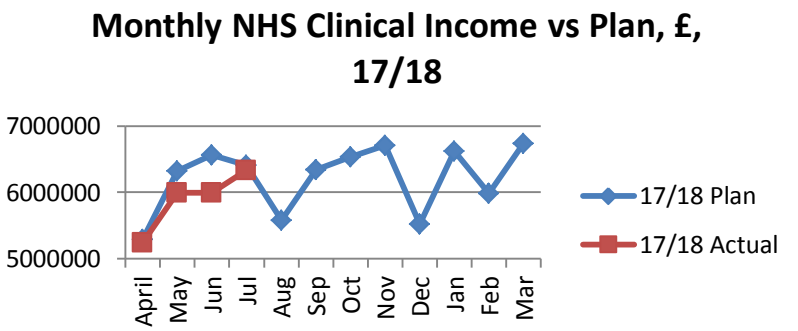
The Trust Executive are monitoring weekly progress against activity improvement and the scheduled care improvement programme. Schemes such as implant rationalisation are in progress to improve the Trust's cost efficiency. Whilst the schemes are constantly being reviewed and refreshed, particular focus will be placed on ensuring the cost control plan is reconsidered and takes into account all of the coming planned CIP schemes which need particular Executive oversight.

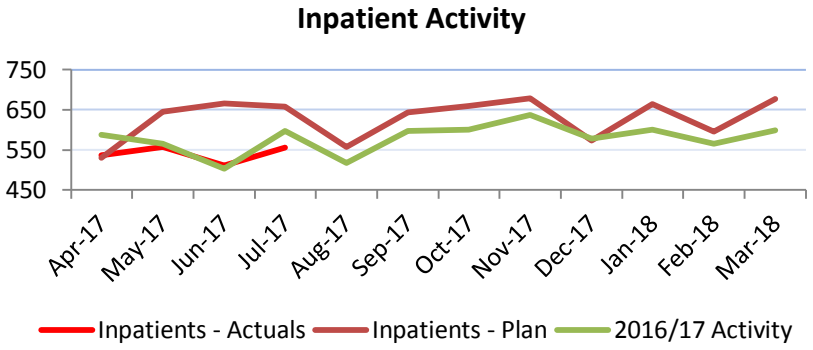
The Interim Chief Operating Officer is also holding weekly challenge and improvement meetings with a range of operational and other stakeholders to identify areas for efficiency improvement. Current areas of focus include an end to end pathway review, and a focus on theatre efficiency. Specialist STP resources are being utilised to assist with delivering improvements at pace.

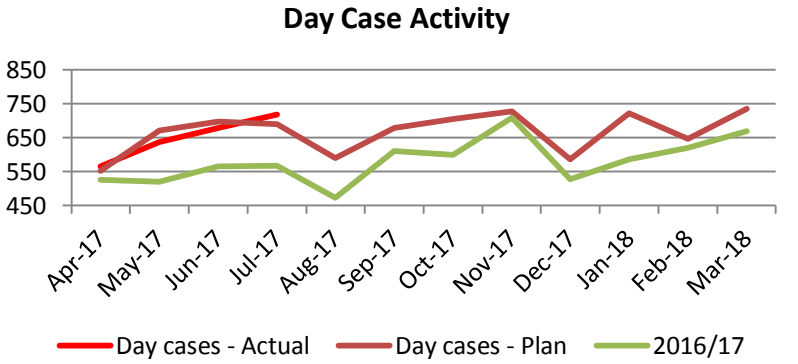
RISKS / ISSUES

There remains a risk that the focus on RTT and operational activity delivery results in CIP schemes not being implemented in a timely enough manner to ensure the required savings for 2017/18.

2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity







NHS Clinical Income – July 2017 £'000			
	Plan	Actual	Variance
Inpatients	3,259	3,112	-147
Excess Bed Days	101	51	-50
Total Inpatients	3,360	3,163	-197
Day Cases	789	925	136
Outpatients	631	551	-80
Critical Care	253	232	-21
Therapies	251	228	-23
Pass-through income	225	229	4
Other variable income	385	477	92
Block income	518	527	9
TOTAL	6,412	6,332	-80

NHS Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	12,463	12,024	-439
Excess Bed Days	387	232	-155
Total Inpatients	12,850	12,256	-594
Day Cases	3013	2832	-181
Outpatients	2408	2355	-53
Critical Care	966	814	-152
Therapies	709	878	169
Pass-through income	862	871	9
Other variable income	1716	1494	-222
Block income	2072	2072	0
TOTAL	24,596	23,572	-1,024

INFORMATION

NHS Clinical income has under-performed against plan by 1.2% in July having under-performed by 8.7% in June. This is being driven by activity underperformance in the month, due to a combination of underutilisation of sessions, fallow lists and cancellations.

Cumulatively, the trust is now 4.1% behind plan. Admitted patient care performance was below plan financially and with regards to activity levels, with discharged activity 73 below target. Case-mix in July sees an increase in day case activity compared to elective, with day case having overperformed against plan by 29 cases (underperformance of 102 cases in elective).

Outpatients continued to under-perform from an income point of view which is driven by the underperformance in outpatient procedures. First and follow up outpatients are over-performing year to date. First to follow up ratio has remained steady year to date.

ACTIONS FOR IMPROVEMENTS

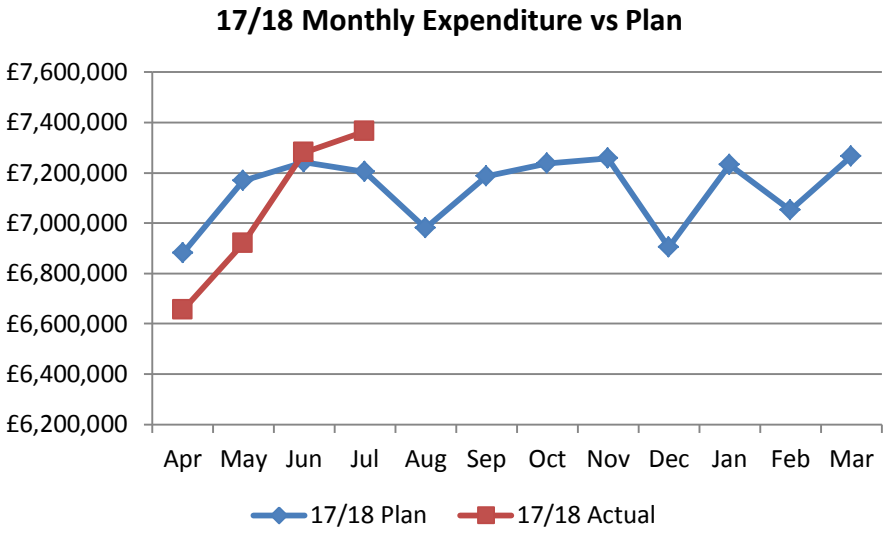
As noted previously, the Interim Chief Operating Officer is holding weekly challenge and improvement meetings with a range of operational and other stakeholders to identify areas for efficiency improvement. Current areas of focus include an end to end pathway review and theatre efficiency.
The daily theatre huddle at 8.30 each morning has also been reinstated to identify potential issues for the day and discuss the previous day's performance. This is led by the Deputy Chief Operating Officer and attended by all senior operational management, with invitation for clinicians to drop in and flag concerns.
In addition large joints and hands have trialling a reversal in the booking process where patients are TCI'd before theatre sessions are booked. This is now being rolled out to spinal activity, which should potential reduce cancellations and churn and improve booking efficiency.

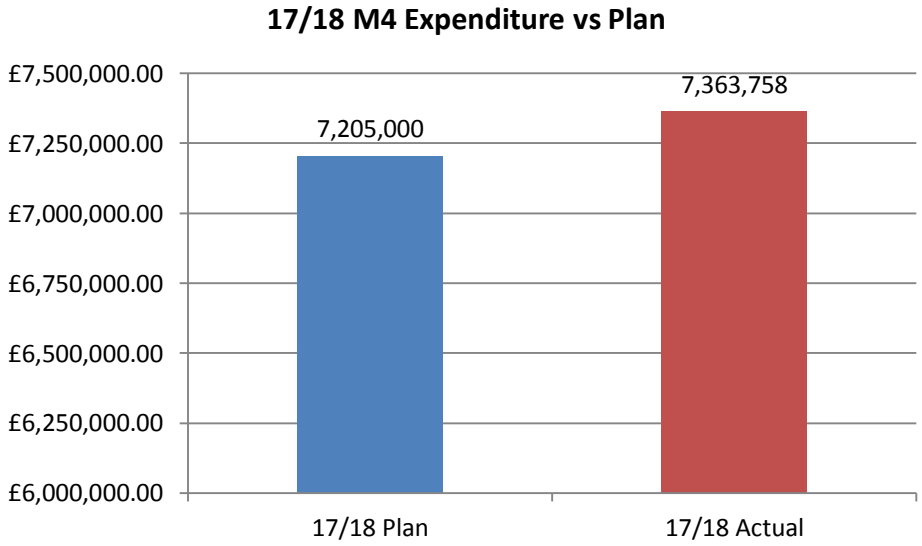
RISKS / ISSUES

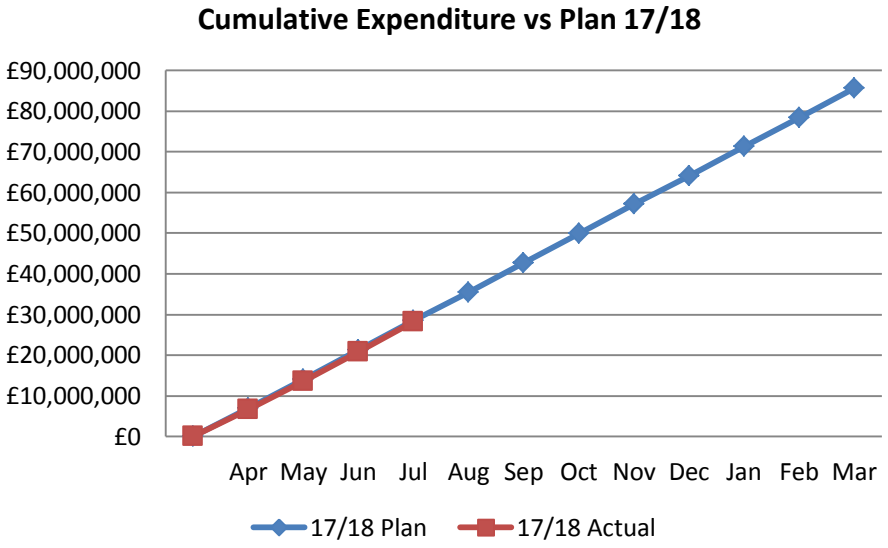
Key risks are the availability of speciality teams to reutilise every fallow list, particularly during periods of high consultant leave, and to ensure that theatre productivity continues to enable fully booked lists to be delivered. There continue to be a high level of patients who cancel their operation a few days before the planned date, which then means that there are replacement patients scheduled at short notice to achieve full utilisation.

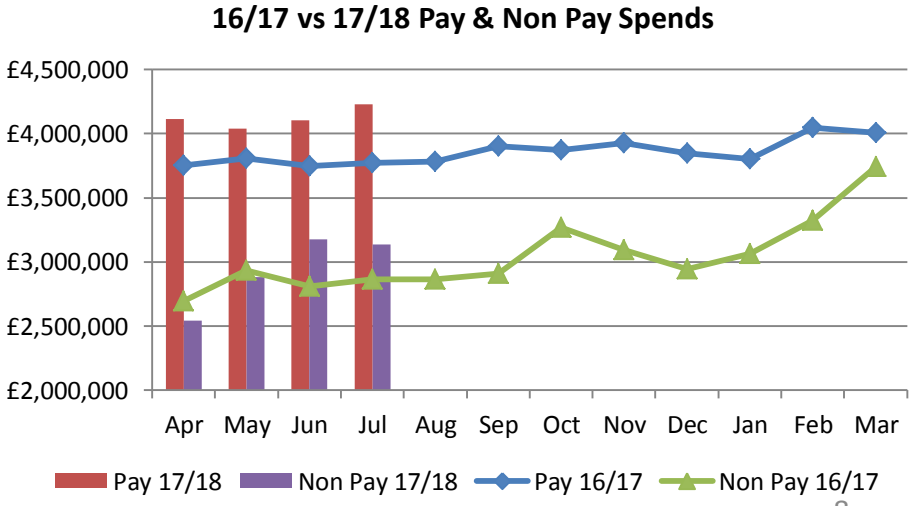
There is increasing clinical engagement in developing improvements to productivity for both operations and out patients. Some consultants have very short, with others having very long, waiting lists, and work is underway to smooth out flows across firms.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends









INFORMATION

Expenditure levels for the month were £7,364,000, which is £159,000 above the in month plan of £7,205,000.

The reason for the overspend was non-pay spend being higher than planned, particularly with regard to legal costs and clinical non-pay costs. At the executive led Division 2 performance meeting, the operational leads were challenged to urgently review non-pay costs in areas such as human bone products and dressings which seem to have increased spend with a disconnect with activity. A workshop to review the current processes in Theatres supported by the development of an action plan is being chaired by the Interim Chief Operating Officer on Friday 1st September .

Pay spend was largely in line with the plan. When the pay categories are reviewed individually, substantive spend was behind plan by £156,000, bank spend ahead of plan by £233,000, and agency greater than plan by £78,000. As noted in prior month, it is clear from a review of the bank plan that this was erroneously set too low in each month, with the balance being taken from substantive pay. When the plans are corrected to what they should have been set as, the spends are much more in line with plan. NHS Improvement have been contacted to see if a correction to the plan can be made, as this variance will otherwise be expected to be seen throughout the year.

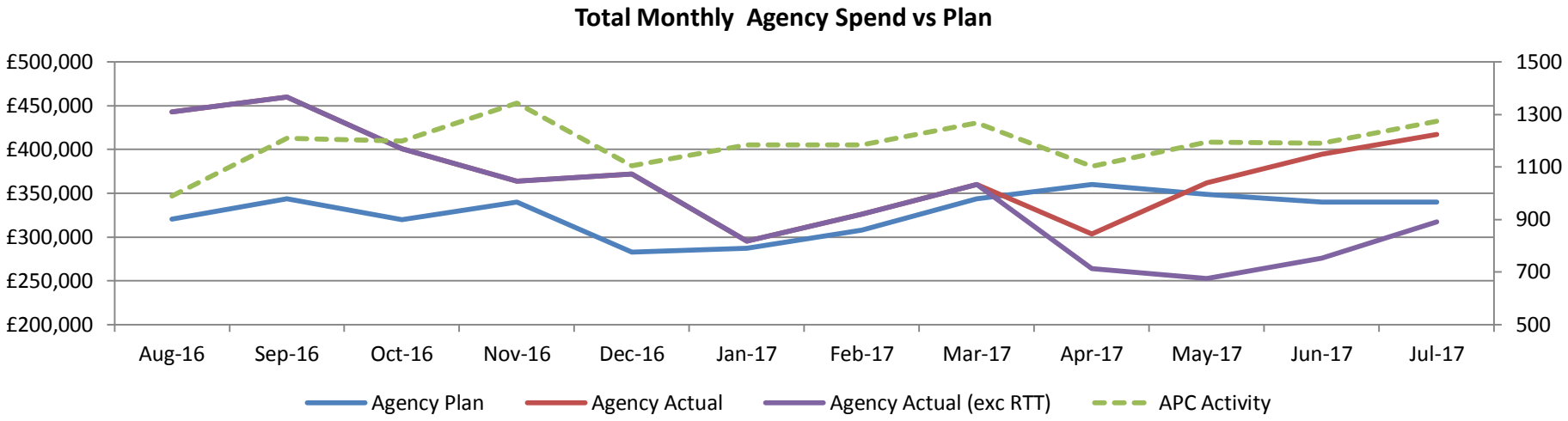
ACTIONS FOR IMPROVEMENTS / LEARNING

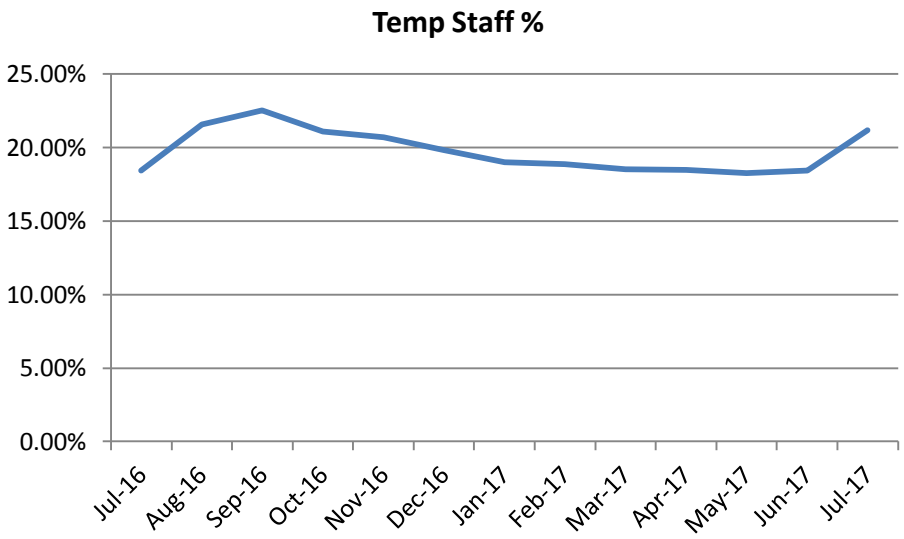
Costs will continue to be scrutinised and minimised, and the alteration of the bank spend plan will be followed up further with NHS Improvement.

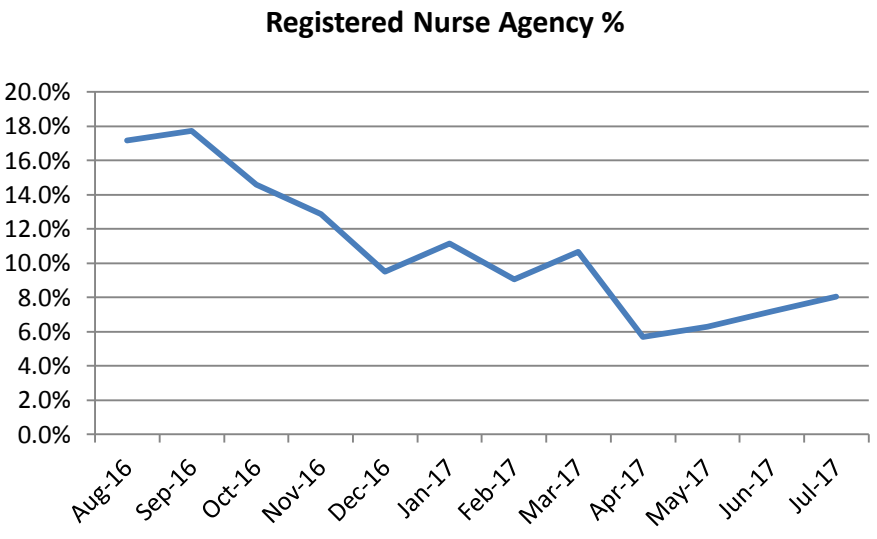
RISKS / ISSUES

Close management of the stock implant rationalisation will be required to control costs and maximise savings as described in further detail in the CIP section of this paper. The Interim Chief Operating Officer is managing this CIP with the Theatre and Divisional Team to ensure that this is fully managed.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements







INFORMATION

July showed an increase in agency spend (£395k to £417k). Significant agency spend continues to be incurred on RTT validators, although the validation of the pathways is nearing completion, and it is expected that all the remaining validators will have left site by the end of September. Healthroster is continuing to give better visibility of rotas and better control of nurse agency. In addition, there have been ward closures as a result of the infrastructure works, and the nursing workforce have been working effectively to group resource in these circumstances to reduce agency spend. There continues to be a pressure on Medical spend due to an under provision of GP trainees from the West Midlands Deanery.

ACTIONS FOR IMPROVEMENTS / LEARNING

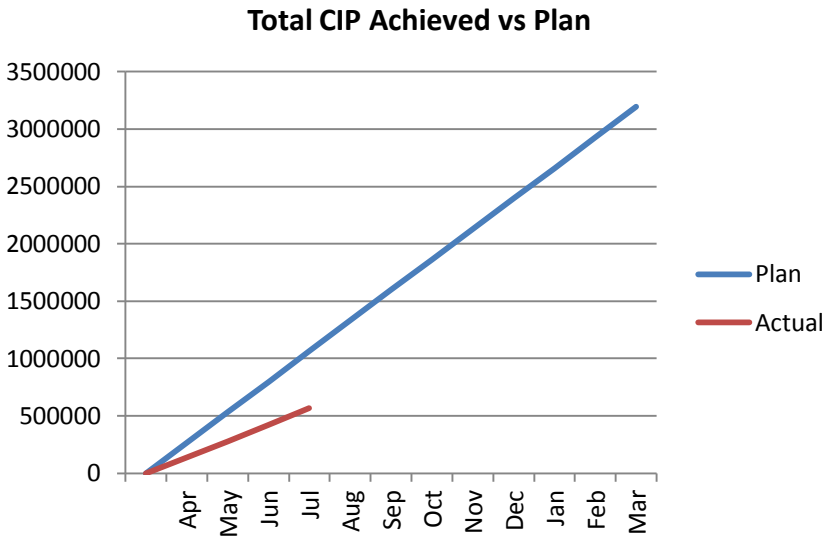
The leadership by the Nurses in addressing use of agency continues to impact positively. This has been delivered by continued and focussed review of the outputs of Healthroster.

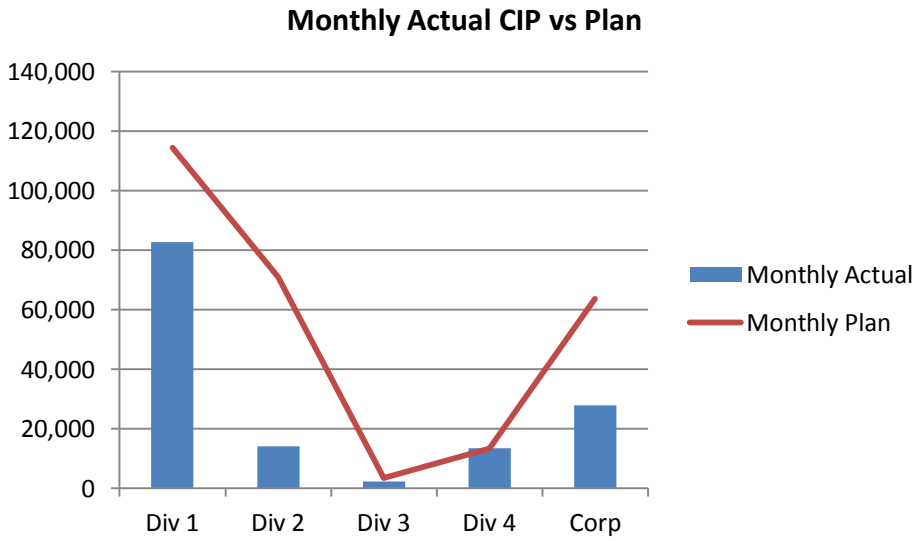
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios. The Trust is currently consulting on a change to rota working patterns as part of this process.

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. An overspend against the trajectory will have a direct impact on our regulator ratings. The Trust has remained at a 2 for agency spend, resulting in the overall UOR rating being a 4.

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2017/18





INFORMATION

As at the end of July, the Trust has recognised £565,000 of CIP savings, against a plan of £1,042,000. £17,000 (3%) of savings to date are non-recurrent. The in-month savings recognised were £141,000 against a target of £260,000. Divisions 1 and 2 have further considered their CIP plans for the year during July and August, but they currently remained poorly defined in some areas due to a focus on improvement of RTT and activity delivery. The Executive Team has challenged CIP progress urgently as part of the Divisional Performance Reviews.

The Trust continues to progress through the implementation of the non-spinal rationalisation scheme, and it will remain important to manage the process of transition closely to the new suppliers to maximise on the savings for the new rates and avoid incurring additional cost by ordering non-primary suppliers. Good progress is being made with the involvement of many teams and individuals around the Trust in the rationalisation of consumable supplies, with some notable successes on implementing alternative products following successful product trials.

Other significant schemes planned for 2017/18 include continue to implement nurse staffing improvements, in addition to embedding the operational and executive team restructures implemented from 1st April.

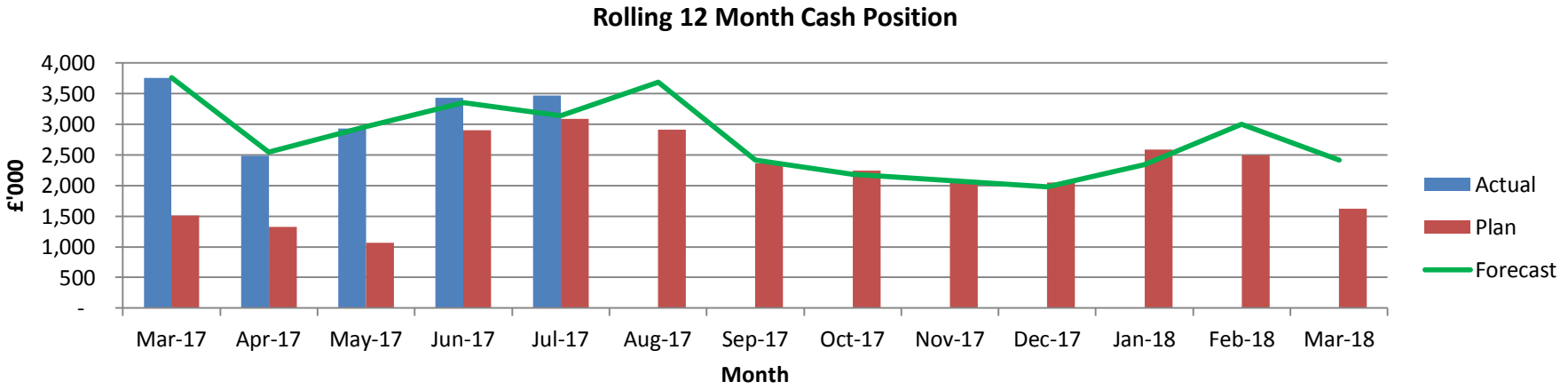
ACTIONS FOR IMPROVEMENTS / LEARNING

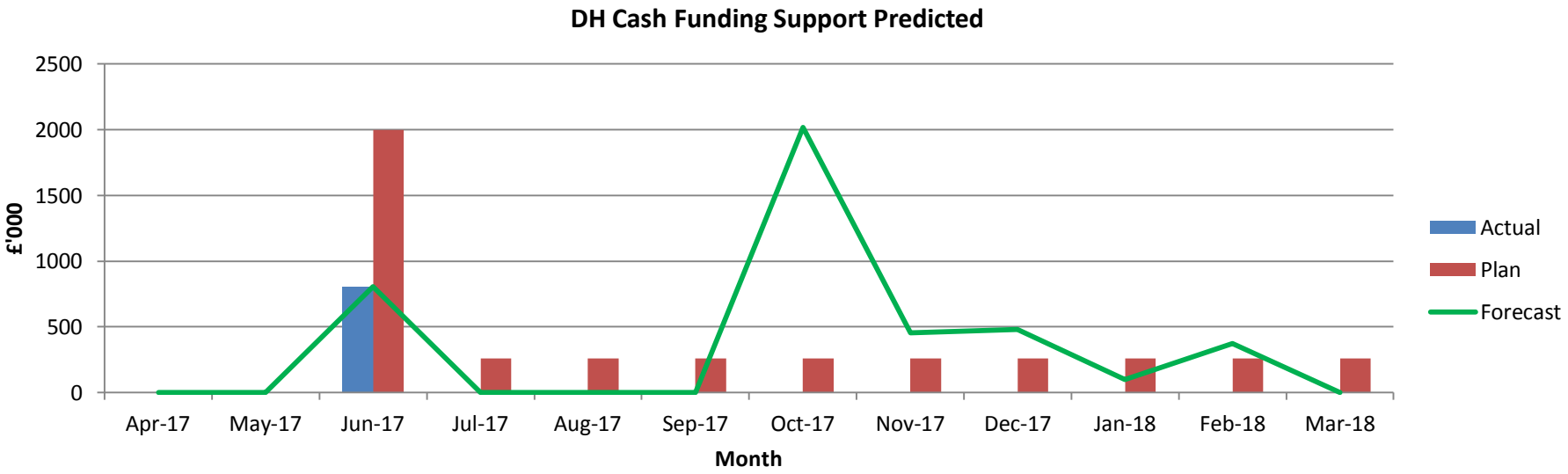
Early focus on unidentified schemes for 2017/18 is needed to ensure the CIP plans are achieved. In addition, a significant proportion of the prior year CIPs were non-recurrent. Focus on ensuring schemes are recurrently delivered will be important in the coming year.

RISKS / ISSUES

The CIP target for 2017/18 will be challenging particularly given the high level of non-recurrent CIP in 2016/17. A number of the schemes in 2017/18 are more transformational rather than traditional cost cutting schemes, and it will be vital that the required changes to working are not only implemented but thoroughly embedded to ensure savings are delivered in a consistent manner.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet in addition to expected borrowing requirements from the Department of Health





INFORMATION

Information

Cash levels are £0.5m higher than planned levels at the end of July, largely driven by cash held at the end of March being significantly higher than planned. The cash position for July is roughly in line with the Trust revised cash forecast for the month.

Due to the reduction in cash, liquidity levels within the Use of Resources Rating have dropped to a 4, the lowest level. Cash support has now been requested from the Department of health, please see section below for more details.

The Trust received its first cash loan from the DH on the 12th June for £804k as previously advised to the committee. Based on the current forecast funding support will not be required again until October 2017.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Head of Financial Accounting has set up a monthly cash control committee attended by the DDOF, and representatives from management accounts and the transaction team. The committee is reviewing cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications of cash from the Department of Health to be actioned.

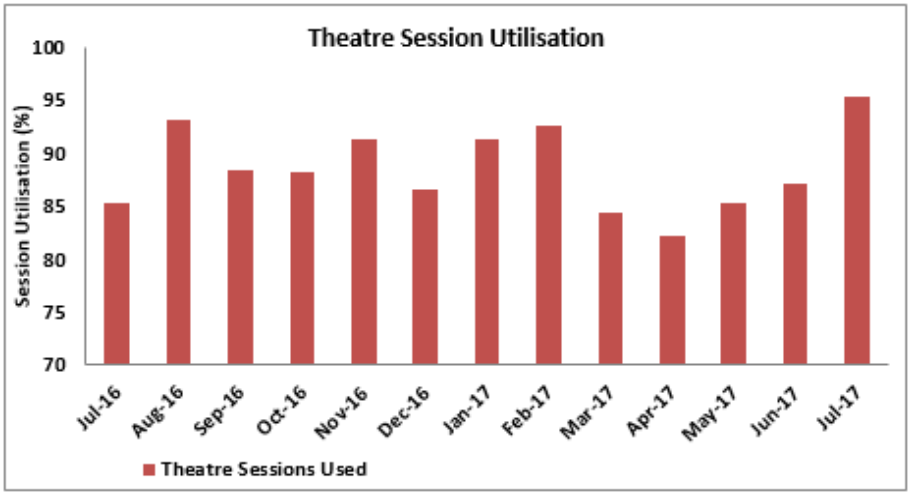
Based on the feedback from NHS Improvement the information provided to request funding was robust. The finance team are however continuing to review this and are looking to gather more information to continue to improve the Trusts management of cash.

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.

There is a risk is in relation to DH not approving a cash loan or approving a lower than requested amount, but the positive feedback to date from NHS Improvement provides assurance that this risk is relatively low.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are potentially available (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we aim to use at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis. July utilisation has continued the month on month trend of improvement and more work is underway to continue to improve this, to support the delivery of the RTT Action Plan.

Due to annual leave / study leave, we typically plan that surgeons will operate over 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.

ACTIONS FOR IMPROVEMENTS / LEARNING

Further improvements have been made to the communications to surgeons of the availability of fallow lists, enabling more effective utilisation. From September there will be an additional 3 session day scheduled to facilitate the 2 x scoliosis cases on a list for spinal deformity. The large joints team are exploring a regular 3 session day list for those consultants with back log issues. In week twin theatre sessions have started in order to drive efficiency and reduce backlogs.

All reasonable efforts are made to recycle, including where it is deemed appropriate the use of sessions additional to job plan (paid ADHs). Since theatres and anaesthetic teams are not yet fully staffed, capacity is flexed up through overtime and bank working, so where lists are not recycled, and deemed 'fallow', the theatre staffing and anaesthetic shifts are removed 1 week ahead, to reduce bank and agency costs.

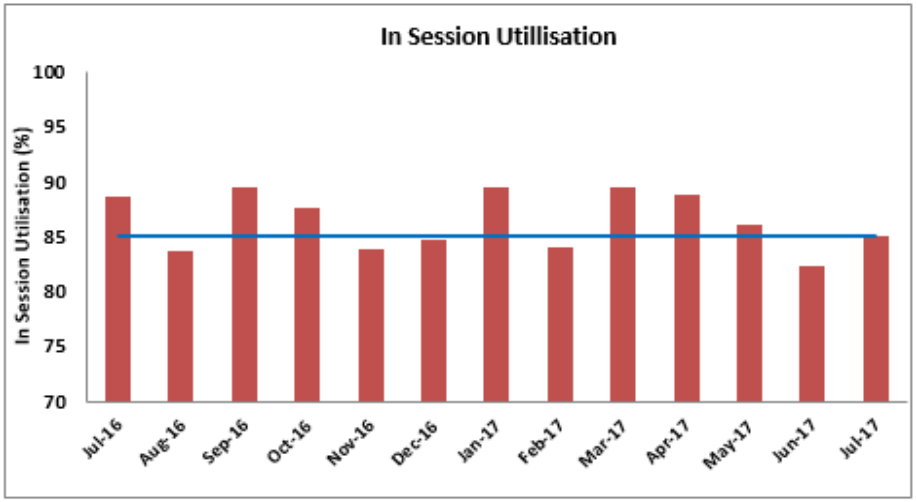
The ops team are proactively monitoring surgeon annual leave in order to manage the reduce the number of fallow lists and to offer appropriately to those services that are most challenged.

Weekend sessions are being planned throughout the remainder of the year with good uptake from consultants.

RISKS / ISSUES

Job planning is now completed for surgeons, with outstanding issues with only 2 surgeons; these are actively being progressed with the involvement of the Associate Medical Director, Clinical Service Manager and Clinical Service Lead.
The new theatre schedules and outpatient schedules started on 1st May 2017, to match the updated agreed job plans.
The next round of job planning is now being planned.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained above the target 85% in the majority of months. However, the previous measure (pre June) 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. The July performance has improved and will continue to be a focus to improve further for the coming months to enable the delivery of additional activity required to address 18 week compliance.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Scheduled Care Improvement work is now underway, with additional support and expertise due to join the ROH in September. The Head of Nursing, Division 2, is continuing to lead work on The Productive Operating Theatre principles.

The new Theatre Management System 'Theatreman' was successfully implemented on 24th May 2017, replacing ORMIS. The reports now available are enabling further scrutiny of variation and opportunities for improvement. Individual operation timings have now been refreshed based on actual times for surgery since May 2017. This allows the team to manage this on a daily basis with the ability to challenge the team real time.

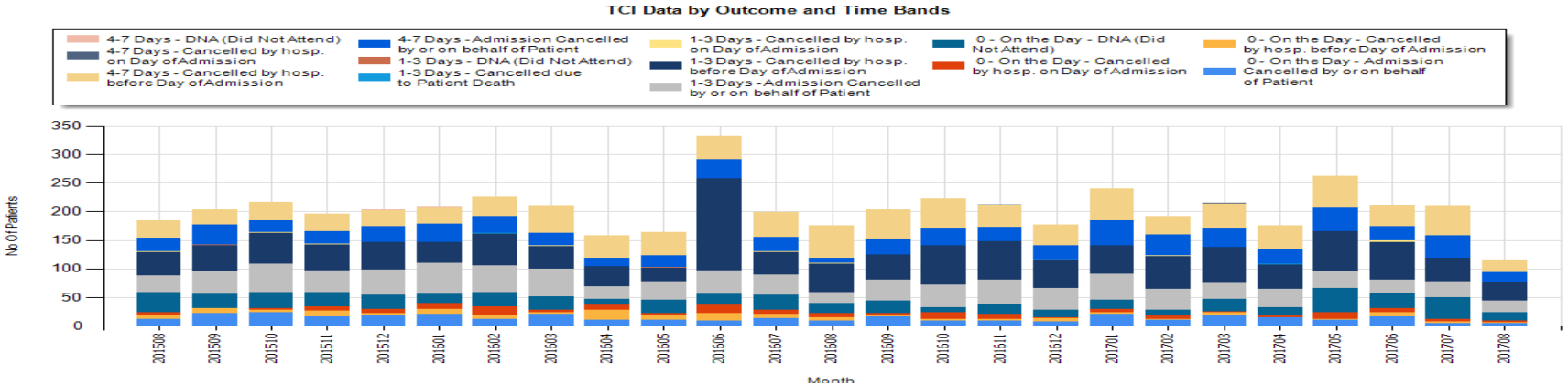
Scrutiny and challenge is via the weekly 6-4-2 meeting, with instructions back through to the surgical teams to book lists to their maximum potential and to POAC and identify patients well in advance so that specific requirements can be planned for to reduce cancellations. From the beginning of September the ability to indicate patients who have been through POAC will be evident so that the operational team can contact those patients at short notice.A weekly review of the last 7 days in theatres now takes place every Friday morning with the Operations Team reviewing opportunities for better performance.
The revised PTL is now available and additional capacity delivery through use of non consultant staff is being explored. As the validation work is finalised, this will confirm an accurate picture of the waiting list and hence the level of additional activity required.

RISKS / ISSUES

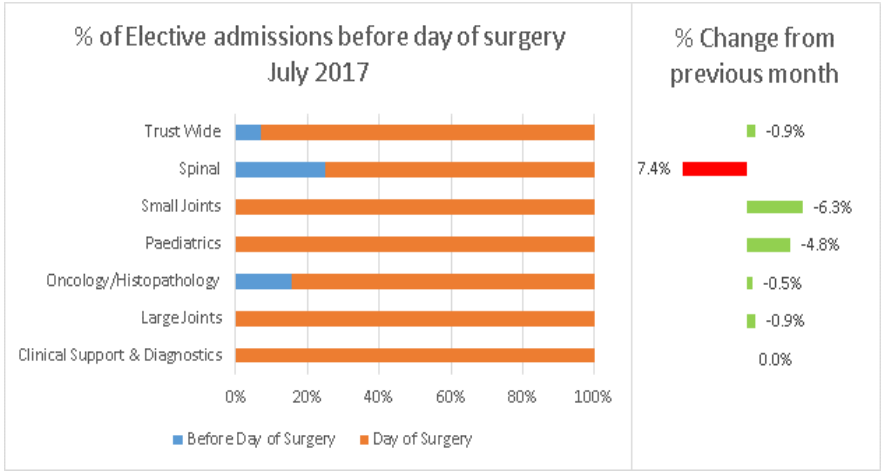
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (e.g. experience in spinal scrub) to ensure the best possible use of available operating time. Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit. Gaps in

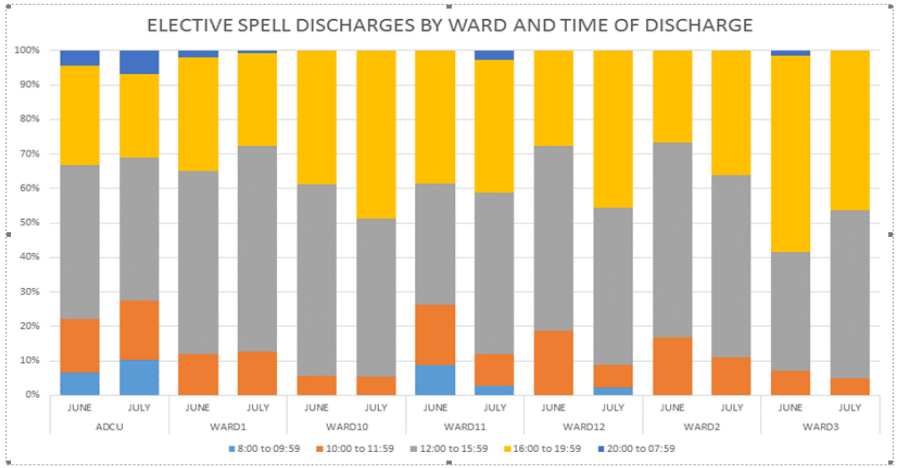
11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

Cancellations by patient / hospital



Admission the day before surgery





INFORMATION

Active management of the Patient Tracking List (PTL) , the planning for the establishment of a separate Oncology PTL weekly meeting to track the booking of individual patients, and a separate PTL weekly meeting for each firm to track patients is creating a new momentum, with lists being booked several weeks ahead where previously they were being booked only days ahead.

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Some of the replacement patients are then booked at short notice. We are working towards booking with 3 week's notice and 2 reasonable offers as per national guidance and our Access Policy.
Now that there are Clinical Service Leads and Clinical Service Managers for each specialty, and regular team meetings, some longstanding issues relating to disparity of waiting lists across consultants, variations in theatre productivity and listing protocols are being addressed and resolved.

Forensic analysis of cancellations continues, with a focussed analysis by the anaesthetic lead and nursing lead for POAC of the majority cause of cancellations on the day of surgery, namely those who are medically unfit, to ascertain what process changes can be made in POAC or to the 72 hour phone call to reduce this.

ACTIONS FOR IMPROVEMENTS / LEARNING

Now that the longstanding vacancies in Medical secretaries, admin support and operational management have been filled, there is now the capacity for transacting the forward booking of patients for both preoperative assessment and surgery. A pilot for medical secretaries to book patients directly is now in place across Hands and Large Joints teams which will be rol out to spinal at the end of August 2017.

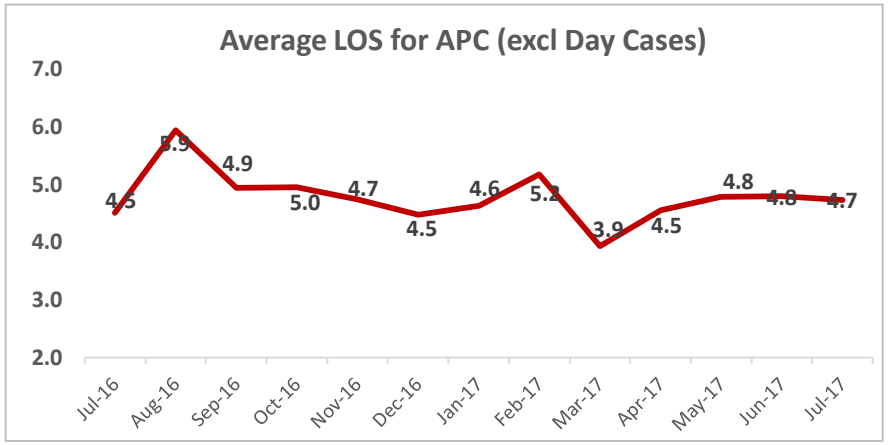
Work is still required to agree criteria for admission the day before, to use beds more effectively and reduce length of stay.
Pre-operative assessment improvements have been delivered, so that there are now 32 slots available each day.
A daily update review by operational management of forward bookings has been established and the 642 and a daily 9am Operations huddle has continued. Daily statistics on beds , admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to deliver activity and patient flow.

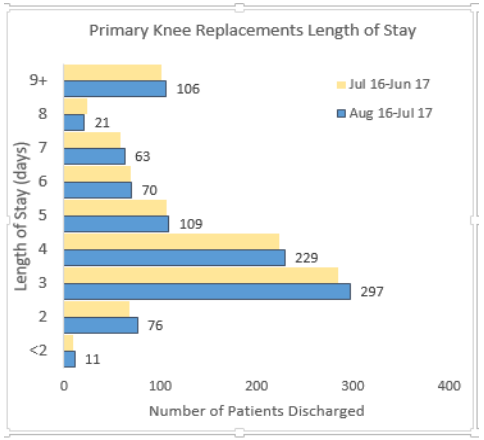
RISKS / ISSUES

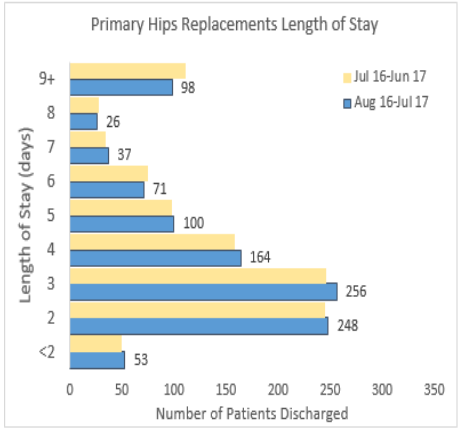
Continued focus with all staff involved to ensure that the operating lists are booked in advance, with sufficient caseloads, together with daily tracking.

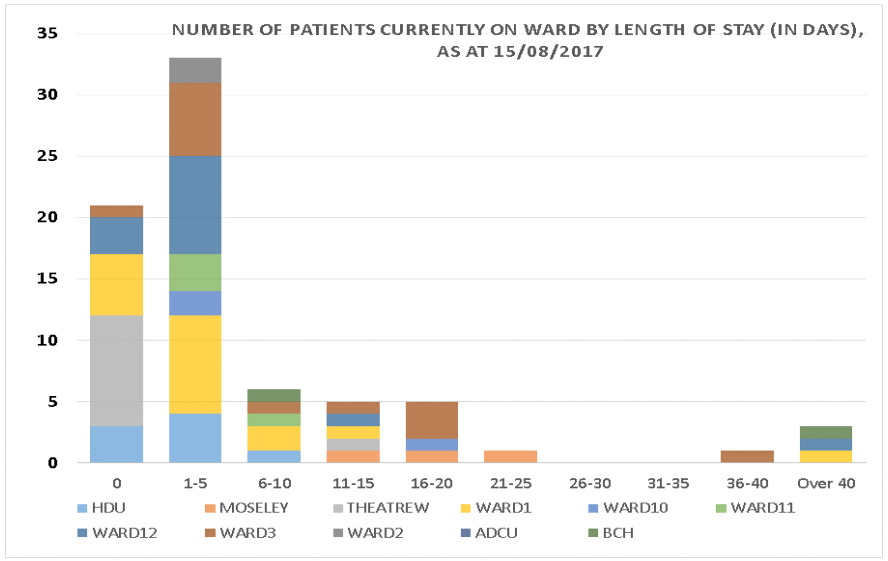
It is currently not possible to identify if the time of day patients are discharged is an accurate reflection of reality, or whether data is being entered onto the system in a delayed manner, making discharges look later in the day.

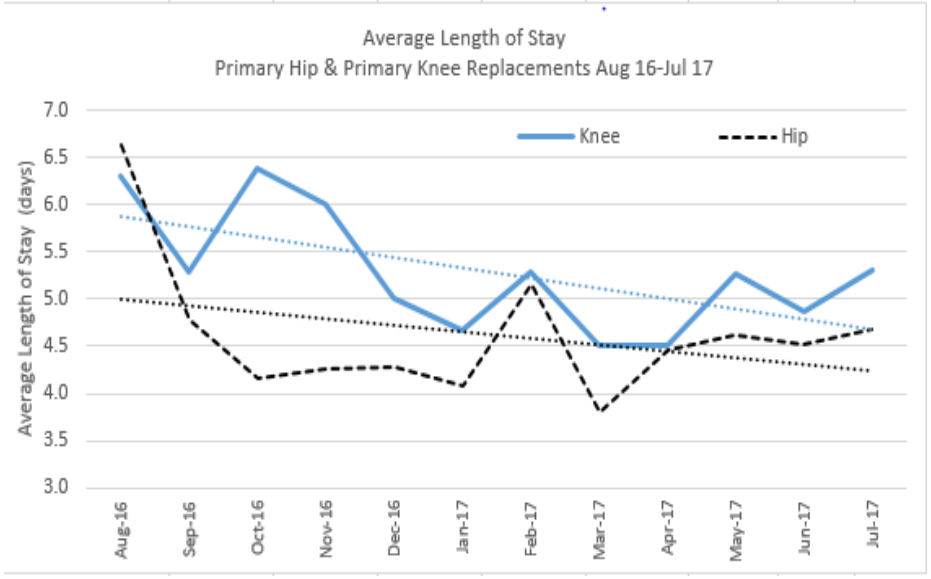
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Under the leadership of the Associate Medical Directors , Clinical Service Leads and Clinical Service Managers, work is progressing to increase activity levels to deliver 18 week compliance by creating additional capacity from within existing resources by improving flow. Length of stay reductions for primary hips and knees is key to achieving this , and an update will be brought to the next committee as to the progress of this work.

In May 2017, a 'Red2Green' process has been started to force better flow of patients hour by hour, partly to facilitate the rolling ward closures for the site infrastructure cabling installation, and mainly to improve overall patient flow. Work is ongoing to ensure that the analysis from Red2Green is highlighted and any areas which are flagging as red are explored further. Further work is underway as part of the Scheduled Care Improvement work to embed this approach across the organisation. This will also see the development of criteria led discharge to support weekend discharge planning.

ACTIONS FOR IMPROVEMENTS / LEARNING

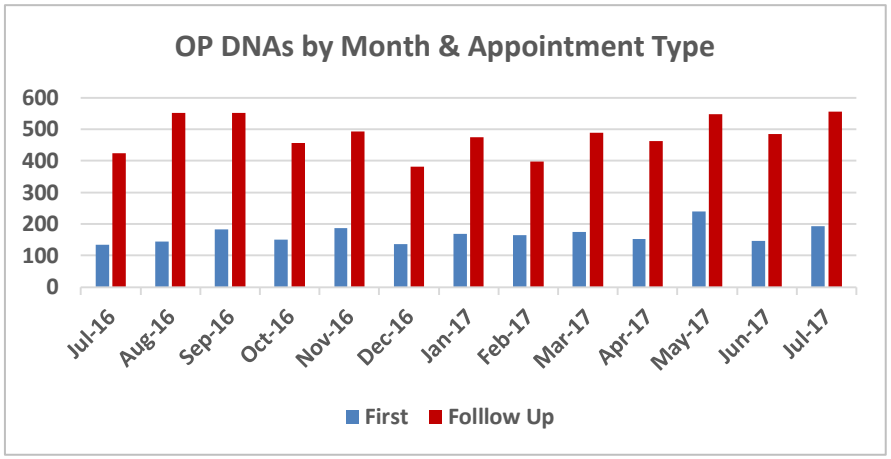
Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.

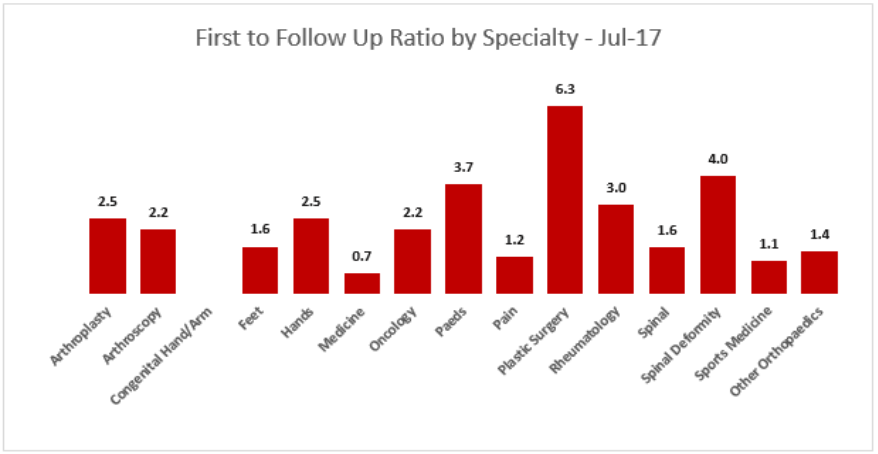
Daily senior reviews are being formalised as part of job planning, and the rising adherence to recording the Expected Date of Discharge (EDD) (now over 90%) is helping all involved in that patient's care to manage their length of stay more effectively.

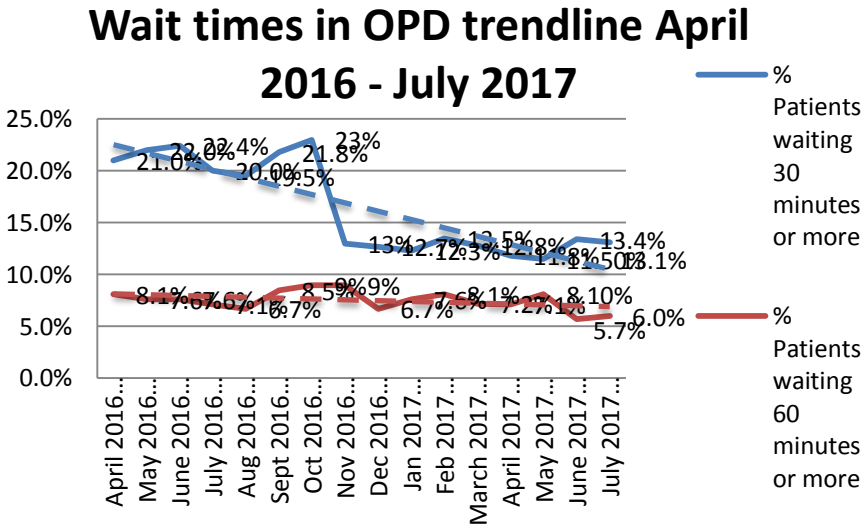
RISKS / ISSUES

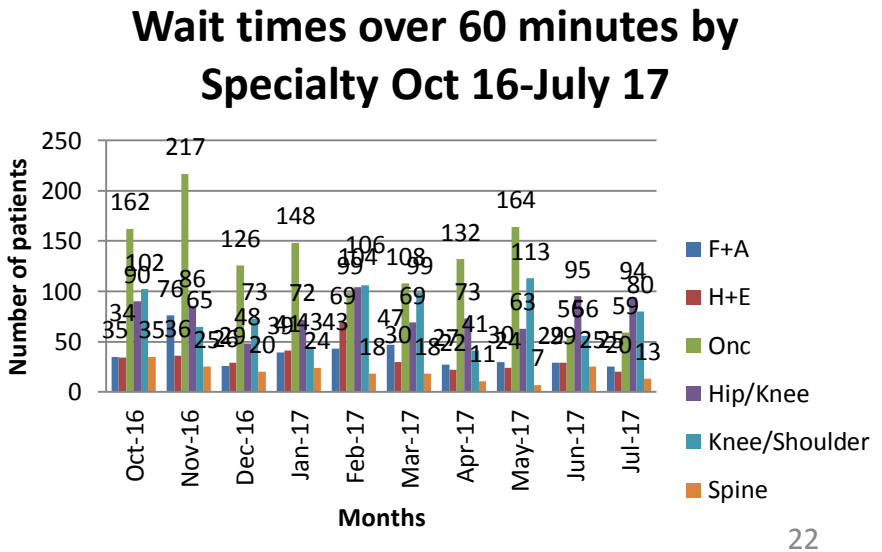
Using individual consultant information, Operational management teams and Clinical Service Leads are reviewing outlying clinical practice to help ensure that all patients are able to go home as soon as possible after their surgery.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients









INFORMATION

Since the initial implementation of the new clinic templates in November there has been a reduction in the 30 minute wait times for patients. For the second month the Trust has been able to demonstrate achieved the target of no more than 6% of patients waiting over 60 minutes. The new Oncology templates, which started on the 6th June, have reduced the number of waits over 60 minutes by 60% . In July 2017 the medical notes not arriving on time to clinic was the main reason for delays. The medical notes process will be the main focus and there is an expectation this will help reduce the 30 minute wait to achieve the 11% target.

The outpatient department continue to audit its compliance against the SOP for wait time and can demonstrate 100% compliance. There is a new standard operating procedure for any clinic running over 60 minutes late. The incident reporting system , Ulysses , has been amended to make it easier for the clinic staff to complete the incident form. An incident form is completed and a new drop down analysis is selected by the staff completing the incident . The reasons documented on the incident forms now form part of a monthly action plan and this will be shared so reasons can be addressed.

ACTIONS FOR IMPROVEMENTS / LEARNING

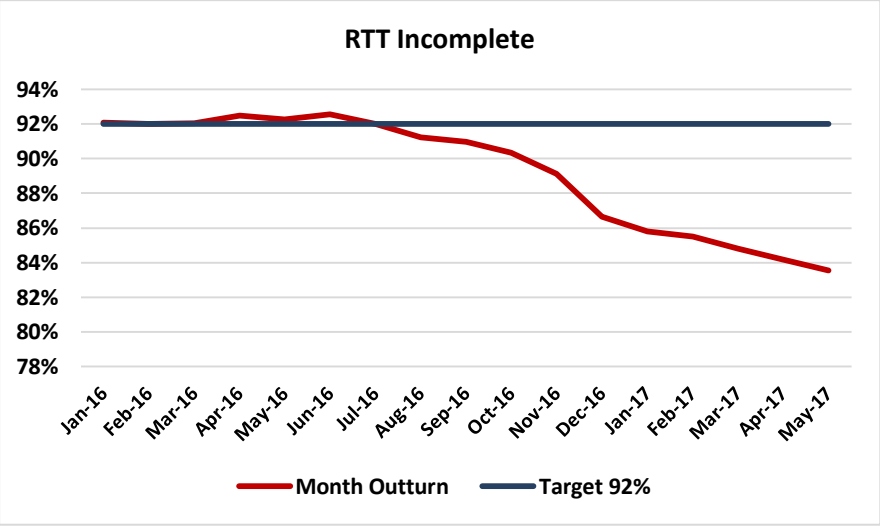
There are a range of actions as part of the CQC action plan and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

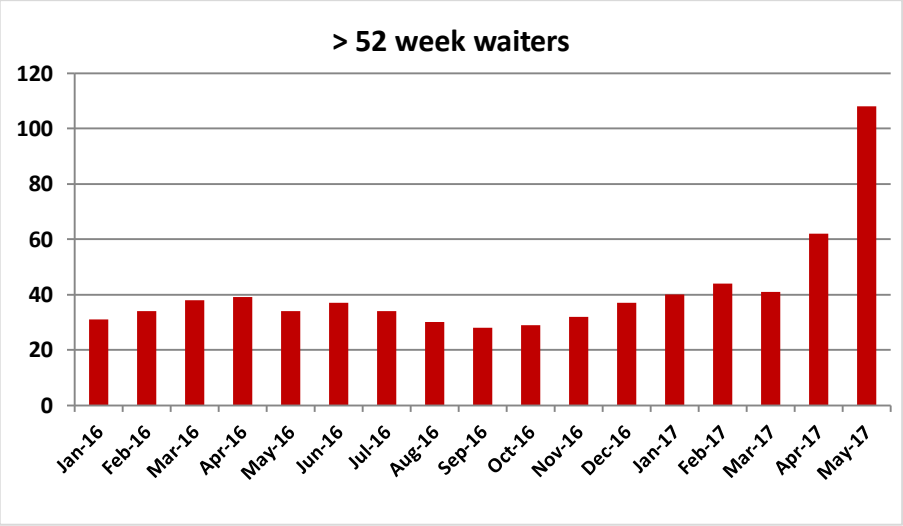
As part of the Trust's RTT recovery work, there will be a focus on out patient pathways and any patients who are in the system awaiting a follow up appointment and have become overdue, for whom a new active RTT clock should be started in line with national guidance. However, if it is found that there is a follow up appointment capacity problem, then this could worsen new to review ratios in the short term. This is being reinforced through RTT training and the clinical service managers working closely with consultants and medical secretaries to ensure that the Trust access policy is being adhered to by all involved.

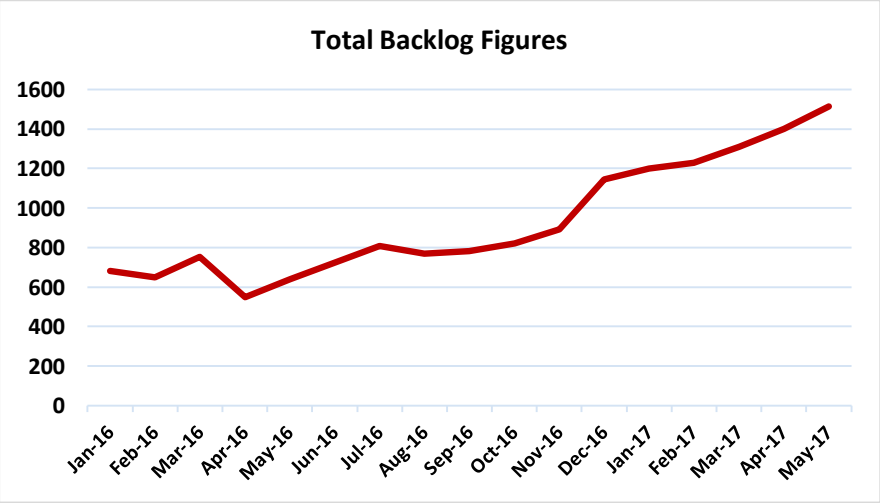
RISKS / ISSUES

Feeding back patient waiting lists to consultants weekly continues, with much focus on improving data quality arising from the validation work that is ongoing .

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







NHSI Performance targets - RTT	Target / Trajectory	Actual (May 17)	Actual (YTD)
52 Weeks Waiters	-	108	108
18 Weeks Incomplete	92%	83.55%	83.86%
NHSI Performance Targets - Cancer	**Target / Trajectory**	**Actual (May 17)**	**Actual (YTD)**
Cancer (2 week wait)	93%	100%	
Cancer (31 days from diagnosis for 1st treatment)	96%	100%	
Cancer (31 days for 2nd or subsequent treatment)	94%	100%	
Cancer (62 days)	85%	60%	

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017, and has been shadow reporting since that time. The Trust will recommence reporting in October, with first submission in November 2017. Validation of open pathways is complete and work to inform 'Business as Usual' validation is nearly complete to ensure that Data Quality standards are maintained going forwards.
Validation is now underway reviewing clock stop data, and a first draft plan for completion is being reviewed. A weekly RTT Recovery Board has been established and met for the first time on 27th April 2017- this work is progressing well and is informing the Scheduled Care Improvement work .
The new PTL went live week commencing 21st August 2017- this has established an accurate waiting list introducing nationally recognised terminology e.g. 'Admitted' and 'Non Admitted' as status points on the patient pathway. The way in which the Trust utilises and manages the planned waiting list is being updated to ensure that it adheres to national guidance, where the treatment date is determined clinically, rather than by resource i.e. a patient who requires a second surgery e.g. removal of metalwork 6 months after first surgery, would be put on the planned waiting list .

	Total pathways	Over 18 weeks pathways	Over 52 week pathways
Admitted	898	355	23
Non-Admitted	1,165	267	19
Incomplete	10,301	2,068	147

The above figures have been used for the shadow reporting of the ROH RTT performance for July 2017

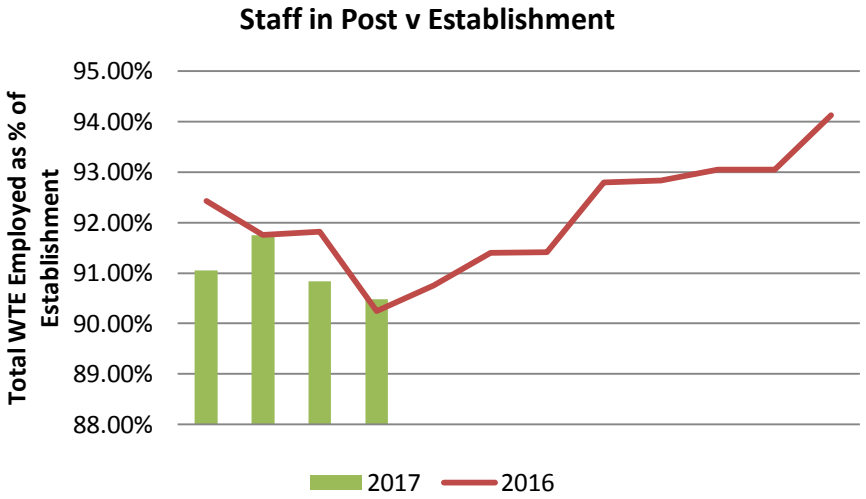
ACTIONS FOR IMPROVEMENTS / LEARNING

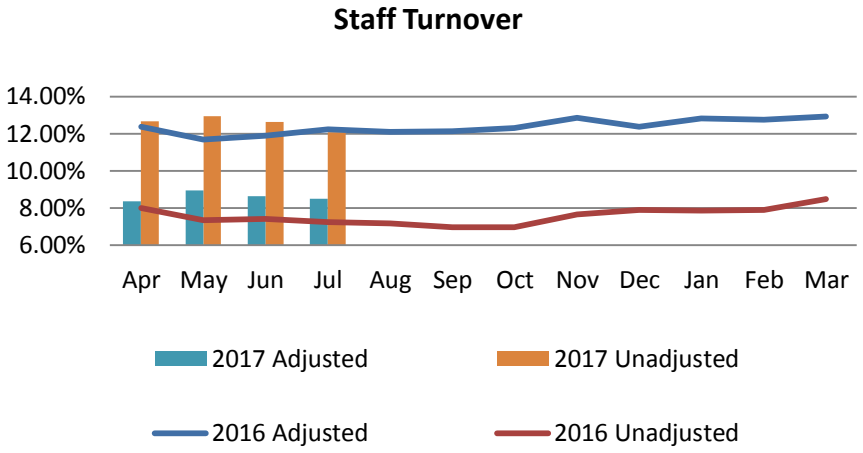
All consultants now receive an updated copy of their individual waiting list (PTL), this is sent electronically from the Operations Team every Friday to all specialities. It is expected that all medical secretaries will review their PTL with their consultant and ensure that all patients are dated in waiting time/clinical priority. The Operations team meet weekly to scrutinise all patients waiting 51 weeks and less across all specialities to ensure all patients have definitive treatment plans and ensuring all patients requiring further validation are identified. A separate review is undertaken of all patients waiting over 52 weeks.

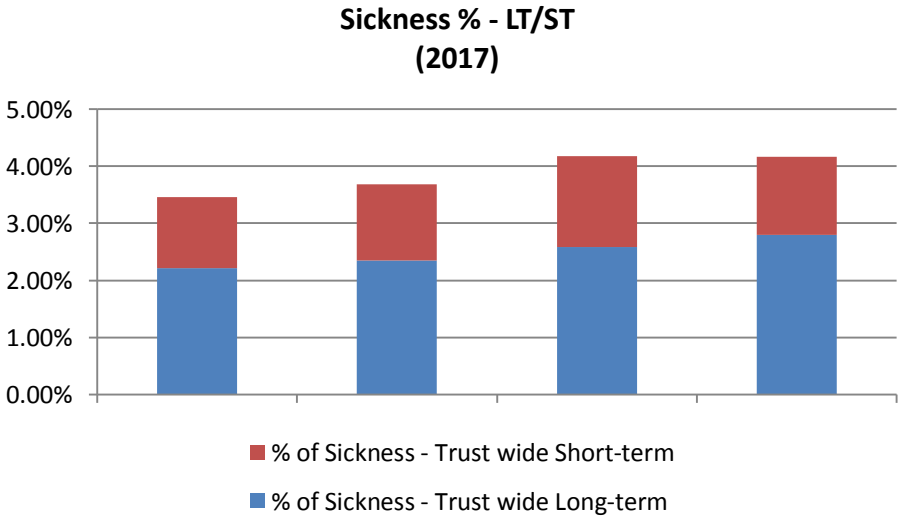
RISKS / ISSUES

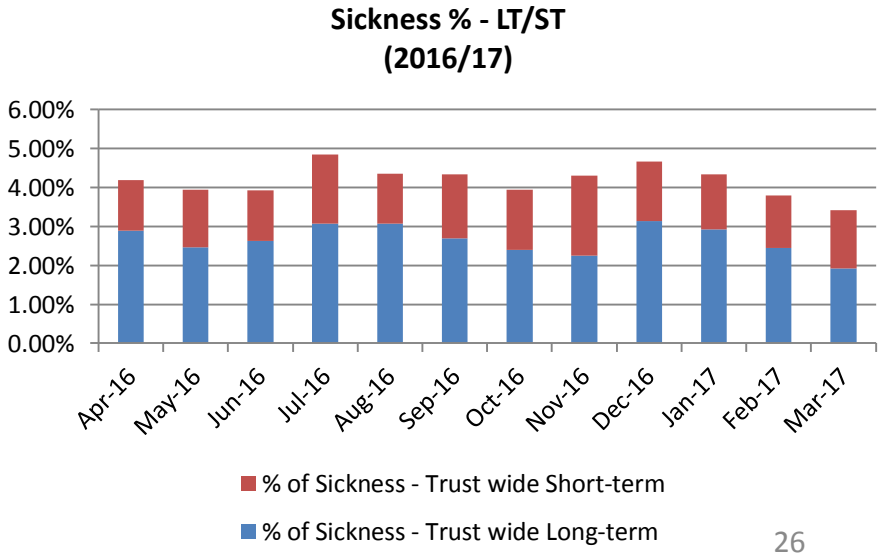
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern.

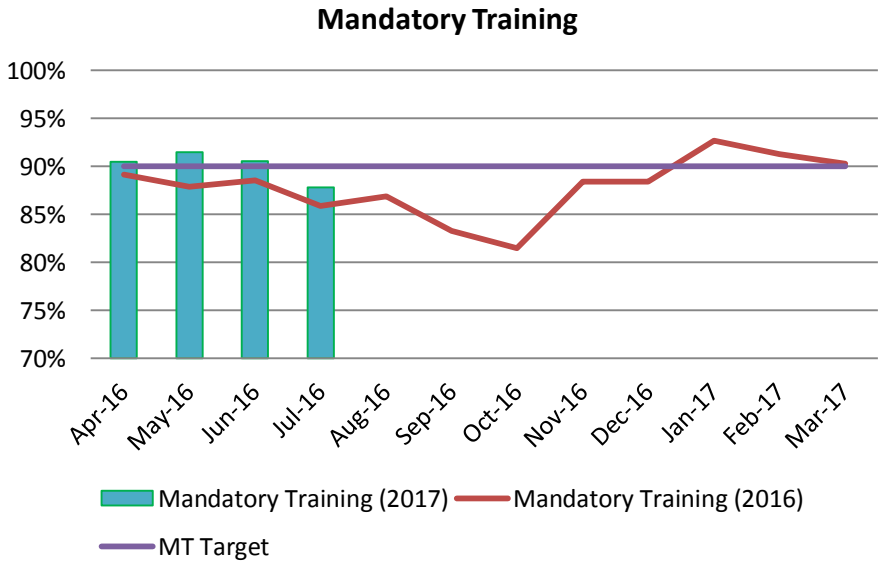
15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

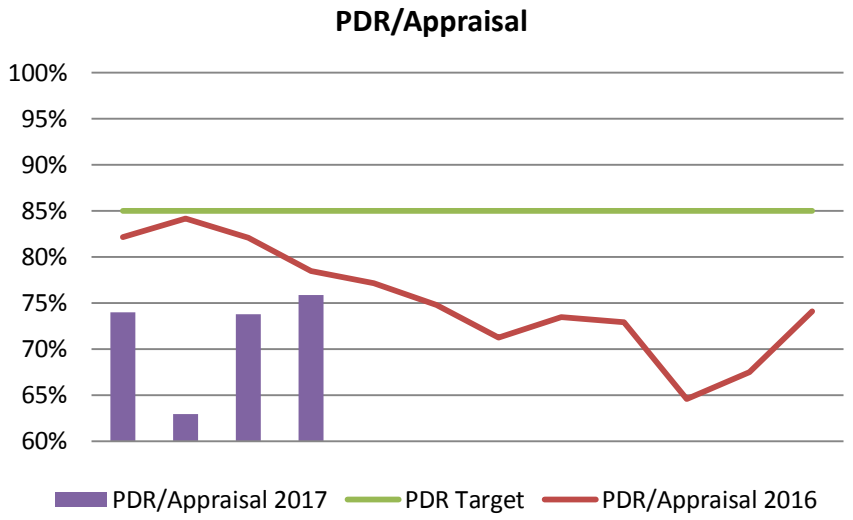









Mandatory Training
100%
95%
90%
85%
80%
75%
70%
Apr-16
May-16
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Mandatory Training (2017)
Mandatory Training (2016)
MT Target


PDR/Appraisal
100%
95%
90%
85%
80%
75%
70%
65%
60%
PDR/Appraisal 2017
PDR Target
PDR/Appraisal 2016

INFORMATION

In general terms, July was an encouraging month in terms of workforce performance. Sickness absence remained green in month and for the 12 month figure; there was a small increase in staff in post, a reduction in turnover and an improvement in the appraisal position. The one disappointment was that statutory and mandatory training fell below 90%, though this was for a genuine operational reason as below.

The Trust's vacancy position decreased very slightly again on last month's figure by 0.36% to 90.48%. This is still amber for July 2017, is within the range of the last 12 months and reflects a small increase in the funded establishment for the month.

July saw sickness absence remain stable at 4.17%, the same as June, with a slight increase in long term absence offset by a decrease in short term. At 4.17% in month, however, it represents the second lowest July figure in the last 5 years and is below the Trust's 4.2% target. The 12 month average figure is also green at 4.18%.

Mandatory training fell into amber this month. It has decreased this month by over 3% - but this was due to the cancellation of one of the training days during July due to an IT crash on the day. At the time of writing, 77 staff were attending on 10th August with a further 45 places booked for later in August. This is therefore expected to return the Trust to green when reporting August data.

Performance relating to PDR/appraisals in July increased by over 2% to 75.84%. To improve the accuracy of reporting, for the last 3 months preliminary PDR data has been issued to Clinical Service Managers as an early alert, to enable them to update records in ESR where no information is recorded but PDRs have been carried out. This system will continue in order to ensure that our data are accurate. Although July's position is still red, this was an improvement.

There was positive movement in the July turnover figures. The unadjusted turnover figure (all leavers except doctors and retire/ returners) decreased again by over half a percent on last month to 12.10%, the lowest level since August 2016. The adjusted turnover figure ("true leavers" meaning "voluntary resignations") decreased by 0.15% and is green in month.

The preliminary data release appears successful with operational managers and appraisal performance in particular was a focus at the Divisional 1 performance meeting in August.

The announcement of the planned transfer of paediatric surgery may cause significant uncertainty for staff. It is possible that sickness absence, turnover and vacancies may increase in the coming months. Clear communications and honest, consistent briefing will help to mitigate the effect of this.

ROHTB (9/17) 007

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Emergency Preparedness, Resilience and Response (EPRR) assessment against the 2017 NHS Core Standards profile**
SPONSOR (EXECUTIVE DIRECTOR):	**Prof Phil Begg, Director of Strategy & Delivery**
AUTHOR:	**Mr Stuart Lovack, Divisional General Manager (Division 4 – Estates & Facilities)**
DATE OF MEETING:	**6th September 2017**

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 36 areas of compliance (Green) and 2 areas of partial compliance (Amber).

An Action Plan has been developed for the areas which are substantially compliant, these relate to participation in multi-agency exercises, and incident commander training for on-call Directors and Managers. The delivery of the training requirements is currently being reviewed / organised.

REPORT RECOMMENDATION:

The Trust Board is asked to note the content of this report which has been assessed against the 2017 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

v5.0

The attached EPRR Core Standards spreadsheet has 6 tabs:

EPRR Core Standards tab: with core standards nos 1 - 37 (green tab)

Governance tab:-with deep dive questions to support the EPRR Governance'deep dive' for EPRR Assurance 2017-18(blue) tab)

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 ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard: designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards: designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V50. The following changes have been made :

• Inclusion of EPRR Governance questions to support the 'deep dive' for EPRR Assurance 2017-18

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	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	Y			Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas	Accountable Emergency Officer - Professor Philip Begg, 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.	Memoradum of Understaanding for mutual aid agreed with local Trusts. Turst is part of the LHRF. Work plans and 'Best Pratice Assessments' in place and undertaken 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, Establishement of the ICC, etc.) EPRR budget established.			
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. Live exercise reported to 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 its 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	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. 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.	• 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	• 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	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.	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 updated and Emergency Response Pack developed			
9		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			
10		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y			Y	Y					Y			No CBRN capability at the Specialist Trust.			
11	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):	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 regarding heatwave and cold weather.			
12		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.			
13		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y			Y		Y	Y				Y		SLA in place with QEHB for Infection Control Doctor Advice and support.			
14		Mass Casualties	Y	Y	Y			Y		Y	Y				Y		Hospital Evacuation and Shelter Plan developed incorporating internal Mass Casualties scenario.			
15		Fuel Disruption	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Road Fuel Shortage / Disruption Plan developed.			
16		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.			
17		Infectious Disease Outbreak	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y		SLA agreement with Infection Control Doctor at QEHB.			
18		Evacuation	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y		Hospital Evacuation and Shelter Plan developed.			
19		Lockdown	Y	Y	Y			Y	Y					Y	Y		Lockdown procedure in place, part of Security Management Policy which is currently under review.			
20		Utilities, IT and Telecommunications Failure	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y		Busines continuity and local hospital arrangements in place to deal with system failures.			
21		Excess Deaths/ Mass Fatalities	Y	Y	Y				Y	Y					Y		Systems in place to deal with excess deaths.			
22		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.			
23		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			Y															
24	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 Shleter Plan, Establishment of ICC and Director/Bleep Holder Information Packs available. Regioanl Mutual Aid Plan available.			
25	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 Rota and Bleep Holder Rota in operation 24/7. Switchboard has cascade procedure in place in the event of an emergency.			
26	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.			
27	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 identifed on site, action card in development.			
28	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.			
29	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		Forms part of MI procedures, hot / cold debriefs and lessons learned identified and developed into an action plan.			
Command and Control (C2)																			
30	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 in operation.			
31	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 trained, Emergency Planning Lead completed DIpHEP programme, all Executive Directors have had further training in emergency planning.			
32	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 establsihed on site, ICC activation pack developed and implemented.			
33	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 / cold debriefs and lessons learned action plan generated following tests / exercises.			
34	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.			
35	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 response would be to dial 999 and seek help and advice from the Emergency Services. Second response would be to contact neighbouring hospital (QEHB) for furthher adivce. Radiation			
36	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	Ambulance service providers	Patient Transport Providers	111	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
37	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. Internal escalation procedure in operation for Trust. External escalation procedure in place for informing EPRR Locality Team for Birmigham, Solihull and the Black Country.			

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	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
38	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																			
39	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 2017. Trust is signed up to ResilienceDirect.			
Co-operation																			
40	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 quorat. • 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.			
41	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		Multi-agency representation at LHRF's and open policy on sharing of information.			
42	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			
43	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		Not applicable.			
44	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y							Y			Y		Not applicable.			
45	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				Trust has good representation at LHFP and LHRF, exercise outcomes and leassons learned shared with group.			
46	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.			
47	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.			
48	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																			
49	Arrangements include a curent 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 • A training needs analysis undertaken within the last 12 months • 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.	Executive On-call training undertaken, Bleep holder training undertaken, Communication exercise training undertaken, live exercise delivered			
50	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 March 2017, Live event occurred in June 2016, tabletop exercise undertaken in Augutst 2017, reports and lessons learnt communicated through structures. JESIP Command training undertaken by Emergency Planning Lead in July 2017.			
51	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, Vital Sign. Attendance / completion of JESIP Com			
52	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 Turst staff to ensures requirements of CPD is maintained.			

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	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
2017 Deep Dive																			
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a public Board/Governing Body meeting for sign off within the last 12 months.	• The organisation has taken the LHRP agreed results of their 2016/17 NHS EPRR assurance process to a public Board meeting or Governing Body, within the last 12 months • The organisations can evidence that the 2016/17 NHS EPRR assurance results Board/Governing Body results have been presented via meeting minutes.	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Organisation's public Board/Governing Body report • Organisation's public website				
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	• There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report	Y	Y	Y	Y	Y	Y	Y			Y			Y	• Organisation's Annual Report • Organisation's public website				
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	• The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio. • The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR portfolio via their public website and annual report • The Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio is a regular and active member of the Board/Governing Body • The organisation has a formal and established process for keeping the Non-executive Director/Governing Body Representative briefed on the progress of the EPRR work plan outside of Board/Governing Body meetings	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Organisation's Annual Report • Organisation's public Board/Governing Body report • Organisation's public website • Minutes of meetings				
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	• The organisation has an internal group that meets at least quarterly that agrees the EPRR work priorities and oversees the delivery of the organisation's EPRR function.	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Minutes of meetings				
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	• The organisation's Accountable Emergency Officer is a regular attendee at the organisation's meeting that provides oversight to the delivery of the EPRR work program. • The organisation's Accountable Emergency Officer has attended at least 50% of these meetings within the last 12 months.	Y	Y	Y	Y	Y	Y	Y			Y			Y	• Minutes of meetings				
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	• The organisation's Accountable Emergency Officer is a regular attendee at Local Health Resilience Partnership meetings • The organisation's Accountable Emergency Officer has attended at least 75% of these meetings within the last 12 months.	Y	Y	Y	Y	Y	Y	Y	Y		Y			Y	• Minutes of meetings				

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	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											
53	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.			
54	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.			
55	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.			
56	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.			
57	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											
58	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.			
59	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 - not a receiving hospital.			
60	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 - not a receiving hospital.			
61	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 - not a receiving hospital.			
62	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 - not a receiving hospital.			
	Training											
63	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		Y		Y				Not applicable - not a receiving hospital.			
64	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.			
65	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		Y		Y				Not applicable - not a receiving hospital.			
66	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.			

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room		
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		
E9	Waste water bladder		
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) 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).		
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		
	Ancillary		
E12	A facility to provide privacy and dignity to patients		
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		

	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 an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.			Y													
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.			Y													
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.			Y													
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.			Y													
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.				Y													
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.				Y													
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).			Y													
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.				Y													
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.				Y													
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.				Y													
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.			Y													
19	Organisations ensure that staff view the appropriate NARU training and briefing DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.			Y													

	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 maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Organiations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Organiations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Organiations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Organiations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Organiations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Organiations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month. • Organiations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.			Y												
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.				Y													
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.				Y													
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.				Y													
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.			Y												
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.				Y													
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.			Y													
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.				Y													
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.				Y													
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.				Y													
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).				Y													
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.				Y													
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.				Y													
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.				Y													
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.				Y													

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Action Plan – Core Standards 2017

Action	Timescale	Responsible Director (s)	Lead Person (s)	Evidence	Status
1. Core Standard 37 – Demonstrate organisation wide (including on-call personnel) appropriate participation in multi-agency exercises	March 2018	Director of Strategy & Delivery	DGM – Estates & Facilities Plus support		Amber
2. Core Standard 38 – Preparedness ensures all incident commanders (on-call directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident/exercise participation	March 2018	Director of Strategy & Delivery	DGM – Estates & Facilities Plus support		Amber

ROHTB (9/17) 007 (c)

Re: **EPRR Assurance Process 2017 – Action Plan Statement**

Please find enclosed the Royal Orthopaedic Hospital NHS Foundation Trust's action plan based on the updated assessment on the 2017 NHS Core Standards. In assessing against the EPRR core standards, the Trust has identified 36 areas of compliance (Green) and 2 areas of partial compliance (Amber).

The action plan for the areas of 'substantial compliance' are as follows:

Core Standard 37 – Demonstrate organisation wide (including on-call personnel) appropriate participation in multi-agency exercises – it is proposed to further develop staff training plans through participation in multi-agency exercises. Timescale: Six months

Core Standard 38 – 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 a commander tabletop exercise. Timescale: Six months

ROHTB (9/17) 008

TRUST BOARD

DOCUMENT TITLE:	**Board Assurance Framework – Quarter 1 2017/18 Update**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary**
DATE OF MEETING:	**6th September 2017**

EXECUTIVE SUMMARY:

Attached is an updated version of the BAF, which represents the position as at the end of Quarter 1 2017.

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.

- 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

There are a number of new risks that have been added to the BAF, reflecting some current and recent developments impacting on the Trust. The new risks concern:

- Failure to have a clear financial and operational plan that will deliver medium to long term sustainability
- Potential loss of income from the recent decision to move Paediatric surgery out of the ROH and the failure to attract additional income from adult work to compensate for this
- Infection control team vacancies
- Compliance with the Hygiene Code
- Non compliance with water safety regulations
- Lack of a robust cancer tracking system
- Poor practice and efficiency in theatres
- Operational capacity to deliver the operational improvement initiatives required
- Cyber security

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

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

ROHTB (9/17) 008

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	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 June 2017

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK Q1 2017/18

Risk Ref	Department	Executive Lead	Risk Statement	Strategic Objective	Primary Assurance Body	Initial risk			Summary of Risk Controls and Treatment Plan	Assurance (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
NEW	Corporate	Paul Athey	The Trust does not currently have a clear financial and operational plan in places that describes how the organisation will delivery sustainability over the medium to long term. The Trust is currently delivering consistent deficits and requires cash support to continue day to day operations	With safe and efficient processes that are patient centred	Trust Board	5	5	25	A two year financial and operational plan was signed off by the Trust Board for 2017/18 and 2018/19. The Trust has support to access cash resources to continue business in the short term The Trust is in year 3 of a 5 year strategy to become the first choice for orthopaedic care	FPC reports; Board approval for cash borrowing; Finance & Performance overview;	5	5	25	NEW	The Trust is supporting an STP review of orthopaedic provision in Birmingham and Solihull. As part of this process, additional resources have been identified to support the Trust is developing a sustainable business model for the ROH which is in line with the requirements of the STP and other commissioning bodies	Mar-18	2	5	10
1117	Ops	Jo Williams	There is a risk that patients may experience a delay in their clinical pathway due to data quality issues, which may result in harm.	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	5	5	25	Harm review process continues and any patient identified as a long waiter due to data quality has a timeline completed and incident form submitted. These are reviewed by the services.	Weekly report to Exec Team & Ops Board	5	5	25	↔	Development of a SOP for the review of patient timelines to provide a consistent approach and level of detail for patients. Use of the harm process to review patients who are perceived to have had a delay in the pathway. Tracker to keep track of these patients. All patients who have been waiting over 40 weeks are reviewed and discussed at the harm review meeting. This process will be ongoing.	Ongoing	4	4	16

1089	Ops	Jo Williams	There is a risk that the Trust's performance against 92% 18 Week RTT deteriorates.	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	5	5	25	Performance continues to decline as a result of the validation work. Teams have completed trajectories for all services. Work is ongoing to increase activity and treat the backlog.	Weekly report to Exec Team & Ops Board	5	5	25	↔	Trajectories developed for services with increasing backlogs e.g. hands, feet and arthroscopy to be submitted to NHSI describing how these services will be recovered to meet 18 week RTT. Contract performance notice issued by CCG requiring remedial action plan submitted. Discussions in service to agree how the Trust will expand capacity to meet demand. The Trust performance will continue to deteriorate whilst it clears its backlog of patients. It has been agreed that the Trust will return to the national performance target of 92% by April 2018	Q4 2017/18	4	4	16
1088	Ops	Jo Williams	There is a risk that the organisation's reported position against the 92% target is inaccurate due to data quality issues	Delivering exceptional patient experience and world class outcomes	Exec Team/Trust Board	5	5	25	Validation continues to better understand the Trust's data quality issues. The team met the trajectory of 20,000 inconsistencies by end of June, with further work undertaken since. Training of admin teams and clinical staff has been completed.	Weekly report to Exec Team & Ops Board	3	5	15	↓	Deliver validation programme within 8-10 week programme (blocks 1 and 2 – refer to resource proposal). Seeking IST input to support information review and targeted validation. Development of a new business platform with which will manage 18 week RTT The validation exercise will be completed at the end of August. The Trust has suspended reporting until the end of September 2017. Development of a training programme to improve knowledge base of RTT in the organisation will be delivered on an ongoing basis. Continued tracking of all issues discovered through the validation programme.	Q2 2017/18	3	5	15
NEW	Operations	Jo Williams	There is a risk that current practice in theatres is hindering operational efficiency, which has the consequence of failure to meet activity targets and associated financial recovery	Delivered by highly motivated, skilled and inspiring colleagues	FPC	4	5	20	Scheduled Care Improvement Programme established to review end to end patient pathway. As part of this, there will be a full review of theatres undertaken, supported by an OD programme to address staffing issues; work is underway at present to identify whether external support is needed to assist with this work	Scheduled Care Improvement Programme Board papers and minutes	4	5	20	NEW	Delivery of the theatres review and OD programme	Q4 17/18	2	5	10
NEW	Infection Control	Garry Marsh	There is a risk presented to the Trust by both vacancies and part time working hours of current infection control team. This leaves a potential gap in the provision of specialist clinical advice on Infection Control matters and impacts on the Trust's responsiveness to the action plan developed in response to the peer review of Infection Prevention and Control	With safe and efficient processes that are patient centred	QSC	4	5	20	Active recruitment processes and robust oversight of rota. The Trust also has access to the external infection control expertise through a Service Level Agreement.	Infection Control Committee minutes; Infection Control upward report to Quality & Safety Committee	4	5	20	NEW	Continued exploration of externals support for Infection Prevention and Control expertise. Recruitment into key vacancies planned for September 2017.	Q2 2017/18	1	5	5

NEW	Fin	Paul Athey	The Trust expects to lose considerable income from the transfer of Paediatric Services without currently having certainty around growth in additional adult work to offset this	With safe and efficient processes that are patient centred	FPC	4	5	20	Risks have been raised with the health system and there is joint stakeholder support to identify and deliver a solution that supports sustainability. A governance structure has been agreed with all stakeholders to manage the transition. This will include clear modelling of demand, capacity and finances. An internal working group is being set up to ensure any final outcome is in the interest of patients and the ROH	FPC reports; Board approval for cash borrowing; Finance & Performance overview	4	5	20	NEW	The Trust is supporting an STP review of orthopaedic provision in Birmingham and Solihull. As part of this process, additional resources have been identified to support the Trust is developing a sustainable business model for the ROH which is in line with the requirements of the STP and other commissioning bodies	Mar-18	2	5	10
NEW	Operations	Jo Williams	Lack of a Cancer operational tracking system to support day to day management and national reporting creates a risk to the accuracy and quality of information reported externally and monitored internally	With safe and efficient processes that are patient centred	FPC	5	4	20	There is a national requirement to report all cancer performance to the Trust Board with information regarding any patients over 62 days and any who have waited over 104 days. The current Onkos system is a research database system and whilst it maintains data it is not fit for purpose to deliver the operational requirements of the service. An action plan has been developed to deliver all the required actions including implementation of a new IT system. The action plan is monitored at Finance and Performance Committee and NHSI Oversight meeting	Divisional Management Board meeting papers; Operational Management Board meeting papers; Finance & Performance Overview	5	4	20	NEW	Delivery of the Cancer Action Plan and implementation of an alternative cancer tracking system	Q4 2017/18	2	4	8
NEW	Infection Control	Garry Marsh	There is a risk of failure to meet the requirements laid out in the Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and related guidance (Regulations 2015 (also known as the Hygiene Code)). Issues relating to the theatre environment and assurance that systems are in place to evidence good practice is in place throughout the Trust. Issues may be identified during external inspections or internal monitoring.	With safe and efficient processes that are patient centred	QSC	5	4	20	The Trust has had a NHSI IPCC peer review visit which has provided us with a report with key recommendations to enable compliance with the Hygiene Code. This review was undertaken at the end of April 2017. The Trust has formulated a responsive action plan to address each of these recommendations. Both the report and action plan have been to Trust Board, Quality & Safety Committee and Infection Prevention Cleanliness & Control Committee. The action plan will be monitored and scrutinised at Infection Prevention Cleanliness & Control Committee, with upward reporting to Quality & Safety Committee of progress, with further escalation of delivery to Trust Board. Quality & Safety Committee is chaired by a Non-Executive Director. The Governance department will own the action plan.	Infection Control Committee minutes; Infection Control upward report to Quality & Safety Committee	4	4	16	NEW	Delivery of the Infection Control action plan. Revise the Trust's estates strategy and incorporate requirements within the new Strategic Outline Case for the Trust's long term sustainability	Mar-18	2	4	8
NEW	Infection Control	Garry Marsh	Non compliance with Healthcare Technical Memorandum 04-01: 'Safe Water in Healthcare Premises'. This HTM gives advice and guidance on the legal requirements, design applications, maintenance and operation of hot and cold water supply, storage and distribution systems in all types of healthcare premises.	With safe and efficient processes that are patient centred	QSC	4	5	20	Update Safe Operation and Maintenance of Water Systems Policy. Expanded Terms of Reference for Water Safety Group. Procedure for recording infrequently used outlets implemented. Water testing undertaken at 6 monthly intervals.	Water Safety Group minutes presented to IPC Group meeting.	4	5	20	NEW	Future meetings scheduled for Water Safety Group (24 Aug/26/Oct/28 Dec 17). Procedure for recording infrequently used outlets implemented. Water testing undertaken at 6 monthly intervals.	Q3 2017/18	1	5	5

7	Operations	Jo Williams	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	FPC	5	4	20	Following an external trial involving BBraun, BWCH, ROH Anaesthetics & Theatres Team, ROH surgeons and ROH Ops management service at BWCH recommenced on 24.05.2017. Discussions continue between ROH, BWCH and NHSE to facilitate sufficient lists to clear long wait patients. Early discussion between ROH and Sheffield Children's Hospital have been held to consider transfer of up to 30 Paed Spinal Deformity patients to their care. Work starting with BWCH for redevelopment of theatre 8 and creation of additional PICU bed capacity at Steelhouse Lane.	Weekly updates to Exec Team; updates to Trust Board.	4	4	16	↔	All patients have been validated: 48 patients are currently waiting over 52 weeks; 28 are dates with additional capacity being sought for the remainder. An action plan is in place to support the operational delivery and is monitored monthly at the Board and NHS I oversight meeting	Q4 2017/18	2	4	8
NEW	Operations	Jo Williams	Operational capacity - there is a risk that the number of recovery programmes, redesign initiatives and services changes may be impacted due to the limited breadth of operational resources including informatics	Delivered by highly motivated, skilled and inspiring colleagues	Trust Board	4	5	20	There are a number of initiatives which the Trust has in place and need to deliver over the next 6-12 months. Operational resource and capability will need to be monitored to ensure that the work is delivered. STP resource will be used to support initiatives where available and appropriate	Trust Board reports on operational initiatives, including validation of 18 weeks RTT, Scheduled Care Improvement Board and theatres improvement programme	3	5	15	NEW	Routine review at weekly at Executive team meeting to ensure that the limited breadth of resource is not impacting on delivery of the projects, evidenced by progress against key action plans and improvements against operational and quality indicators	Q4 17/18	2	5	10
1030	Ops	Garry Marsh	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	F&PC	4	5	20	The theatre equipment in use is, in many instances, at the end of its useful life and a replacement regime is being further developed to enable the timely replacement of worn out equipment which is beyond economic repair. A prioritisation exercise is being re-performed in light of recent incidents reports relating to equipment. Creative options, e.g. lease or rental arrangements are being investigated to explore possibilities within the realms of the available capital budgets. Cell savers and power tools for small joints team have recently been purchased. Through repair and replacement	Funding requests. Outputs of the prioritisation exercise. Capital plan.	3	4	12	↔	Current exercise reviewing risks and re-prioritisation of equipment replacement/repair is ongoing to direct the spending of the existing 2017/18 equipment budget	Ongoing	2	2	4
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	FPC	4	5	20	After a pause in development on a BI Portal, due to a range of data quality issues. The new BI portal went live in Spring 2017. The BI portal will give users access to the a range of information, including referrals, outpatients, inpatients, referral to treatments. Reports will be available at a trust, directorate, and consultant level and cover a range of indicators e.g. DNA rates, Hospital Cancellations, Average Length of Stay, etc.	Daily huddle outputs ; Weekly 6-4-2 and list review by Interim Chief Operating Officer and review by Executive of weekly activity tracker and governance trackers for complaints, SIs and Duty of Candour incidents; monthly finance and performance overview; safe staffing report; Internal Audit reports; CQC report & action plan; IM&T Programme Board minutes; Root Cause Analysis/Lessons learned communications to staff	2	4	8	↓	Development of the data warehouse and ongoing development of in house intelligence	Ongoing	1	4	4

27	Workforce	Phil Begg	Inability to control the use of unfunded 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	FPC	5	4	20	Since the introduction of e-rostering the forensic oversight and forward planning of nursing rotas have led to a significant and sustained reduction in the use of agency staff. Recurrent use of agency staff is now limited to specialist areas such as Paediatrics, HDU and theatres, all of which are areas influences by national shortages. Exceptional use of agency staff required for validation exercise re: RTT issues and is due to be completed by late summer 2017.	Updates to Major Projects & OD Committee. Minutes from Workforce & OD Committee. . Agency staffing cost position as outlined in the Finance Overview received by the Board on a monthly basis.	2	3	6	↓	Continued embedding of e-rostering. Revised theatre staffing model to be developed to further reduce reliance on temporary staffing.	Q1 2017/18	2	3	6
5270	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	FPC	4	4	16	The tariff for 2017/18 - 18/19 has been received and has been modelled for impact. The risks associated with operating with this tariff have been made clear in discussions with regulators & commissioners and outlined within the Trust's operational plan submission for 2017/18 - 18/19. As a result, an additional £2.2m of tariff has been negotiated by the DOF for some of the Trust's more complex procedures.	Reference costs submissions Audit report on costing process 2017/18 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	4	4	16	↑	The Trust is currently taking part in the Group advising on pricing improvements (GAP1) which aims to use patient costing data to more accurately understand the cost of procedures, thereby enabling more accurate prices to be set	Mar-18	2	4	8
269	Fin	Jo Williams	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	FPC	4	4	16	Operational Plan agreed by NHS Improvement. Weekly monitoring of activity by the Executive Team. Additional operational resource secured to support the 6-4-2 process. Integrated recovery plan provides a range of actions	Integrated action plan; minutes of Trust Board & Finance & Performance Committee; Finance & Performance Overview; Executive Team papers. Scheduled Care Improvement Programme papers.	4	4	16	↑	Embedding and delivery of Scheduled Care Improvement Programme. Delivery of the integrated action plan round 18 weeks RTT, cancer services and spinal deformity. Development and delivery of recovery plan.	Q4 2017/18	2	4	8
770	Ops	Jo Williams	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	The risk will continue to remain as a very significant risk and the likelihood of problems will increase as time goes on.	Estates maintenance schedule	4	4	16	↔	Revisit of the capital plan to reprioritise key equipment of concern. Medical Devices Group to review the maintenance schedule for theatre equipment.	Ongoing	2	4	8
1031	Ops	Jo Williams	There is a risk that stock in theatres is not well controlled as the Trust does not currently have an electronic inventory management system. As a consequence the financial liability associated with the control of stock in Theatres that were identified previously may materialise. The position also impacts on the day to day efficient operational delivery and care to patients due to not having the correct implants or other consumable items.	Safe and efficient processes that are patient-centred	FPC	4	4	16	EDC Gold has been implemented and is used for a range of products in implant stores although the robustness of this system to fully manage all theatre stock needs to be explored further.	Stock internal audit report. FPC minu	4	4	16	↔	Following full implementation there will now a focus on developing reporting going forward. A full work programme for theatres is being developed and the clinical service manager will be leading this.	Q4 2017/18	2	2	4

NEW	IM&T	Paul Athey	There is a risk that the Trust's technical infrastructure could be vulnerable to a range of different cyber attacks, which could cause interruption to patient services, reputational damage and loss of income	At the cutting edge of knowledge, education, research and innovation	Major Projects & OD Committee	4	4	16	The Head of IT has been designated as the cyber security lead for the Trust and is working closely with NHS Digital and the CareCert team nationally to identify current weaknesses. This risk will be reviewed monthly. The Trust has become an early adopter in the national NHS Digital CareCert scheme and will undergo external assessment of the cyber security threats and weaknesses. The proposed network infrastructure improvements, if approved, will implement more up to date and secure network devices that will go some way towards addressing some of the issues.	Executive Team briefing on cyber security; IM&T Programme Board meeting papers	4	4	16	NEW	In addition to the existing controls and plans, it is the intention to review IT priorities and frequent tasks so that cyber security-related tasks can be performed. For example, reducing IT resource allocated to certain projects or requests for change, so that the resource can be released to upgrade unsupported databases and operating systems such as Windows XP.	Ongoing	2	4	8
275	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	Work to include action monitoring within the Ulysses system and work to improve the functionality of Ulysses overall 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 17/18. 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 QSC and Board Clinical Audit meeting shared events/claims/SIRIs/Incidents Directorate Governance meetings	3	4	12	↔	Trust clinical audit days 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. This is a Quality Priority for 2017/18.	Ongoing	2	2	4
798	WFOD	Phil Begg	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	Major Projects & OD Committee	3	5	15	The Trust has undertaken a review of the Executive level roles and responsibilities, and has now restructured the executive team. The Executive Director of Strategy and Delivery, is reviewing the outputs from the recent staff survey and the impact on the culture of the organisation.	New Executive and Operational structure; minutes of Major Projects & OD Committee	3	4	12	↔	Throughout 2017/18 a review and action plan will be developed to improve the staff and stakeholder engagement and work proactively with the variety of staff groups across the Trust to improve and develop the capacity and culture of change across the organisation	Ongoing	2	4	8
1074	FIN	Paul Athey	There is a risk that the Trust will not be able to access cash to continue day to day business through either poor cash management or an inability to access cash borrowing	Safe and efficient processes that are patient-centred	FPC	3	5	15	Scrutiny of cash through the cash committee is ongoing, with process improvements and team restructuring showing some improvements in areas such as the collection of long term debts. Despite this the Trust has had to borrow its first tranche of cash from the Department of Health. Feedback on the cashflow modelling provided to the DOH and NHS Improvement in advance of the loan was positive. It will continue to be vitally important to track and manage cash closely, in addition to long term planning to return to surplus, and remove the need for cash borrowing.	FPC reports; Board approval for cash borrowing	2	5	10	↔	Continued focus on efficiency and cost control through the recovery plan	Ongoing	2	5	10

801	Acting CEO	Paul Athey	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	The Trust is part of a national Vanguard model and regional STP, 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: NHSI 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 Finance & Performance overview to Board.	3	3	9	↔	Vanguard model and STP 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
799	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	The Trust has been working proactively with the STP and the NOA Vanguard in developing a 'placeholder' in the STP strategy. In Spring 2017, outline agreement for a BSOL STP footprint review of orthopaedic care was agreed, with which the Trust's Medical Director is involved. Resource has been secured from the STP to support the development of the Trust's long term sustainability model - a major enabler to this is clinical engagement, which has been built into the programme of work.	CEO and Chair updates to Trust Board; STP updates to Trust Board; presentation from STP staff on the development of the Strategic Outline Case	3	3	9	↔	During 2017/18 a Strategic Outline Case for the future of the Trust will be developed in line with an overall Strategy Refresh, staff across the organisation will be involved and engaged in the development of both of these strategic plans	Ongoing	2	3	6
800	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	Clinical Governance Team now fully established and governance facilitators form an integral part of the discussions with the Divisions at Divisional Management Board. Corporate Governance Officer appointed in late 2016 with responsibility for supporting the Associate Director of Governance & Company Secretary on risk management, policy governance and litigation. Processes for reporting up into the Quality & safety Committee are largely working well and form a key part of the Committee's agenda at each meeting.	Divisional Management Board agendas, papers and minutes. Clinical Governance structure chart; TOR and workplan for Quality & Safety Committee; Awareness, understanding application of organisational structure and processes at sub Board level; Key policies: Complaints and Duty of Candour policies; Policy on Policies; Risk Management; weekly trackers reviewed by Exec Team; Patient Safety & Quality report	2	3	6	↔	Identified that further training of staff is required in some key processes, such as incident reporting, Root Cause Analysis and Risk Management. Ulysses system being updated to provide better functionality for management of incidents, complaints, claims and risk register development.	Q3 2017/18	1	3	3

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	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. Board members visiting wards and departments speaking directly to patients and staff. Formal programme of Board walkabouts.	Patient Quality Report; finance & performance overview; Patient & Carer Council; Clinical Quality Group papers and agendas; Patient Harm Review outputs; FFT feedback; Complaints & PALS review; Patient Stories. Communication to patients and relatives around Paediatric services decision.	2	3	6	↔	Governor representative to continue routinely observing Quality & Safety Committee meetings; continued patient stories at Trust Board; improved membership engagement and plans to redevelop the membership & governor engagement plan.	Q3 2017/18	1	3	3

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	26 July 2017 (assurance meeting) and 30 August 2017
Guests	Mr Mustafa Ahmed, Quality Improvement Manager Mrs Evelyn O'Kane, Matron & Safeguarding Lead
Presentations received	Ulysses update
Major agenda items discussed	The meeting on 26 July 2017 was not quorate and discussed in summary the key issues from the papers that would have otherwise been received for scrutiny by the full committee. The meeting on 30 August considered the following: • Quality & Patient Safety report • Harm review update • Never Event action plan and WHO checklist processes • Nurse staffing update • Infection Control update • Clinical Quality Committee upward report • Safeguarding Committee upward report • Serious Incident Policy (for comment) • RCPCH and CQC action plan status report • Quality & Patient safety risks on the Corporate Risk Register • Committee workplan • Terms of Reference for the Quality & Safety Committee
Matters presented for information or noting	• None
Matters of concern, gaps in assurance or key risks to escalate to the Board	*26 July 2017* • The Committee discussed a clinical risk around timely access to patient records in outpatient clinics. Recruitment was planned to assist with medical records staffing issues and some support was being provided from the medical records lead at University Hospitals Birmingham NHSFT. A further update was requested for the August meeting. • As part of the Quality & Patient Safety report it was noted that there was a higher number of incidents that had been reported, which reflected the impact of the ongoing validation work and harm review process. The incident involving a wrong-side injection was a concern, however the processes for addressing this and preventing a recurrence were being handled by the Associate Medical Director by implementing the WHO checklist practice for

	these cases. • There had been a number of pressure ulcers reported, these being associated with Paediatric patients who had a cast. This was a known complication following surgery for these patients however the Children's Board would be reviewing the situation in detail. • The low Friends and Family Test response rates on Ward 3 were noted to reflect a temporary absence of leadership for this area, although the position had recently been addressed and it was anticipated that the situation would improve. • In terms of the CQC and RCPCH action plans, Paediatric nurse vacancies remained a key concern for HDU. Some nurses offered positions had declined their offers of employment and there was limited opportunity to rotate other Paediatric nursing staff given the current level of maternity leave. • Some poor practice around sharps handling in theatres had been noted and some training needs were to be addressed. *30 August 2017* • A further update on patient records availability & storage was provided. There were some clear storage issues and adding more staff into the department would not solve the issues due to space available. Shift patterns would be introduced to provide an extended period over which notes could be 'pulled'. The matter was within the remit of the Heathcare Records Committee to review and to direct where needed. • There had been some injury to patients caused by overheating light leads in theatres. Further work was planned to review theatre equipment and routine maintenance through the Medical Devices Committee which would report to the Quality & Safety Committee in September. • Three VTEs had been declared during the month, although it was noted that there had not been an avoidable VTE since March 2017. • It was noted that of the complaints reviewed, 80% did identify some issues that needed to be addressed. • There were some concerns over the robustness of the WHO checklist process, particularly as the new Theatreman system could not yet produce a report to demonstrate that this process was being routinely followed. Work was underway with the Theatreman system developers to provide this functionality. • The Committee was concerned that as part of the nurse

	staffing update, it was reported that wards had been closed as they were not needed, which suggested ongoing inefficiency with the Trust's operational processes. This had the potential impact of limiting the experience of new trainee doctors and deskilling key staff. • A presentation on the improvements to the Ulysses system was delivered – it was reported that there were a large number of historical incidents on the system which remained open and had not been reviewed. A sample-based approach would be used to close these and it was agreed that the investigations into those prior to 1 April 2015, when the Duty of Candour regulation was introduced should not be reviewed. An improvement plan was under development to improve the functionality of Ulysses from an incident reporting, risk management and complaints handling perspective. • The Committee was concerned over the current gaps in the establishment of the Infection Control Team and the proposal to temporarily lead the team by a non-clinical member of staff. It was agreed that this was an inappropriate arrangement that carried a high degree of risk, particularly should an urgent situation arise which needed a clinical perspective and decision-making. The situation would be reviewed and clarified by the Executive Director of Patient Services. • The update from the Clinical Quality Group highlighted that there was a risk around the use of standalone IT systems across the Trust, particularly those for Infection Control and Tissue viability. • From the Safeguarding Committee's point of view, there was a risk around data sharing between systems and the potential that given that alerts were not working as robustly as they should be, some vulnerable patients could be missed. • The Committee was concerned to understand that the Medical Director had been stood down from his active clinical role as part of the work to review of the complete orthopaedic pathway across the STP.
Positive assurances and highlights of note for the Board	*26 July 2017* • The harm review process was working well and had been endorsed by the Clinical Commissioning Group and by Specialist Commissioners. The remaining spinal deformity cases would be reviewed shortly. • The outcome of the peer review quality walkabouts was presented, which had identified some good practice, in addition to some improvement. A refined set of questions, particularly for those non-clinical staff and Non Eceutive Directors participating in the walkabouts was currently

	being devised. • The Trust had been recently rated as 'Green' following an inspection of its infection control processes. This reflected its responsiveness to the addressing the issues identified in the April review, rather than compliance with the Hygiene Code. • A Learning Disability nurse had joined the organisation and was now working to a defined timeframe for the development of a Learning Disability strategy. *30 August 2017* • It was reported that there had been a reduction in the number of incidents reported. • The 'I Want Great Care' results showed that 96.5% of patients would be likely to recommend the Trust as a place for treatment. • New quality assurance dashboards were being developed and would be presented at future meeting of the Committee by the Heads of Nursing • There was continued good progress with the harm reviews and the validation work of the open pathways was continuing. The Trust was regarded as an exemplar for its harm review work. • There was good progress with the delivery of the Never Events action plan, with those actions remaining open largely related to longer-term cultural changes needed. • The nurse staffing update did not highlight any cause for concerns; e-rostering would be rolled out to theatres in September. • There was evidence of continued consideration of the patient voice by the Safeguarding Committee via a regular patient story.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A report back on the review of cast-related pressure ulcers is to be presented at the next meeting. • Arrange for the recently-appointed joint postholder for the National Orthopaedic Alliance to undertake some benchmarking against a set of quality standards • Update on the WHO checklist functionality of Theatreman at the next meeting • Provide a breakdown of the funded establishment for ADCU at the next meeting • Circulate the Ulysses improvement plan • Provide an update on the arrangements to cover the Infection Control Team vacancies and leadership at the next meeting • Consideration be given to reviewing the possibility of nurse-led protocols for ordering routine post-op imaging • Arrange for a Safeguarding patient story to be presented

	to the Board in the Autumn • Arrange for the Serious Incident policy to be presented to the Executive Team on 5 September
Decisions made	• The Committee considered proposed revisions to its terms of reference and did not agree that the Director of Operations should be removed from its membership. It was agreed that the attendee list should be widened to incorporate the divisional Heads of Nursing. These are attached for the Trust Board's approval. • The Committee approved its revised cycle of business.

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

For the meeting of the Trust Board scheduled for 6 September 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Royal Orthopaedic Hospital NHS Foundation Trust
Quality & Safety Committee
Terms of Reference
Revised August 2017

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1 Constitution

The Constitution of the Trust provides that the committees and sub-committees established by the Board of Directors are:

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(i) Remuneration Committee;
(ii) Nominations Committee;
(iiii) Quality & Safety Committee; and
(iv) Audit Committee
(v) Major Projects & OD Committee
(iv) Finance & Performance Committee

The Constitution states that "Quality & Safety Committee" means a committee whose functions are concerned with the arrangements for scrutiny and monitoring and improving the quality of healthcare for which the Trust has responsibility.

2 Delegated Authority

The Committee has the following delegated authority:
2.1.1 The authority to require any Officer to attend a meeting and provide information and/or explanation as required by the Committee;
2.1.2 The authority to establish Sub-committees. The Committee shall determine the membership and terms of reference of those Sub-committees.
2.1.3 The authority to establish Advisory Groups including forums. The Committee shall determine the membership and terms of reference of those Advisory Groups including forums.

3 Accountability

The Trust Board

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4 Reporting Line

The Trust Board

5 Objective

Oversight and scrutiny of all aspects of quality, patient safety, clinical outcomes, effectiveness and experience
To assure the board that robust systems, clinical policies and processes are in place to enable the Trust to:
5.1.1 Fulfil its statutory duty to act with a view to securing continuous improvement in the quality of services provided to individuals; and,
5.1.2 Identify and effectively manage any quality or clinical risks associated with performing statutory and non-statutory functions

6 Duties

The Committee will deliver its Objectives by seeking assurance across the following areas:

6.1 **Contract management and Commissioning**
6.1.1 The committee will oversee, by appropriate monitoring of actions taken by responsible officers the provision of evidence of trust performance in line with contractual requirements commissioners.

6.2 **Leadership for quality**
6.2.1 Provide oversight to maintain a focus on quality by the Trust's leadership provide assurance to the Board regarding the adequacy of skills to lead efforts across the organisation to drive continuous quality improvement.
6.2.2 The committee will review the Trust's quality reports and approve the annual Quality Account for inclusion in the Annual Report

6.3 **Regulatory Assurance** – NHS Improvement and CQC (review of guidance, CQC outcome assurance report,)
6.3.1 The committee will oversee, by appropriate monitoring of actions taken by responsible officers, compliance with standards set by the Care Quality Commission and, insofar as they relate to clinical matters, those set by NHS Improvement.
6.3.2The Committee will seek assurance that there are robust systems and processes in place for monitoring and assuring the quality of services and for driving continuous quality improvement.

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6.4 **Clinical Audit of outcomes and effectiveness**
6.4.1 The committee will oversee the annual programme of clinical audit – this will include surgical audit, anaesthetic audit, histopathology audit, radiology audit, participation in national audits and locally determined audits

6.5 **Other**
6.5.1 The committee will assure the Board that the Trust's research activity

complies with necessary regulations and supports the Trust's strategy (reports from the Knowledge Hub)
6.5.2 The committee will assure the board that the Trust's medical and clinical education meets the required standards.

6.6 **Risk management**
6.6.1 The committee will regularly review clinical risk - in particular, Board Assurance Framework clinical risks, Corporate Risk Register and those risks owned by executive committees providing assurance to the Quality & Safety Committee.
6.7 The committee will review reports from other committees as outlined below:
6.7.1. Committee reports at agreed intervals from drugs and therapeutics, infection control, safeguarding children and adults groups, Children's Board and Clinical Quality Group
6.8 The committee will consider feedback from the Trust's patient groups and from peer reviews.
6.9 As part of the Quality & Patient Safety report, the committee will receive updates on cases which are dealt with by the NHSLA or any successor body and will seek to monitor lessons learnt.

7 Permanency

The Committee is permanent

8 Membership

The Committee membership will comprise no fewer than three Non Executive Directors and the Chair of the Committee will be a Non Executive holding a clinical background.

The Vice Chair of the Committee will be a Non Executive with a clinical background and will take on the Chair's duties in their capacity as chairman of the Quality & Safety Committee if the Chair is absent for any reason.

Executive members
Executive Director of Patient Services
Medical Director
Chief Executive
Director of Operations

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9 Quorum

At least two NEDs and one from Executive Medical Director or Executive Director of Patient Services.

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10 Secretariat
Associate Director of Governance & Company Secretary

11 In attendance, by invitation

Deputy Director of Nursing & Clinical Governance
Clinical Governance Manager
Heads of Nursing
Others relevant to the agenda of the meeting such as chairs of advisory groups and Clinical Directors and successor roles
A representative from the Council of Governors may attend in a non-participative, observatory capacity

12 Internal Executive Lead

Executive Director of Patient Services

Deleted: Nursing and Clinical Governance

13 Frequency of meetings

At least 8 meetings per annum

14 Work programme

The Committee will prepare an annual work programme covering at least 12 months. The Work Programme is to be a living document which steers the agenda for the committee.

15 Review of terms of reference

This should be undertaken annually.

Date of adoption September 2017
Date of review August 2018

Deleted: 1 January 201
Deleted: 6
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The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	31 July 2017 and 1 September 2017
Guests	Alex Gilder, Deputy Director of Finance
Presentations received and discussed	None
Major agenda items discussed	31 July 2017 • Audit of consultant annual leave • Delivery of the integrated action plan (18 weeks RTT; cancer; spinal deformity) • Scheduled Care Improvement Programme • Finance and Performance Overview • Updates on: cancellation; increase in pay costs; activity targets 1 September 2017 • Consultant annual leave • Progress with the delivery of the 18 weeks RTT plan • Scheduled Care Improvement Programme • Finance and Performance Overview • Recovery plan • Reference costs • Progress with the development of the Strategic Outline Case • Terms of Reference for the Finance & Performance Committee
Matters presented for information or noting	• Extract of the Corporate Risk Register was considered at both meetings, with the one held on 1 September including additional and reframed risks based on a refresh undertaken by the Executive Team
Matters of concern, gaps in assurance or key risks to escalate to the Board	*31 July 2017* • The financial position was noted to be poor and was significantly behind plan. This reflected some cost pressures associated with the work to validate the 18 weeks open pathways but was mainly attributable to the activity position. The Quarter 1 control total had not been met.

	• Agency spend was above plan. • Delivery of the Cost Improvement Programme was behind plan, with a number of schemes having not been started or were now not feasible to deliver • Performance against the activity plan was poor, with this being below the level for the same period during the previous year when theatres were closed for a week • The booking system for operations was noted to not be fit for purpose and there was a culture of tolerating cancellations • There had been a spike in non-pay costs, mainly in theatres which was being investigated • In session utilisation in theatres was poor although there was greater clarity around minutes lost given the introduction of Theatreman • The increase in pay costs was associated with increases in the pay associated with consultants, substantive nursing staff and the external validation team • Cancellations were noted to be high, however effort was being directed into ensuring that patients were given a reminder by 'phone and to ensuring that patients were aware of the financial impact of cancelling their appointments • As a result of the ongoing validation work, it was reported that the absolute performance against the 18 week RTT target would deteriorate • The current cancer tracking system was noted to not be fit for purpose and consideration was being given to changing this to another system that was used elsewhere in the NHS • As part of the spinal deformity action plan, it was noted that confirmation of the timing of the additional capacity at Birmingham Children's and Women's NHSFT needed to be confirmed 1 September 2017 • It was noted that there were some long waits in Physiotherapy and that activity levels had fallen. This was being investigated to understand the reasons • A key concern at present was the operational efficiency in theatres; this was a major workstream within the Scheduled Care Improvement Programme • Activity remained behind plan, although day case activity had risen, this having been driven by the improved '6-4-2' process. Oncology activity was a concern and was impacting on the financial positon significantly. • There had been a further increase in non-pay spend in theatres, which was at odds with the poor activity position; an emergency meeting was planned to understand the

	reason for this issue. There appears to be a lack of control of stock. • Agency spend was above plan as a result of RTT validation costs. • Delivery of the Cost Improvement Programme was behind plan and was a key risk to the achievement of the Trust's financial targets • The current disrepair of the MRI scanner was impacting on the ability to undertake some surgical activity • Length of stay had increased for hips and knee procedures, although the discharge initiatives would assist it this • The Committee considered the recovery plan, which it was noted included a high degree of risk to its achievement • The Committee received an update on the work to develop the Strategic Outline Case. The Committee was concerned over the proposed governance arrangements for the work, particularly the planned reporting line into the Board of Birmingham Women's and Children's NHSFT, given that this would clearly impinge on the work being undertaken separately to manage the transition of Paediatric care. The creation of a separate stakeholder oversight group was also a concern as its purpose was not clearly understood.
Positive assurances and highlights of note for the Board	*31 July 2017* • Good progress was being made with the validation of the open 18 week pathways and the list of patients waiting over 52 weeks had reduced significantly as a result of the validation work. There had been a productive session with consultants to train them in the management of the 18 week pathways; this would also be added into the Junior Doctor training programme • Enhanced controls had been implemented to reduce the number of cancellations by the Trust • Additional resource would be added into the Business Intelligence team to boost capacity in this area • A Scheduled Care Improvement Programme had been developed to review the end to end patient pathway • 'Red2Green' and 'End Pyjama Paralysis' initiatives were being reinvigorated which would impact positively on discharge • New Oncology clinic templates had been introduced which reduced waiting times in Outpatients • The Operational Management Board had been reintroduced which would drive ownership of activity targets and operational improvements 1 September 2017 • It was noted that additional measures had been introduced to show when consultants were taking annual

	leave and there was a plan to better use e-rostering to improve annual leave planning and approval for other staff groups • The number of open pathways had reduced to c. 8000 and these had been validated which confirmed that these were patients waiting for treatment. A new Patient Tracking List had been introduced which would monitor more robustly admitted and non-admitted pathways. The Head of Business Intelligence was congratulated for his work on this. • Performance against the 18 week RTT national target had risen to 82%; it was planned to recommence external reporting following consideration of an assurance report on performance that would be presented to the Finance & Performance Committee and Trust Board in October • Overall there was good progress with the delivery of the 18 week RTT action plan • The Committee was informed that there had been a change in view around centralised booking; instead of a central system, the medical secretaries would take the lead with populating forward lists – this created local ownership of waiting lists. Theatre lists that were not populated two weeks before the day of surgery were being removed from consultants and offered to others. This had created an imperative to populate lists further in advance. • Pre-operative assessment processes had been improved to ensure that patients did not need to be seen multiple times prior to surgery and to create pool of patients that could be accessed in the event another patient needed to be cancelled • The Scheduled Care Improvement Programme Board was working well and a Non Executive had recently attended the meeting; a communications plan was currently being developed to support the work • The number of cancellations on the day of surgery had reduced, however there remained a number of patients who cancelled their own appointments
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• An update on the audit of annual leave is to be presented at the next meeting • A demonstration of Theatreman is to be organised • Update the Trust Board on the Scheduled Care Improvement Programme • Present a 18 weeks RTT assurance report to the Finance & Performance Committee and Trust Board prior to recommencing external reporting of the Trust's performance • Present a report to the next meeting to evidence the success of pooling waiting lists

	• Update the Committee on the reasons for long waiting times and reduced activity levels in Physiotherapy at the next meeting • Arrange for patients to be made aware of the financial impact of cancelling appointments • Amend the Finance & Performance overview to provide clearer information on cancellations • Confirm the accuracy of the data around theatre session utilisation in July • Check whether there remained gaps in the provision of doctors in training from the Deanery as part of the new rotation • Present the cancer and spinal deformity action plans at the next Finance & Performance Committee • Present the recovery plan to the Trust Board at its next meeting
Decisions made	• The Committee supported the proposed changes to its terms of reference (attached)

Rod Anthony on behalf of Tim Pile
VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 6 September 2017

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 Executive Director of Finance & Performance, the Executive Director of Strategy & Delivery 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 Vice Chairman and if the Chair is absent from the meeting then another Non-Executive Director shall preside.

Deleted: the Trust Chairman

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.

Deleted: including August

7 DUTIES

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

Deleted: Corporate Performance Report

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 Review progress with the development of the Trust's Strategic Outline Case

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

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

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

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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 Foundation Trust

MAJOR PROJECTS & OD COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	5 July 2017
Guests	Jonathan Bamford, Transformation Manager Clare Mair, Head of OD & Equality Yve Buckland, Chairman
Presentations received and discussed	Network Infrastructure and ePMA project updates
Major agenda items discussed	• Network Infrastructure Project update • ePMA (electronic prescribing and medicines administration) Project update • Regenerative Medicine Laboratory project • Staff survey
Matters presented for information or noting	• Network infrastructure project update • ePMA project update • Regenerative Laboratory project update • National staff survey results • People Committee reporting structure and terms of reference.
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• The ePMA project go-live date is at risk due to external factors beyond the Trust's control. • Insufficient Train the Trainer courses are being provided for ePMA • The staff survey showed only 23% of staff were happy with communications from senior management. This has deteriorated from last year (29%) and again from the previous year (33%).
Positive assurances and highlights of note for the Board	• Network Infrastructure Project is on target and under budget. It was noted that the project has been managed very professionally without a single complaint being received. Staff have worked well with the construction team to deliver this project. • ePMA Project is on budget; Finance have found a series of savings which, if confirmed, will total approximately £300,000. • Plans for the Regenerative Laboratory project are in the detailed design stage. Final design and checking is expected to be completed shortly and the plan is to go to tender on 14 July. • Informal Board to Floor visits are being scoped to give Board

	members more visibility with staff. • Theatre refurbishment has gone well.
Significant follow up action commissioned including discussions needed with any other Executive Boards/ Committees	• Benefits realisation plan for ePMA to be refreshed. • A paper underpinning Board objectives to be prepared showing how these cascade to individual objectives so that staff can understand how their objectives impact on the Trust. • Plan how to cascade metrics to staff weekly to show where the Trust is against objectives. • Board to Floor visits to be scoped and a plan put together for the remainder of the year.
Decisions made	• The Committee approved the proposed terms of reference for People Committee.

Mr Richard Phillips
NON EXECUTIVE DIRECTOR AND CHAIR OF THE MAJOR PROJECTS & OD COMMITTEE

For the meeting of the Trust Board scheduled for 6 September 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 4 October 2017

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 4 October 2017 commencing at **1130h** 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, Claire Kettle at the Management Offices or via email claire.kettle@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

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 4 October 2017: 1130h – 1400h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Rod Anthony	Non Executive Director	(RA)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Acting Chief Executive	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)	
Mr Steve Washbourne	Interim Director of Finance	(SW)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Guests

Sue Smith	Head of Nursing	(SS)	[Item 3]
Clare Mair	Head of OD & Inclusion	(CM)	[Item 11]
Mandy Johal	Freedom to Speak Up Guardian	(MJ)	[Item 12]

TIME	ITEM	TITLE	PAPER	LEAD
1130h	1	Apologies	Verbal	Chair
1132h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1135h	3	Patient story – Throne Project	Presentation	TBC
1155h	4	Minutes of Public Board Meeting held on the 6 September 2017: *for approval*	ROHTB (9/17) 013	Chair
1200h	5	Trust Board action points: *for assurance*	ROHTB (9/17) 013 (a)	SGL
1205h	6	Chairman's and Chief Executive's update including new guidance on Data Protection and cyber security: *for information and assurance*	ROHTB (10/17) 001 ROHTB (10/17) 001 (a) ROHTB (10/17) 001 (b)	YB/PA
QUALITY & PATIENT SAFETY				
1220h	7	Patient Safety & Quality report: *for assurance*	ROHTB (10/17) 002	GM

	7.1	Patient deaths	Verbal	AP
1235h	8	Care Certificate update: *for information*	ROHTB (10/17) 003 ROHTB (10/17) 003 (a)	GM
1245h	9	Scheduled Care Improvement Programme update: *for assurance*	ROHTB (10/17) 004	JWI
FINANCE AND PERFORMANCE				
1255h	10	Finance & Performance overview: *for assurance*	ROHTB (10/17) 005	PA
GOVERNANCE, RISK AND COMPLIANCE				
1305h	11	Staff survey action plan: *for assurance*	ROHTB (10/17) 006 ROHTB (10/17) 006 (a)	CM
1320h	12	Whistleblowing update: *for assurance*	Presentation	MJ
UPDATES FROM THE BOARD COMMITTEES				
1335h	13	Quality & Safety Committee: *for assurance*	ROHTB (10/17) 008	KS
1340h	14	Finance & Performance Committee: *for assurance*	ROHTB (10/17) 009	TP
1345h	15	Audit Committee including changes to Standing Orders, Standing Financial Instructions and Scheme of Delegation: *for assurance and approval*	ROHTB (10/17) 010 ROHTB (10/17) 011	RA
MATTERS FOR INFORMATION				
1350h	16	Any Other Business	Verbal	ALL

Date of next meeting: Wednesday 1st November 2017 at 1100h, Board Room, Trust Headquarters

Notes

Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 6 September 2017: 1130h – 1315h

Members attending:

Dame Yve Buckland	Chairman	(YB)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Rod Anthony	Non Executive Director	(RA)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Richard Phillips	Non Executive Director	(RP)
Mr Paul Athey	Acting Chief Executive and Director of Finance & Performance	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Nicky Lloyd	Associate Director of Operations	(NL)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Guests:

Ms Alicia Stanton	Senior Physiotherapist	(AS)	[Item 3]

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from Tim Pile, Vice Chair & Non Executive Director	
2 Declarations of interest	**Verbal**
There were none.	
3 Patient Story – Rapid Recovery	**Presentation**
Alicia Stanton, Senior Physiotherapist joined the meeting to present an update on Rapid Recovery. The patient perception of the Rapid Recovery pathway was good and much	

positive feedback had been received. It was noted that pain control as part of the Rapid Recovery pathway was reported as being good, although this was not in accordance with anecdotal information received by some members of the Board. Mrs Sallah suggested that protocol led nursing care would address the issues with ordering routine x-rays. It was noted however, that this was not possible under current IRMER regulations. Instead it was noted that efficiency with booking x-ray slots needed to be improved. It was noted that there were some improvements to the pathway needed which would fit into the Scheduled Care Improvement Programme, such as communications and other issues in Physiotherapy. It was highlighted that the process was well embedded with two main consultants and suggested that this needed to be rolled out to other consultants in future. The issues preventing this approach being 'business as usual' were discussed, namely that consultants needed to start to identify patients suitable for this pathway based on set inclusion/exclusion criteria. It was reported that there remained a degree of scepticism from some consultants and they needed to make the time to better communicate with patients, as required by the approach. It was suggested that it needed to be mandated that all patients suitable needed to be treated using a rapid recovery pathway and that additional focus and resources needed to be dedicated to the work. Ms Stanton was thanked for her work and for her presentation.	
4 Minutes of Public Board Meeting held on 5 July 2017	**ROHTB (7/17) 014**
The minutes of the previous meeting were approved as a true and accurate record of discussions held at the last meeting.	
5 Trust Board action points	**ROHTB (7/17) 014 (a)**
The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern.	
6 Designation of Acting Accounting Officer	**ROHTB (9/17) 012**
It was reported that during a period of absence of the substantive Chief Executive of a foundation trust, the Board was required to appoint an Acting accounting officer. On this basis, the Trust Board was asked to agree the designation of Paul Athey as Acting accounting officer, this being in line with his current responsibilities	

as Acting Chief Executive. This was agreed.	
7 Chairman's & Chief Executive's update, including update on planned changes to regulatory guidance	**ROHTB (9/17) 001**
The Acting Chief Executive reported that the STP Board had been held on 4 September which considered progress on the development of the STP plan and how it would move forward. The key focus of the meeting had been on addressing the challenges at Heart of England Foundation Trust and Birmingham Women's Hospital. There was work to revise the vision and plan on a more sustainable footing. The STP Board had received an update on the support being provided to the ROH and this was seen as an open way of working and was a key success of the STP. There were some discussions around the role of the community Trust and its role in the STP. It was reported that NHS Improvement was keen for the ROH to articulate its vision within the STP and therefore this also needed to translate into the work on strategy development being undertaken by Matt Boazman. It was noted that the NHS Improvement joint oversight meeting had been positive and stakeholders were assured by the delivery and that those issues that still needed to be addressed would be tackled. It was reported that plans were being put into place to secure the support of an interim director of finance who would join the organisation shortly. The Chairman reported that since the last public Board meeting a successful bicentenary fete held on 8 July, which was well attended and a positive occasion for all. During the period Paul Athey had been appointed as Acting CEO, a decision that was made by the Trust's Remuneration Committee. Some guidance on the proposed changes to the Single Oversight Framework and the introduction of a new Use of Resources Framework was noted to be provided for information.	
8 Patient Safety & Quality Report	**ROHTB (9/17) 002**
It was noted that the Patient Safety & Quality report had been considered at the previous meeting of the Quality & Safety Committee. There had been a reduction in the number of incidents, as previous high levels reflected the impact of the 18 weeks RTT validation work. A moderate harm had occurred as a result of an infection incurred during a long stay. The Duty of Candour process had	

commenced. There had been a number of pressure ulcers associated with children in casts. There were no trends and it appeared that all were unavoidable. The Children's Board was scrutinising this position further however. Mrs Sallah noted that a number of children who had acquired a pressure ulcer had learning disabilities. The results for the Friends and Family Test on Ward 11 and Outpatients were noted to be as a result of poor response rates.	
9 Safe Nurse Staffing	**ROHTB (9/17) 004** **ROHTB (9/17) 004 (a)**
The Executive Director of Patient Services reported that there was a statutory requirement to report on nurse staffing levels to the Board and this previously had been reported through Quality & Safety Committee. The paper presented the outcome of the safe staffing reviews undertaken in July 2015 and July 2017. It was highlighted that the Trust was compliant with statutory UNIFY upload and there were no concerns. The current level of nursing vacancies was not a significant issue for the Trust. Theatre recruitment was consistent with the 2015 picture but the process was stronger. All Band 7 positions in theatres were filled and a secondment to the matron post had been arranged. Acuity was reported using the Safecare tool and was linked to e-roster. This was a change to 2015. The use of agency nurse staffing had reduced. Ward 11 in July 2017 showed deterioration from 2015 and this was because the number of registered nurses on duty had been altered. The bank staff used on the ward were the Trust's own nurses however. It was reported that an establishment review was underway, with it being likely that some financial savings would arise from this. A NICE staffing alerts process was in place and the Trust was compliant with the requirements set out by the National Quality Board. Overall the picture was positive and nurses continued to be recruited well. There was no further use of overseas nurses. Mrs Sallah highlighted that the nurse staffing information was received routinely at Quality & Safety Committee. It was noted that a commentary on other staffing	

groups had been asked for in future however. It was noted that consistent monitoring of KPIs on wards was in place. The percentage of patients affected by pressure ulcers and VTEs would also provide some context in future. The link between agency nurse staffing and harm was also to be given as part of this update on KPIs. The investment agreed by the Board for nights and had shown improvement against some of the quality indicators.	
ACTION: **GM to highlight any linkage between agency nurse usage and harm as part of the report on nursing KPIs to Quality & Safety Committee**	
10 Learning from Deaths Policy	**ROHTB (9/17) 005** **ROHTB (9/17) 005 (a)**
The Executive Medical Director advised that there had been some new national guidance issued around how Trust's should learn from deaths. It was noted that all deaths at the ROH were reviewed robustly through a Root Cause Analysis. A new policy around Learning from Deaths had been developed, which would ensure that there was further guidance around the systematic review of patient deaths. In terms of the few deaths that the Trust had experienced, it was noted that one of the recent deaths had been expected and the individual had received a blessing in the chapel. The individual had been undergoing palliative care. This case had been well handled. One of the first Board stories however, related to a death that had not been as well handled and there had been learning as a result of this. It was highlighted that patients were not operated on at the ROH if they were terminally ill, however issues presented if the referring hospital would not accept the individual back for care. It was reported that the Quality & Safety would look at review of death through the Clinical Audit and Effectiveness Committee upwards report. Where faults were identified then actions were taken. It was suggested that a discussion around timeliness of reviews of death and any preventability was needed outside of the meeting. The Learning from Death policy was formally approved.	
ACTION: **AP to present an update on deaths to the Quality & Safety Committee report, to include timeliness of review and**	

preventability	
11 Finance & Performance overview	**ROHTB (9/17) 006**
The Acting Chief Executive reported that the overall financial position was one of underperformance. Activity was low but income had also underperformed. There was much work in theatres and that was being addressed through Scheduled Care Improvement Programme. In session utilisation was particularly poor and was a key point of challenge by the Finance & Performance Committee.	
12 Emergency Preparedness and Resilience Response	**ROHTB (9/17) 007** **ROHTB (9/17) 007 (a)**
The Executive Director of Strategy & Delivery asked the Board to receive and note the latest position against the national Emergency Preparedness and Resilience Response Core Standards. The review process had identified 36 areas of compliance (Green) and two areas of partial compliance (Amber). An action plan had been developed for the areas which were partially compliant, these relating to participation in multi-agency exercises, and incident commander training for on-call Directors and Managers. The delivery of the training requirements was currently being reviewed. The Trust Board approved the statement of compliance.	
13 Board Assurance Framework	**ROHTB (9/17) 008** **ROHTB (9/17) 008 (a)**
The Associate Director of Governance & Company Secretary presented the latest version of the Board Assurance Framework (BAF). It was reported that there was some further work to do on the Corporate Risk Register that would impact on the overall BAF.	
14 Quality & Safety Committee – assurance report and Terms of Reference: *for assurance and approval*	**ROHTB (9/17) 009** **ROHTB (9/17) 009 (a)**
The Board received and noted the notes of the assurance teleconference that had been held in July and the assurance report from the full meeting held in August. The proposed amendments to the terms of reference for the Quality & Safety Committee were approved.	
15 Finance & Performance Committee – assurance report and Terms of Reference: *for assurance and approval*	**ROHTB (9/17) 010** **ROHTB (9/17) 010 (a)**
The Board received the assurance report of the meeting of the Finance & Performance Committee held in August. The proposed amendments to the terms	

of reference for the Finance & Performance Committee were approved.	
16 Major Projects & OD Committee	**ROHTB (9/17) 010**
The Board received the assurance report of the Major Projects & OD Committee meeting held in July. It was noted that a series of Board to Floor visits were being worked up.	
17 Any Other Business	**Verbal**
The Board was invited to taste a selection of food served to patients.	
Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 4 October 2017 at 1100h, Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 4 October 2017, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

6 September 2017, Boardroom @ Trust Headquarters

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 037	Patient Safety & Quality Report	ROHTB (6/17) 003	07/06/2017	Arrange for the Throne Project to be used as a patient story at a future meeting	GM	04-Oct-17	Included on the agenda of the October 2017 meeting	
ROHTBACT. 038	Staff Survey and Analysis	ROHTB (6/17) 006 ROHTB (6/17) 006 (a) ROHTB (6/17) 006 (b)	07/06/2017	Schedule a further update on the delivery of the staff survey action plan	SGL	04-Oct-17	Included on the agenda of the October 2017 meeting	
ROHTBACT. 041	Safe Nurse Staffing	ROHTB (9/17) 004 ROHTB (9/17) 004 (a)	06/09/2017	Highlight any linkage between agency nurse usage and harm as part of the report on nursing KPIs to Quality & Safety Committee	GM	30-Dec-17	ACTION NOT YET DUE. New set of nursing KPIs being developed which will provide this perspective	
ROHTBACT. 042	Learning from Deaths Policy	ROHTB (9/17) 005 ROHTB (9/17) 005 (a)	06/09/2017	Present an update on deaths to the Quality & Safety Committee report, to include timeliness of review and preventability	AP	25-Oct-17	Verbal update at the Trust Board meeting on 4 October, with a full update to the Quality & safety Committee planned for end of October 2017	
ROHTBACT. 036	Patient Story - Rapid Recovery	Video	01/03/2017	Update on progress to be brought to a future meeting.	SGL	06-Sep-17	Included on the agenda of the September Trust Board meeting	

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):	**Paul Athey, Acting Chief Executive**
AUTHOR:	**Paul Athey, Acting Chief Executive**
DATE OF MEETING:	**4 October 2017**

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:

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 (10/17) 001 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CHIEF EXECUTIVE'S UPDATE

Report to the Board on 4th October 2017

1 EXECUTIVE SUMMARY

1.1 This paper provides an update on a number of key actions that have taken place since the September Trust Board.

2 CQC DATA COLLECTION

2.1 Throughout September, the Trust's governance team have been collecting information and evidence as part of the CQC annual Routine Provider Information Request (RPIP). This was submitted to the CQC on 25th September.

2.2 Engagement across the trust was positive and, in general, the Trust was able to provide far more detail that was the case in previous submissions.

2.3 Through the review of the information collated, some areas of focus have been highlighted. These will be considered by the Executive Team and any actions required will be documented and monitored through the Quality and Safety Committee.

2.4 As part of the submission, we were asked to self-assess ourselves against the five CQC domains of safe, effective, caring, responsive and well-led. Overall, we concluded that the Trust remained "requires improvement", particularly as a result of the ongoing RTT work which would impact upon our ratings under the responsive and well-led domains.

3 NHS PROTECT ASSESSMENT

3.1 On 20th September, the Trust was visited by NHS Protect for a focused assessment. This is part of their rolling programme of audit and assurance across the NHS.

3.2 NHS Protect is the national body that leads on the protection of NHS staff and resources from crime and tackles fraud, bribery and corruption within the NHS. The visit independently reviews the Trust's self-assessment of our compliance against NHS protect standards.

3.3 A formal report is due to be received in October and will be submitted to Audit Committee for review and to oversee any recommendations. Informal feedback at the end of the visit was generally positive and the inspector felt that the Trust had a realistic understanding of our current performance and on the areas for future focus.

4 NATIONAL ORTHOPAEDIC ALLIANCE

4.1 I represented the Trust, along with John VaFaye (our Associate Medical Director for Division 1), at the National Orthopaedic Alliance Board Meeting on 18th September. The key actions taken at the meeting were:

- Mark Brandreth, Chief Executive Officer of the Robert Jones and Agnes Hunt NHSFT, was elected as Lead CEO for the NOA. He replaces Jo Chambers in this role.
- Consideration of the future of the NOA, with particular focus on how the group could deliver tangible actions (not just a "talking shop") and how new members could be integrated such that it moved away of the specific priorities of the previous Specialist Orthopaedic Alliance.
- The NOA portal was demonstrated and is due to be launched in the autumn.
- Ophthalmology has become the first speciality to look to develop an NOA national model for their specialty.

5 CONSULTANT STAFFING

5.1 Recruitment is ongoing for a new spinal deformity surgeon to support the additional capacity due to be provided at Birmingham Children's Hospital from February 2018. Interviews are due to take place in early November. Candidates are aware of the ongoing discussions with regards to the future of paediatric surgery in Birmingham.

5.2 The Executive Team have supported in principle the business case for an additional oncology surgeon to support growing referrals, developments around MDT working and the potential increase in split-site working. This is subject to further finalisation of activity implications and agreement from the Royal College with regards to a proposed job plan.

6 DATA PROTECTION

6.1 The EU General Data Protection Regulation comes into force in May 2018 and the Executive Team have been considering the implications for the organisation. These are described in detail in the attached appendix.

6.2 The Executive Team have also been reviewing the output of the national review of data security undertaken by Dame Fiona Caldicott, detail of which is also appended to this paper.

6.3 Action plans are in place to ensure delivery of these recommendations and this will be monitored through the Trust's Information Governance Group.

7 KEY PRIORITIES

7.1 Following conversations at Trust Board earlier in the year, a set of six very simple priorities have been developed to enable clear communication with staff at all levels of the organisation. The six priorities are:

- High quality care
- Care for more patients
- Shorter waiting times
- Value for money
- Staff motivation
- Defining the future

A brief infographic providing further detail on these, including the way in which we intend to measure their delivery is attached.

7.2 The Scheduled Care Improvement Project will be the vehicle to deliver these priorities, and consideration is being given to how this is launched to the organisation such that this is owned and embraced by all staff, not just middle management and above.

7.3 A series of staff briefings are arranged for the week commencing 9th October and, throughout the rest of the month, the Executive will be attending local team meetings to give all staff the opportunity to ask questions and raise both opportunities and concerns.

8 RECOMMENDATION(S)

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

Paul Athey
Acting Chief Executive
4th October 2017

Appendix 1

The Royal Orthopaedic Hospital NHS Foundation Trust

European Union General Data Protection Regulation (GDPR)
Impact and Action Plan

1. Purpose of Report

1.1. To set out impact of the European Union General Data Protection Regulation (GDPR) on the trust and the actions required to implement it.

2. Background

2.1. GDPR will come into force 25 May 2018. The UK will still be in the EU so the Trust needs to comply. The current Data Protection Act will be repealed but when the UK comes out of the EU it is likely that there will be replacement legislation compatible with the GDPR.

2.2. GDPR is largely the same as the current Data Protection Act (DPA) but there is more focus on transparency and security measures. Also we there is a move from passive to active compliance and the Trust will not only be obliged to comply with the new law, but also to demonstrate compliance.

2.3. The Trust complies with current data protection legislation and we pass the Information Governance Toolkit so we are a long way towards complying with GDPR but some actions are required.

3. Summary of Impact and Actions

3.1. Appendix A provides an action plan. Work is needed to update registers, policies and procedures but this can be accommodated into the IG manger work plan working with colleagues. Additional work is required around Training and Communications and the IG Manager will be seeking support from Comms to help with materials and publicising these.

3.2. There are however two areas which need addressing earlier which have cost and resource implication as detailed below.

4. Data Protection Officer

4.1. The Trust must appoint or designate a Data Protection Officer. The role, in summary:

- Can be fulfilled by an employee part or full time
- Can be an external and/or shared resource
- Will most likely sit within a Risk, Compliance or Governance function
- Must have independent reporting line and be empowered to report directly to the board without interference.
- Must have expert knowledge of data protection law and practices.
- SIRO, IG manager, Caldicott Guardian, CIO, IT Manager, Records Manager would NOT be suitable

4.2. Options include:

Option	Comment
Do Nothing	Not an option. Would be breach of the GDPR, leaving the Trust vulnerable to fines
Appoint an existing Board Member	DPOs are allowed other functions but this must not give rise to conflicts of interests e.g. if they determine the purposes and the means of processing personal data. The role cannot be held by the Trust's existing SIRO or Caldicott Guardian which rules out ED Finance and Performance and Medical Director, and the ED Patient Services has overall responsibility for records which could lead to conflict of interest. This leaves ED Strategy and Delivery but this person does not currently have the required skills.
Appoint an existing staff member (Department or Division Head)	An existing Staff Member would need: • Data Protection Legislation knowledge and experience and regularly completes CPD in relation to Data Protection • To be accessible to patients/service users/carers/staff/members of the public • To have links with the SIRO and Caldicott Guardian and Information Governance Manager • Reports to the Board This role cannot be carried out by the IG Manager. There is no obvious internal candidate with the required skills unless they received training
Recruit a new post (full or part time) or Use an external person/organisation on service contract	Requires additional funding i.e. Salary, on costs, possible support function. Trust would obtain correct skills, knowledge and expertise. However, ROH is a small Trust and it would be difficult to justify this additional cost. The Trust could consider sharing this role with another Trust

4.3. It has been agreed that Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary will take on this responsibility. It fits with his current portfolio which already includes elements of Information Governance (Freedom of Information) and his position supporting the Trust Board will be useful in terms of reporting requirements. Simon has agreed to undertake the necessary training requirements to equip him for this responsibility.

5. Subject Access Request Process

5.1. Under GDPR the Trust will no longer be able to charge when patients (or their representative) request access/copies of access health records. Also the target response time is reduced to 1 month, down from 40 days currently (although the NHS aspires to 21 days).

5.2. Current trust data and performance is as follows:

Current Staff resource and cost: • Health Records Litigation Clerk 25 hours Band 3 • Team Leader: 3 hours Band 4	 £13,200 p.a. £2,100 p.a.

Total cost: (approximate based on top end of band):	£15,300 per annum. (plus cost of disks)
Number of Requests:	64 per month
Annual income 2016/17:	£26,422
Performance (Based on past 28 months)	10% processed within 30 days 90% processed within 40 days

5.3. Worryingly the Trust is not achieving the required 40 day target at present currently caused partly by moving scanning in-house and staff diverted other health records work. To address this, it is proposed to engage with an external company to provide a scanning service, which on initial review appears to be at minimal cost.

6. Recommendations

6.1 The Trust Board is asked to receive and note the update and the plans to meet the requirements of the new regulations.

APPENDIX A: DETAILED ASSESSMENT AND ACTION PLAN

Ref	GDPR Requirement	ROH Status	Action	Who	When
1	**Information we hold** We must document the personal data we hold, where it comes from and who we share it with	Mostly compliant. We already maintain the following which is refreshed annually by the IG Manager • Information Asset Register • Data flows register • Information sharing list However recent management changes and interim management have left some gaps particularly around the larger shared IT systems. Also gaps in IG assessment of smaller systems (electronic, paper and scanned)	Refresh IG assessments and registers for main systems. Identify and document small systems, paper records and scanned records Review third party contracts/SLAs with IT suppliers and service providers where we share/transfer information. Review and update Information sharing agreements	JCa	Ongoing
2	**Privacy Notices** We must tell people what we do with their information including: • Legal basis for processing • How long we hold data for • How people can complain	Mostly compliant We have Fair Processing Notice on website and leaflet available to patients	Update website and patient leaflet: • Add ICO contact details • Add more details about retention and who we share with. Comms campaign for patients e.g. posters, leaflets in outpatient letters	JCa Comms	Jan 2018 Mar - May 2018
3	**Individuals' rights** a) Data portability: for subject access requests or transferring data to other provider we must be able to do this electronically in a structured, commonly used and machine readable format. b) Right to rectification i.e. Right to have inaccuracies corrected and data completed (e.g. if staff records said long term sick, subject would want mitigating reasons included) c) Right to object e.g. No direct marketing using information d) Prevent automated decision-making and profiling e.g. linking with other sources to target	Mostly compliant a) We have access to health records process and provide the information on a CD using common format files. We use PACS IEP or DVDs to send images. We tend to photocopy notes and reports to other providers. b) We tell people in the Privacy notice they can ask us to change or delete inaccurate information but we withhold the right to disagree and we will record their object and our decision. c) We do not use patient data to do marketing	a) Review SARS procedures Review process for sending information to other providers b) Review privacy notice (see 2 above) c) Training and comms to remind staff about using information d) Not applicable e) Await national guidance around rights to be forgotten.	TBC JCa	 Apr 18

	individuals (e) New right to be forgotten but this may be tempered e.g. if it would adversely affect patient's safety or scientific research. It is likely this this does not apply to health record or for public health or research purposes (unless lawful basis in consent)	(only e.g. follow up surveys as part of their care) d) We do not have automated decision making or profiling. EPMA is decision support but not "making." e) This should not apply to ROH – to be confirmed			
4	**Subject access requests** a) Cannot charge b) One month to comply with request c) Different grounds for refusing to comply e.g. manifestly unfounded or excessive requests can be charged for or refused. Need clear policy and criteria for refusing d) Provide some additional information e.g. data retention periods and the right to have inaccurate data corrected	a) We currently charge £50 (or £10 if just an image). Approx 60 requests per month. Annual income: £26,422 – 2016/17 This income will be lost b) NHS standard is 21 days which we aspire to but allow 40 days. c) Very rare we refuse a request d) Additional information is already on our Privacy Notice – 2 above	Identify current performance in meeting less than 30 days. Assess impact and identify staff resource required to achieve one month response Add information to subject access request communications. Train staff dealing with SARS including Health Records, Governance, PALS, Litigation, Human Resources. Awareness sessions/materials for Medical Secretaries and consultants.	TBC JCa JCa JCa	TBC
5	**Lawful basis for processing personal data** There lawful bases relevant to Healthcare are: 6(1)(e) – Processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller 9(2)(h) – Processing is necessary for the purposes of preventative or occupational medicine, for assessing the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or management of health or social care systems and services on the basis of Union or Member State law or a contract with a health professional	We currently rely on implied consent and legitimate purposes for heath records. Implicit consent will no longer be a lawful basis and legitimate purpose does not apply to public bodies. However the new articles listed will apply. We already obtain explicit consent for e.g. research, secondary use and the new article will apply. GDPR allows derogation (exemptions) for health data which the ICO are working on currently.	Await guidance from ICO and then amend our Privacy notice. As part of the review of information assets, document the lawful basis for each system/service.	JCa	Feb 18

	We may also use the following e.g. for research and information sharing. 6(1)(a) – Consent of the data subject				
6	**Consent** • Where consent is required (as under the DPA) it must be a freely given, specific, informed, and unambiguous indication of an individual's wishes and individuals must be able to withdraw consent • Recognition that for research it may not be possible to list all purposes at the time data is collected • Consent is not required if the processing is necessary for the purposes of: o Preventive or occupational medicine, o Medical diagnosis, o Provision of health or social care or treatment, o Management of health or social care systems and services, o Under a contract with a health professional or another person subject to professional secrecy under law (the 'medical care' ground). o And if necessary in the public interest for public health reason or if it can be argued as necessary for scientific research.	Currently we obtain consent for research but not clinical audit or service evaluation. The research policy and process is clear about consent and Knowledge Hub adhere to processes. Less clear is how we use information for education and publication. There is currently no photo/image policy.	Review Research policy and ensure it meets GDPR standards. Address use of consent for other purposes in IG Policy. Awareness and Comms with relevant staff	JCa Carolyn JCa Comms	Nov 17 Apr 18 Apr 18
7	**Children** • Defined as under 16 but could be lowered by UK to 13 • Special protection for children's personal data • Need a parent or guardian's consent in order to process their personal data lawfully • Privacy notes must be written in a language children will understand	The lawful basis for processing children's data for healthcare is as described above. Where we use children's data for other purposes e.g. research, there could be changes. ICO are going to release more guidance children's privacy including more detail on identifying an appropriate lawful basis for processing children's data, and	Await ICO guidance and adjust research policy/protocols as required.	***TBC***	

		issues around age verification and parental authorisation.			
8	**Data breaches** • Must have procedures in place to detect, report and investigate a personal data breach • Notify the ICO of a breach where it is likely to result in a risk to the rights and freedoms of individuals. Within 72 hours and to data subject "without undue delay" • Failure to report a breach when required to do so could result in a fine, as well as a fine for the breach itself • Very large fines - increased to up to 4% of total worldwide annual turnover . And possible compensation • Other powers: Admin sanctions, warnings, enter premise.	The Trust has existing policies and procedures in place for reporting confidentiality breaches. Currently Level 2 breaches are reported through IG Toolkit and escalated to ICO. Awaiting guidance from ICO, IGA and/or NHS Digital on future reporting and escalation and fines.	Respond to any new reporting requirements from ICO. Review and update Incident Reporting Policy Review and update Ulysses categories if required. Training and Comms.	JCa Governance Governance Comms /JCa	Jan 18 Mar 18 Mar 18 April 18
9	**Data Protection by Design and Data Protection Impact** • GDPR makes privacy by design an express legal requirement i.e. consider data protection at the start of a project • Date Protection Impact Assessments (DPIA) are mandatory for large scale processing (e.g. new patient IT system - but not e.g. for processing patient health data by a doctor. • If a DPIA indicates data processing is high risk you will have to consult the ICO	Privacy Impact Assessment is already part of IM&T change control process. We have a New Systems and Service Procedure but this is not widely known or followed. Not clear what is meant by "large scale processing" and how it would apply to an Acute Trust. Awaiting guidance from ICP	Review and update New Systems and Service procedure to include more stringent DPIA process. Ensure we apply DPIA consistently and early Training and awareness for business/information asset owners/ project managers to ensure they include DPIA for all new systems and services	JCa IM&T Project Board JCa CSMs	Dec 2018 Jan - Mar
10	**Data Protection Officer** Designate a Data Protection Officer i.e. someone to take responsibility for data protection compliance • Can be fulfilled by an employee – part or full time. Can be external • Will most likely sit within a Risk, Compliance or Governance function	The level and responsibilities of this role are not clear. Only what is not suitable i.e. current SIRO/IG manager/Caldicott Guardian/IT Manager/Records Manager	Consider options and identify role for DPO. IG Manager would benefit from, a training course. Indicative price: £1,800 for 4 day practitioner course in Birmingham	Exec Board	Sept 2018

	• Must be part of Board agenda • Must have independent reporting line and be empowered to report directly to the board without interference. • Must have expert" knowledge of data protection law and practices. • Currently no specified qualification				

Appendix B: Data Protection Officer

Source: CEO Briefing Note – Changes to Data Protection legislation: what this matters to you (IGA July 2017
Based on Guidelines on Data Protection Officers ('DPOs') (Article 29 Working Party, 13 December 2016): http://ec.europa.eu/newsroom/just/item-detail.cfm?item_id=50083

Appointing a Data Protection Officer as mandated by the GDPR, is essential to achieving effective facilitation across the organisation. The organisation must ensure that the Data Protection Officer has proven expert knowledge of data protection law and practices, and the ability to perform the tasks specified in the GDPR:-

- provision of advice to the organisation on compliance obligations, and when data protection impact assessment is required
- monitoring compliance with the GDPR and organisational policies
- co-operating and liaising with the Information Commissioner
- taking into account information risk when performing the above.

Further requirements of the role are:

- that the Data Protection Officer directly reports to the highest management level of the organisation
- that there is timely involvement of the Data Protection Officer in all data protection issues
- that the Data Protection Officer is supported by the necessary resources and is able to maintain expertise
- that the Data Protection Officer is not pressurised by the organisation as to how to perform his or her tasks, and is protected from disciplinary action when carrying out those tasks
- where the Data Protection Officer performs another role or roles, that there is no conflict of interest.

The role of the Data Protection Officer may be shared by multiple organisations that are 'public authorities' taking into account organisational structure and size, and may be either a member of staff or may fulfil the tasks on the basis of a service contract, provided there is no conflict of interest. The Data Protection Officer should have a good understanding of the organisation's business, and how it processes personal data.

This briefing is not intended to give a specific steer to CEOs on who should be the appointed as the Data Protection Officer. However it is important to consider EU Guidelines that '[t]he DPO cannot hold a position within the organisation that leads him or her to determine the purposes and the means of the processing of personal data. Due to the specific organisational structure in each organisation, this has to be considered case by case. Positions that involve the authorising or commissioning of IT or manual records management systems are likely to meet the criteria for determining the purposes and the means of processing.

The Royal Orthopaedic Hospital NHS Foundation Trust

National Data Guardian Review/CQC Safe Data, Safe Care
Impact and Action Plan

1. Purpose of Report

1.1. To set out impact of the National Data Guardian Review and the associated report CQC Safe Data, Safe Care, on the Trust and the actions required to implement it.

2. Background

2.1. In June 2016 the National Data Guardian (Dame Fiona Caldicott) published 'A Review of Data Security, Consent and Opt Outs'1 which set out 10 new data security standards. It also covered a new opt out model for sharing information not used for direct care. Around the same time, the CQC published 'Safe Data, Safe Care'2 which set out recommendations for ensuring NHS providers protect personal data, and how the new data security standards specified in the NDG review can be assured through CQC inspections.

2.2. The Government responded to the review in July 2017 in its document 'Your Data: Better Security, Better Choice, Better Care'3 and agreed to adopt and promote all the recommendations of the NDG review and the CQC recommendations on data security.

3. Data Security Standards

3.1. The national data guardian made 9 recommendations relating to Data Security Standards – See Appendix A. Key points:

- New Information Governance toolkit will go live in April 2018 to support and underpin the new standards
- Data security will be part of CQC's well led inspection framework from September 2017 and supported by IG toolkit from April 2018
- In summer 2017 NHS Improvement will publish a new 'Statement of Requirements' which will clarify required actions. CEOs will be required to respond with an 'Annual statement of Resilience including a named executive Board member responsible for data and cyber security, and confirming actions being taken to meet the data standards
- The NHS Standard Contract 2017/18 requires organisations to implement the NDG review recommendations

3.2. The expectation is that data security owned at the highest level of the organisation equal with clinical and financial assurance. This is reflected in their headings to support the new 10 Data Security standards which are grouped under "Leadership Obligations" for People, Process and

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535024/data-security-review.PDF
[2] http://www.cqc.org.uk/sites/default/files/20160701%20Data%20security%20review%20FINAL%20for%20web.pdf

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/627493/Your_data_better_security_better_choice_better_care_government_response.pdf

Technology.

3.3. Several requirements of the old IG toolkit exist around asset, data flows and information sharing registers, and training and awareness, and business continuity. The key difference is a big shift to providing a lot more assurance around cyber security in particular:

- Access control is well managed for all systems, particularly leavers
- Removing unsupported systems or having remedial action plans in place
- Annual penetration testing
- Antivirus in place, up to date and actively monitored
- Security patches up to date on all systems
- Ensuring our IT suppliers comply with the data security standards

3.4. Appendix B lists the 10 data standards and, based on an early view of the proposed new IG toolkit, indicates the type of evidence that may be needed to support the standards, with an initial action plan. This will be refined as further information about the new IG toolkit is published.

3.5. Like GDPR, the work to implement the NDG and CQC review from an IG perspective is challenging but can be accommodated in the IG Manager's workload as it is building on a sound foundation of existing evidence. Some additional support will be required from relevant colleagues in other department (e.g. Governance, L&D, Comms).

3.6. The IT actions are more demanding and the IT Department is already under pressure following the greater awareness of cyber security after the recent WannaCry attack and weaknesses identified in IT Security audits. Of particular concern is the ability to keep up with security patching and to monitor attacks. Penetration testing could add extra cost if done externally.

3.7. However if we fail to meet the 10 data security standards we will fail to comply with the NHS Standard Contract and would not meet the CQC KLOE standards so the mandate to comply is strong.

4. CQC "Safe Data, Safe Care"

4.1. CQC produced 6 recommendations which have been accepted by the Government - See Appendix C. Key points:

- CQC will seek assurance against the new data security standards and have appropriate Key Levels of Enquiry (KLOE).
- Emphasis on leadership at the highest level and making data security equal with financial integrity confirmed by internal data security audit and external validation.
- Give staff tools and training to be effective and safe [Xref Data Standard 3]
- Avoid workarounds – Design systems and data security around needs of patient care and front line staff
- Replace unsupported hardware and software by March 2018 [Xref Data Standard 8]

4.2. KLOE relating to confidentiality are as follows. These have come out before the new IG toolkit so it is not clear yet the extent to which the IG toolkit will or can be used to provide assurance for these KLOE[4].

[4] https://www.cqc.org.uk/sites/default/files/20170609_Healthcare-services-KLOEs-prompts-and-characteristics-FINAL.pdf

a) Caring

- C3.3 How are people assured that information about them is treated confidentially in a way that complies with the Data Protection Act and that staff support people to make and review choices about sharing their information?
- C3: How is people's privacy and dignity respected and promoted?

b) Well Led

- W6.7 Are there robust arrangements (including appropriate internal and external validation) to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?

4.3. In summary, we will not know more until further information about the new IG Toolkit and how it maps to CQC assurance is provided. The IG Manager will liaise with the CQC lead.

5. National Opt Out

5.1. The National Data Guardian also examined how patients could be informed and be able to have a clear choice about how their personal information is used for purposes beyond their direct care. She recommended an 8 point model - see Appendix D. The NDG has recommended a national opt out where the person states their preference about how their information is used and this follows the patient - a single and simple mechanism. There will still be circumstances where opt outs will not apply e.g. where there is a legal requirement, overriding public interest or exceptional circumstances e.g.

- Safeguarding
- CQC so they can ensure health services are safe and high quality.
- NHS Protect to investigate fraud
- FGM which must be reported to the police
- Invoice validation where personal is needed for payment of services not covered by a contract
- Cancer, congenital anomalies and rare diseases will operate separate opt out mechanisms and exempt from national opt out.

5.2. Anonymised information for non- direct care should be used and the Information Governance Alliance is due to publish guidance based on the ICO code of practice.

5.3. In summary, not much has changed as yet and government bodies are planning a lot more work around consultation, communication and implementing digital service to support a national opt out. There is no immediate impact on the Trust other than to provide ongoing training and awareness to staff about how and when they can share personal confidential information, and for Research to continue to obtain consent (see Appendix B - Data Standard 1 actions).

6. Recommendations

6.1. The Trust Board receives and accepts this update.

Appendix A: Data Security Recommendations

Recommendation	Comment/Government Response
1. The Leadership of every organisation should demonstrate clear ownership and responsibility, just as it does for clinical and financial management and accountability	CQC and NHSI will assess that Boards are implement the 10 data security standards In summer 2017 NHS Improvement will publish a new "statement of requirements" which will clarify required action. CEOs will be required to respond with an "annual statement of resilience" including a named executive Board member responsible for data and cyber security, and confirming actions being taken to meet the data standards.
2. A redesigned Information Governance Toolkit embedding the standards. Exemplar organisation to enable peer support and cascade lessons learnt	Being tested September 2017 (IG manger is involved) Going live April 2018
3. Use a tool to identify vulnerabilities such as dormant accounts, default passwords and multiple log ons from same account.	IG Toolkit will signpost suitable tools
4. Trust to provide evidence they are taking action to improve cyber security e.g. Cyber Essentials scheme.	IG toolkit will be main vehicle. Government will assess if Cyber Essentials Plus is suitable. Signposts from IG Toolkit
5. NHS England should change its standard financial contracts to require organisations to take account of the data security standards.	Already in NHS Standard Contract for 2017/18
6. Arrangements for internal data security audit and external validation should be reviewed and strengthened to a level similar to those assuring financial integrity and accountability	IG Toolkit will provide and strengthen assurance. [No mention of external assurance e.g. who and will it be mandatory]
7. CQC should amend its inspection framework to include assurance of internal and external validation against the standards. NHS Digital should use the IG Toolkit to inform CQC of "at risk" organisations	Data security will be part of CQC's well led inspection framework from September 2017 and supported by IG toolkit from April 2018
8. Primary care related	Not Applicable to ROH
9. Where malicious or intentional data security breaches occur, the DoH should put harsher sanctions in place	The new GDPR/UK Data Protecting Act will implement more severe sanctions from May 2018

Appendix B: 10 Data Standards – Evidence and Actions

Yellow = overlap with GDPR Green = overlap with CQC recommendation

Data Standard	Likely Evidence needed	Action	Who	When
Leadership Obligation 1 **People: Ensure staff are equipped to handle information respectfully and safely, according to the Caldicott Principles.**				
1. All staff ensure that personal confidential data is handled, stored and transmitted securely, whether in electronic or paper form. Personal confidential data is shared for only lawful and appropriate purposes.	• Senior ownership • Defined roles – SIRO, IG, CG, IS • Policies – understood and available to staff and public • SARS and FOI processes and performance • Staff survey results • Data flows documented • Data sharing register and agreements • CareCert rating? (will this be mandated?) • Anonymisation/pseudon controls • Data quality controls	• Ensure Board is clear about their responsibilities. • Confirm SIRO and CG roles (CQC Rec 1) • Review and update policies. Publish on intranet. Provide user friendly summaries. • Review and update Data Flows Register, Information Sharing Register and agreements. • Ensure use of PID for non-direct care is clear on key areas and anonymization processes are clear. BI, Finance, Contracts, Learning Hub • Staff survey • Data Quality ?	IG/SIRO SIRO/CG IG IG IG IG ?	Sep 17 Sep-Mar Dec 17 Dec 17 TBC
2. All staff understand their responsibilities under the National Data Guardian's data security standards, including their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.	• Information Asset Register • Information sharing register and agreements • Staff survey results • DP and security induction for all new starter	• Review and update information sharing register (see 1 above) • Review and possibly strengthen data sharing agreements/contracts T&Cs/SLA • Training via Mandatory or elearning for all new starters AND agency and temporary staff (CQC Rec 2) • Staff survey	IG IG IG IG	Sep-Mar Ongoing TBC
3. All staff complete appropriate annual data security training and pass a mandatory test, provided through the redesigned Information Governance	• TNA for all roles including any specific training needed including Exec and Board • IG/Data Security training via mandatory and/or Elearning	• Revisit overall Trust TNA • Produce IG specific TNA for staff groups • Implement training • Implement elearning	IG/L&D	Jan-Mar

Toolkit. X ref CQC Recommendation 2	• Pass rates	• Produce supporting materials and handouts (CQC Rec 2)		
Leadership Obligation 2 **Process: Ensure the organisation proactively prevents data security breaches and responds appropriately to incidents or near misses**.				
4. Personal confidential data is only accessible to staff who need it for their current role and access is removed as soon as it is no longer required. All instances of access to personal confidential data on IT systems can be attributed to individuals.	• List of staff and roles • User lists by system • SA Roles with specific roles and activity monitored • Shared log ons documented and risk assessed • Starter and leavers process	• Compare IT user list with individual lists held by local system administrator • Review all SA roles and accesses • Risk assess shared log on areas – Outpatient Pods, Theatres (CQC Rec. 3) • Review/rewrite starters leavers ad movers process – leavers in particular. • Consider centralising or review and strengthen systems admin role for leavers for individual systems	IT IT/IAOs IG/IT IT CIO/PA IAOs	Oct-Nov Oct 17 Nov 17 Sep 17 TBC
5. Processes are reviewed at least annually to identify and improve any which have caused breaches or near misses, or which force staff to use workarounds which compromise data security	• Incidents/SIRIs • Formal process review – involving clinicians • Known workarounds – documented and assessed (e.g. Kiosk accounts)	• Set up table top review of key data risks – 2 per year - IT and Human error. • Improve lessons learnt and feedback to individuals and ensure processes changed if needed • Publish key lessons on website and ebulletin • Identify, document and risk assess workarounds (See Data Standard 3 and CQC Rec 3)	IG/IT/Governance	Feb 18
6. Cyber-attacks against services are identified and resisted and CareCERT security advice is responded to. Action is taken as soon as possible following a data breach or near miss, with a report made to senior management within 12 hours of detection. Significant cyber-attacks are to be reported to CareCERT immediately following detection	• Whistle blowing available for security breaches • Incident reporting performance • Staff survey	• Check whistle blowing policy include security breaches • Review and if needed update Incident Reporting Policy • Awareness to staff about what is a cyber incident and importance of reporting. • Monitor cyber reporting and report to IG Group. Escalate to ?? • Do staff survey on staff awareness	IG IG IG/IT IT IG	Nov 18 Dec 18

		• Monitor via CareCERT Collect Links to GDPR Data Breaches although this targets data breaches rather that service loss	IT	
7. A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum,	• Disaster recovery and BCPs in place • Staff survey to assess knowledge of plan • Annual test for data security incidents. Board representation. Use credible and likely scenarios	• Complete Disaster Recovery plan • Carry out annual test of likely scenarios e.g. Another Wanna Cry attack, Network failure, ePMA loss. • Get business areas to do BCPs • Carry out staff survey to id if they know about BCP in their areas	IT IT IG/SIRO IG	Dec 18 Sep-Mar TBC
Leadership Obligation 3 **Technology: Ensure technology is secure and up-to-date.**				
8. No unsupported operating systems, software or internet browsers are used within the IT estate.	• Asset register to highlight unsupported systems/software. Remediation in place, or if retained risk assessments • SIRO and Board sign off	• Identify, document and risk assess all unsupported systems, software and internet browsers. e.g Macs, Imaging equipment, BI systems • Put plan in place for remedial action or replacement – Target March 2018 • Implement Microsoft fix issued Aug 2017) (CQC Rec 4)	IT IT IT	Sep 17 Mar 18 Mar 18
9. A strategy is in place for protecting IT systems from cyber threats, based on a proven cyber security framework such as Cyber Essentials. This is reviewed at least annually.	• Default passwords changed • Penetration testing – in house or externally at least annually • Penetration testing of web applications against OWASP • Antivirus in place and evidence it's kept up to date • Performance/volumes of threats • Number of Phishing emails reported • Security patches up to date • Improvement plan – approved by SIRO • KPIs (to be defined) • Use of national tools	• Schedule and identify penetration testing – could be done internally • Password review. Ensure all systems adhering to standard • Actively and regularly monitor results of antivirus and take actions • Record volumes of attacks and near misses • Patching strategy and plan. Implement all security patches as they are published	IT IT IT IT IT	Jan 18 Dec 17 Ongoing Sep 17 Ongoing

10. IT suppliers are held accountable via contracts for protecting the personal confidential data they process and for meeting the National Data Guardian's data security standards.	• List of IT suppliers , products delivered and start/end date of contracts • List of IT systems and criticality • Supplier GDPR preparedness statement • Contract data security clauses in place including statements about running on supported systems, browsers and plug ins • Documented issues/incidents with supplier • If supplier the cause we can't comply with Data Standards, record and flag to NHS Digital • Suppliers must complete CareCERT Assurance? Plus?	• Bring together Asset and Information Asset register and identify suitable platform e.g. Excel, Sharepoint. • Add supplier and contract time details • Get all suppliers to provide a statement on their preparedness for GDPR and Data Security Standards. Provide a template of our expectations. • Record data security incidents caused by supplier	IG/IT IT IT/SO IT	Mar 18

Appendix C: CQC Recommendations

Recommendation	Action/Comment
1. The leadership of every organisation should demonstrate clear ownership and responsibility for data security, just as it does for clinical and financial management and accountability	See Data Standard 1 Inform Exec Team and Board of responsibilities
2. All staff should be provided with the right information, tools, training and support to allow them to do their jobs effectively while still being able to meet their responsibilities for handling and sharing data safely [Xref Data Standard 3	See Data Standard 3 actions
3. IT systems and all data security protocols should be designed around the needs of patient care and frontline staff to remove the need for workarounds, which in turn introduce risks into the system	Check and confirm processes in Theatres and Outpatients and use of generic log-ons. See Data Standard 4 action.
4. Computer hardware and software that can no longer be supported should be replaced as a matter of urgency. [by March 201 -Xref Data Standard 8]	See Data Standard 8 actions
5. Arrangements for internal data security audit and external validation should be reviewed and strengthened to a level similar to those assuring financial integrity and accountability	Establish internal audit controls for data security e.g. KPIs, incident report Await further guidance re. level and type of external assurance (e.g. CareCERT plus, IG toolkit, ISO 2700
6. CQC will amend its assessment framework and inspection approach to include assurance that appropriate internal and external validation against the new data security standards have been carried out, and make sure that inspectors involved are appropriately trained.	See KLOEs. Await further guidance from CQC on the extent to which the IG toolkit will provide assurance

Appendix D: NDG 8 Point Model

1. **You are protected by the law.** Your personal confidential information will only ever be used where allowed by law. It will never be used for marketing or insurance purposes, without your consent.

2. **Information is essential for high quality care**. Doctors, nurses and others providing your care need to have some information about you to ensure that your care is safe and effective. However, you can ask your healthcare professional not to pass on particular information to others involved in providing your care.

3. **Information is essential for other beneficial purposes**. Information about you is needed to maintain and improve the quality of care for you and for the whole community. It helps the NHS and social care organisations to provide the right care in the right places and it enables research to develop better care and treatment.

4. **You have the right to opt out**. You have the right to opt out of your personal confidential information being used for these other purposes beyond your direct care. This opt-out covers:

a) Personal confidential information being used to provide local services and run the NHS and social care system.
b) Personal confidential information being used to support research and improve treatment and care.

5. **This opt-out will be respected by all organisations that use health and social care information**. You only have to state your preference once and it will be applied across the health and social care system. You can change your mind and this new preference will be honoured.

6. **Explicit consent will continue to be possible**. Even if you opt out, you can continue to give your explicit consent to share your personal confidential information if you wish, for example for a specific research study.

7. **The opt-out will not apply to anonymised information**. The Information Commissioner's Office (ICO) has a Code of Practice that establishes how data may be sufficiently anonymised that it may be used in controlled circumstances without breaching anyone's privacy. The ICO independently monitors the Code of Practice.

NHS Digital as the statutory safe haven for the health and social care system, will anonymise personal confidential information it holds and share it with those that are authorised to use it. By using anonymised data, NHS managers and researchers will have less need to use people's personal confidential information and less justification for doing so.

8. **Arrangements will continue to cover exceptional circumstances.** The opt-out will not apply where there is a mandatory legal requirement or an overriding public interest. These will be areas where there is a legal duty to share information (for example a fraud investigation) or an overriding public interest (for example to tackle the ebola virus).

Our key priorities to March 2018

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

Priority	Reason	Key actions	Measurement
Patient experience frames all of our priorities			
Provide safe high quality care	Ensure patients have the best experience and outcomes	Achieve regulatory action plans Meet IPC compliance	**Meet the local and national standards for quality and safety and maintain patient experience scores**
Care for more patients	Provide care to more people to increase activity and income	Improve the patient pathway through the Scheduled Care Improvement Plan	**Meet our weekly activity targets**
Ensure shorter waiting times	We want people to wait less time for their treatment	Clear our backlot of long-waiting patients Maintain improvements to waiting list management	**Comply with 92% Referral To Treatment (RTT) guidelines, national cancer waiting times and diagnostic targets**
Value for money	Be stable and sustainable through efficiency and productivity	Achieve our financial recovery plans Reduce spending on agency staff	**Achieve our planned deficit**
Improve staff engagement	Improvements to care and safety are positively influenced by engaged and motivated staff	Complete all the actions in the engagement plans	**Improvement in local and national staff survey results**
Define our future	To be the first choice for orthopaedic care both locally and nationally	Complete our Strategic Outline Case (options appraisal)	**Board approval for fully developed future operating model**

ROHTB (10/17) 002

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

September 2017

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Patient Services
AUTHOR:	Ash Tullett	Clinical Governance Manager

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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 and the CQC for routine engagement visits.

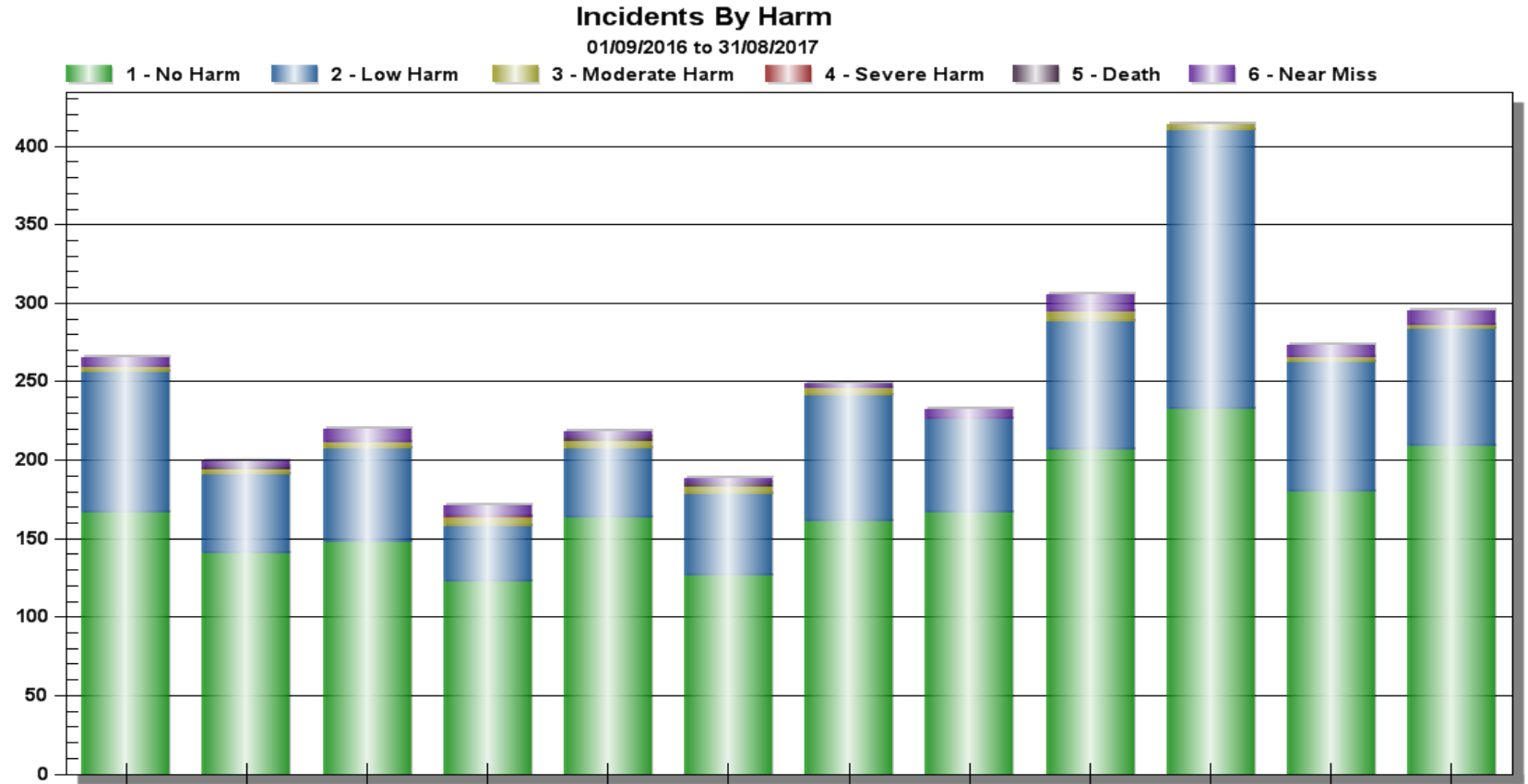
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

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.



Month and Year	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017
1 - No Harm	166	140	147	122	163	126	161	166	206	232	180	209
2 - Low Harm	90	51	60	36	44	52	80	60	82	178	82	74
3 - Moderate Harm	3	3	4	5	5	5	5	0	6	4	3	3
4 - Severe Harm	0	0	0	1	0	0	0	0	0	0	0	0
5 - Death	0	1	0	0	2	2	0	0	0	0	0	0
6 - Near Miss	6	4	9	7	4	3	3	6	11	0	8	9

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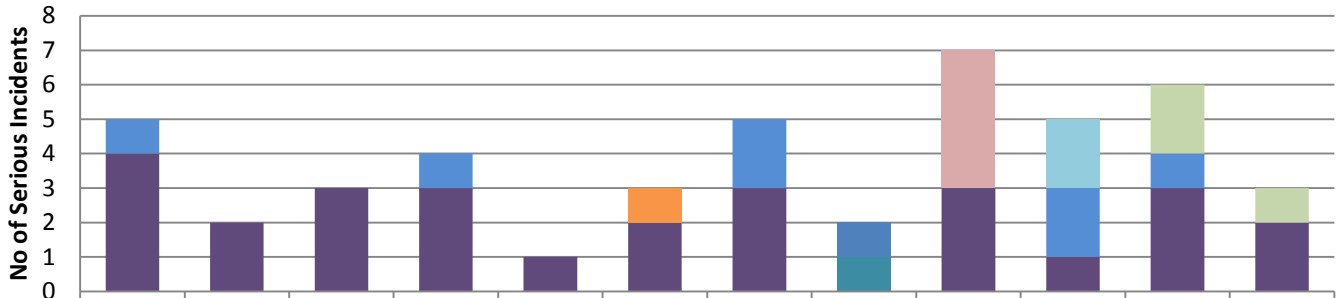
INFORMATION
In August 2017 there was a total of 295 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is at follows; 209 – No Harm 74 – Low Harm 3 – Moderate Harms 9 – Near Miss
ACTIONS FOR IMPROVEMENTS / LEARNING
An ongoing Ulysses action plan continues to make changes and improvements to the Incident management system
RISKS / ISSUES
None

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 .

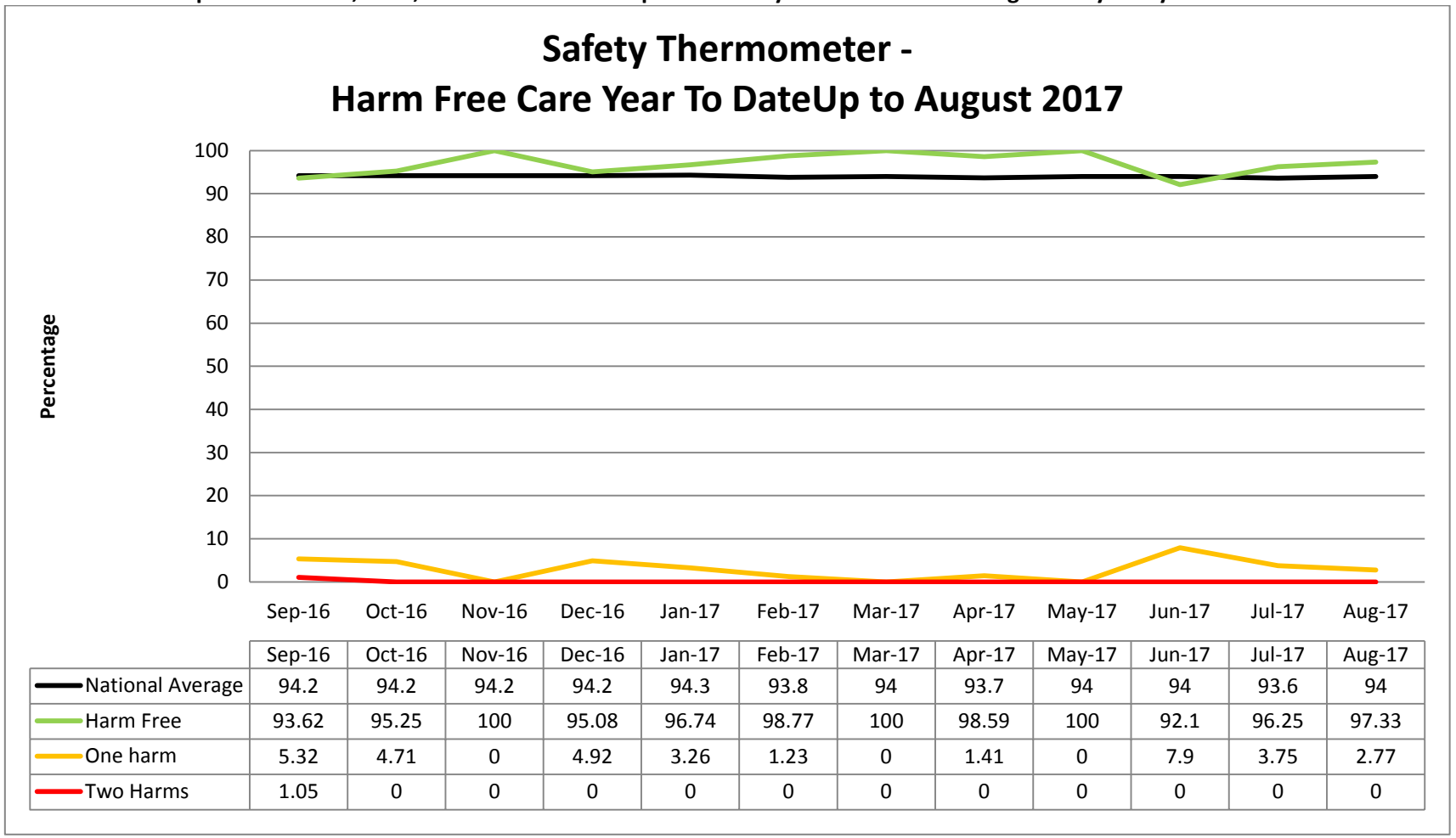
Serious Incidents Declared Year to Date to August 2017



	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	July	Aug-17
Unexpected Injury											2	1
RTT Harm review									4			
Emergency transfer to HDU												
Exposure to hazardous substance						1						
Wrong Site Incision												
Wrong Implant												
Suspension to services												
RTT Data Issue								1				
Wrong side injection										2		
Suspension of Service (BCH Spinal)								1				
Slips, trips & falls												
Pressure Ulcers	1			1			2			2	1	
VTE meeting SI criteria	4	2	3	3	1	2	3		3	1	3	2

INFORMATION
There were **3 Serious Incidents Declared in August 2017;**
ACTIONS FOR IMPROVEMENTS / LEARNING
Two serious incidents were closed by the Commissioners in August 2017. The incidents were reported in the May 2017 Quality report.
RISKS / ISSUES
None.

3. **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-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
National Average	94.2	94.2	94.2	94.2	94.3	93.8	94	93.7	94	94	93.6	94
Harm Free	93.62	95.25	100	95.08	96.74	98.77	100	98.59	100	92.1	96.25	97.33
One harm	5.32	4.71	0	4.92	3.26	1.23	0	1.41	0	7.9	3.75	2.77
Two Harms	1.05	0	0	0	0	0	0	0	0	0	0	0

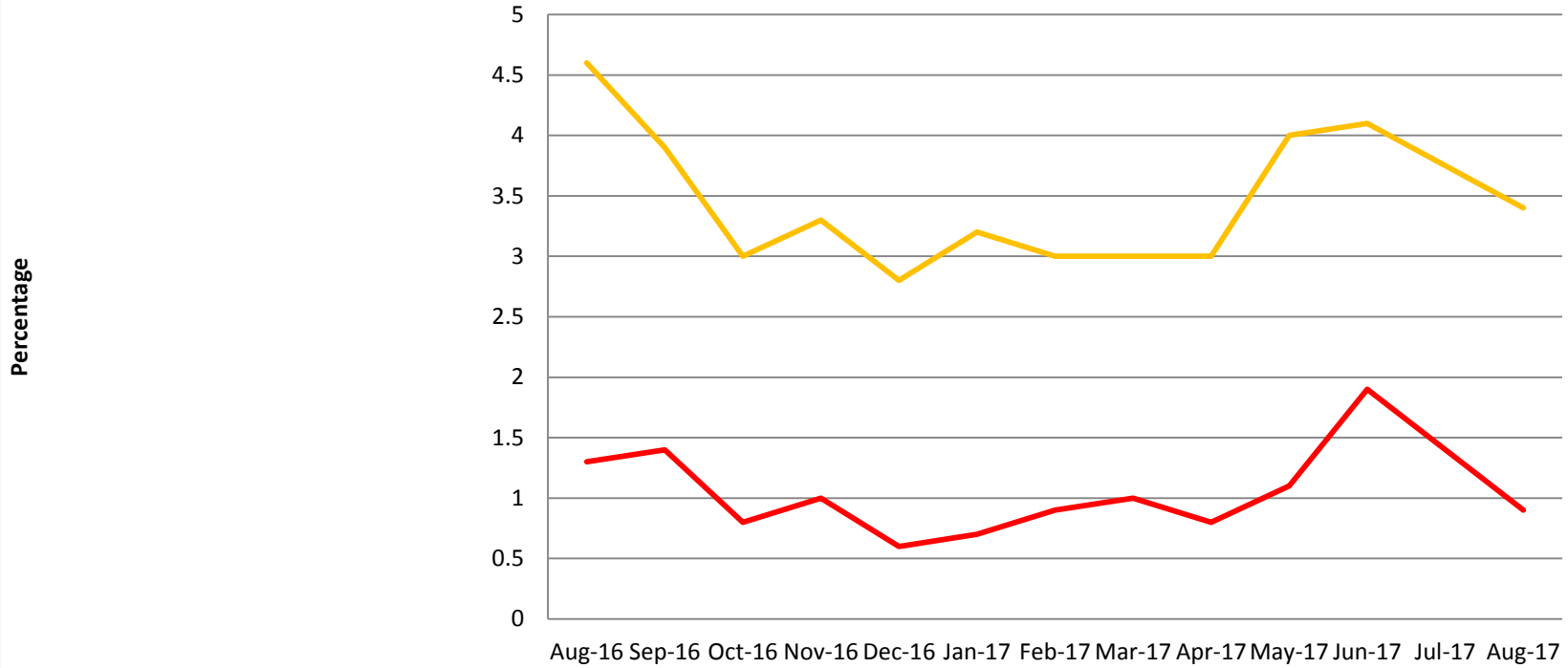
The harms highlighted on the safety thermometer were;
1 Fall with harm on ward 3 and 1 New VTE on HDU

4. 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 inAugust 2017 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-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
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794
Feb-17	52	5	0	2	59	188	6429
Mar-17	80	6	0	0	86	250	7326
Apr-17	62	0	0	0	62	232	7328
May-17	83	5	0	0	83	303	6918
Jun-17	178	4	0	0	182	414	9162
Jul-17	82	4	0	0	86	273	8743
Aug -17	74	3	0	0	77	295	8560

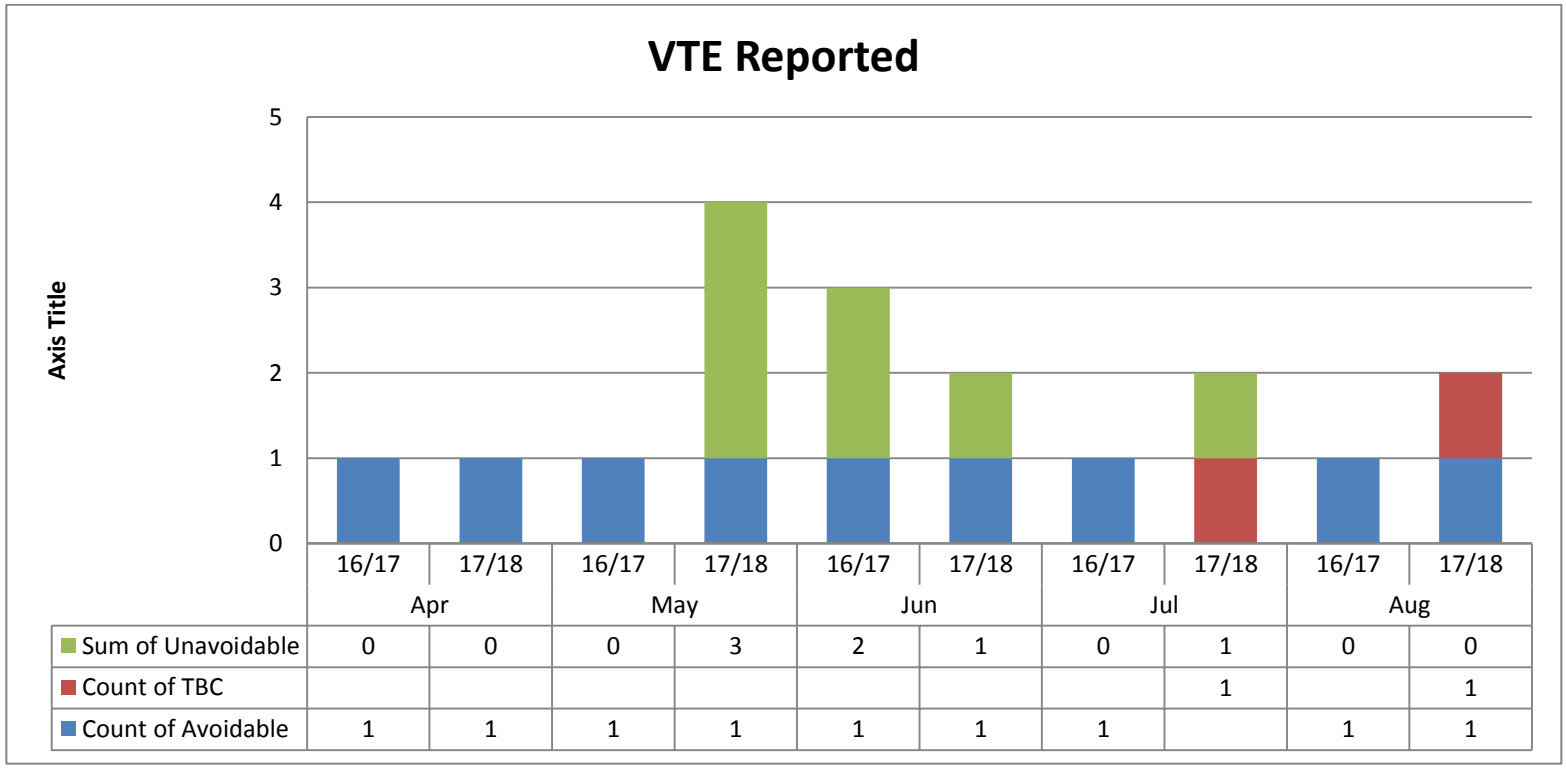
In August 2017, there were a total of 8743 patient contacts. There were 295 incidents reported which is 3.4 percent of the total patient contacts resulting in an incident. Of those 295 reported incidents, 77 incidents resulted in harm which is 0.9 percent of the total patient contact.

% of Patient Contact Compared to Number of Incidents and Incidents with Harm August 2016 to August 2017



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Aug-17
% of Patient Contacts with Incidents Causing Harm	1.3	1.4	0.8	1	0.6	0.7	0.9	1	0.8	1.1	1.9	0.9
% of Patient Contact With All Incidents Reported	4.6	3.9	3	3.3	2.8	3.2	3	3	3	4	4.1	3.4

5. **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).**



	Apr 16/17	Apr 17/18	May 16/17	May 17/18	Jun 16/17	Jun 17/18	Jul 16/17	Jul 17/18	Aug 16/17	Aug 17/18
Sum of Unavoidable	0	0	0	3	2	1	0	1	0	0
Count of TBC								1		1
Count of Avoidable	1	1	1	1	1	1	1		1	1

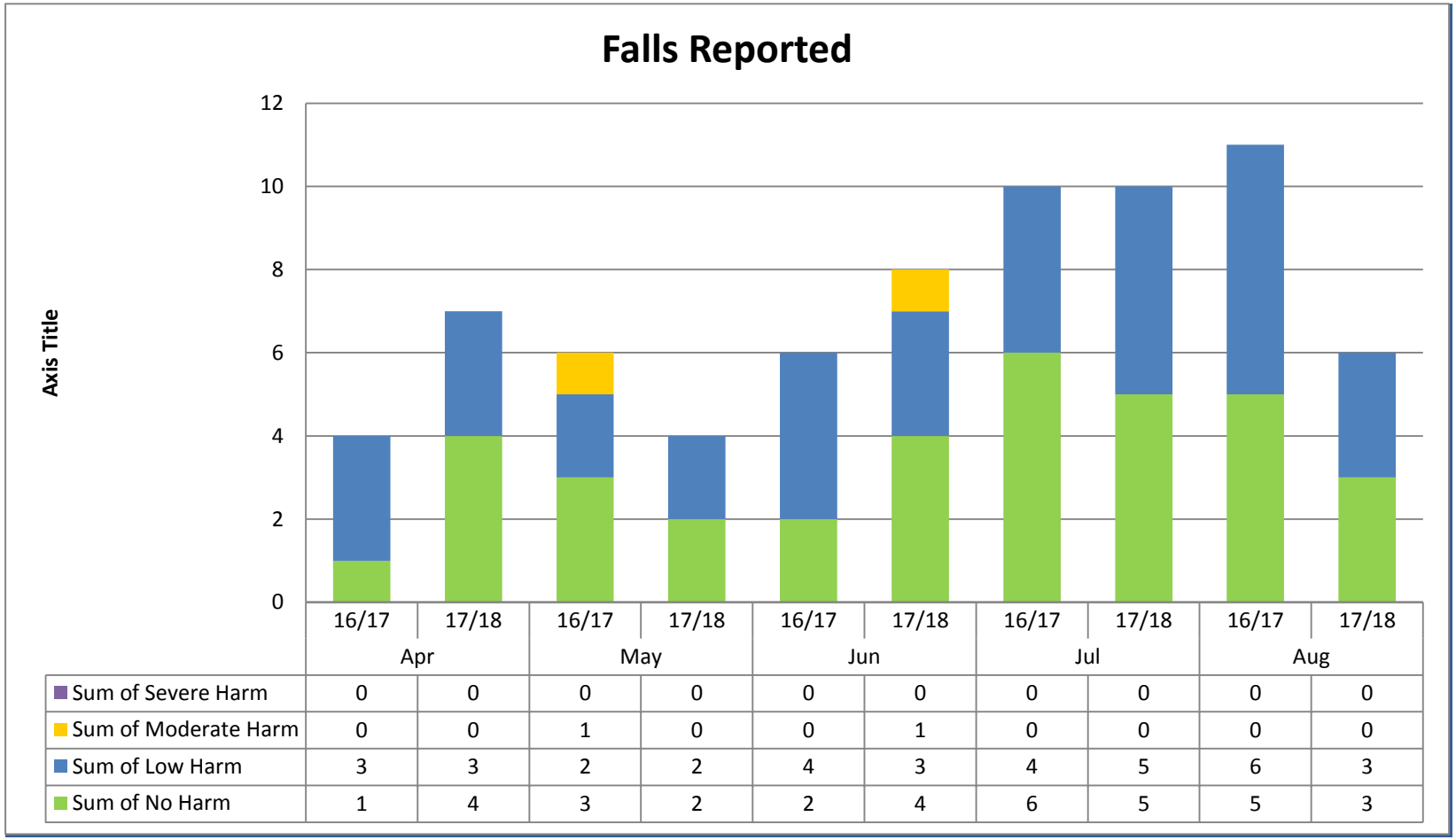
11

total		Avoidable
16/17	27	13
17/18	8	0*

***not classified**

INFORMATION
There were two VTE's declared in August 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
All commissioner KPI's /audits have been completed and continue to be consistently achieved VTE training continues for Student nurses, training for registered and non-registered staff (clinical update days) was suspended in Q4 but will re-commence in April 2017. It is mandatory for clinical staffs 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. Now that the VTE guidelines have been finalised and approved the requirements for meeting exemplar site status are met which has enabled application to be completed in Quarter 4.
RISKS / ISSUES
On-going learning and management in relation to non-compliance with 24 hour re-assessment by medical staff and Advanced Nurse Practitioners is required. Once the electronic system is implemented this will enforce completion.

6. **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.**



	16/17 Apr	17/18 Apr	16/17 May	17/18 May	16/17 Jun	17/18 Jun	16/17 Jul	17/18 Jul	16/17 Aug	17/18 Aug
Sum of Severe Harm	0	0	0	0	0	0	0	0	0	0
Sum of Moderate Harm	0	0	1	0	0	1	0	0	0	0
Sum of Low Harm	3	3	2	2	4	3	4	5	6	3
Sum of No Harm	1	4	3	2	2	4	6	5	5	3

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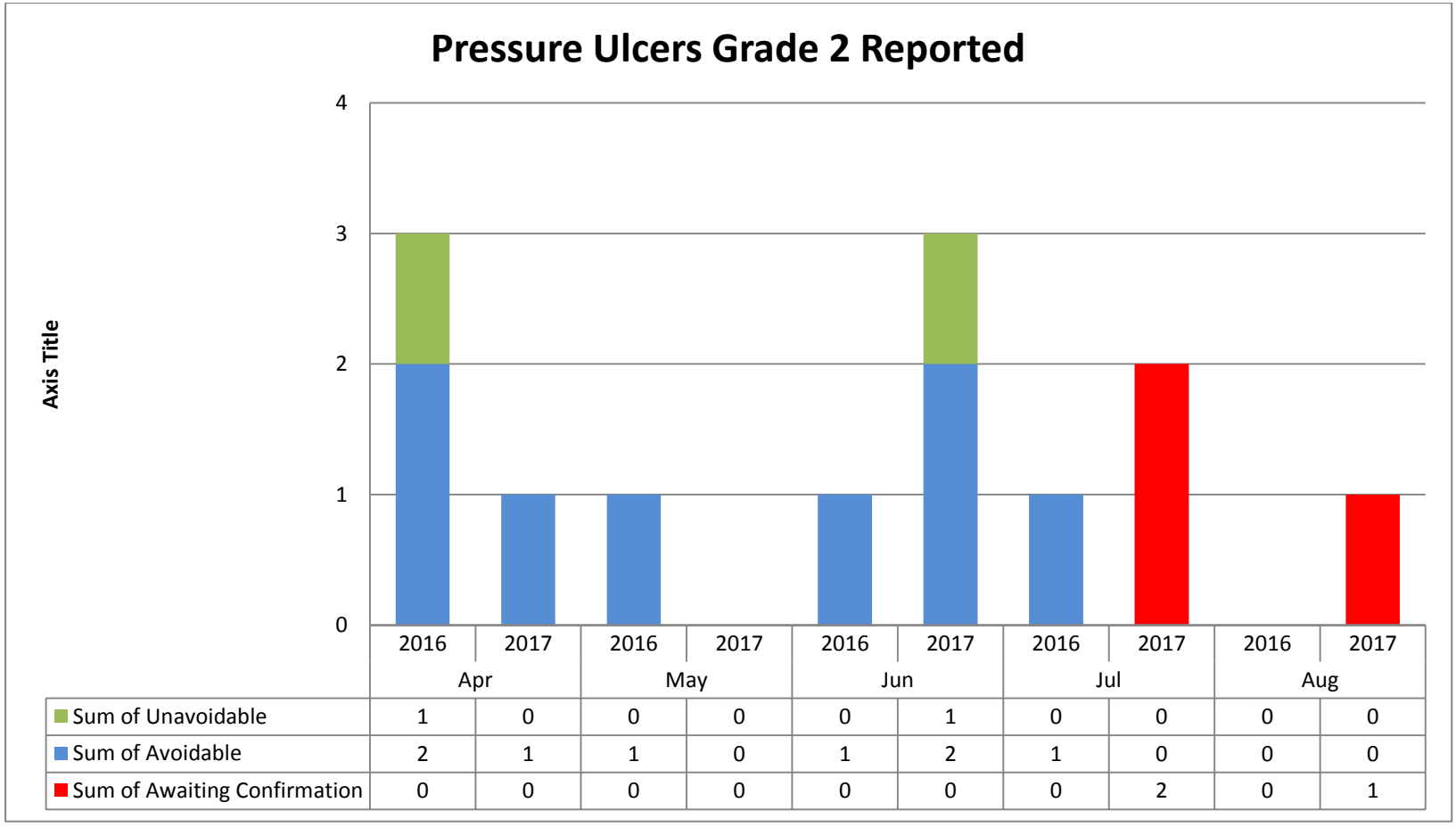
INFORMATION
Overall 8 fall related incidents were reported across the Trust in August 2017, six of these related to adult inpatient falls. All incidents have been subject to a post-fall notes review by the ward manager or deputy and a falls questionnaire has been completed for each fall. The inpatient falls are all reported to CQG via the Divisional Condition reports from the Heads of Nursing and are reported in the Monthly Quality Report.

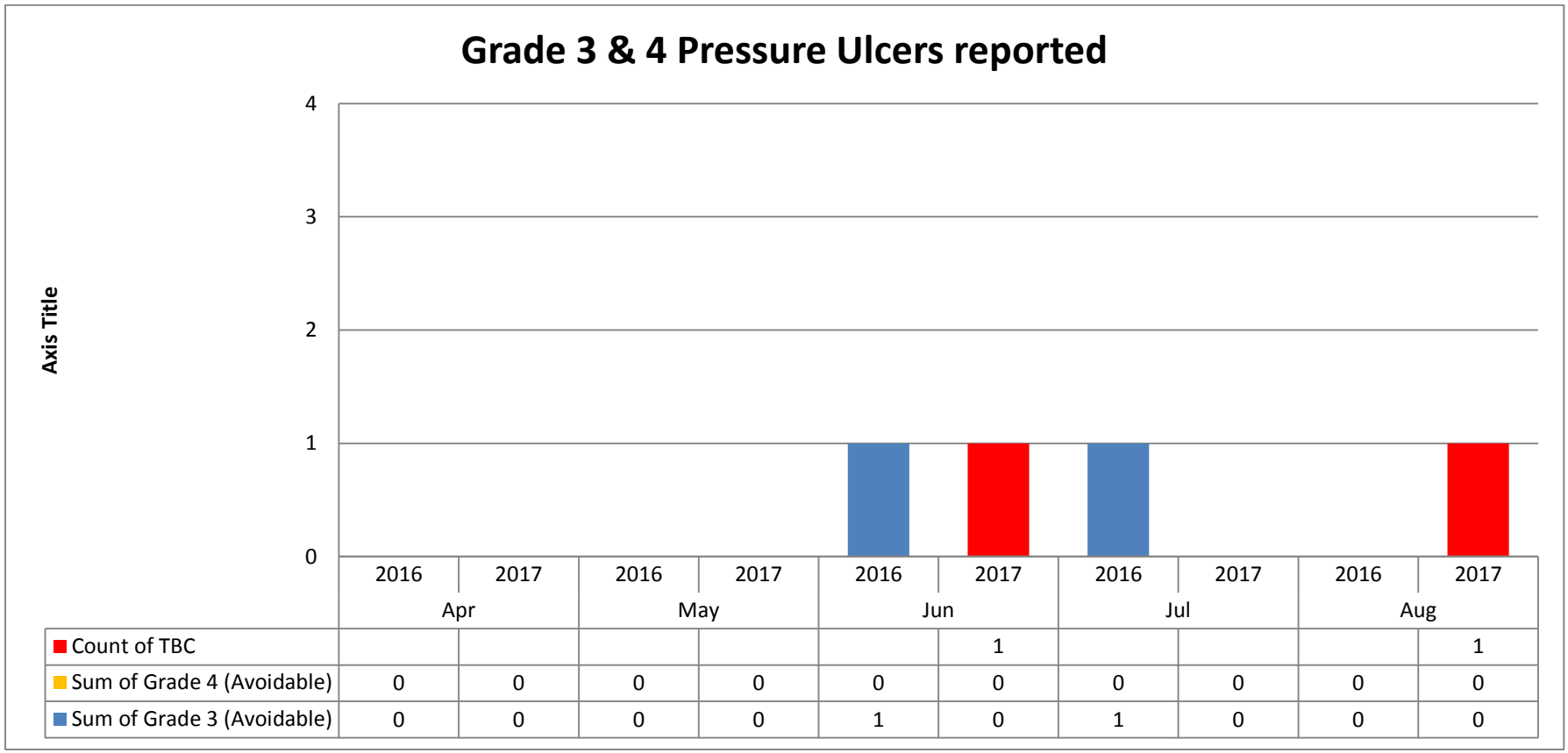
ACTIONS FOR IMPROVEMENTS / LEARNING
• The Falls Working Group (FWG) meetings recommenced in December 2016 and are scheduled bi-monthly after the January 2017 meeting. • Through the FWG the work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller is in progress. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care. • Falls information boards are to be standardised across all ward areas, with the information being agreed at the FWG meeting. 'Walking stick' visual information to be produced on a monthly basis for all ward areas for cascading of information regarding the number of falls per ward, per month to all staff. • Recommendations from the Throne Project will be overseen by the Falls Group on a Bi-monthly basis. • A review of the falls assessment and care plan documentation to take place, to include development of a post falls medical review template report, which is with the Documentation task and finish group currently. • Monthly reporting via the Ward Quality Dashboards to continue.

RISKS / ISSUES
None

7. **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 2016	Apr 2017	May 2016	May 2017	Jun 2016	Jun 2017	Jul 2016	Jul 2017	Aug 2016	Aug 2017
Sum of Unavoidable	1	0	0	0	0	1	0	0	0	0
Sum of Avoidable	2	1	1	0	1	2	1	0	0	0
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	2	0	1



	Apr 2016	Apr 2017	May 2016	May 2017	Jun 2016	Jun 2017	Jul 2016	Jul 2017	Aug 2016	Aug 2017
Count of TBC						1				1
Sum of Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0
Sum of Grade 3 (Avoidable)	0	0	0	0	1	0	1	0	0	0

INFORMATION

In August 2017 there has been;
1 x Grade 2 pressure ulcers and 1x Grade 3 pressure ulcer. The avoidability is to be determined

In total, from 1st April 2017 the Trust has reported the following avoidable pressure ulcers:

1 avoidable Non Device Related Grade 2 pressure Ulcers against a limit (target) of 12.

1 avoidable Device Related Grade 2 pressure Ulcers against a limit (target) of 12.

0 avoidable Grade 3 pressure Ulcers against a limit of 0. (Two Grade 3 Pressure Ulcers currently awaiting RCA's to establish avoid ability and are therefore not included in these figures)

Royal Orthopaedic Hospital and Stop the pressure campaign

The 'Stop the Pressure' campaign was launched in the UK in by NHS Midlands and East, and 19 November 2015 marked a national celebration of the campaign, aiming to raise awareness and educate about the ways that pressure ulcers can be prevented, and act as a vehicle for change to make life better for patients.

The NHS has reported that:

- 700,000 people are affected by pressure ulcers each year;
- Each pressure ulcer adds additional costs of care of over £4,000;
- 95% of pressure ulcers are preventable.

In 2016/2017 The Royal Orthopaedic Hospital had a total of 16 avoidable pressure ulcers in a total of 13989 inpatient's. This is equal to 0.11% of patients with avoidable Grade 2 or higher pressure ulcers at the Royal Orthopaedic Hospital. This is well below the national average.

Updates from June/July:

- **1 x Grade 3** and **1 x Grade 4** (relating to same patient) no 21115 device related pressure ulcers
- **1 x Grade 3** - device related pressure ulcers investigation (20769) concluded damage as result of traction prop used in theatre, lessons learnt regarding consent and skin examination. Changes required to documentation for theatres. Awaiting outcome
- **1 x 3 Grade** hospital acquired pressure ulcers under investigation (20930) report should be concluded this month and submitted to commissioners, initial outcome is this being an avoidable pressure ulcer.

ACTIONS FOR IMPROVEMENTS / LEARNING

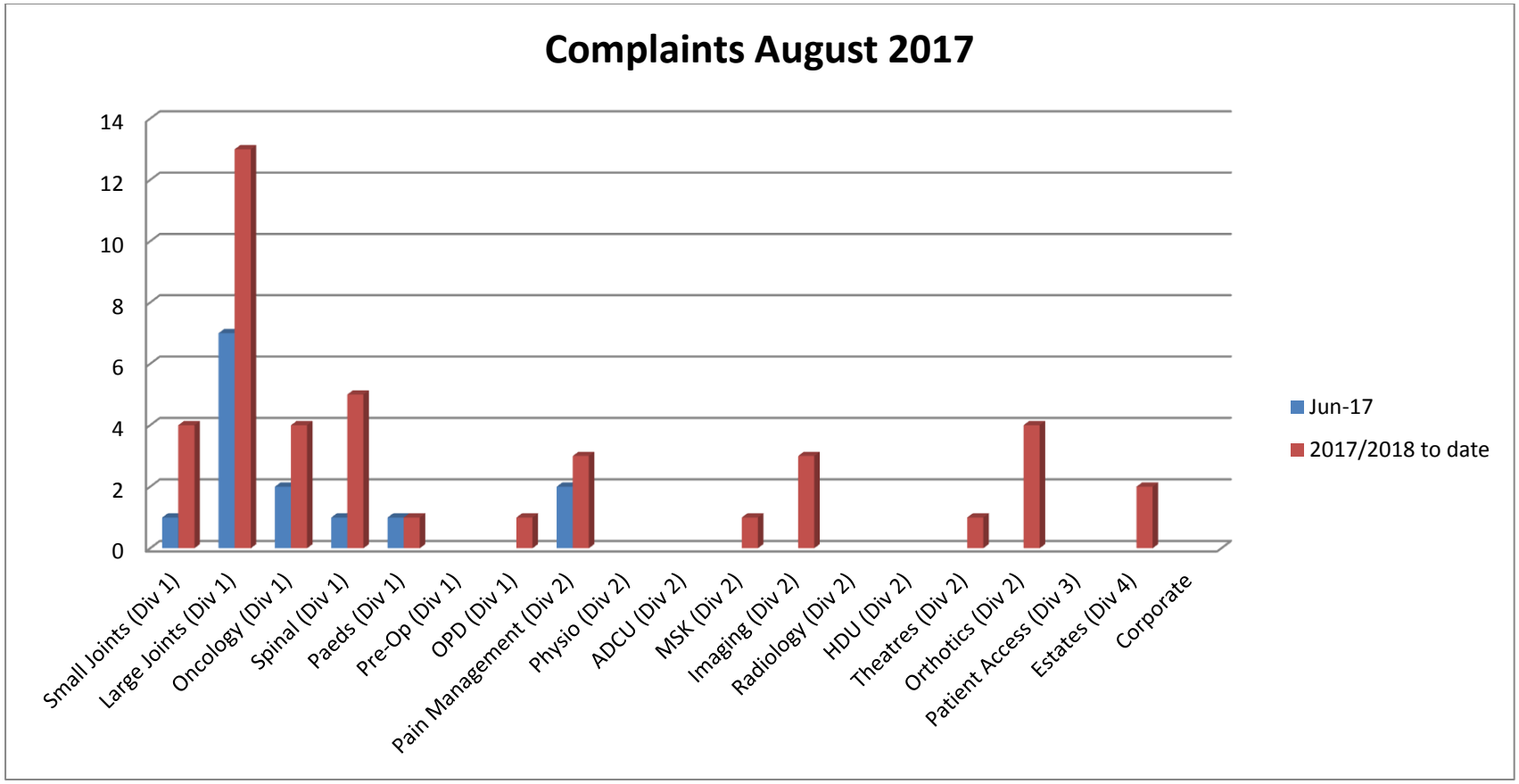
Identified from reviews and investigations /RCA's:-

- Risk of pressure damage not elucidated at time of consent this must be discussed and documented on the consent form.
- Perineum not examined pre operatively
- Tissue viability information stored separately on their database and not recorded in medical notes
- Importance of documenting discussion with patients about advises on repositioning themselves and pressure prevention information been given and understood by the patient.
- Transfers form other hospital to check and challenge documentation and care plans received and handover, ensuring skin inspection on admission to ward/area is undertaken and documented.
- GP referring back to ROH there is a possibility that further breakdown may not have occurred, importance of information sharing

RISKS / ISSUES

Currently have 2 Tissue Viability Nurse Post vacancies Lead Nurse –Band 7 and Sister Band 6. The Band 7 has been recruited to staff member should commence early December 17. Band 6 previous recruitment unsuccessful, advertised and interviews to take place 27 September 2017. Interim cover is being provided by ward managers and ward and departmental tissue viability nurse nurses and band 6's nursing from ROCS team as required for support and grading of pressure areas supporting ward staff until recruitment into the vacancies.

8. 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.



INFORMATION

PALS

The PALS department handled 375 contacts during August 2017 of which 88 were classified as concerns. This brings the total of PALS contact for the year to date to 2368 (546 concerns) This represents a much higher figure than at the same point last year (1558 PALS contacts). This increase is likely due to the changes to the Trusts appointment letters now including the PALS contact details.

Compliments

There were 424 compliments recorded in August 2017, with the most being recorded for Div 1. This is slightly higher than last month with the Pre-Operative Assessment Clinic continuing to receive a significant number of compliments. Areas have been reminded to submit their records for central recording.

All compliments are sent electronically to the Patient Experience Team who holds the records. A Compliment is recorded if there is tangible evidence such as a card, a thank you letter, a box of chocolates or an e-mail. Teams are reminded monthly to submit their compliments for central logging.

Complaints

There were a total of 11 formal complaints in August 2017. It has been noted that Large joints in Division 1 has the highest amount of complaints in the Trust. Further analysis of this will be included in the next quality report.

The subjects of this month's complaints were:

Initially Risk Rated Red:

- Wrong side procedure, under investigation (Div. 1, oncology)

Initially Risk Rated Amber:

- Wrong side injection, approach of Consultant (Div. 2, Pain Management)
- Lack of communication regarding treatment; cancelled surgery (Div. 1, Oncology)
- Clinical diagnosis provided by initial Consultant (Div. 1, Paeds)
- Delays to treatment and communication about what is happening (Div.1, Oncology)
- Treatment for spinal condition (Div. 1, Spinal)
- Information about who carried out operation on left knee (Div. 1, Oncology)

Initially Risk Rated Yellow:

- Experience in ADCU and care provided by staff on Ward 2 (Div. 2, ADCU)
- Transport not booked (Div. 4, Transport)
- Unhappy with hydrotherapy appointment (Div. 2, Therapies)
- Attitude of secretary; non-receipt of requested information; apt delay (Div.1 , Oncology)

ACTIONS FOR IMPROVEMENTS / LEARNING

Complaints closed in August 2017

There were 10 complaints closed in August 2017, all of which were closed within the agreed timescales. This gives a 100% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in August 2017 was 26.5 days which is within normal limits.

Learning/Actions from complaints

Of the 10 complaints closed in July 2017:

- 2 were upheld
- 6 were partially upheld
- 2 were not upheld

Learning identified and actions taken as a result of complaints closed in August 2017 include:

- Communication about needs of inpatients with Learning Disability is not robust
  Action: Discussion with new Learning Disability Nurse has been commenced

- The system for pre-booking x-rays for Outpatients isn't always followed
  Action: Staff have been reminded of the expected protocols for pre-booking imaging

- Communication to patient about discharge arrangement and what needs to happen before being allowed to go home is not always clear.
  Action: New patient information leaflet on the steps to discharge is being created for the bedside

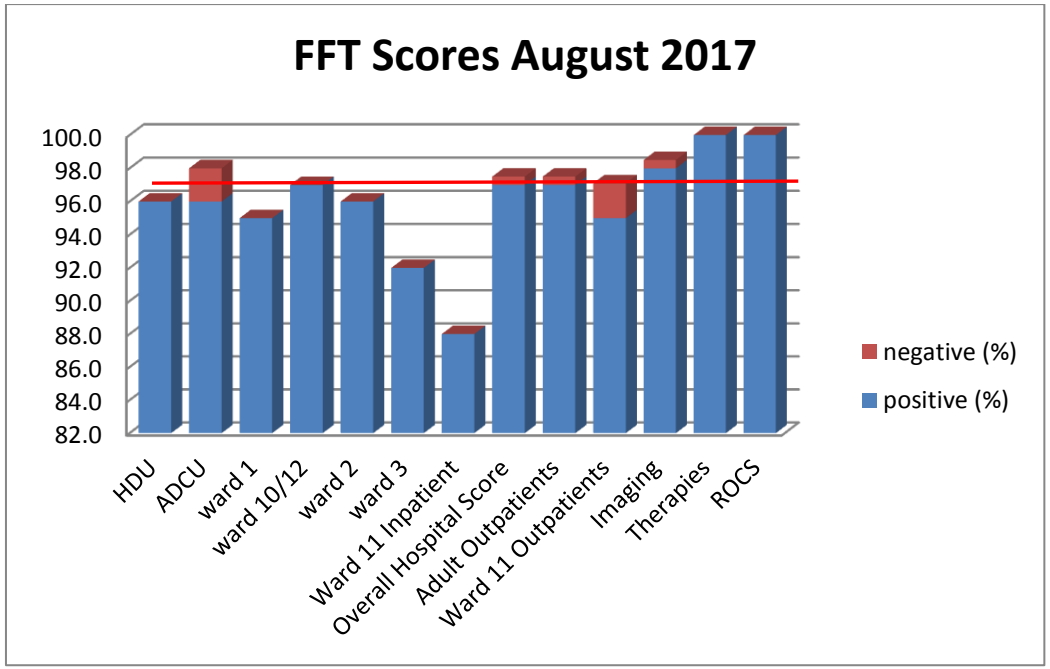
RISKS / ISSUES

None Identified.

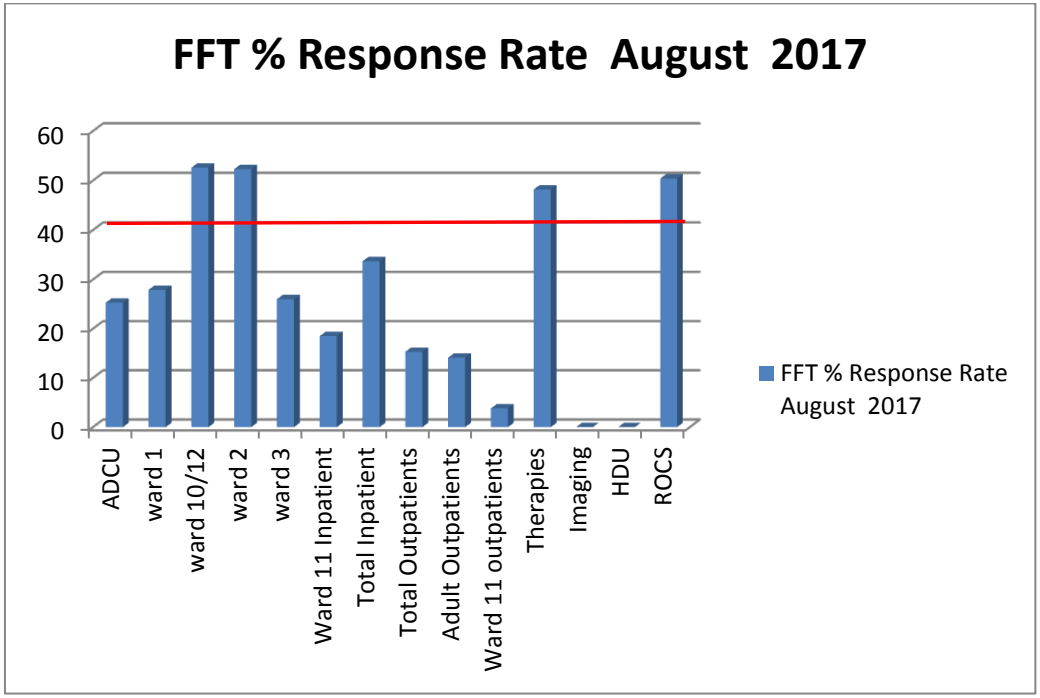
10. Friends and Family Test Results and iwantgreatcare - The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

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.



There are several areas of low response rate which have clearly affected the score received. The management of FFT has now returned to the Public and Patient Services Manager, who will be working with departmental colleagues to improve these rates over the next three months. The Trust has set an internal target to reach a 40% response rate across all areas within the first quarter of 2017/18. This has not been met and will form part of the work for improvement. In addition, it has been noted that the ipad online data collection system in place in the wards is not currently being used to collect FFT. This will also be reviewed over the next three months.

I Want Great Care - iWantGreatCare makes it simple to collect large volumes of meaningful, detailed outcomes data direct from patients on your organisation, clinical locations and whole clinical teams. It Continuously monitor and compare performance of individual services, departments and wards and Aggregated, graphical monthly reporting meets needs of both providers and commissioners for robust, patient-centric metrics to track quality and performance.

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.

12. Litigation

No new litigation to report in August 2017.

13. Coroner's

No new Coroner's inquest for August 2017.

14. **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 perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**

INFORMATION
No Data available due to theatre man
ACTIONS FOR IMPROVEMENTS / LEARNING
The Clinical Standards Lead and Theatres Manager are discussing the development of a new report to ensure that we give an accurate reporting and provide the correct assurances.
RISKS / ISSUES
The Audit Data for WHO checklist is not available for May/June/July/August 2017 due to the migration to the new theatre man software. A new report is currently being generated that will show the WHO compliance and audit. This will be included next month

ROHTB (10/17) 003

TRUST BOARD

DOCUMENT TITLE:	Care Certificate Update
SPONSOR (EXECUTIVE DIRECTOR):	Garry Marsh, Executive Director of Patient Services
AUTHOR:	Karen Hughes, Clinical Nurse Tutor
DATE OF MEETING:	4 October 2017

EXECUTIVE SUMMARY:

The Care Certificate was developed by Health Education England and formally launched in April 2015 following publication of the Cavendish report in 2014. This report recommended that unregistered (Band 1-4) staffs that provide support to patients are trained to a recognised standard. The Care Certificate provides confidence that all workers have the same skills, knowledge and behaviours to deliver safe, compassionate care.

The attached paper summarises the ROH's approach to the Care Certificate and discusses progress with implementing it over the past year.

REPORT RECOMMENDATION:

Trust Board is asked to:

- Receive and accept the update

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	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:

Good governance and national policy

PREVIOUS CONSIDERATION:

None

FOR INFORMATION

ROHTB (10/17) 003 (a)

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Care Certificate Update

REPORT TO THE TRUST BOARD – 4 OCTOBER 2017

1.0 Background

1.1 The Care Certificate was developed by Health Education England and formally launched in April 2015 following publication of the Cavendish report in 2014. This report recommended that unregistered (Band 1-4) staffs that provide support to patients are trained to a recognised standard. The Care Certificate provides confidence that all workers have the same skills, knowledge and behaviours to deliver safe, compassionate care.

1.2 CQC expectations are that individuals complete all 15 standards to be awarded the Care Certificate and that employers prioritise 'new staff, new to care'. The minimum level for quality assurance of the Care Certificate, and the certification itself, is the responsibility of employers

1.3 The standards embedded in the Care Certificate support ROH to deliver its vision to be "First choice for orthopaedic care".

1.4 The Clinical Nurse Tutor leads on delivery of this at ROH.

2.0 Agreed key principles at ROH

2.1 Subsequent to a presentation to Trust Board in April 2016, the following was agreed:

- All unregistered health care staff (bank and substantive) will complete the Care Certificate. This exceeds the required standard (new to care) but was felt necessary to ensure consistency and assurance.
- Existing staff who could demonstrate evidence of additional training e.g. NVQ in care, can complete a self-assessment document (HEE approved)

- All new to care (including bank staff) or those who have not completed Band 2 competencies will attend a 2 week Care Certificate programme as part of induction and complete the care certificate workbook within the agreed timescale
- Bank staff do not receive payment for attendance at 2 week programme until a minimum of 6 bank shifts have been worked at ROH (reduced dropout rate)
- Student nurses who join the bank are exempt from requirement to complete the Care Certificate.
- A formal moderation process developed
- Presentation ceremony on successful completion-certificate and badge.

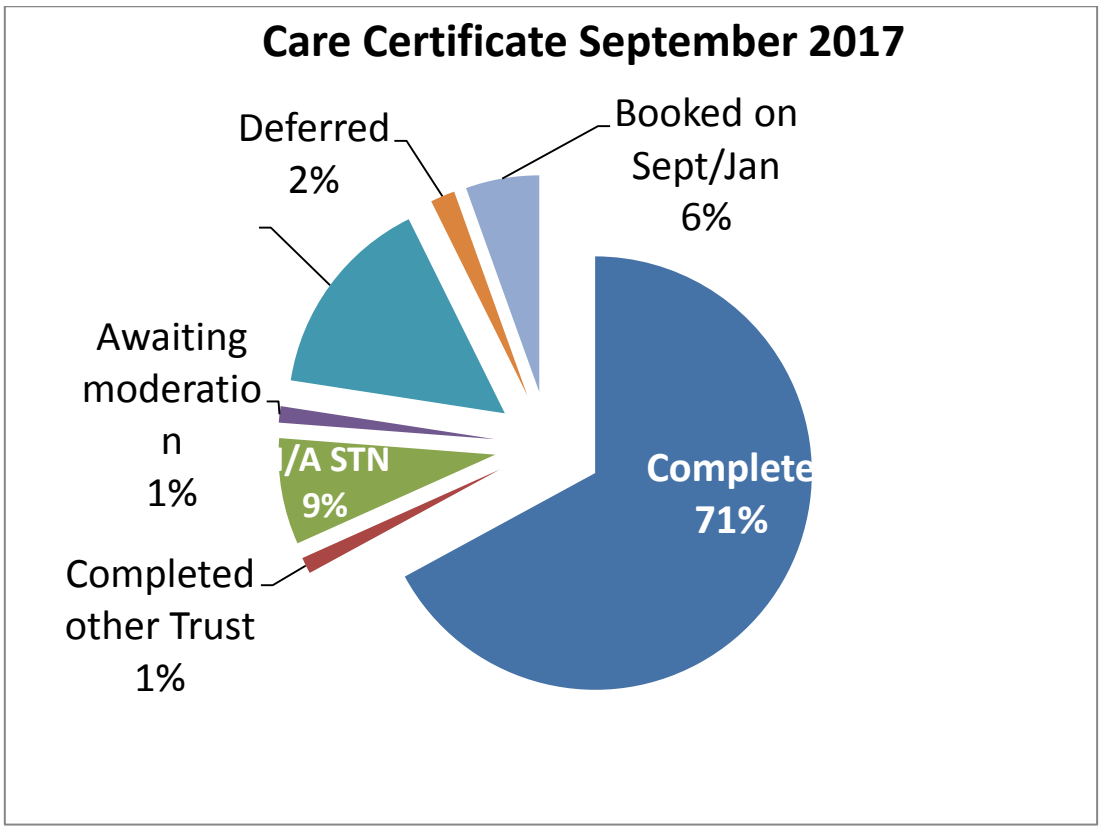
3.0 Progress to date

- 6 care certificate cohort programmes have been run by the 2 Clinical Trainers since March 2016.
- The figures within this report relate to Healthcare/Theatre Assistants and Phlebotomists. However it should be noted that Physiotherapy and Imaging Assistants are also completing the care certificate programme. It is also being trialled within Housekeeping.

Total Number to complete	Complete-Award given	In progress	Outstanding
151*	112**	30	9

*Excludes 13 Student nurses currently on Nurse Bank.
**Includes 2 who had completed at previous Trust

- Those in progress are at different stages e.g. some just commenced, some awaiting moderation, some deferred following initial moderation process.
- Of those outstanding:
    - 8 are booked to attend September cohort programme.
    - 1booked to attend January cohort programme



4.0 Next steps

4.1 Agreed standardisation of the HealthCare Assistant (HCAs) recruitment process will ensure all new HCAs will complete the care certificate programme as part of their starting induction to ROH.

4.2 The frequency of the recruitment and care certificate programme will be regularly reviewed with Heads of Nursing based on workforce need

4.3 The Care Certificate requirement is now included in all relevant Job Descriptions and Personal specifications. Bank staff not complying with the required standard will have their contract terminated. Substantive staff will be managed under the relevant HR policy e.g. Capability or Disciplinary.

5.0 Summary

- Evaluations from attendee's have been positive. Whilst many have found the amount of work challenging, all, including existing staff acknowledge learning and have found it beneficial over all. For new to ROH staff, attendance at the programme ensures they have completed mandatory training and have core skills and knowledge before being released into clinical areas.

- For managers this provides assurance that their staff have received training and assessment in the core skills and knowledge to provide care. New staff completing the mandatory training as part of the induction two week programme means they do not have to be released to attend, once no longer supernummary

- For patients this provides assurance that unregistered staff have the required skills and knowledge to provide safe, quality care.

- For those who complete this provides evidence of completion of a nationally recognised training standard which can then be utilised when applying for new roles or role progression.

Garry Marsh
Executive Director of Patient Services

28 September 2017

Scheduled Care Improvement Programme (SCIP) Trust Board 4th October 2017

Overview of programme

- Referral to Outpatients
- Pre-assessment & Pre-admission
- Theatres
- Inpatients & Discharge
- Programme Structure & next steps
- Questions

Outpatient Services – As a patient

- Being seen on-time for my appointment
- Being informed of the length of delay where applicable
- Professionalism & being treated with dignity and respect
- Feeling that I have been listened to
- Involvement in decisions about my care and treatment.
- Confirming the reasons for any treatment or action
- Explain the risks and benefits of treatments and what happens during treatments
- Why tests are needed, test results, the purpose of medication and side effects.
- Being able to book appointment at a convenient time, first time

REFERRAL & OUTPATIENTS

Referral to Outpatients

- Initiatives in Progress :-
  - Clinic Outcome forms refresh following daily validation issues
  - 6 weeks action plan to support medical records- including development of KPIs
  - Letter turnaround – improvements in performance, KPIs and weekly reports to support progress
  - Exploring option to include narrative in text reminder re cost of appointment
  - E-referral project to "switch off" paper in October 2018
  - Participating in OPD benchmarking – results in February 2018
  - Commenced clinic templates review
  - Standard operating procedures – refresh and relaunch to support the operational team (72)
  - One stop listing for injection – OPD, pre-op and date

- Next month:-
  - Explore introduction of an OPD charter
  - Change in management structure – back to the floor
  - RTT outcome form training
  - Oncology clinic review
  - Extend pilot for electronic booking form (pilot in Oncology)

REFERRAL & OUTPATIENTS

KPIs

- Wait to be seen in OPD – CQC "how long are patients waiting?"
- Clinic start and finish times
- DNAs
- Friends and Family test
- Clinic cancellation/under 6 weeks
- New to FU ratio (benchmarking)
- Complaints and compliments
- Slot availability
- Use of Text reminders
- Number of appointments cancelled on day or day before by patient
- Notice period for appointments
- Missing notes for clinics
- Clinic utilisation
- OPD first and FU waiting times
- RTT performance (Pts >52wks)

REFERRAL & OUTPATIENTS

Pre-assessment & Preadmission- As a Patient

- Being able to contact someone if I have any questions and the information to support
- Someone explaining what will happen and when and giving notice and choice of date
- Well coordinated service avoiding duplication – e.g. when do I arrive & how long will I stay
- Being able to talk about my fears about pain relief and anaesthesia
- Explaining why any tests are needed and how will I get the results – if not fit for surgery I will be told in advance
- Knowing what to expect post-operatively
- When I can go home and can I be discharged at the weekend
- Not to wait around unnecessarily

Pre-assessment & Preadmission

- Initiatives in Progress :-
  - POAC date added to PAS system
  - ADCU , patient process & timing e.g. not all turning up at the same time
  - Dedicated resource to manage the workstream

- Next month:-
  - POAC multi-disciplinary workshop to be held beginning Oct, full process map and agree new process
  - Change in management structure- align to theatres
  - Review of POAC notification system (internal)
  - Start to scope “drop off” zone outside ADCU
  - Reviewing activity in ADCU e.g. injections

KPIs

- Preadmission length of stay
- Late cancellations due to patient fitness
- DNAs
- Screening rates
- Friends and family test
- Not requiring pre-op
- 72 hours calls pre-surgery
- Utilisation of clinic
- Start and finish time of clinic

PRE-ASSESSMENT
& PRE-ADMISSION

Theatres – As a patient

- If my procedure is cancelled let me know as soon as possible and DON'T do it on the day
- Keep me informed and if I want to be accompanied they can wait for me
- Allow me to walk or go in a wheelchair rather than a trolley to Theatre
- Meet the Theatre team before entering the Theatre environment e.g. ADCU
- I don't want to see clutter and I want it to look tidy & organised
- For my family to be told when I'm out of theatre
- All paperwork e.g. X Ray form and pain relief is organised for me ahead of my op
- That I know if I am staying on a Ward which one it will be and when will I be discharged

Theatres

- Initiatives in Progress :-
  - Automatic start for the first patient on the list 8.20am
  - Consolidation of stock , better management and control (decluttering)
  - Matron & Theatre Manager appointed
  - Senior of day role being refreshed
  - Ward nurses pick up patients from Recovery – to introduce themselves to patient
  - (IMS) Instrumentation refreshed tracking process and non conformity SOP re-launch TBALD
  - Lock down Theatre sessions at 1 week

- Next month:-
  - Recruitment fair with full team engagement
  - Theatre utilisation KPI adjusted 85%-90%
  - Review Phase 1 Theatreman implementation and scope Phase 2
  - Create dashboard
  - 6-4-2 to include quick review of previous week
  - Scope lock down of Theatres at week 2

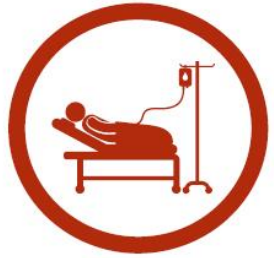
THEATRES

KPIs

- Theatre Utilisation – list used and in session activity
- Late starts and early finishes
- Patient cancellations
- Elective & Daycase activity
- WHO checklist compliance
- % of patients admitted on the day of surgery
- Overall day case rate
- Vacancy rates
- Non conformity issues for instrumentation
- Cancellation not rebooked within 28 days
- Cases per session
- Turnaround time between cases

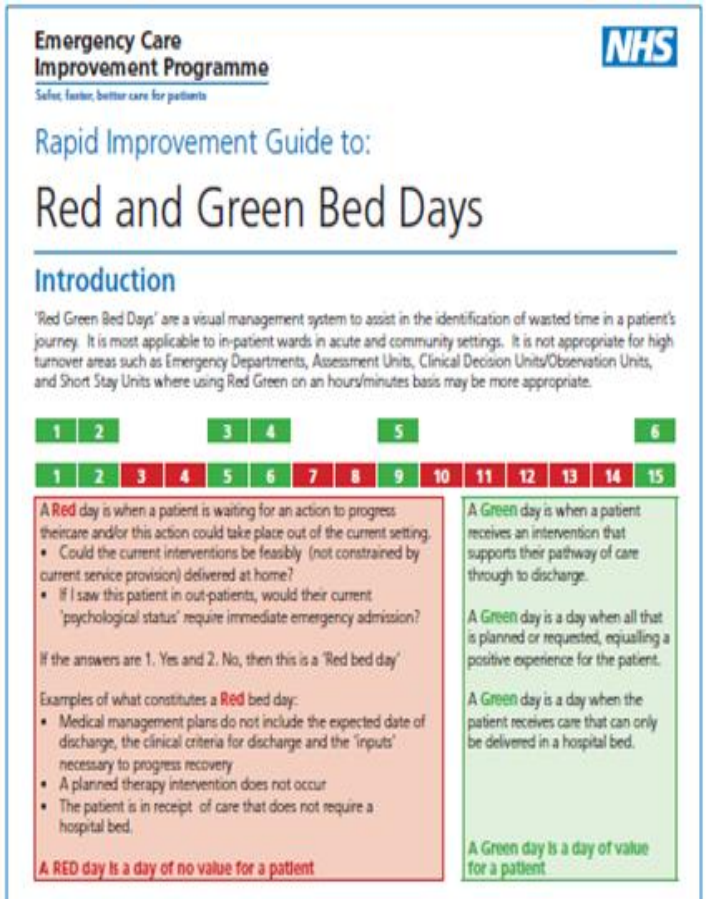
Inpatients & Discharge – As a patient

- I will be greeted as I arrive on the ward, and I will know what the plan is for my care
- Unless I do not meet the clinical criteria, I will be on the Rapid Recovery pathway and know exactly how and when I will be discharged
- I will be mobilised as early as possible to avoid a DVT
- I will be up and dressed every day
- I will have access to TV/wifi and a choice of food
- I will have my pain managed well
- I will know how and when I will be leaving hospital, as will my family and carers



Inpatients & Discharge – As a patient

#Red2Green



Emergency Care Improvement Programme

Safer, faster, better care for patients

NHS

Rapid Improvement Guide to:

Red and Green Bed Days

Introduction

'Red Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey. It is most applicable to in-patient wards in acute and community settings. It is not appropriate for high turnover areas such as Emergency Departments, Assessment Units, Clinical Decision Units/Observation Units, and Short Stay Units where using Red Green on an hours/minutes basis may be more appropriate.

1 2 3 4 5 6

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

A Red day is when a patient is waiting for an action to progress their care and/or this action could take place out of the current setting.

- Could the current interventions be feasibly (not constrained by current service provision) delivered at home?
- If I saw this patient in out-patients, would their current 'psychological status' require immediate emergency admission?

If the answers are 1. Yes and 2. No, then this is a 'Red bed day'

Examples of what constitutes a Red bed day:

- Medical management plans do not include the expected date of discharge, the clinical criteria for discharge and the 'inputs' necessary to progress recovery
- A planned therapy intervention does not occur
- The patient is in receipt of care that does not require a hospital bed.

A RED day is a day of no value for a patient

A Green day is when a patient receives an intervention that supports their pathway of care through to discharge.

A Green day is a day when all that is planned or requested, equalling a positive experience for the patient.

A Green day is a day when the patient receives care that can only be delivered in a hospital bed.

A Green day is a day of value for a patient

Thinking about patient's time as the greatest currency

Inpatients & Discharge

- Initiatives in Progress :-
  - Launch the knee handbook for patients
  - Review and refresh of private facility
  - Dashboard on wards to show progress with ward KPI's
  - Pilot of Red2Green on Wards 1 & 3

- Next month:-
  - Roll out of Rapid Recovery (Opt out mandate)
  - Review of discharge processes (relating to Delayed Transfers of Care CQUIN)
  - Re-launch 'pyjama paralysis' campaign #endPJparalysis
  - #last1000days

KPIs

- Length of stay, by ward / consultant / procedure
- Number of patients on Rapid Recovery pathway
- Delayed Transfer of Care (DTOC) rate
- Patient feedback through compliments/concerns/complaints
- Friends & family test
- Ward dashboard indicators such as falls, VTE
- Number of patients over 14 day length of stay
- Number of patients who go to the discharge lounge in nightwear
- Number of patient moves & moves after 10pm
- Discharges before 11am
- Expected date of discharge (EDD)

Programme structure & next steps

- Monthly project meetings
- Support 3 day a week with Deputy Director of Nursing and Clinical Governance
- Need to set up a team to develop dashboard to agree KPIs and data collection
- Regular feedback and communication to support the progress and success
- Further discussion around supporting team
  - Problem solving and process mapping
  - Learning new improvement tools & skills
  - Measuring process
  - Training the trainers ?
- Patient involvement
- Celebrate success

Questions

Finance and Performance Report

AUGUST 2017

CONTENTS

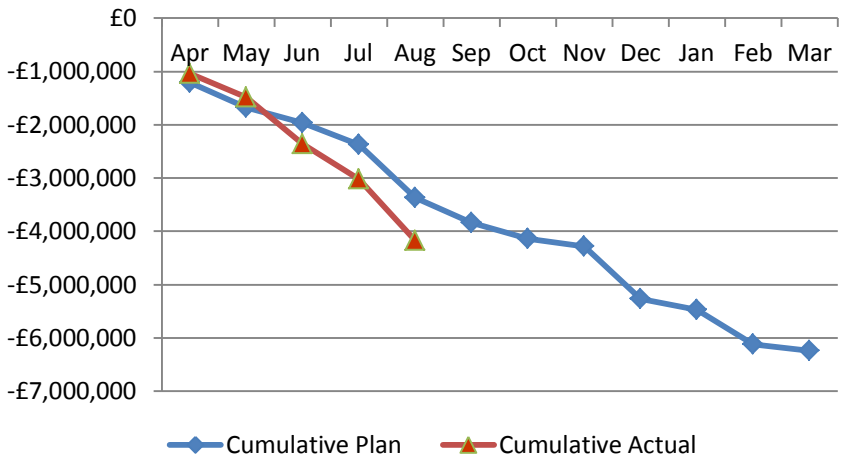
INTRODUCTION

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.

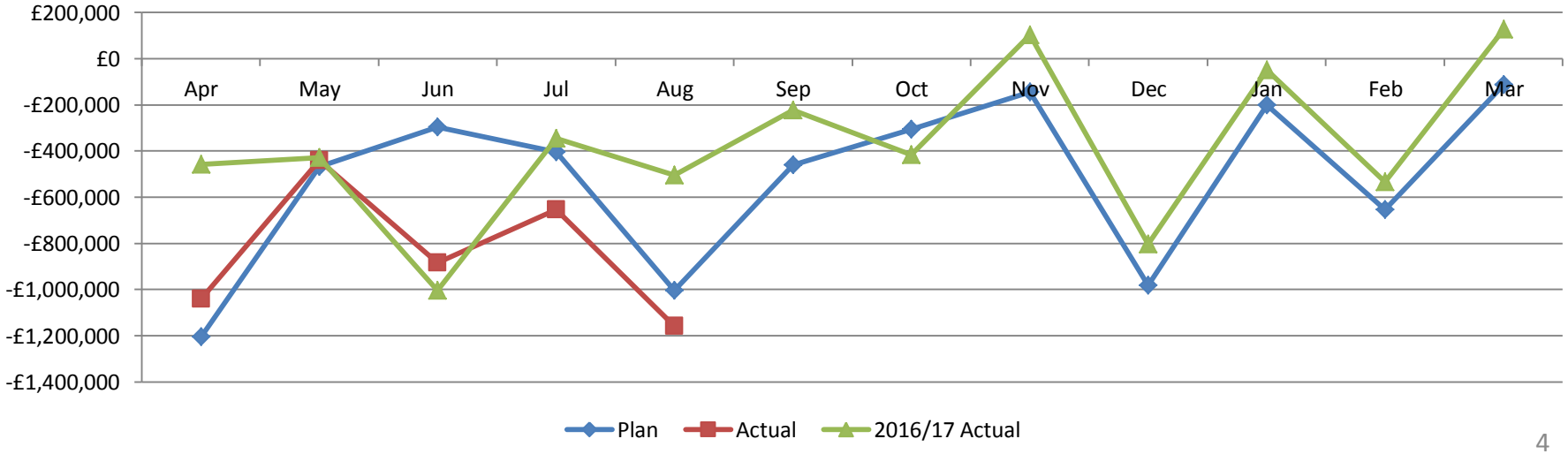
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Cumulative Deficit vs Plan



NHSI Use of Resources Rating (UOR)		
	Plan	**Actual**
Capital Service Cover	4	4
Liquidity	4	4
I&E Margin	4	4
I&E Margin – Variance against plan	1	4
Agency metric	1	2
Overall UOR	N/A	4

Monthly Surplus/Deficit Actual vs Plan



INFORMATION

The Trust has delivered a deficit of £1,157,000 in August against a planned deficit of £1,005,000, a result £152,000 behind plan. This brings the Trust's year to date position (on a control total basis) to £4,148,000 against a plan of £3,355,000, £793,000 behind plan.

The in-month position remains behind plan in August, although an improved position on the £250,000 the position was behind plan in July. Part of the variance year to date is the spend on RTT resources, including consultancy and agency. This alone results in c.£450,000 of cost pressure against the original plan. This spend is expected to reduce as the majority of the RTT validation is complete, with in-month spend being c.£50,000 in comparison to months' 1-4 average of c.£100,000 a month. RTT spend in itself does not explain the variance; as previously described, the position has benefited from £101,000 of fire insurance income. The remaining variance is as a result of two key factors – poor activity performance, particularly in June, but also a trend for increased spend on non-pay items, particularly within theatres. Indeed, in an unprecedented position for the Trust, income over-performed slightly against plan, but non-pay significantly overspent, largely driving the August position. In month performance will be discussed further in the slides to follow.

As at the end of August, the Trust has recognised £558,000 of CIP savings, against a plan of £1,089,000. £49,000 (7%) of savings to date are non-recurrent. A review of the original CIP Plans is underway and has highlighted some areas of risk but also some new areas of opportunity. As such a revised CIP Plan has been drafted with forecast CIP of £2,754,000 against an original plan of £3,191,000.

With regards to the Trust's Use of Resources Risk Rating (UOR), the deficit position against plan results in the Trust reporting ratings of 4 for Capital Service Cover, I&E Margin and I&E Margin variance. The negative variance from plan has also resulted in a 4 for I&E Margin Variance. The Trust's requirement for cash support has resulted in the Trust being a 4 for liquidity. Whilst agency spend in month was below plan, previous month's RTT spend means the agency spend is overspent year to date and remains at a 2. As a result, the overall rating for August remains at a 4.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Trust Executive are monitoring weekly progress against activity improvement and the scheduled care improvement programme. In addition, fortnightly meetings are being held with operational, clinical and finance stakeholders to improve the theatre environment and give better visibility of stock levels and spend. In addition, increased and new senior resourcing in theatres has been put in place, with a particular priority on improving theatre flow and understanding and controlling theatre spend.

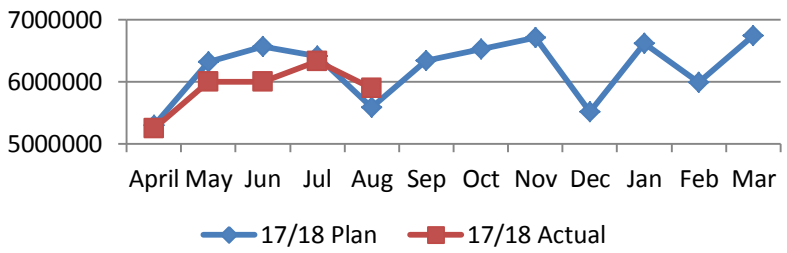
The new Assistant Director of Finance – Financial Delivery is performing a detailed review and refresh of CIPs as described further in the CIP section.

RISKS / ISSUES

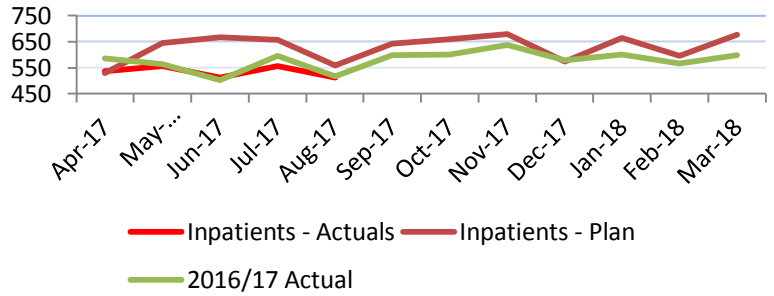
There remains a risk that the focus on RTT and operational activity delivery results in CIP schemes not being implemented in a timely enough manner to ensure the required savings for 2017/18.

2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity

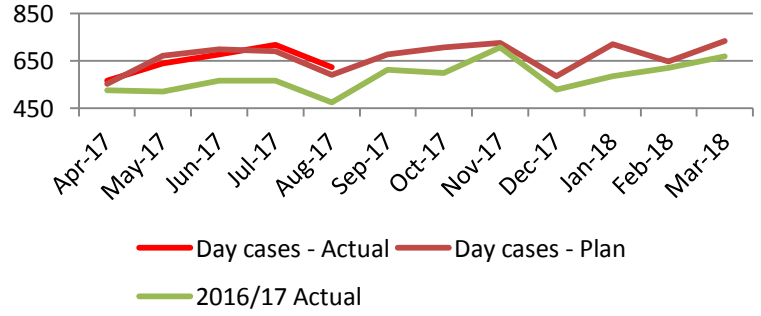
Monthly NHS Clinical Income vs Plan, £, 17/18



Inpatient Activity



Day Case Activity



NHS Clinical Income – August 2017 £'000			
	Plan	Actual	Variance
Inpatients	2,806	3,094	288
Excess Bed Days	87	62	-25
Total Inpatients	2,893	3,156	263
Day Cases	677	650	-27
Outpatients	541	637	96
Critical Care	217	138	-79
Therapies	216	219	3
Pass-through income	194	244	50
Other variable income	329	334	5
Block income	518	518	0
TOTAL	5,585	5,896	311

NHS Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	15,268	15,146	-122
Excess Bed Days	474	265	-209
Total Inpatients	15,742	15,411	-331
Day Cases	3690	3482	-208
Outpatients	2949	2992	43
Critical Care	1183	952	-231
Therapies	1175	1097	-78
Pass-through income	1055	1116	61
Other variable income	1797	1830	33
Block income	2590	2590	0
TOTAL	30,181	29,470	-711

INFORMATION

NHS Clinical income has over-performed against plan by 5.5% in August having under-performed by 1.2% in July. This is being driven largely by final activity for July being higher than was initially recorded in the draft activity position (the difference between draft and final SLAM). This accounted for c.£200k of the £311k over performance. There are always slight differences between draft and final, but this was higher than usual, and is driven by activity being entered late onto the system by individual teams throughout the hospital.

In addition, unavailability of BCH lists in the early months of the year had an impact on spinal performance, which should be recovered by the end of the year.

Cumulatively, the trust is now 2.4% behind plan. Admitted patient care performance was below target by 46 cases, but case mix was richer within these cases, explaining the over performance in income terms. Day case activity over performed against plan by 34 cases by case mix was poorer (e.g. increased injections) resulting in a small underperformance in income terms.

Outpatients continued to over-performed in month from an income point of view, driven by over performance in first and follow up appointments, despite outpatient procedures underperforming against plan.

ACTIONS FOR IMPROVEMENTS

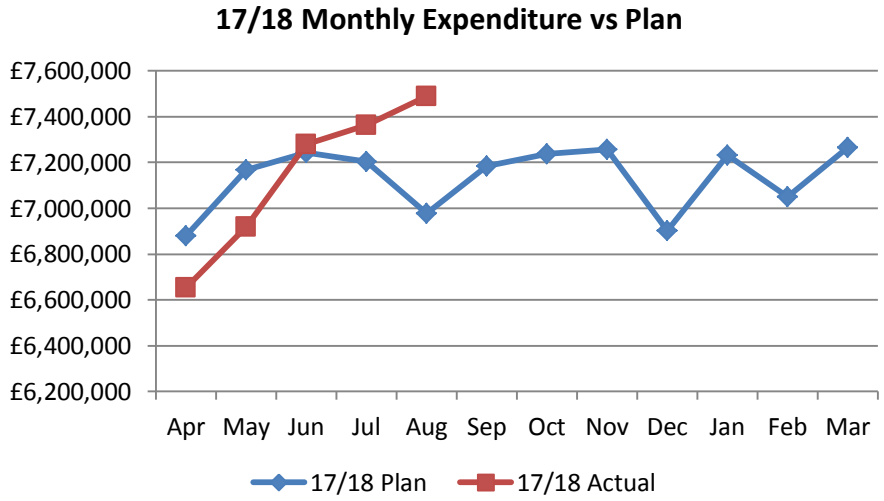
As noted previously, the Interim Chief Operating Officer is holding weekly challenge and improvement meetings with a range of operational and other stakeholders to identify areas for efficiency improvement. Current areas of focus include an end to end pathway review and theatre efficiency.
In addition the spinal firm are following the example of large and small joints in reversing their booking processes to allow medical secretaries to TCI patients before they book the theatre sessions. This appears to be having a positive effect on the forward activity look with future activity being booked further out.

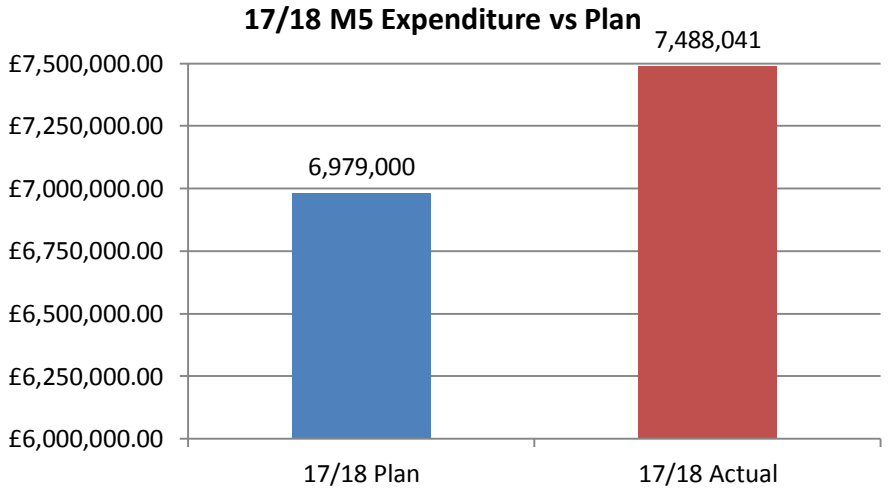
The firms are developing their activity recovery plans to assist with the process of financial recovery. There remains actions ongoing to give further assurance around the ability of the teams to deliver that activity in areas such as ensuring theatre teams are available, and patients are fit and willing to attend over the Christmas period.

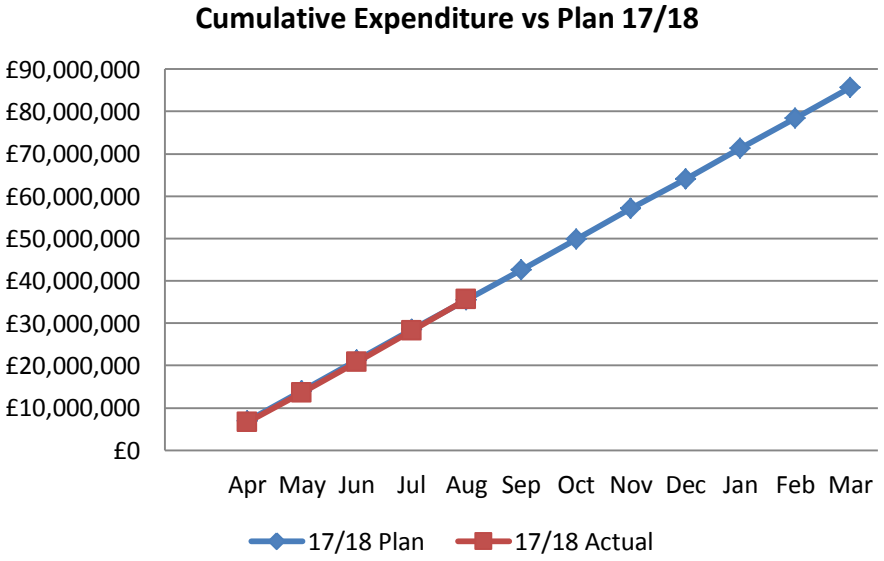
RISKS / ISSUES

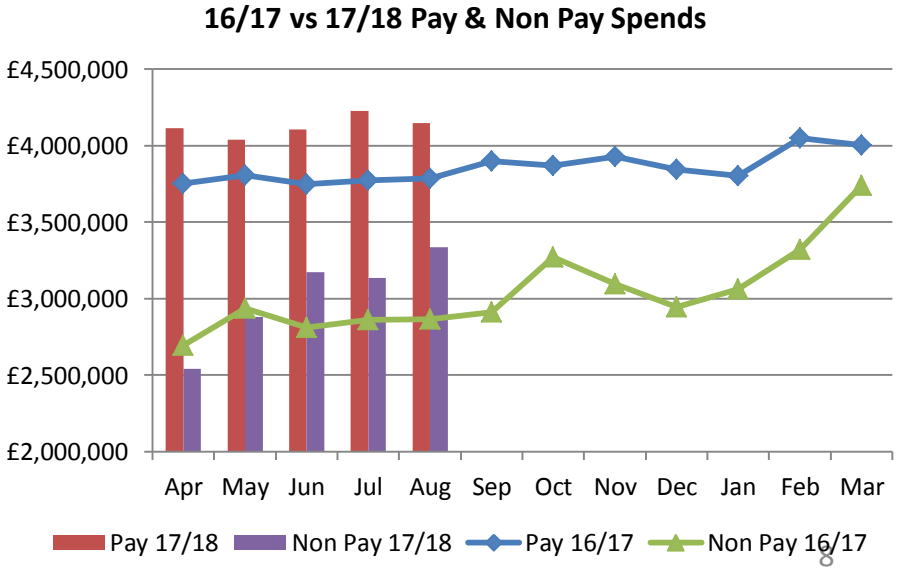
There remains good clinical engagement in developing improvements to productivity for both operations and out patients. Some consultants have very short, with others having very long, waiting lists, and work is underway to smooth out flows across firms. As noted above, a key risk will be the ability of the Trust to staff the lists offered by the consultant body in order to maintain clinical buy-in in recovery.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends









INFORMATION

Expenditure levels for the month were £7,488,000, which is £509,000 above the in month plan of £6,979,000.

The reason for the overspend was non-pay spend being higher than planned, particularly with regard to theatre non-pay costs. At the last executive led Division 2 performance meeting, the operational leads were challenged to urgently review non-pay costs in areas such as human bone products and dressings which seem to have increased spend with a disconnect with activity. The next divisional meeting is occurring on 22nd September, at which the executive are expecting a report on the key findings to date and actions. In addition, a new theatres group of operational, clinical and financial staff has been set up to identify the key issues within theatres, which is recognised as key to the Trust's success with recovery. Stock and non-pay spend in particular is seen as a urgent area of focus within these groups. Action plans are being developed and implemented urgently.

In addition, new theatre management is now in place, with initial objectives being particularly focussed on non-pay spend.

Pay spend was largely in line with the plan. When the pay categories are reviewed individually, substantive spend was behind plan by £28,000, bank spend ahead of plan by £229,000, and agency lower than plan by £35,000. As noted in prior month, it is clear from a review of the bank plan that this was erroneously set too low in each month, with the balance being taken from substantive pay. When the plans are corrected to what they should have been set as, the spends are much more in line with plan.

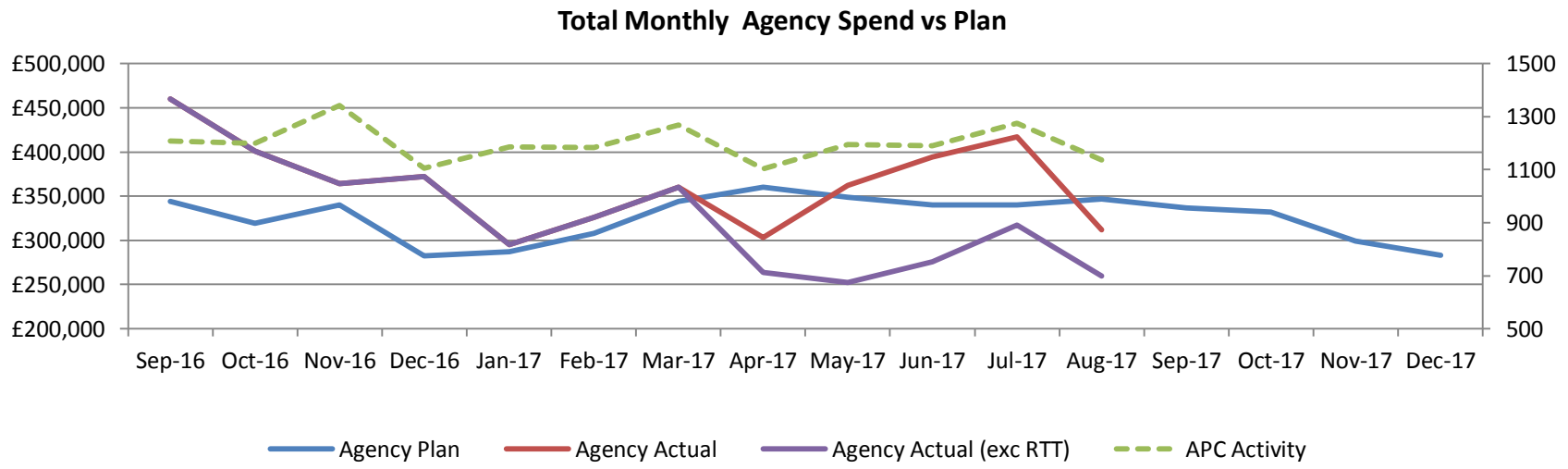
ACTIONS FOR IMPROVEMENTS / LEARNING

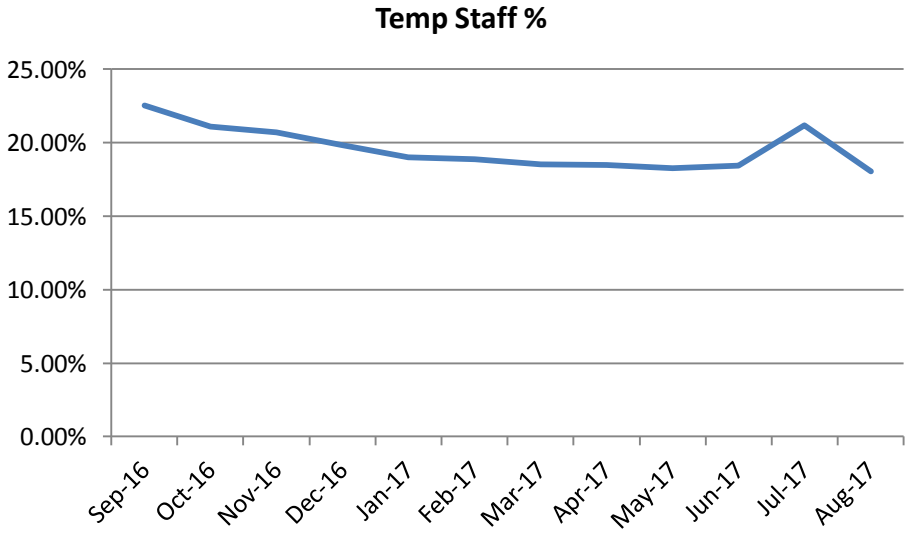
Costs will continue to be scrutinised and minimised, and the alteration of the bank spend plan will be followed up further with NHS Improvement.

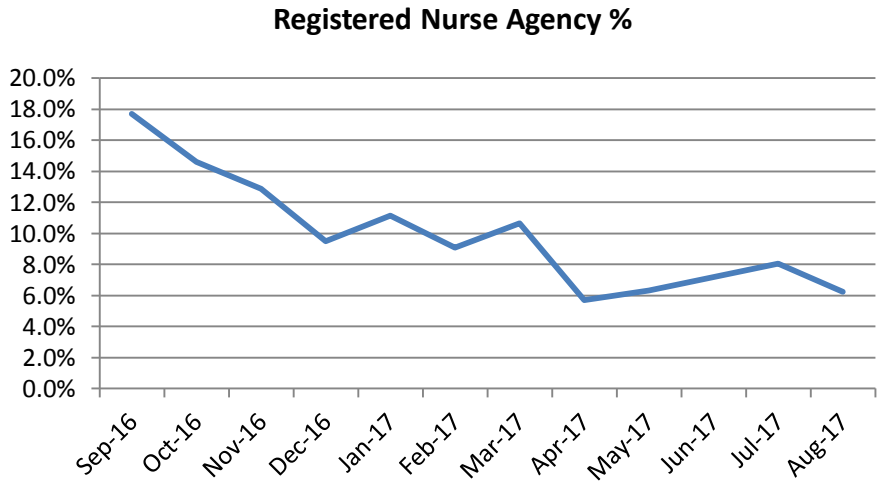
RISKS / ISSUES

Gaining a greater understanding and control of theatre spend is essential to the recovery of the financial position, and will be mitigated via the workgroups stated above.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements







INFORMATION

August showed an decrease in agency spend (£417k to £312k). Fewer RTT validators on site has resulted in RTT agency spend reducing significantly in month. Both with and without the RTT agency spend, agency spend was below in month plan, although it remains overspent year to date. Healthroster appears to be yielding some excellent savings on nursing spend, although agency spend on the wards was higher than expected in month, and is being reviewed further. There continues to be a pressure on Medical spend due to an under provision of GP trainees from the West Midlands Deanery and gaps in rotas hence needing to be covered through locums.

ACTIONS FOR IMPROVEMENTS / LEARNING

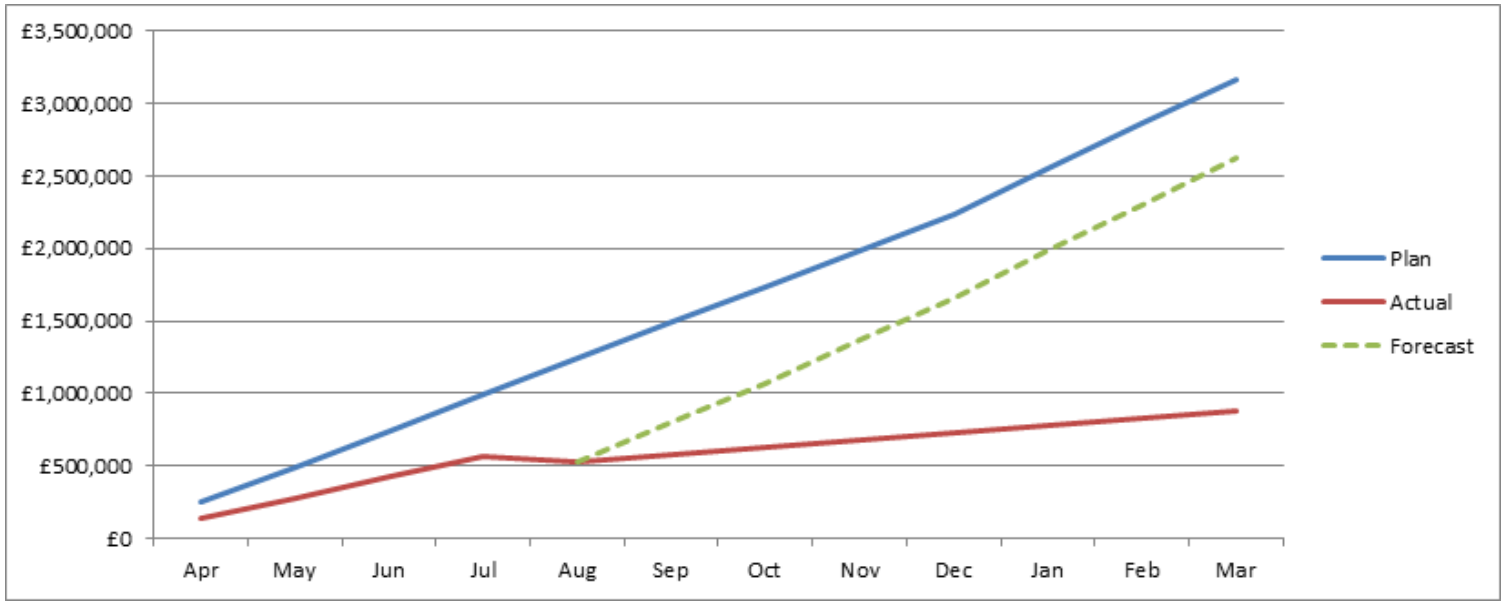
The leadership by the Nurses in addressing use of agency continues to impact positively, although as explained above, ward spend was higher than had been expected in August.

Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios. The Trust is currently consulting on a change to rota working patterns as part of this process. Further work is planned to introduce Healthroster for the medical workforce, to enable further forward planning of annual leave and rota cover.

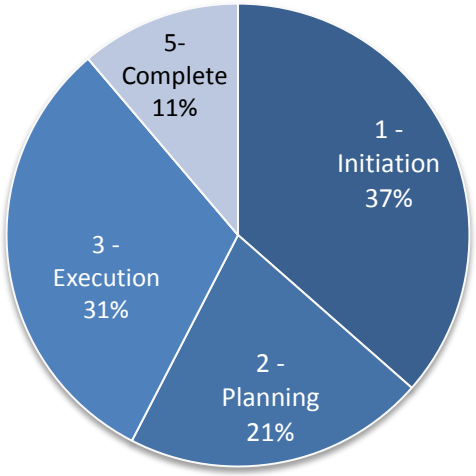
RISKS / ISSUES

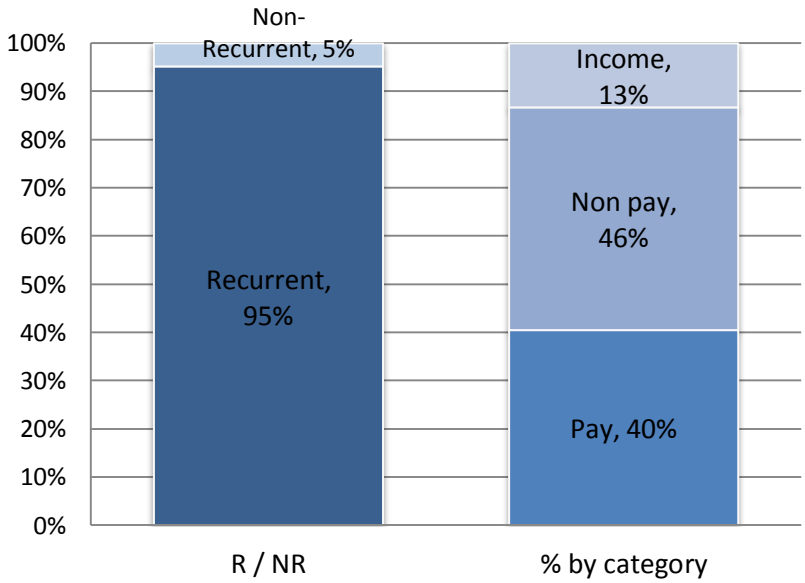
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory will have a direct impact on our regulator ratings. The Trust has remained at a 2 for agency spend, resulting in the overall UOR rating being a 4.

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2017/18



Stage of development





INFORMATION

As at the end of August, the Trust has recognised £558,000* of CIP savings, against a plan of £1,089,000. £49,000 (7%) of savings to date are non-recurrent.

A review of the original CIP Plans is underway and has highlighted some areas of risk but also some new areas of opportunity. As such a revised CIP Plan has been drafted with forecast CIP of £2,754,000 against an original plan of £3,191,000.

The current plan only contains 13% of income related schemes which is an area to explore and identify if there is more opportunity to grow both NHS and Non NHS income. The remainder of the plan is split 46% non pay and 40% pay.

The majority of the CIP is within the Initiation and Planning stage (58%) with 11% complete (i.e. fully achieved against Plan) and 31% at execution stage.

*Please note, within the NHS Improvement monthly return year to date actuals of £718,000 were reported. A detailed review exercise has been performed (since submission of the return) of achieved CIPs in addition to likely forecasts and has identified that some CIPs have been prematurely recorded as achieved.

ACTIONS FOR IMPROVEMENTS / LEARNING

Many schemes do not have robust delivery plans, and as such assurance that timescales will be met in order to deliver the savings in the time needed. Work is underway with CIP leads to develop the plans and identify other areas for CIP opportunity.

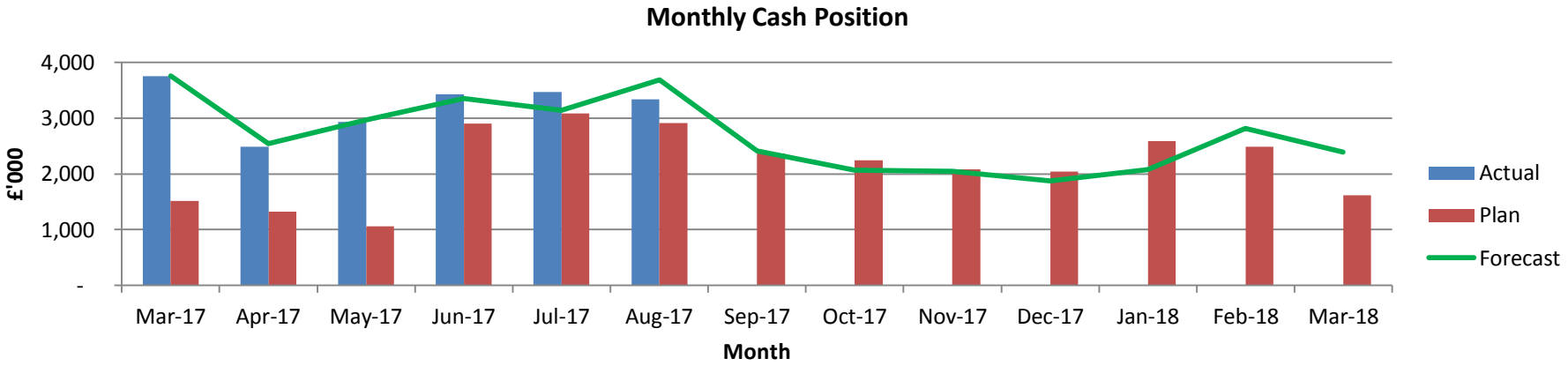
The schemes which specifically require increased focus to ensure the full CIP is delivered are;

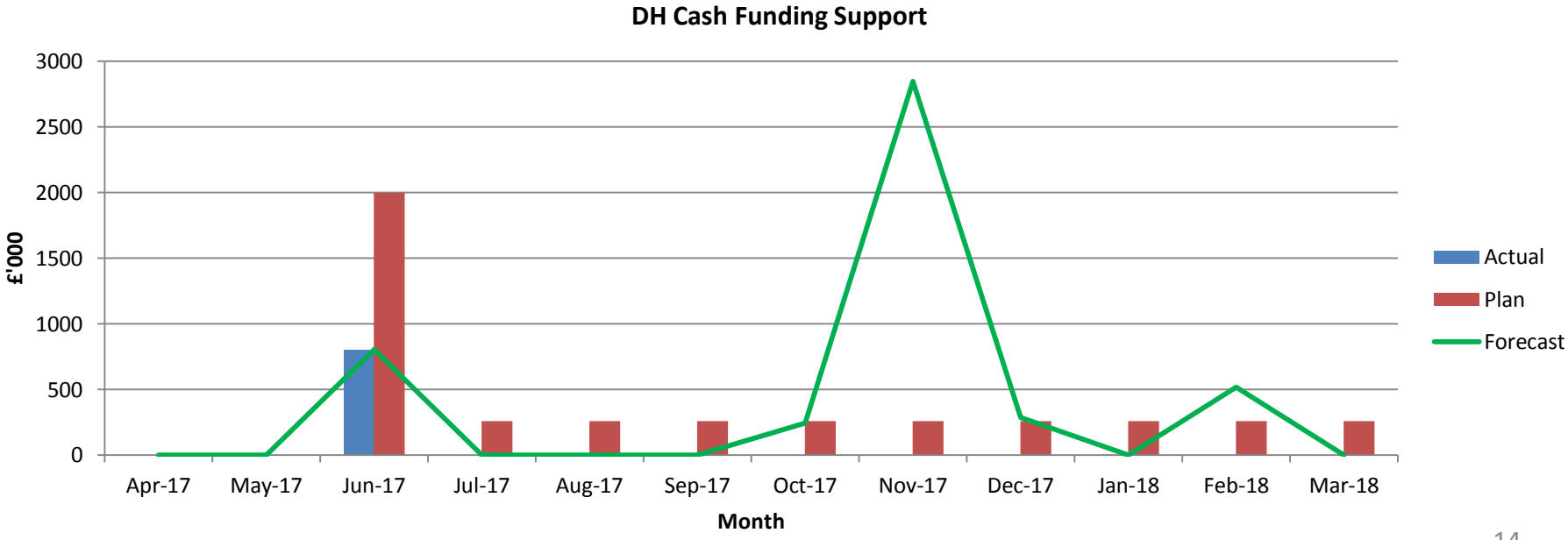
- Theatres stock management and rationalisation
- Implant rationalisation – ensure compliance against the agreed framework
- Other non pay consumables – rationalisation and product changes
- Coding improvements

RISKS / ISSUES

A review of CIP documentation has identified a risk around completeness of documentation in relation to CIP plans particularly delivery plans and Quality Impact Assessments (QIAs). To address this work has started with the CIP leads to accelerate the completion of these. A review of the CIP policy is also underway in readiness for CIP planning for 2018/19.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet in addition to expected borrowing requirements from the Department of Health





INFORMATION

Information

Cash levels are £0.4m higher than planned levels at the end of August, largely driven by cash held at the end of March being significantly higher than planned. The cash position for July is roughly in line with the Trust revised cash forecast for the month.

The Trust received its first cash loan from the DH on the 12th June for £804k as previously advised to the committee and has submitted its second request for funding required in October of £244k, this is lower than the forecast provided previously as the Q1 underperformance payments have been deferred until November.

The Trust has recently revised its Cash and Treasury Management policy and it was highlighted that it was felt necessary to consider investment, borrowing, interest rate and foreign exchange risk management strategy and policies. It was therefore agreed that this would be included within the cash section of the F&P paper to be reviewed monthly.

Given the Trust's current cash position and the need to request cash loans, the Trust is not in a position to hold any investments and at present the Trust does not hold any bank accounts other than those operated by the Government Banking Service. This means that interest and foreign exchange rate risks are determined to be low risk.

As in previous months, the requirement for borrowing has kept the Use of Resources Rating liquidity rating at a 4, the lowest level.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Head of Financial Accounting has set up a monthly cash control committee attended by the DDOF, and representatives from management accounts and the transaction team. The committee is reviewing cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications of cash from the Department of Health to be actioned.

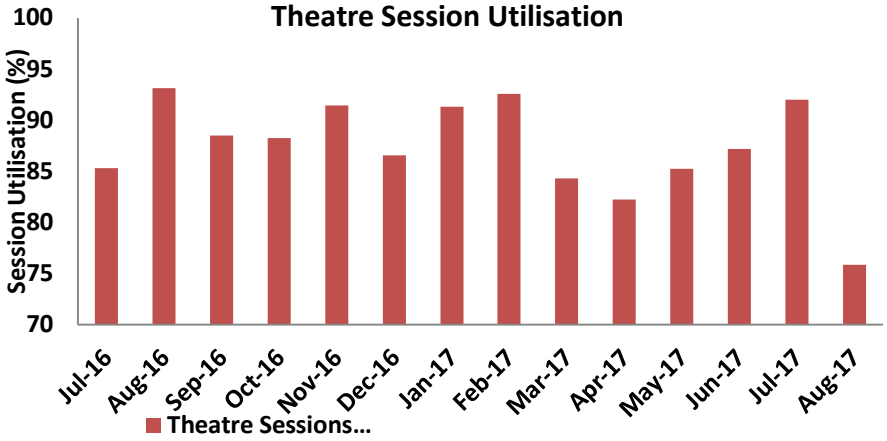
Based on the feedback from NHS Improvement the information provided to request funding was robust. The finance team are however continuing to review this and are looking to gather more information to continue to improve the Trusts management of cash.

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.

There is a risk is in relation to DH not approving a cash loan or approving a lower than requested amount, but the positive feedback to date from NHS Improvement provides assurance that this risk is relatively low.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are potentially available (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we aim to use at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis.

Due to annual leave / study leave, we typically plan that surgeons will operate over 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.

ACTIONS FOR IMPROVEMENTS / LEARNING

Further improvements have been made to the communications to surgeons of the availability of fallow lists, enabling more effective utilisation. From September there has been an additional 3 session day scheduled to facilitate the 2 x scoliosis cases on a list for spinal deformity. The large joints team are exploring a regular 3 session day list for those consultants with back log issues. In week twin theatre sessions have started in order to drive efficiency and reduce backlogs.

All reasonable efforts are made to recycle, including where it is deemed appropriate the use of sessions additional to job plan (paid ADHs). Since theatres and anaesthetic teams are not yet fully staffed, capacity is flexed up through overtime and bank working, so where lists are not recycled, and deemed 'fallow', the theatre staffing and anaesthetic shifts are removed 1 week ahead, to reduce bank and agency costs.

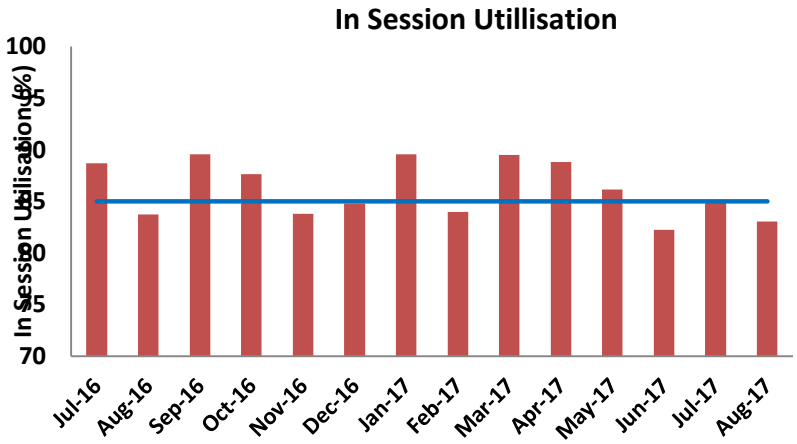
The ops team are proactively monitoring surgeon annual leave in order to manage the reduce the number of fallow lists and to offer appropriately to those services that are most challenged.

Weekend sessions are being planned throughout the remainder of the year with good uptake from consultants.

RISKS / ISSUES

Job planning is now completed for surgeons, with outstanding issues with only 2 surgeons; these are actively being progressed with the involvement of the Associate Medical Director, Clinical Service Manager and Clinical Service Lead.
The new theatre schedules and outpatient schedules started on 1st May 2017, to match the updated agreed job plans.
The next round of job planning is about to start.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained above the target 85% in the majority of months. Weekly reviews at 6-4-2 and other focus groups continue to improve the quality of listing and hence forward preparation to ensure smooth delivery of activity planned.

Several surgeons have now established a pattern of 6 primary joints on a two session list, and the learning from repeating this efficiency is being replicated across all firms and all lists to improve productivity. Starting Monday 25th September automatic call for first patients on lists commences following an engagement and training programme with all parties.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Scheduled Care Improvement work is now underway, with additional support and expertise joining in September. The Head of Nursing, Division 2, is continuing to lead work on The Productive Operating Theatre principles.

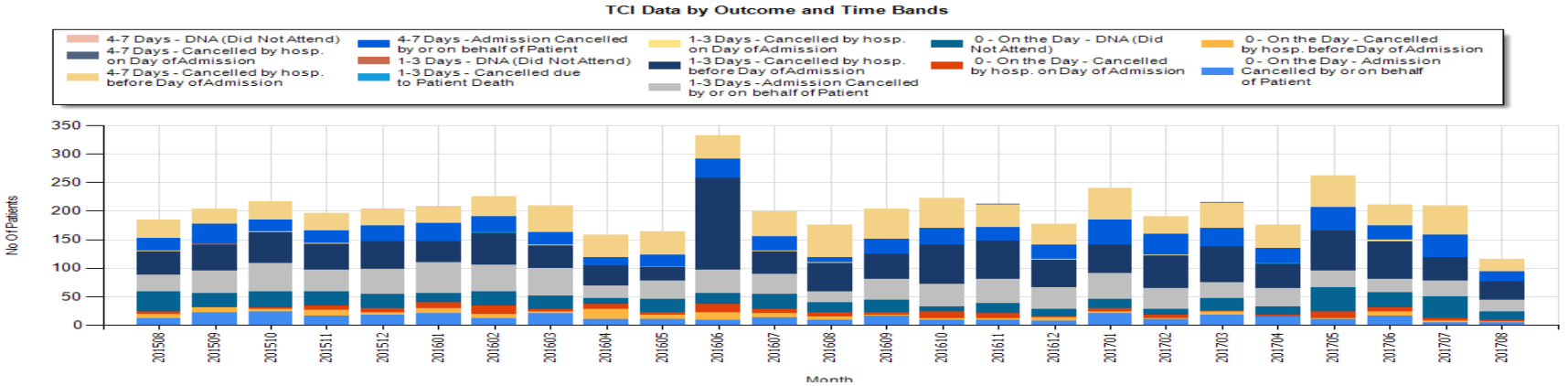
The new Theatre Management System 'Theatreman' was successfully implemented on 24th May 2017, replacing ORMIS. The reports now available are enabling further scrutiny of variation and opportunities for improvement.
Individual operation timings have now been refreshed based on actual times for surgery since May 2017. This allows the team to manage this on a daily basis with the ability to challenge the team real time.
Scrutiny and challenge is via the weekly 6-4-2 meeting, with instructions back through to the surgical teams to book lists to their maximum potential and to POAC and identify patients well in advance so that specific requirements can be planned for to reduce cancellations. From the beginning of September the ability to indicate patients who have been through POAC has been evident so that the operational team can contact those patients at short notice. A weekly review of the last 7 days in theatres now takes place every Friday morning with the Operations Team reviewing opportunities for better performance. Work also continues in the validation of the theatre data set, to ensure the accurate reporting of theatre performance, lead by the newly appointed Clinical Services Manager for theatres.
The revised PTL is now available and additional capacity delivery through use of non consultant staff is being explored. As the validation work is finalised, this has confirmed an accurate picture of the waiting list and hence the level of additional activity required.

RISKS / ISSUES

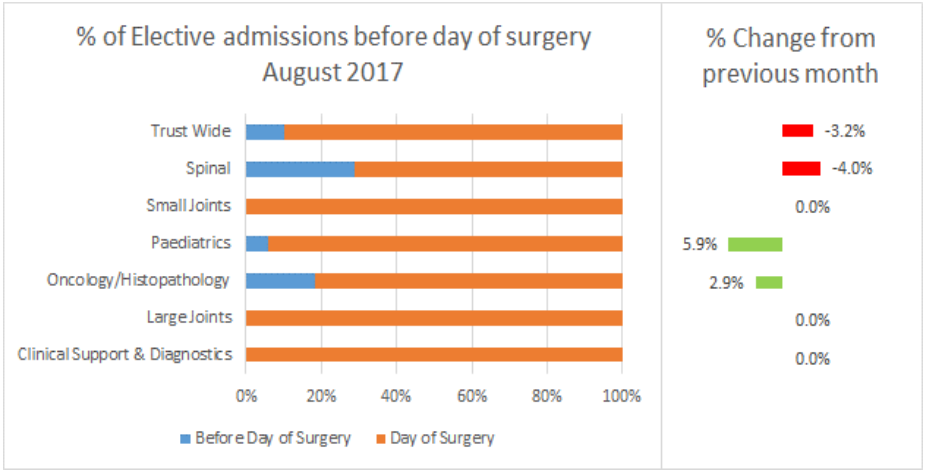
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (e.g. experience in spinal scrub) to ensure the best possible use of available operating time. A theatres recruitment open day is scheduled for Sunday 15th October, with the aim of recruiting across all theatre vacancy types. Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit.

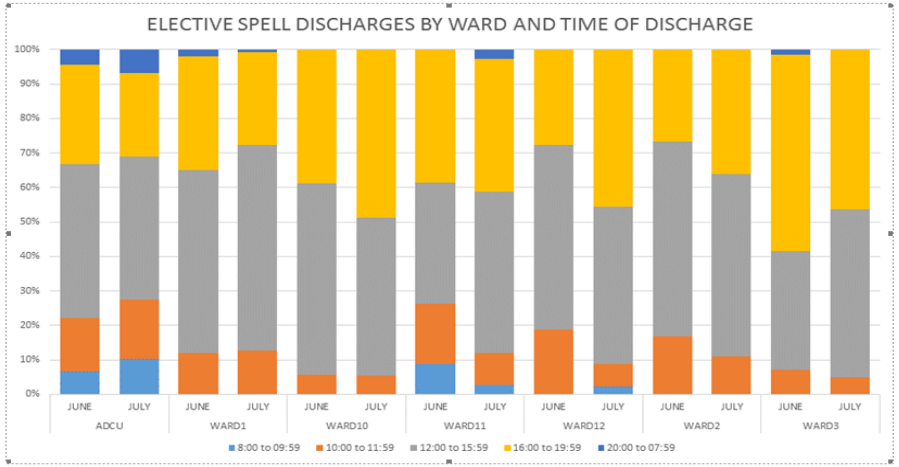
11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

Cancellations by patient / hospital



Admission the day before surgery





INFORMATION

Active management of the Patient Tracking List (PTL) , the planning for the establishment of a separate Oncology PTL weekly meeting to track the booking of individual patients, and a separate PTL weekly meeting for each firm to track patients is creating a new momentum, with lists being booked several weeks ahead where previously they were being booked only days ahead.

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Some of the replacement patients are then booked at short notice. We are working towards booking with 3 week's notice and 2 reasonable offers as per national guidance and our Access Policy.
Now that there are Clinical Service Leads and Clinical Service Managers for each specialty, and regular team meetings, some longstanding issues relating to disparity of waiting lists across consultants, variations in theatre productivity and listing protocols are being addressed and resolved.

Forensic analysis of cancellations continues, with a focussed analysis by the anaesthetic lead and nursing lead for POAC of the majority cause of cancellations on the day of surgery, namely those who are medically unfit, to ascertain what process changes can be made in POAC or to the 72 hour phone call to reduce this.

ACTIONS FOR IMPROVEMENTS / LEARNING

Now that the longstanding vacancies in Medical secretaries, admin support and operational management have been filled, there is now the capacity for transacting the forward booking of patients for both preoperative assessment and surgery. A pilot for medical secretaries to book patients directly is now in place across Hands and Large Joints teams which will be rolled out to spinal at the end of September 2017.

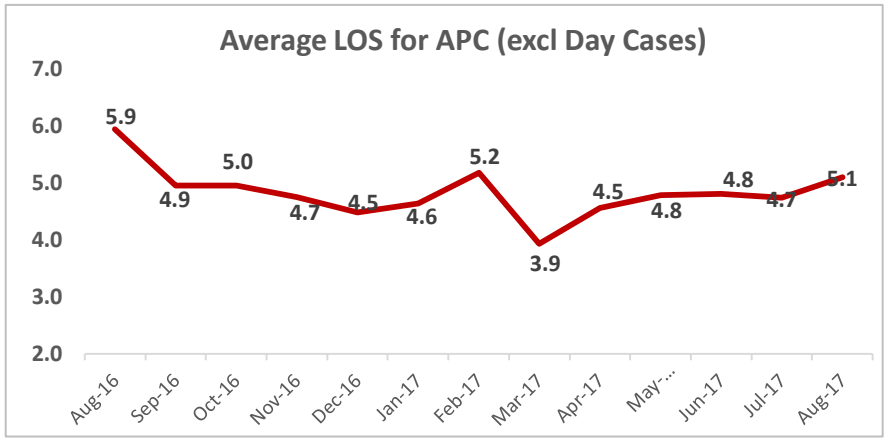
Work is still required to agree criteria for admission the day before, to use beds more effectively and reduce length of stay.
Pre-operative assessment improvements have been delivered, so that there are now 32 slots available each day.
A daily update review by operational management of forward bookings has been established and the 642 and a daily 9am Operations huddle has continued. Daily statistics on beds , admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to deliver activity and patient flow.

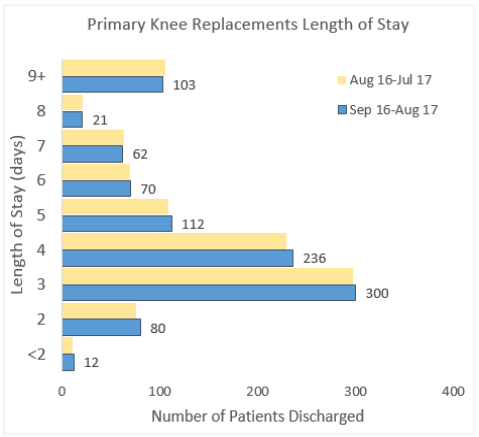
RISKS / ISSUES

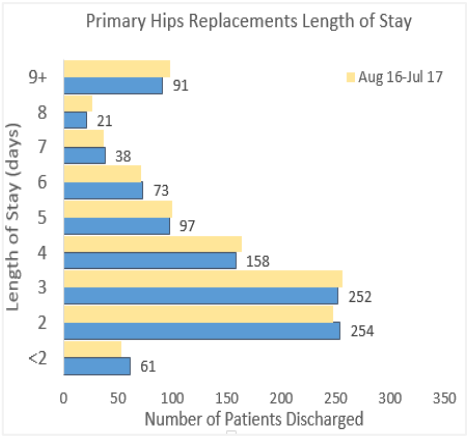
Continued focus with all staff involved to ensure that the operating lists are booked in advance, with sufficient caseloads, together with daily tracking.

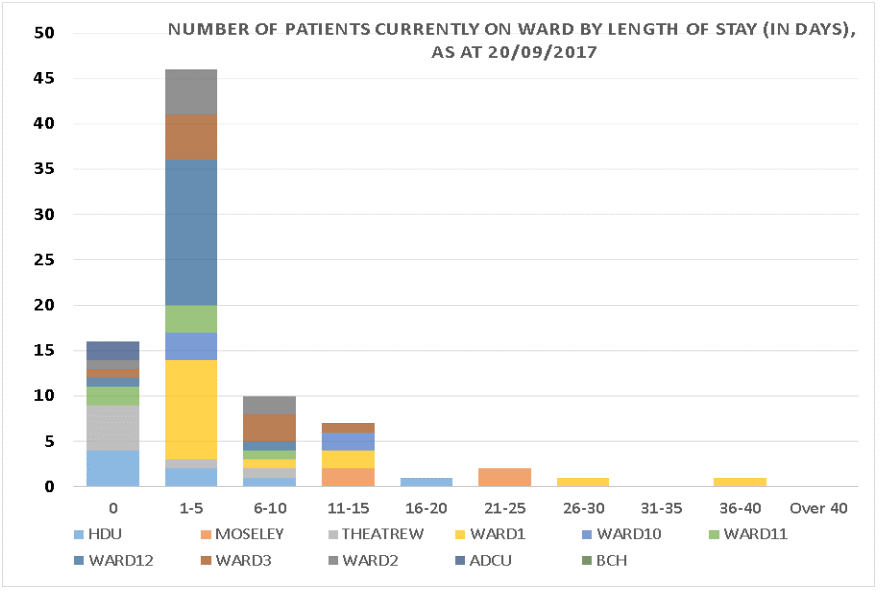
It is currently not possible to identify if the time of day patients are discharged is an accurate reflection of reality, or whether data is being entered onto the system in a delayed manner, making discharges look later in the day.

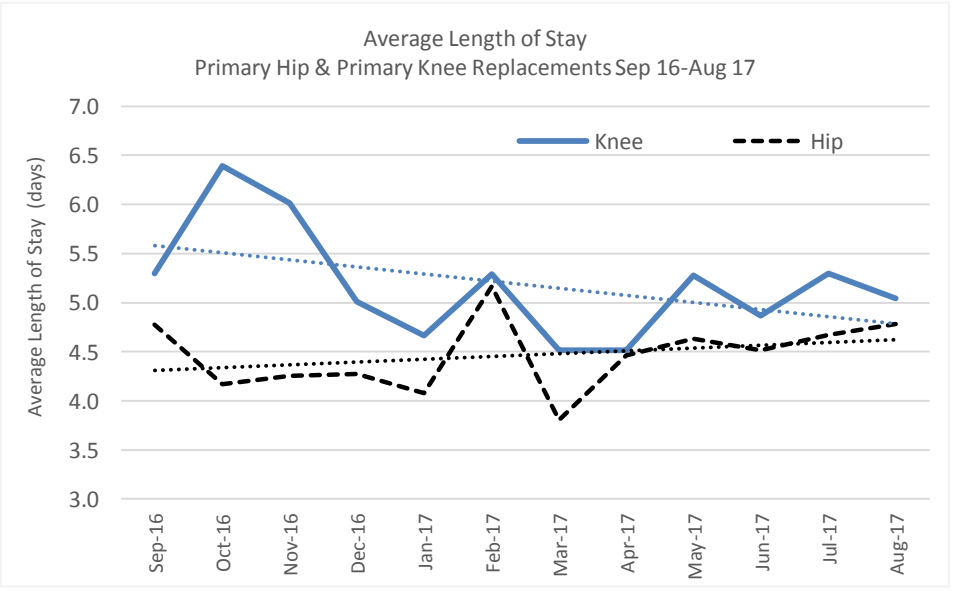
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Under the leadership of the Associate Medical Directors , Clinical Service Leads and Clinical Service Managers, work is progressing to increase activity levels to deliver 18 week compliance by creating additional capacity from within existing resources by improving flow. Length of stay reductions for primary hips and knees is key to achieving this , and an update will be brought to the next committee as to the progress of this work.

In May 2017, a 'Red2Green' process has been started to force better flow of patients hour by hour, partly to facilitate the rolling ward closures for the site infrastructure cabling installation, and mainly to improve overall patient flow. Work is ongoing to ensure that the analysis from Red2Green is highlighted and any areas which are flagging as red are explored further. Further work is underway as part of the Scheduled Care Improvement work to embed this approach across the organisation. This will also see the development of criteria led discharge to support weekend discharge planning.

ACTIONS FOR IMPROVEMENTS / LEARNING

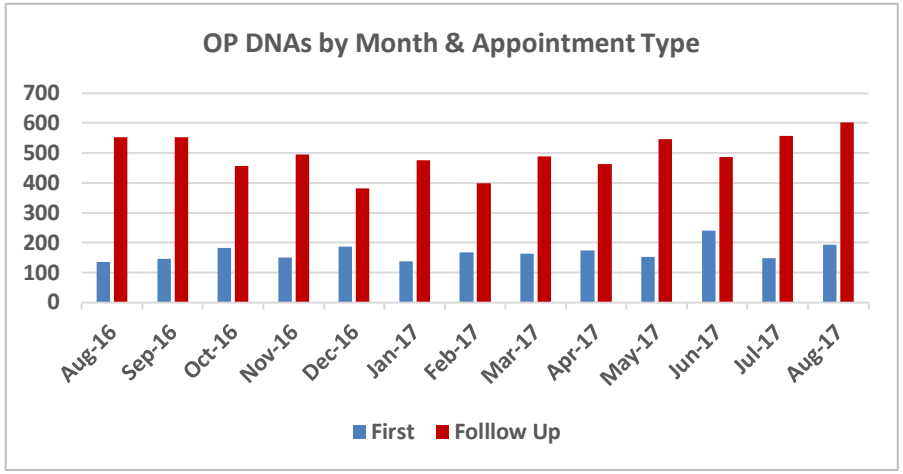
Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.

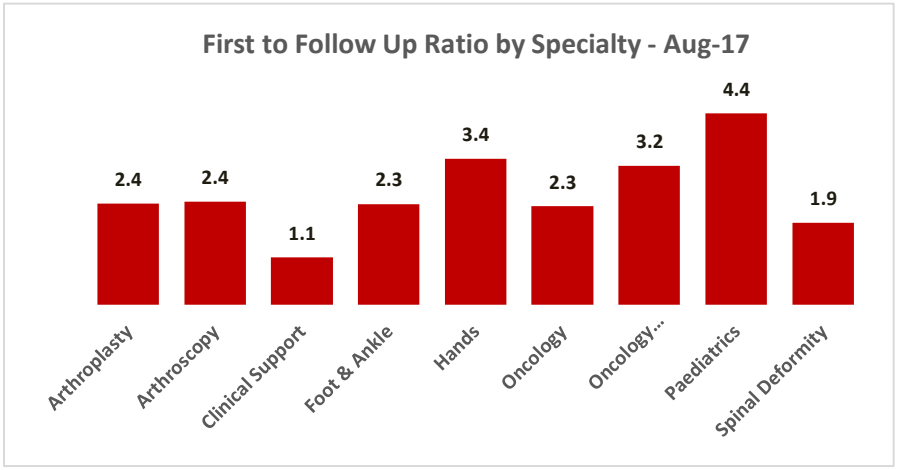
Daily senior reviews are being formalised as part of job planning, and the rising adherence to recording the Expected Date of Discharge (EDD) (now over 90%) is helping all involved in that patient's care to manage their length of stay more effectively.

RISKS / ISSUES

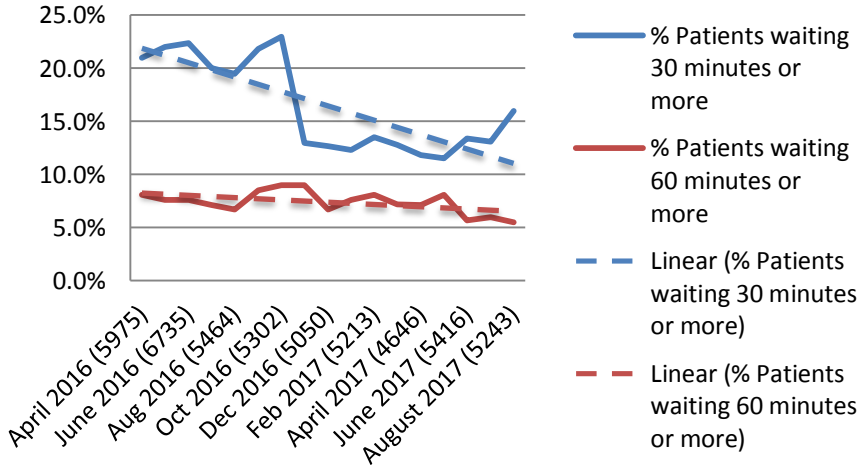
Using individual consultant information, Operational management teams and Clinical Service Leads are reviewing outlying clinical practice to help ensure that all patients are able to go home as soon as possible after their surgery.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients

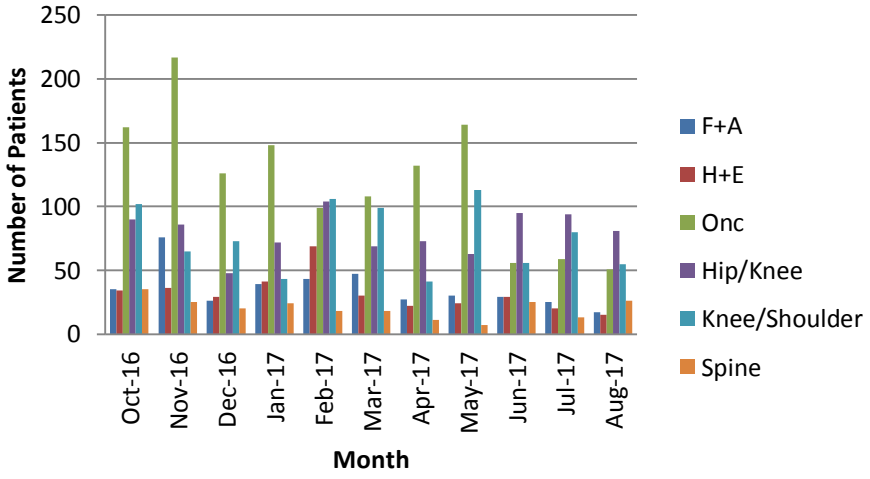




Wait times in OPD trend line April 2016 - August 2017



Wait times over 60 minutes by Specialty Oct 16-Aug 17



INFORMATION

Since the initial implementation of the new clinic templates in November there has been a reduction in the 30 minute wait times for patients. For the third month the Trust has been able to demonstrate achieving the target of no more than 6% of patients waiting over 60 minutes. The new Oncology templates, which started on the 6th June, have reduced the number of waits over 60 minutes by 60% . In July 2017 the medical notes not arriving on time to clinic was the main reason for delays. The medical notes process will be the main focus and there is an expectation this will help reduce the 30 minute wait to achieve the 11% target.

The outpatient department continue to audit its compliance against the SOP for wait time and can demonstrate 100% compliance. There is a new standard operating procedure for any clinic running over 60 minutes late. The incident reporting system , Ulysses , has been amended to make it easier for the clinic staff to complete the incident form. An incident form is completed and a new drop down analysis is selected by the staff completing the incident . The reasons documented on the incident forms now form part of a monthly action plan and this will be shared so reasons can be addressed.

In August 2017 the main 3 contributing factors for delays are: 1) delay in medical notes arriving on time to clinic. 2) Overbooked / not reduced clinic due to junior staff late notice leave. 3) Issue with Logging in to Winscribe. The 30 minute wait times have increased this month, a predicted result in the 60 minute waits reducing. The medical notes process will be the main focus again this month together with a review of the annual leave process for junior doctors.

ACTIONS FOR IMPROVEMENTS / LEARNING

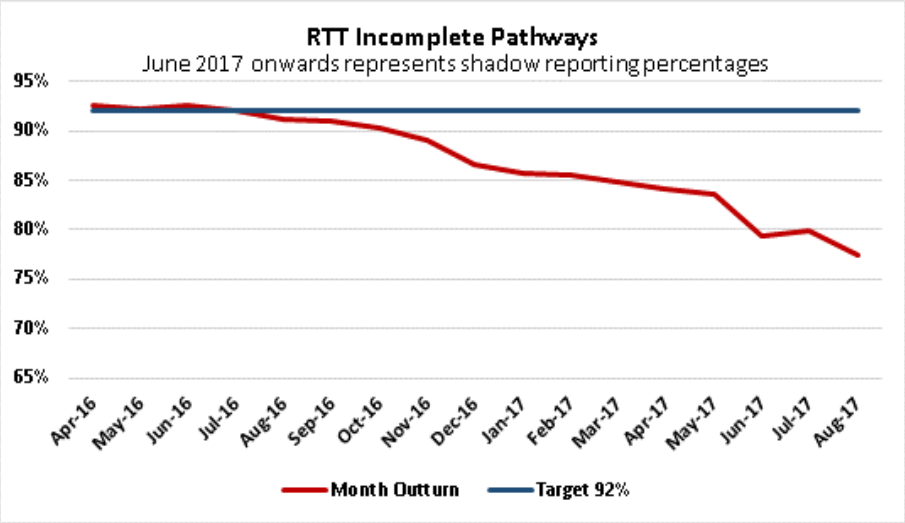
There are a range of actions as part of the CQC action plan and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

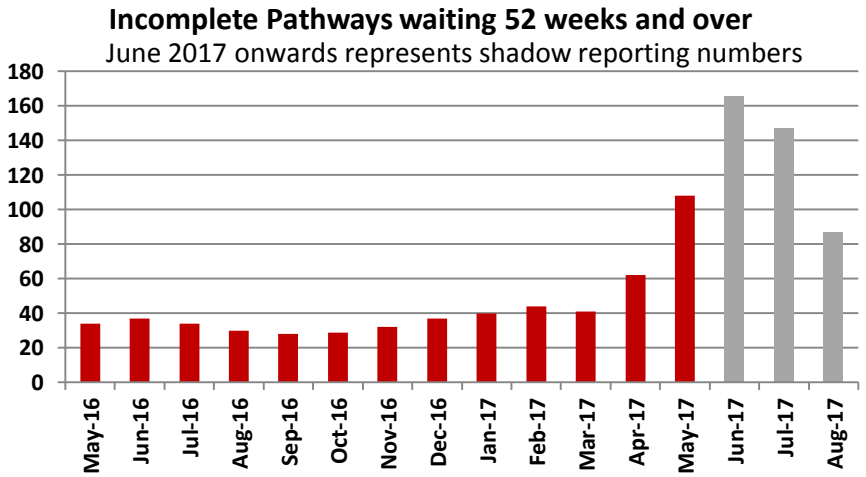
As part of the Trust's RTT recovery work, there will be a focus on out patient pathways and any patients who are in the system awaiting a follow up appointment and have become overdue, for whom a new active RTT clock should be started in line with national guidance. However, if it is found that there is a follow up appointment capacity problem, then this could worsen new to review ratios in the short term. This is being reinforced through RTT training and the clinical service managers working closely with consultants and medical secretaries to ensure that the Trust access policy is being adhered to by all involved.

RISKS / ISSUES

Feeding back patient waiting lists to consultants weekly continues, with much focus on improving data quality arising from the validation work that is ongoing .

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories





Cancer Target's	National Standard	Unreported		Reported Month							Reported Quarter					
			Indicative August *	July	Jun	May	Apr	Mar	Feb	Jan	Q1 17/18	Breaches	Total	Q4 16/17	Breaches	Total
2ww	93%		100%	100%	95.65%	100%	97.30%	93.75%	100%	100%	97.56%	3	123	98.41	2	126
31 day first treatment	96%		100%	100%	91.67%	100%	100%	100%	88.89%	95%	96.55%	1	29	100%	0	33
31 day subsequent (surgery)	94%		100%	100%	100%	100%	100%	100%	100%	90%	100%	0	22	96.30%	1	27
31 day subsequent (drugs)	98%		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
62 day (traditional)	85%		100%	37.5%	71.43%	60%	66.67%	100%	66.70%	75%	66.67%	3	9	84.21%	1.5	9.5
62 day (Cons Upgrade)	n/a		75%	100%	100%	100%	100%	n/a	n/a	n/a	100%	0	4	n/a	n/a	n/a
31 day rare (test, ac leuk, child)	n/a		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
No. day patients treated 104+ days			0	3	1											

*Performance for August is indicative reportedin arrears submisison date 3rd October 2017

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017, and has been shadow reporting since that time. The Trust will recommence reporting in October, with first submission in November 2017. Validation of open pathways is complete and work to inform 'Business as Usual' validation is nearly complete to ensure that Data Quality standards are maintained going forwards.

Validation is now underway reviewing clock stop data, and a first draft plan for completion is being reviewed. A weekly RTT Recovery Board has been established and met for the first time on 27th April 2017- this work is progressing well and is informing the Scheduled Care Improvement work .

The new PTL went live week commencing 21st August 2017- this has established an accurate waiting list introducing nationally recognised terminology e.g. 'Admitted' and 'Non Admitted' as status points on the patient pathway. The way in which the Trust utilises and manages the planned waiting list is being updated to ensure that it adheres to national guidance, where the treatment date is determined clinically, rather than by resource i.e. a patient who requires a second surgery e.g. removal of metalwork 6 months after first surgery, would be put on the planned waiting list .

Aug-17	Total pathways	Over 18 weeks pathways	Over 52 week pathways
Admitted	830	283	12
Non-Admitted	1216	233	14
Incomplete	7997	1799	87

The above figures have been used for the shadow reporting of the ROH RTT performance for August 2017

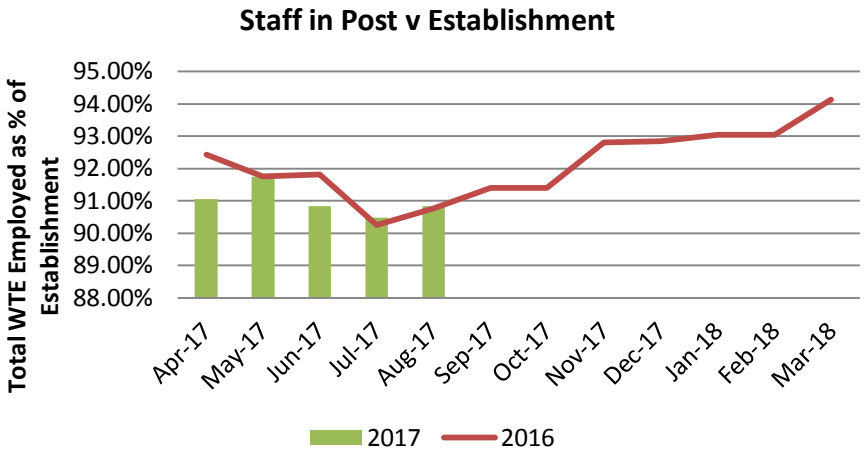
ACTIONS FOR IMPROVEMENTS / LEARNING

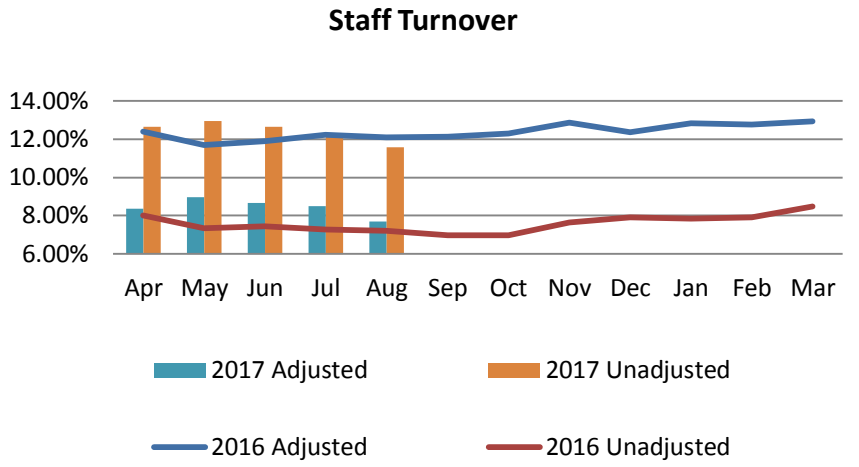
All consultants now receive an updated copy of their individual waiting list (PTL), this is sent electronically from the Operations Team every Friday to all specialities. It is expected that all medical secretaries will review their PTL with their consultant and ensure that all patients are dated in waiting time/clinical priority. The Operations team meet weekly to scrutinise all patients waiting 51 weeks and less across all specialities to ensure all patients have definitive treatment plans and ensuring all patients requiring further validation are identified. A separate review is undertaken of all patients waiting over 52 weeks.

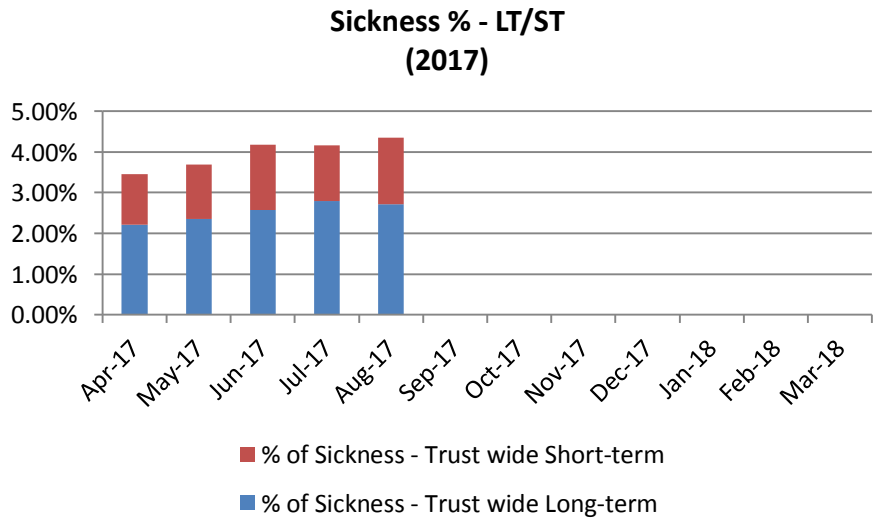
RISKS / ISSUES

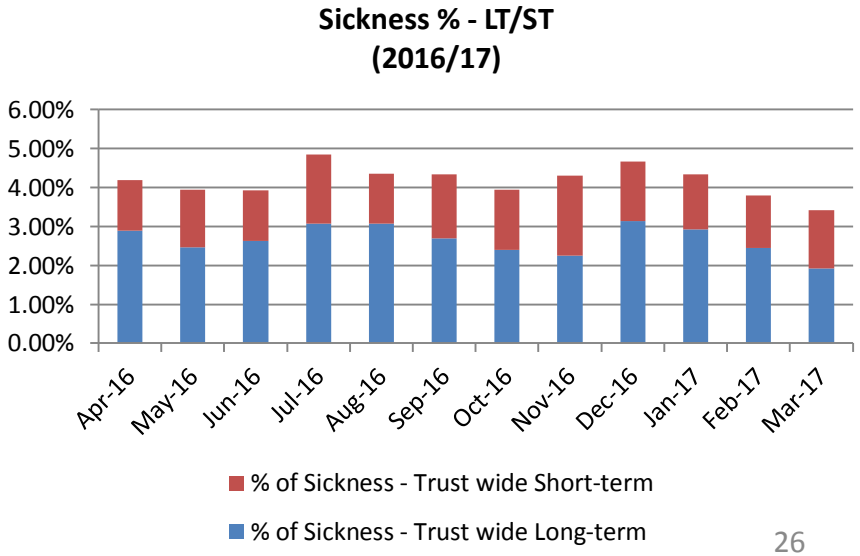
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern.

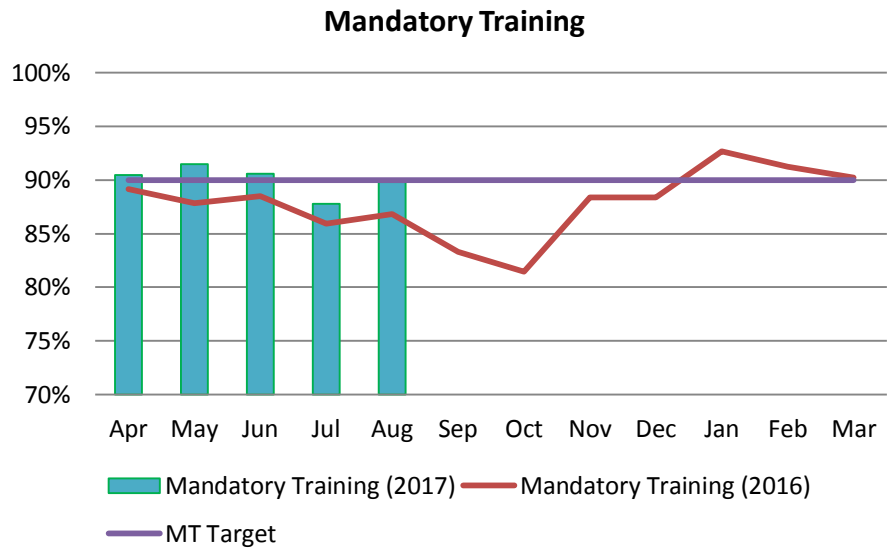
15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

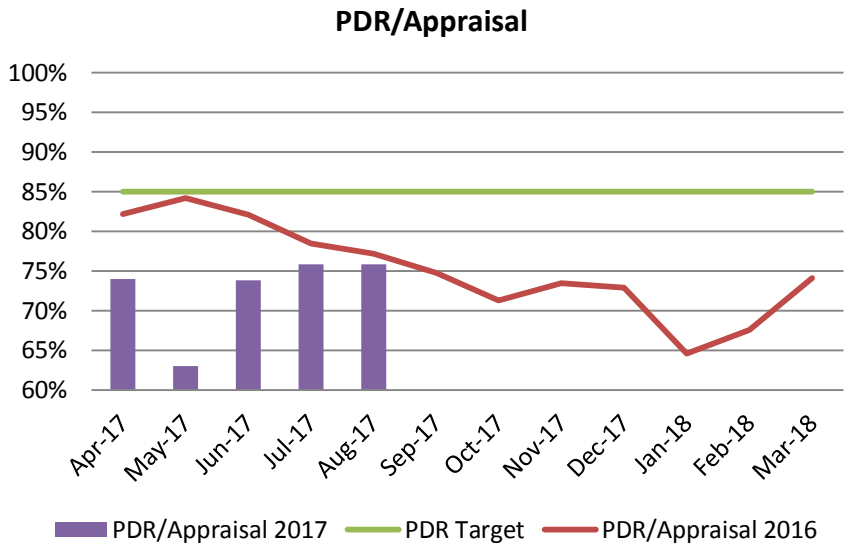









Mandatory Training
100%
95%
90%
85%
80%
75%
70%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Mandatory Training (2017)
Mandatory Training (2016)
MT Target


PDR/Appraisal
100%
95%
90%
85%
80%
75%
70%
65%
60%
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
PDR/Appraisal 2017
PDR Target
PDR/Appraisal 2016

INFORMATION

Taken in the round, August was an encouraging month in terms of workforce performance.

Whilst sickness absence increased slightly moving the Trust into amber in month, the 12 month underlying figure remained green; staff in post increased slightly; there was a reduction in turnover and an improvement in mandatory training. Appraisal remains the area for improvement, although performance did not deteriorate in month.

The Trust's vacancy position improved very slightly on last month's figure by 0.36% to 90.84%. This is still amber for August 2017, is within the range of the last 12 months and reflects a small decrease in the funded establishment for the month.

August saw sickness absence increase to 4.35%, the highest month of the calendar year to date, with a slight decrease in long term absence being offset by an increase in short term absence. The 12 month average figure is also green at 4.18%.

Mandatory training improved back to green this month as expected (although only just), following the reinstatement of a missed training session in July. Further work is being carried out this month by the L&D Team to encourage staff to book onto or carry out their Mandatory Training via e-learning. With the new E-learning and IT Training Facilitator now in post, we expect this figure to further improve for September data.

Performance relating to PDR/appraisals in August remained steady at 75.83%. To improve the accuracy of reporting, for the last 3 months preliminary PDR data has been issued to Clinical Service Managers as an early alert, to enable them to update records in ESR where no information is recorded but PDRs have been carried out. This system will continue in order to ensure that our data are accurate. Although August's position is still red, it does appear to be holding.

There was positive movement again in August turnover figures. The unadjusted turnover figure (all leavers except doctors and retire/ returners) decreased again by over half a percent on last month to 11.57%, the lowest level since October 2015. The adjusted turnover figure ("true leavers" meaning "voluntary resignations") also greatly decreased by 0.81% and remains green in month.

The preliminary data release appears successful with operational managers. Appraisal performance in particular was a focus at the Divisional 1 performance meeting in August and will remain a feature of the current round of divisional performance reviews.

As was the case last month, the announcement of the planned transfer of paediatric surgery may cause significant uncertainty for staff, although little has actually changed in the last month. It is possible that sickness absence, turnover and vacancies may increase in the coming months.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**UPDATE: National Staff Survey Results 2016/17**
SPONSOR (EXECUTIVE DIRECTOR):	**Professor Philip Begg – Executive Director of Strategy & Delivery**
AUTHOR:	**Clare Mair – Head of OD and Inclusion**
DATE OF MEETING:	**4th October 2017**

EXECUTIVE SUMMARY:

Each NHS Trust is required to participate in the national staff survey on an annual basis. An external data management provider is required to administer the survey, and for ROH this partner is Capita.

Due to the size of the ROH Trust, all permanent staff members are invited to participate either online or via a paper based survey. For 15/16 this equated to 955 staff members in total with a 46% completion rate.

The results from the survey 15/16 were officially published in March 2017 and distributed to the Trust Board in June 2017. A staff survey action plan was also presented and agreed by the Board.

This report gives a progress update for the staff survey action plan. It was agreed with the Board that a poster would be produced to highlight the key actions taken as a result of staff feedback in the national survey. This poster is included in the report.

Work completed on the quarterly Staff Friends and Family Test (FFT) and feedback received from staff is also included.

We ask the Trust Board to review the information and comment on any further actions or recommendations required. It is requested that a further update is provided to the Trust Board at the January Board meeting.

REPORT RECOMMENDATION:

The Trust Board is asked to receive the report which includes an update on the Staff survey action 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

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

Financial	**X**	Environmental		Communications & Media	X

Business and market share	**X**	Legal & Policy		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:

Safe, efficient processes that are patient centred.

Fully engaged patients and staff

Creating a culture of excellence innovation and service

PREVIOUS CONSIDERATION:

The Trust Board last considered the staff survey and action plan at its meeting in June 2017

ROHTB (10/17) 006 (a)

BOARD UPDATE – STAFF SURVEY

The information in this update includes:

National staff survey 2016 which was sent to ALL staff to be completed in Q3 between October and December 2016. In this exercise a number of questions were asked with results summarised in 32 Key finding areas.

Staff FFT (Friends and Family Test) survey sent out each time to 1/3 staff members in Q1, Q2 and Q4. This is short survey focussing on 'whether staff would recommend ROH for work or treatment'.

Results and feedback from both surveys are used to inform and update action plans across the Trust in areas such as Leadership, Inclusion, Engagement, Incident reporting, FTSU Guardian, Directorate objectives and Exec engagement.

1. Progress on National survey results 2016

	ROH Current year	Current Acute Specialist		ROH Previous year	Acute Specialist last year
Recommend as place to work or receive treatment	3.73	4.12		3.85	3.91
Engagement score	3.80	3.92		3.83	3.82

See action plan below with an update on progress. The following headings were identified as key areas of improvement for managers to concentrate on:

Performance – every staff member to have a clear understanding of what they need to do and how it fits with the Trust strategy (PDR) - More PDR workshops are available and Priorities are to be communicated

Communication – to ensure that all staff are well informed about the Trust and have the opportunity to meet and feedback to management on a regular basis – New approach to Team Brief and Exec engagement plan

Resources – to ensure all staff have the correct resources to do their job and are empowered to make the right decisions – Coaching programme in place

There is also strong evidence of positive staff feedback and engagement where three key activities are completed: **PDRs, robust absence management and attendance at Core Mandatory.**

National staff survey 2017

The survey starts on 9th October for an 8 week period and all staff will be invited to complete the survey. Marketing material will be provided in the form of posters, flyers, Team brief updates, Intranet information etc. There will be no incentives for completion this year.

ROHTB (10/17) 006 (a)

2. Key information from Staff Friends and Family Test (FFT) Q1

Response rate = **44.2%** up from 34% last year.

	ROH Q1 2017	Net Promoter 2017		ROH Q1 2016	Net Promoter 2017
Recommend as place to receive treatment	87.0	26		86.1	28
Recommend as place to work	63.0	-16		64.0	-9.0
Engagement score	74% (3.92)	-		-	-

The overall employee score is 74% and comprises of nine questions, which are displayed below alongside the percentages scores. The score are:
Q1 How likely are you to recommend The Royal Orthopaedic Hospital NHS Foundation Trust to friends and family if they needed care or treatment? (87%)
Q2 How likely are you to recommend The Royal Orthopaedic Hospital NHS Foundation Trust to friends and family as a place to work? (63%)
Q3 I look forward to going to work 57%
Q4 I am enthusiastic about my job 68%
Q5 Time passes quickly when I am working 75%
Q6 There are frequent opportunities for me to show initiative in my role 72%
Q7 I am able to make suggestions to improve the work of my team / department 83%
Q8 I am able to make improvements happen in my area of work 75%
Q9 Care of patients / service users is my organisation's top priority 84%

Themes of Feedback for Staff FFT Q1

Strengths	**Areas for Improvement**
Quality of service is good Good patient care Friendly and caring Skilled surgeons Hard working staff Really good place to work Great staff Family feel	Concerns about finance Waiting lists Lack of direction Need more incentives to retain staff Poor performance needs to be managed More effective action plans Unsettled time Concerns about senior management structure changes

3. Key information from the remaining Staff (Friends and Family) FFT

Q2 - Deadline is 29th September with results to follow.

Q4 – January 2018

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

ROHTB (10/17) 006 (a)

4. Action plan

National Staff Survey: ROH 2016/17 Action Plan – September 2017 update

Activity	Who	When	Status	Comments
Briefing with CEO	CM PB	End of May 2017		
Paper for the Trust Board presenting the results.	CM, PB	7th June 2017		
Initial results to be shared with all staff and Board members	AC	March 2017		
Briefings with senior managers and key stakeholders in the Trust to share initial data and agree support required	CM	May – July 2017		
Communicate results and suggested organisational actions to the Executive team.	PB	May/June 2017		
Different departments to confirm action plans (using agreed areas of priority)	Senior Managers supported by CM	May – June 2017	**Ongoing**	
Proposal presented to Exec Team and Trust Board for senior manager role modelling	CM YB	July 2017		
Board member engagement proposal agreed	PB	July 2017	**Ongoing**	Delayed – 6 Trust priorities now confirmed and roll out plan to follow. Supported by Rebecca Buswell
Communication poster to publish results of national survey and actions to date	Comms CM	June 2017	**Started**	Poster distribution delayed. See attached
Staff FFT Q1 survey	OD and 33% staff members	June 2017		
Bicentenary celebrations	Comms and All	July 2017		
Review IT access for national survey 2017 to support completion rates	CM IT	July 2017		New IT Trainer to support
OD to review any training requirements needed to support action plans	CM	Mid July 2017	**Started**	Ongoing review working with Trust managers

ROHTB (10/17) 006 (a)

Trust led PDR briefing sessions	CM Exec	July – September 2107	**Started**	Delayed – 6 Trust priorities now and roll out plan to follow
Results from Staff FFT Q1 survey results presented to Exec Team and Trust Board	CM PB	August 2017		Also presented to Ops Board
Staff FFT Q2 survey	OD and 33% staff members	August 2017	**On track**	Survey start changed to September
Review at Divisional meetings	CM Exec	September 2017		Ops Board, Exec meeting, Service meetings
Comms Team to provide key update briefing information for all staff	AM CM	July, October 2017	Started	July completed, October ongoing
OD to review all local action plans and provide summary and update to the Executive Team and Trust Board	CM	End of August 2017	Started	Not complete
Staff FFT Q2 survey	OD and 33% staff members	September 2017		Deadline - 29th September
Comms and OD to produce 'You Said, We will improve' briefings for staff	AM/CM/PB	September 2017		Final version of poster attached
Schwartz Round – First meeting	RB CM SS	September 2017		Positive number of delegates and excellent feedback
OD to review actions against Equality and Diversity actions	CM E&D Group	July, October 2017	Started	Review completed in July E&D group still to be formed
OD to support departments on progress with local action plans	CM E&D Group	July to December 2017	Ongoing	E&D group still to be formed
National staff survey	CM All	October to December 2107		
OD to review completion of local action plans	CM	January 2018		
Publish key findings	Exec	March 2018		

NHS STAFF NATIONAL SURVEY RESULTS

KEY ACTIONS YOU SAID WE DID...

3.9 OUT OF 5 OF YOU SAID

THAT YOU WANTED A BETTER QUALITY NON MANDATORY TRAINING

(LOWER THAN THE ACUTE SPECIALIST TRUST AVERAGE)

IMPROVEMENT

Lots of new career development workshops are now available in areas such as assertiveness and conducting 1:1s. Look on the intranet for more information.

IMPROVEMENT

Additional training of contact officers, staff side and the FTSU guardian has enabled more support for staff who want to speak up. We are also piloting an app to make it even easier for staff to report a concern.

49% OF YOU SAID

THAT YOU ARE REPORTING MOST RECENT EXPERIENCE OF HARASSMENT

(HIGHER THAN ACUTE SPECIALIST TRUST AVERAGE)

3.7 OUT OF 5 OF YOU SAID

YOU GET SUPPORT FROM YOUR IMMEDIATE MANAGER.

(LOWER THAN THE ACUTE SPECIALIST TRUST AVERAGE)

IMPROVEMENT

We are offering more workshops to improve management skills. These include the Management Skills Programme, coaching and Values Based Recruitment.

IMPROVEMENT

Team Brief is now run in a different way. We organised paediatrics updates with more face to face briefings. Your feedback has been positive.

ONLY 24% OF YOU SAID

THAT YOU THOUGHT THERE WAS GOOD COMMUNICATION WITH SENIOR MANAGERS

3.5 OUT OF 5 OF YOU SAID

THAT ORGANISATION AND MANAGEMENT HAD AN INTEREST IN AND ACTION ON HEALTH AND WELLBEING.

IMPROVEMENT

We have relaunched the '**wishing you well**' Health and Wellbeing programme on the Intranet. We are also training internal coaches to support you. Additionally, Schwartz Rounds have just been launched

IMPROVEMENT

We are running more PDR workshops to ensure all staff members are clear about what they need to do and to what standard.

ONLY 3.2 OUT OF 5 OF YOU SAID

THE QUALITY OF YOUR PDR WAS AT THE RIGHT STANDARD

(SAME AS ACUTE SPECIALIST TRUST AVERAGE)

STAFF FFT SURVEY RESULTS QUARTER ONE

OVERALL WE HAVE AN ENGAGEMENT SCORE OF 74% WHICH IS AN INCREASE FOR QUARTER ONE FROM LAST YEAR.

THIS IS A POSITIVE SCORE BUT WE WANT TO CONTINUE TO IMPROVE IN QUARTER TWO.

IMPROVEMENT

In response to staff feedback, the Exec Team have organised to spend more time in wards and departments in the next month to listen to staff and share our Trust priorities.

The survey is a key way to hear your views and take action. The more staff members take part in the survey, the more improvements we can make. To find out more speak to your line manager, visit the intranet or email **claremair@nhs.net**.

ask.listen.act

RESPECT COMPASSION
EXCELLENCE PRIDE
OPENNESS INNOVATION

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	27 September 2017
Guests	Mr Matt Revell, Associate Medical Director Sandra Millward, Head of Imaging Dr Graham Caine, Head of Pathology Ms Maureen Milligan, Chief Pharmacist Rani Virk, NHS Improvement
Presentations received	None
Major agenda items discussed	• Quality & Patient Safety report • Nursing key performance indicators • Radiation Protection update • Human Tissue Authority licence compliance • Harm review update • Nurse staffing update • Infection Control update • Annual complaints report • Quality assurance walkabouts • Paediatrics update • Clinical Quality Committee upward report • Drugs & Therapeutics Committee upward report and minutes • HDU Improvement Board upward report and minutes
Matters presented for information, update or noting	• CQC Provider Information requests • Divisional governance updates • Quality & Patient safety risks on the Corporate Risk Register • RCPCH and CQC action plan status report • Update on performance against the contract quality requirements
Matters of concern, gaps in assurance or key risks to escalate to the Board	• The Committee was advised that reports on WHO checklist compliance could not be readily obtained from the Theatreman system, however manual audit and validation highlighted that compliance rates remained high. • In September to the date of the meeting, there had been seven VTEs reported, which had included inpatients as well as patients post discharge. Investigations were underway on all cases to identify any common themes. • There had been six inpatient falls and two staff falls; there

	were no apparent themes that needed to be addressed. • The development of a trajectory to address the spinal deformity waiting list was reported to be predicated on the provision of a Paediatric Intensive Care Unit (PICU) bed by the Birmingham Children's Hospital. The system wide ownership of the management of this risk would be discussed at the next joint stakeholder oversight meeting. Work was underway with BCH to secure additional paediatrician cover and a service that ensure that an on-call service was available which could review a deteriorating child within 30 minutes of a request; this was in line with national standards. There continues to be a robust risk assessment process for Paediatric patients being treated by the Trust. • There had been a 48% increase in the numbers of complaints year on year, with the increase mainly associated with the administrative systems in Oncology and spinal services; these were issues understood by the Trust and would be addressed through the Scheduled Care Improvement programme and the delivery of the 18 weeks RTT action plan. • The significant increase in PALS complaints was noted to be associated with the direction to call this department in case of a query on the appointment letters. • The quality assurance walkabouts had rated Outpatients as 'Requires Improvement'. There were plans to introduce an Outpatient Improvement Board analogous to that of the Children's Board and HDU Improvement Board. • The risk registers of the Clinical Quality Group were currently being reviewed. • A number of risks were escalated from the Clinical Quality Group to the Quality & Safety Committee, including the robustness of the PAS alert process for dementia; standardisation of resuscitation trollies; the operation of the Resuscitation Committee; the failure of the bleep named within the massive haemorrhage/ transfusion policy; histopathology consultant recruitment; the delivery of life support training; and paediatric nurse cover in HDU. • It had been identified that governance around medical gases needed was weak and needed to improve. • Following a recent exercise to respond to the CQC's Provider Information Requests, a number of areas for strengthening had been identified including: clinical supervision; patient movement for non-clinical reasons; audit for patients with complex care; bereavement surveys; and clinical audit. • The Trust had one Contract Performance Notice around the 18 weeks RTT position, although this was well

	understood and being addressed. PREVENT training levels needed to be improved and the Trust Board would be asked to participate in this training shortly.
Positive assurances and highlights of note for the Board	• A new set of nursing Key Performance Indicators had been developed as a further step from the previous overall ward dashboard. Where there were areas of concern these would result in a condition report which would be presented to the Clinical Quality Group; this would contain the actions planned to address the issues or themes. Additionally, ward notice boards would be implemented which provided a visual display as to how the ward or area was performing against a set of quality indicators. • The harm review panel was working well and had recently reviewed 76 spinal patients; no harm had been identified • There had been no radiation protection incidents during the quarter. All those reported previously had been closed and the learning from these included the introduction of a standard set of standard operating procedures which provided clarity on the standards required in Imaging more clearly. Incidents however were noted to be very rare. Waiting times for diagnostic tests were reducing. • The update on the compliance with the Human Tissue Act licence showed that there were no concerns and overall Dr Caine was commended for the improved assurance on the operation and compliance of the Pathology service overall. • A new set of Key Performance Indicators would be introduced to monitor the care of children who might deteriorate while in the care of the ROH. This would further mitigate the risks of the current Paediatric care model while it remained with the Trust. These would be monitored by the Children's Board. • The use of agency nurse staffing had reduced. • Two offers had been made to individuals to be appointed into the Infection Prevention & Control team. Interviews were planned shortly for the lead Infection Control nurse. This would address the vacancies currently carried by the Trust. There was good medical staff input to the selection process for these posts. • The quality assurance walkabouts had rated Ward 11 as 'Good'. • The new system within Pharmacy was operating well and identifying any trends of increased usage of medicines. • The Trust was the highest reporter in the region for patients with adverse reaction to medicines (higher reporting is a positive indicator) • A draft Learning Disabilities strategy had been developed • Discussions at divisional governance boards were reported to be positive and provided a productive multi-disciplinary

	forum for operations, nursing and medical staff
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Themes associated with near miss incidents would be presented at the next meeting • The complaints report to be revised to provide a greater breakdown of some categories of complaints and to better illustrate the changes that had occurred as a result of the complaints received • Details of the consultants' level of participation in Mandatory Training to be presented at the next meeting • Detail of external reporting of controlled drugs incidents to be provided to the Committee when the Drugs & Therapeutics Committee was next to report • There was concern over the level of risk that the ROH would be carrying around the continued provision of paediatric surgery in the light of the reduction in nurse staffing in paediatric HDU
Decisions made	• The Committee recommended that the OD Committee should consider information on staffing groups other than nurse staffing which was considered by the Quality & Safety committee

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

For the meeting of the Trust Board scheduled for 4 October 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	26 September 2017
Guests	Matt Boazman, Chief Officer for Strategy & Innovation, STP representative
Presentations received and discussed	None
Major agenda items discussed	• Progress with the delivery of the 18 weeks RTT plan; cancer action plan; and spinal deformity action plan • Scheduled Care Improvement Programme update • Finance and Performance Overview • Recovery plan • Progress with the development of the Strategic Outline Case
Matters presented for information, brief update or noting	• Effectiveness of pooling waiting lists • Extract of the Corporate Risk Register was considered including additional and reframed risks based on a refresh undertaken by the Executive Team
Matters of concern, gaps in assurance or key risks to escalate to the Board	• As part of the discussion around the spinal deformity action plan, it was noted that the delivery of the trajectory for improvement of the 52 week waiting time position was predicated on continued access to PICU beds at Birmingham Children's Hospital. The plan needed to be system-owned. There was also further work underway to explore setting elsewhere to treat patients who had been waiting for a long time – every effort was being made to ensure that these would be locations convenient for patients. • Although there was good progress with addressing processes in theatres, the Committee agreed that due to the criticality of the operation of the theatres, it would seek additional assurance of improvement at a granular level and so the planned presentation on Theatreman would be rescheduled for October, rather than November. • Although every effort was being made to reach the 92% national 18 weeks RTT target by April 2018, this would be a considerable challenge from where the Trust was currently performing. • The financial deficit incurred in August was noted to be

	above the planned level and delivery of the Cost Improvement Programme was behind where it was anticipated to have been; a shortfall against the delivery of the CIP was expected by the year end, which was concerning as this was a key element of the Recovery Plan • The Committee was concerned at the high level of non-pay spend, which was mainly associated with theatres. Additional controls were being arranged around implants and other consumables, however the position was being reviewed further. Work was underway to establish average cost per procedure to identify variation between consultants and this information would be shared at the next meeting. There was also further work to do to control theatre stock usage. • Cancellations and DNAs by patients were noted to remain high. The 72 hour call before admission was being reinstated however, and information would be sent to patients to advise them of the financial impact of not turning up for appointments. • The Recovery plan was reviewed, the achievement of which was noted to carry a high degree of risk around delivery of higher activity levels and achievement of the Cost Improvement targets.
Positive assurances and highlights of note for the Board	• There was good progress with delivery of the action plans to address the regulatory concerns and in particular with the 18 weeks RTT action plan. The number of open pathways stood at 8,800, a reduction from the previous level of 59,000. New dashboards were available which helped monitor the position on daily basis and a formal weekly meeting was held to review the waiting list. • The visit by the Intensive Support Team recently had been positive and they were assured on the Trust's processes now in place to manage the 18 weeks RTT pathways. There was further work to do to address the 'clock stops', although this would be completed by the end of September. The draft report from the visit would be received shortly. The Head of Business Intelligence was congratulated for his work to support the improvement. • The move away from centralised booking was working well and good feedback had been received from the Acting Chief Executive on the revised process and better local ownership at a recent Team Brief session. Centralised booking was now confirmed to only a small number of referrals. • The management of the Oncology pathways had been amended to follow national guidance. • The Scheduled Care Improvement Programme was progressing well and included a number of improvement

	activities including: rationalisation & refining Standard Operating Procedures; more prompt letter turnaround; learning from elsewhere on best practice in relation to pre-assessment and pre-admission; changes in leadership in the theatres team; commencement of automatic starts in theatres; tracking of theatre trays to identify any issues and non-conformities; more robust theatre list lock-down; further embedding of Rapid Recovery and 'Red2Green' (discharge) initiatives; and more appropriate use of the discharge lounge • There was good progress with the development of the Strategic Outline Case. The work had good clinical engagement and a series of clinical reference groups had been set up which would feed into a set of workshops to develop the long list of options. Arrangements had been made for the Executive Medical Director to provide a lead role and strategic clinical input to the wider review of the orthopaedics pathway. The Long Term Financial Model base case would be presented for review at the October Finance & Performance Committee.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The Interim Chief Operating Officer to issue a note outlining the result of the sample testing of 20,000 historical pathways, this being the final stage of the RTT validation work. • Circulate the report from the recent visit by the Intensive Support Team • Arrange for the Finance & Performance Committee to receive a presentation on Theatreman at the October meeting • Present average cost per procedure information at the next meeting • Provide an explanation behind the increase in non-pay costs at the next meeting • Provide a further update on measures to reduce patient instigated cancellations and DNAs at the next meeting • Revise the finance & performance overview to provide additional clarity on some performance metrics • Present the Recovery Plan to the Trust Board at its next meeting
Decisions made	• None specifically

Tim Pile
VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 4 October 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	29 September 2017
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. Mr Matt Revell, Associate Medical Director Ms Marie Raftery, Clinical Services Manager (Theatres) Mr Will Overfield, Clinical Services Support Manager (Theatres) Mrs Mandy Johal, Freedom to Speak Up Guardian
Major agenda items discussed	• Update on Amplitude implementation • Internal Audit progress report • External audit progress report and plan 2017/18 • Counterfraud progress report and annual report • Recommendation tracking update, including update on stock management and eDC Gold • Cash & Treasury Management policy • Losses and compensations register • Breaches of waivers and SFIs register • Scheme of Delegation and Standing Financial Instructions • Whistleblowing and Freedom to Speak Up progress • Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• Following concerns raised via the governors, the Committee received an update on the Amplitude System, which was designed to provide information on clinical outcomes. The system has the potential to enhance the Trust's reputation and provide a diverse range of clinical outcome data for improvement. It was suggested that further consideration is needed to deal with the delays to the project and to the support arrangements for the implementation of this system, including project management and resource to collect data in clinics. It was clear that the system needed to be owned by the clinical outcomes team. • Two of the three internal audit reports finalised since the last meeting provided only partial assurance, these being: research & development processes and e-rostering. Of these, the findings from the e-rostering audit needed considerable attention, as it was clear that staff were not closely following the e-rostering policy and there were

	delays with signing off rotas which impacted on the ability to fill gaps in rotas with bank staff. It was noted that the clinical governance team was assisting with addressing these process issues. • The external audit plan for 2017/18 would focus most closely on cash and CIP and the overall financial sustainability of the Trust. • The feedback from the Quality & Safety Committee included the need to gain assurance on the WHO checklist through the use of the Theatreman system. Paediatric nurse staffing was also raised as a risk, particularly as two substantive nurses had tendered their resignation recently.
Positive assurances and highlights of note for the Board	• The recent assessment by NHS protect had been positive: the 'prevent and deter' element was particularly positive, with the pre-employment check process being commended • The Committee were joined by Marie Raftery and Will Overfield from Theatres who provided some sound assurance on the measures being taken to implement controls around stock in theatres and to implement more robust stocktake & monitoring procedures. Of note was the measure taken to centralise the stock and to encourage the Trust's own stock to be used before consignment stock. The arrangements with the firm that undertook decontamination of theatre trays were also being made more robust and eDC Gold would be used in future for initiating automatic ordering of stock. • There was good progress noted with updating the accuracy of the recommendation trackers, with updates being received for the majority of actions. As a next step, the evidence to provide assurance that the actions were closed would be worked through. It was agreed that the actions associated with the reports relating to stock, 18 weeks RTT and consent would be separated out from the tracker in future as these were being addressed through separate action plans. • The Committee received a positive presentation from the Freedom to speak Up Guardian – she was making good progress with encouraging staff to raise patient safety concerns and as a next step would be getting behind the reasons why some individuals might still be reluctant to raise concerns. It was agreed that positive feedback to staff when things had changed as a result of them raising their concerns was crucial.
Significant follow up action commissioned including discussions needed with any other	• A further update on stock management in theatres is needed for the next meeting • The Executive were encouraged to think through the next steps for the Amplitude system and it was suggested that a

Executive Boards/Committees	status report outlining where the project was at and the measures needed to implement it more fully was needed • Consideration was needed as to the balance between R&D and clinical audit within the overall Knowledge Hub • Consider the means by which the effectiveness of the internal and external audit could be assessed
Decisions made	• The Audit Committee supported the Treasury management Policy • The Audit Committee supported the proposed changes to the Scheme of Delegation and Standing Financial Instructions • A revised schedule of meetings for the Audit Committee was agreed to ensure that they were more evenly spaced throughout the year

Rod Anthony

NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Trust Board scheduled 4 October 2017

ROHTB (10/17) 011

TRUST BOARD

DOCUMENT TITLE:	Changes to the Scheme of Delegation & Reservation and Standing Financial Instructions
SPONSOR (EXECUTIVE DIRECTOR):	Paul Athey, Acting Chief Executive
AUTHOR:	Alex Gilder, Deputy Director of Finance Simon Grainger-Lloyd, Associate Director of Governance & Company Secretary Antony Upton, Local Counter Fraud Specialist
DATE OF MEETING:	4 October 2017

EXECUTIVE SUMMARY:

The Scheme of Delegation & Reservation and Standing Financial Instructions have been updated as to reflect:

- new guidance around counter fraud and bribery;
- changes to titles of Executive Directors and other key staff;
- a change in the name of the Trust's regulator
- a change to the policy approval process

The full versions of the documents are available from the Company Secretary if needed.

REPORT RECOMMENDATION:

Trust Board is asked to accept the Audit Committee's recommendation that it should:

- approve the proposed changes to the Scheme of Delegation & Reservation and Standing Financial Instructions

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	
Clinical		Equality and Diversity		Workforce	

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:

Good governance and national policy

PREVIOUS CONSIDERATION:
Audit Committee on 29 September 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Date: Monday 2 October 2017

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 Thursday 5 October 2017 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.

Questions for the Council of Governors should be received by the Associate Director of Governance & Company Secretary no later than 24hrs prior to the meeting by post or e-mail to Associate Director of Governance & Company Secretary, Simon Grainger-Lloyd, Trust Headquarters or via email s.grainger-lloyd@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** 5 October 2017: 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 19 July 2017 and notes of the briefing session held on 12 September 2017	ROHGO (7/17) 006 ROHGO (10/17) 001	Chair
1410h	4	Update on actions arising from previous meeting	Verbal	SGL
1415h	5	STP update	Verbal	YB
1425h	6	Progress with action plans to address regulatory concerns	ROHGO (10/17) 002 ROHGO (10/17) 002 (a) ROHGO (10/17) 002 (b) ROHGO (10/17) 003 (c)	JWI/TP
1450h	7	Paediatrics services update	Verbal	YB/PA
1500h	8	Freedom to Speak Up update	Presentation	MJ
1520h	9	Update from the Board Committees: Finance & Performance Committee Quality & Safety Committee Audit Committee	 ROHGO (10/17) 004 ROHGO (10/17) 005 ROHGO (10/17) 006	 TP KS RA
1545h	10	Governor Matters: • Membership update • Governor elections • Lead governor nomination	 Presentation Verbal Verbal	 EC SGL YB
1555h	11	For information: • Quality & Patient Safety Report • Finance & Performance Overview	ROHGO (10/17) 007 ROHGO (10/17) 008	
	12	Any other business	Verbal	
	Date of next meeting: Wednesday 17 January 2018 @ 1400h – 1600h in Trust Headquarters			

MINUTES

Council of Governors - Version 0.3

Venue Boardroom, Trust Headquarters **Date** 19 July 2017 @ 1400h

Members present

Yve Buckland	Chairman	YB
Alan Last	Lead Governor	AL
Rob Talboys	Public Governor	RT
Brian Toner	Public Governor	BT
Marion Betteridge	Public Governor	MB
Anthony Thomas	Public Governor	AT
Lindsey Hughes	Public Governor	LH
Sue Arnott	Public Governor	SA
Karen Hughes	Staff Governor	KH
Mel Grainger	Staff Governor	MG
Alex Gilder	Staff Governor	AG
Paul Sabapathy	Stakeholder Governor	PS

In attendance

Tim Pile	Vice Chair and Non Executive Director	TP
Richard Phillips	Non Executive Director	RP
Kathryn Sallah	Non Executive Director	KS
Paul Athey	Acting Chief Executive	PA
Jo Williams	Interim Chief Operating Officer	JWI

Minutes	**Paper Ref**
1 Apologies and welcome	
Apologies were received from Carol Cullimore and Petro Nicolaides. It was noted that Lynda Hindley had resigned from her post as staff governor. Councillor Changese Khan was not present.	
2 Declarations of interest	
There were none.	
3 Minutes of the previous meeting on 17 May 2017	**ROHGO (5/17) 007**
The minutes of the meeting held on 17 May were accepted as a true and	

accurate record of discussions held.	
RESOLVED: The Council of Governors approved the minutes of the meeting held on 17 May 2017	
4 Update on actions arising from previous meetings	**Verbal**
It was noted that Lisa Kealey was to join the meeting later to present an update on complaints. Enderjit Aulja, Head of Business Intelligence was to be invited to join a meeting later in the year and Stuart Lovack was to join the meeting later to provide some assurance on the fire safety of the Trust's estate.	
5 STP update	**Verbal**
The Chairman advised that increasingly the STP was taking a leadership role on system issues and a plan would be developed by Autumn around how services would look across Birmingham and Solihull. It was noted that the STP leadership was provided by University Hospitals Birmingham NHSFT and Heart of England NHSFT, while the strategic project management infrastructure would be provided by Birmingham Women's and Children's NHSFT, part of which would look at Orthopaedic pathways across the region. It was noted that the myths around University Hospital Birmingham NHSFT taking over the ROH were not true. The STP was working well to support the Trust and address the complexities. The ROH would remain as a centre of expertise for orthopaedics but within the STP. The resources to undertake the underpinning work around the strategic oversight case, which would set out the options for the future sustainability of the ROH had been lacking previously and a team had been commissioned to assist the Trust. It was likely that a federated model would be the future system-wide model, within which would be a set of hospitals. It was noted that there was an increasing market for orthopaedics given the aging population.	
6 Follow up to NHS Improvement letter	**Verbal**
The Interim Chief Operating Officer reported that the number of open patient pathways prior to the commencement of the validation work was 59,000. Although this had reduced significantly, there remained a large number outstanding and targeted work would be undertaken to reduce this further to see which patients still needed treatment. Another key indicator being tested was the number of patients having waited for 52 weeks or over for treatment, some of which were spinal deformity patients. It was underlined that there was no expectation that any patients other than spinal deformity should wait longer than 52 weeks for treatment. There was some training underway on the management of the 18 weeks pathways and consultants were being engaged with this work. A number of stakeholders were scrutinising the Trust's progress with validation and the Trust's performance against the national 18 weeks Referral to Treatment Time target.	

The Acting Chief Executive added that there was now a much better understanding of the remaining cohort of open pathways.

It was reported that the effectiveness of theatres was a key concern, however rather than organise a theatre improvement programme, a scheduled care improvement programme would be developed which looked at the entire patient pathway. This would address the need to meet the correct guidelines for admission and would ensure that patients were fit, willing and able to undergo surgery. The programme would also address outdated practice where identified and better manage the communications sent out to patients.

Although RTT was a priority area of focus it was suggested that there had been some previous explanations of the 18 weeks issues that now seemed outdated based on the current information. The Interim Chief Operating Officer reported that a document had been issued to provide some national guidance, but the ROH had not fully adopted this and therefore work was being done to implement updated practice based on this. The Trust would also introduce planned waiting lists for some specialities. It was noted that any messages going out of the organisation with regard to the work and any updates from the 18 weeks RTT action plan were being filtered through the Interim Chief Operating Officer.

The Lead Governor asked what assurance was available to show that learning had been gained, especially given the significant investment in funding for some experts that had been brought in previously. The Chairman highlighted that the RTT issues dated back to 2009 and were therefore not recent. Resources were now brought in under the scrutiny of the NHS Improvement and their Intensive Support Team at no cost to the ROH. Some other organisations may have had similar problems but may have handled them differently. It was noted that the previous interims had looked at specific parts of the pathways, so it was reassuring to know that the entire pathway was being reviewed. The Interim Chief Operating Officer noted that she brought with her the expertise gained in large acute trusts and that this would be shared rather than drafting additional people in to do the jobs of those already employed. It was noted that clinical buy in was needed and cultural change was critical. Appropriate attendance by clinicians at key meetings was also necessary and so the Associate Medical Directors would be closely engaged where needed. Staff would be encouraged to challenge practice. Deadlines would also need to be met and the pace of change needed to be different. It was reported that there was no suggestion that the RTT issue was deliberate poor practice but reflected a lack of training. It was suggested that there were some teams that performed really well and shared practice needed to be encouraged. This would occur once the RTT imperative had been addressed. A more personal and patient-centric approach was also necessary. The Acting Chief Executive added that access to a range of others who had undertaken the role elsewhere was a real benefit, especially given the size of the organisation and this in turn would provide the confidence to raise issues. Lindsey Hughes noted that as part of her voluntary work, it was

obvious that patients did not know about their discharge arrangements. It was reported that the national initiatives 'Red2 Green' and 'Home for Lunch' initiatives would be revisited and would assist with this. It was noted that now the problems were well understood, there was a need to address grip, pace and overall better operations management. The future of the ROH was about clinical engagement and delivery. It was noted that the mood in the organisation did appear significantly different and there was an understanding that there needed to be a focus on change. The Acting Chief Executive reported that a letter from NHS Improvement had put the ROH in breach of licence on a range of matters and timescales needed to be agreed for the actions to address these. One of the actions was around cessation of external reporting performance against the 18 weeks RTT target. A deadline of September had been set to resolve this. NHS Improvement would be taking a judgement as to when all of the requirements in the undertakings letter had been met. This was unlikely to be a quick process and embeddedness needed to be demonstrated. It was agreed that there was a need for ownership and a commitment to completion. In terms of patient harm, all patients who had been waiting over 40 weeks who had been identified for treatment had been entered into a patient harm process. The process would be finished following the validation at the end of August. A staff governor noted that this process needed to be improved particularly if there was no record of agreements made at the harm review panel. The Interim Chief Operating Officer agreed to pick up this with the chair of the panel. In terms of the four patients that had been identified as experiencing harm, two had been operated on, and by the end of July all would have been treated. A Duty of Candour process was to be followed. It was noted that there had been some recent adverse publicity around metal on metal implants. These had been used at the ROH and the outcomes were good from this surgery, however there was already a requirement to review certain cohorts in a planned way. The cohort of patients to which this new guidance applied was now larger and needed to be built into the ROH's existing review process. This might cause challenges although this was a national issue and the National Orthopaedic Alliance was also looking at this and would need to be resourced nationally.	
7 Paediatrics services update	**Verbal**
The governors were asked about their concerns about the recent Board decision to move Paediatric surgery away from the ROH from 31 December 2017. It was suggested that there were serious concerns that some patients were seen in clinics and had been added to a waiting lists without knowing when and where the surgery would occur. There was also a serious concern that there was no capacity in the region and Birmingham Children's Hospital did not have the	

space. Staff did not appear to be aware that some Paediatrics services may be retained. There was also some potential damage reputationally and fears that in the light of the decision that staff may leave. The Acting Chief Executive reported that staff were aware of the uncertainties around the future of Paediatrics in its entirety at present. Cessation of referrals was not ideal, but the approach was to be as open as possible. Communication was underway with patients in the system and letters would be issued to patients to explain the decision and any information that was known. The Specialist Commissioner branch of NHS England had been made aware that the Trust wanted to work at pace and was looking at where efforts should be focussed. Some services would be addressed quickly with others less so. It was possible that there might be an element of additional funding for Birmingham Children's Hospital to assist if the decision was to move services there, although this was not certain. The Board was being open with staff as to the implications and had made it clear that the decision was around Paediatric surgery only. The future model could exist without any Paediatric services or equally could exist with some elements of Paediatric work. It was acknowledged that there was a key risk around staffing in the light of the service change, however as and when there was greater clarity, then the recruitment strategy would change. Conversations were also being held with those currently applying for Paediatric posts. Every effort had been made to reassure staff that they would be relocated to where the services would be move to under TUPE arrangements. Individual circumstances would be discussed as and when necessary. There was some degree of reasonableness as to where staff might need to travel following the transition of the service elsewhere. The Interim Chief Operating Officer added that she had spoken to dual registered nurses who had been encouraged to think about their opportunities and options. The potential lost income was £8m (10% of the ROH's total income). This had an impact on sustainability unless the capacity could be replaced. Conversations were being held with adult orthopaedics teams around this. It was noted that there was an opportunity to restructure to provide adult care. This was also an opportunity to pursue a different strategic model. The Chairman emphasised that the Board would be very focused on this work over the next few months, however ownership of the issue by the system was necessary. It was suggested that as the plans firmed up, it needed to be clear that children's operations would not cease; they would occur elsewhere. In terms of communications, a Frequently Asked Questions briefing was being developed. It was suggested that a weekly blog might also be needed. There were a number of meetings with staff that had happened already.	
8 Complaints update	**Verbal**
Lisa Kealey, Patient and Public Liaison Manager joined the meeting to present an	

update on complaints and she outlined the key changes to the complaints handling process. It was suggested that it would be useful to link the number of complaints to activity. The annual report would be circulated to provide this context when this was prepared. It was noted that it was a requirement of the CQC action plan to reduce waiting times in Outpatients, and the high number of complaints associated with Outpatients was a concern. It was suggested that a comparison to peer organisations would also be useful. The information needed to be benchmarked and absolute numbers were needed rather than percentages. It was noted that the Trust was better at investigating which had led to a high level of complaints upheld. The NHS was nationally having more complaints. The complexity of complaints received was also increasing. The details of concerns were logged on Ulysses and trends were noted. In terms of sickness and annual leave, the complaints team cross covered each other. The Interim Chief Operating Officer noted that it was inappropriate as part of the patient appointment letters to ask patients to call a PALS team as this did not create ownership of the service. Learning from complaints was needed and the evidence suggested that this was not as robust as it could be. This reflected the complexity of the complaints however. In terms of the Friends and Family Test (FFT), some of the comments in the free text suggested areas for improvement and these needed to be captured and fed into the improvements already underway. It was noted that the changes to the FFT meant that the information was not captured as robustly however. It was agreed that a further update on complaints was needed at a future meeting.	
9 Update from Board Committees: • **Finance & Performance Committee** • **Major Projects & OD Committee**	**Verbal** **ROHGO (7/17) 002** **ROHGO (7/17) 002 (a)**
The Chair of the Finance & Performance Committee reported that the his committee had last met in June to look at the May performance data. The financial position was ahead but only due to insurance payments received and the underlying position was behind plan. Activity was behind plan and theatre	

utilisation was poor. There was some good progress was on agency costs, other than those areas associated with data validation. Procurement processes were working well. Service level reporting data had been considered and this information would be shared to create ownership. The improvement needed was complex and was about pace, grip and delivery and the model needed to change. In terms of the June position, the results continued to be poor and the Quarter 1 Control Total target would been missed due to income shortfall. There were some cost pressures but the fundamental issues were around activity. This was associated with filling lists and poor utilisation. Demand for the ROH's services was significant but processes needed to change. A staff governor reported that there was a concern about jobs due to the low activity and poor finances. It was noted that this was a repeated discussion at meetings of the Council of Governors. It was acknowledged that a systematic way in addressing these issues was needed from start to the end of the process. There was now recognition that there was a need to access external expertise and this was now in place from the STP. Work was underway on future projections as a result of the Paediatrics decision, with the longer term piece of work being around replacing the Paediatric activity as had been explained earlier. The plan before the Paediatrics decision was to achieve a £6m deficit, however a view needed to be built into the three year operational plan based on the recent developments. In terms of agency control the Trust was below the agency cap for reasons beyond closed beds. The Chair of the Major Projects & OD Committee reported that his committee was a new committee of the Board. There were a set further groups that reported up into it, the key upward report being the People Committee which would replace the current Workforce & OD committee. The major projects part of the committee's remit would be self-selecting and in the terms of reference, there was a definition as to what constituted a major project. At present ePMA, network infrastructure and regenerative lab from the Dubrowsky legacy were the key major projects of focus. The regenerative lab would be onsite and sent a strong message to the organisation about its future and the value placed on pioneering work. Further progress would be reported at a future meeting. In terms of the Trust's ability to deliver transformational change there was not a great deal of headroom financially so a prioritisation approach might be needed. The other committees would also look at working together to deliver the wider agenda. It was reported that an Associate Non Executive had been appointed who had a background on OD.	
10 Governor Matters: • **Fire safety update**	**ROHGO (7/17) 003** **ROHGO (7/17) 003 (a)**
The Head of Estates joined the Council to provide an update on fire safety on	

the back of the Grenfell Tower disaster. He reported that an assessment of the buildings with the fire service had been undertaken and a report back was submitted centrally. Of the buildings assessed there were a number of buildings that were risky, however the ROH was not an issue. The Trust had no high rise or medium rise buildings on site. There was limited cladding on the buildings and it was not of a dangerous nature. There was a fire safety advisor in the Trust and risk assessments were undertaken routinely. An exercise had been undertaken to confirm that the fire safety arrangements were adequate. The governors were reassured and noted that the team had responded quickly. It was noted that the Trust did not have sprinklers, although this might be built into future regulations and requirements. In terms of the ward areas, all had alternative means of escape. Patients were also removed via a ski sled if required. Car parking was discussed. It was reported that a system was on site for charging patients and visitors, which was based on expected hours at the Trust. Pay on exit would require number plate recognition and the system was expensive. Alternatives were going to be explored, including moving away from the need to enter a vehicle's registration number. There were a number of free spaces for blue badge holders previously, however as these were limited, there had been conflict between those trying to park, therefore these had been removed. It was agreed that the Head of Estates would update the Patient & Carer's Forum on this matter in future.	
12 For information: • **Finance & Performance overview** • **Quality & Patient Safety report**	**ROHGO (7/17) 004** **ROHGO (7/17) 005**
The finance & performance and quality & safety reports were received for information.	
13 Any other business	**Verbal**
There was none.	
14 Details of next meeting	**Verbal**
The next meeting is planned for Thursday 5 October 2017 at 1400h – 1600h in the Boardroom, Trust HQ.	

The Royal Orthopaedic Hospital NHS Foundation Trust

COUNCIL OF GOVERNORS PRIVATE BRIEFING SESSION
12 SEPTEMBER 2017

Present: Yve Buckland (Chair), Paul Athey, Jo Williams, Alan Last, Karen Hughes, Alex Gilder, Mel Grainger, Marion Betteridge, Tony Thomas, Sue Arnott, Petro Nicolaides (part)

All were welcomed and it was explained that this was an opportunity in between formal meetings to update the governors on progress with key initiatives and the performance of the Trust.

Delivery of the 18 weeks Referral to Treatment action plan

The Interim Chief Operating Officer explained that the number of open pathways had reduced from 59,000 to 8,800 and these were now categorised into non-admitted (patients not requiring treatment that would result in an inpatient stay) and admitted (patients needing an inpatient spell) pathways. The number of patients waiting for treatment for 52 weeks or over was c. 100 and work was underway to ensure that these patients were given a date for surgery or are aware how long it would be before they were treated. All patients were being personally contacted. It was agreed that this was good progress with addressing the challenges reported to the governors previously; regulators were also pleased with the progress made. The key challenge was to ensure that patients were treated as speedily as possible. Consultants availability was key to this and so various measures were being taken to ensure that there was sufficient opportunity for patients to be treated, including undertaking work over the Christmas period, which would traditionally have been quiet time and to undertake weekend sessions. Other resources from University Hospital Birmingham NHSFT were joining the ROH to support the recovery work and assist with operational improvement.

It was reported that NHS Improvement was pleased with the progress made and suggested that this was a 'text book' example of how the issue should be resolved. They had signalled that there would be a move away from the need to meet on a monthly basis to check progress from their perspective.

It was highlighted that the Trust had not been good at forward planning, therefore conversations were being held with patients to determine that they wanted to come in for treatment and to make pre-operative processes made more robust.

A question was asked around how the effectiveness of the new training in the management of 18 weeks pathways would be monitored. This was via a daily validation of the open pathway position, where errors were picked up and allowed traceability back to the individual who had undertaken the data entry. Part of induction for junior doctors would also include RTT management training. Additionally, external assurance would be used where possible, drawing on resources from the STP for instance. Internal and external audit would also be used to review practices and identify areas for improvement. A new suite of information was also available and if any of the numbers on the patient tracking list changed, then the reasons for this could be verified.

Financial and operational performance

In terms of financial performance, this was driven by activity and there was a sound order book and therefore a good opportunity to deliver an acceptable financial result. Arranging the flow of activity through the hospital was still a challenge however and due to this inefficiency, the Trust was £0.5m behind plan at present. There was sufficient capacity to treat patients but practice in theatres needed to change. A theatre group had been established, which was led clinically and there was a new theatre manager who would start in post shortly. A matron for theatres had also been appointed. Simple process issues were being worked through including automatic starts, meaning that the day in theatres started as promptly as possible by calling for the first patient ready to start the first procedure at 0830h. There was also work to do to ensure that staff from the wards would collect a patient from theatres, rather than solely relying on the portering staff. The Deputy Director of Nursing was supporting this work. A staff governor commented that despite the improvement work, there seemed to be the same issues that the consultant staff were facing, particularly around cancellations which meant that lists could be under utilised. There was also not a forward look available as to what theatre slots were available which could be offered out further in advance. Pre-operative assessment remained an issue and filling vacant theatre slots at short notice was difficult. Starting times remained a problem and there remained reluctance by staff to complete additional cases on a list. There was also variation in terms of the anaesthetic procedures but peer to peer challenge around this was difficult; this would be reviewed by the anaesthetics lead at QEH. There was a culture where barriers were put in place to prevent additional cases being added to lists and it was suggested that there was little incentive for staff to undertake additional work in the week, where some people were paid enhancements at a weekend. It was suggested that these messages needed to be conveyed to those staff who had it within their gift to address them at the '6-4-2' meeting.

It was reported that a change in practice that had recently been implemented was that should there be an unfilled list two weeks in advance then these would be closed down; it was hoped that this would deliver a culture change where consultants proactively filled their lists to prevent them being closed. There was more work to do to ensure that only fit, willing and able patients were added to the lists. In terms of the automatic starts, assurance was given that should there be a delay to the operation starting, then patients would not be kept in the anaesthetic room until the anaesthetist arrived. It was suggested that the middle part of the theatre process needed to be sorted, not just the start time. The changes in leadership that had taken place and were planned would assist with improving the turnaround and efficiency in this respect. It was agreed that the culture in theatres needed to be changed and motivation was key. It was anticipated that the major blockages in theatres this would be part of the Scheduled Care Improvement Programme but the issues predominantly related to culture which was not a quick fix. The right 'ingredients' were being invested into theatres to secure a longer term change, however.

In terms of the overall activity position, there was uncertainty on the wards as a result of the ward closures. It was reported that there had been incremental improvement but the casemix was not appropriate. Staff morale was also an issue and there needed to be more stability for staff currently being asked to move elsewhere when their ward was closed. It was agreed that the communication of the messages around the ward closures needed to be careful, given that the efficiency improvements and driving down length of stay would reduce the requirements on the bed stock.

There was also effort directed to reducing admissions on the day before surgery and a switch from processing cancer inpatients to day cases.

In terms of finance, there were some areas of expenditure which needed to be reviewed – there was an increase in consumables which was not consistent with the theatre activity, therefore there was some work around stock control to undertake. There also needed to be a robust set of CIP schemes to support the financial position and help deliver financial recovery.

Paediatrics

The governors were reminded of the decision taken by the Board to cease providing Paediatric surgery after 31 December. Since this decision, there had been much work with the system to develop a transition model. The aim was a Birmingham solution, which relied on support from and capacity at Birmingham Children's Hospital. The model for 16-18 year olds also needed to be defined and the ROH's role in this in the future needed to be decided. The decision regarding Paediatrics needed to fit in to the future business model for the ROH and this work was ongoing through the development of the Strategic Outline Case (SOC). In terms of the governance process for this work, a set of workstreams had been set up to review the various modelling options for all groups of patients, each being led by a clinician and a monthly commissioning group had been established to review progress and any risks; the reference group for Paediatrics had met once and there was some good discussions around the progress and achievement. Following the Paediatric surgery decision, a meeting with all consultants had been held to explain the rationale for the decision and the way in which they could feed into the work. The first priority was to look at the service for children with spinal deformity and consider the options. The focus was now on what the future models needed to look like. It was noted that there were some clinicians who remained dissatisfied, although the rationale was clear and the issue had been a concern of the Board for some time. The matter was complex and it was now within the remit of the specialist commissioners to handle who had confirmed that there was a desire for a Birmingham solution. It was suggested that there needed to be clarity as to the future direction as soon as possible although it was likely that until capacity plans were confirmed, then there would not be this clarity in the short term. Patients were also still being listed for surgery, although this was based on the plans for BCH to invest in capacity to take on this work in future. The Trust was being open with patients about the possibility that in the longer term they might be treated in a different setting. It was suggested that an update to staff was needed. The Clinical staff governors highlighted that there was not great dissention from staff around the decision. The consultants role in managing expectations was critical for patients.

Strategic planning process

It was reported that the STP was now led by Dame Julie Moore from University Hospital Birmingham NHS FT. The rationale behind the STP was that in this era of less money and growing demand, the decision making and resource sharing was delivered better through collaboration and subsidiarity. The big focus remained on the wider public health agenda and there was a growing view that hospitals need to work together more closely, this being one of the reasons for the support from Jo Williams as Interim Chief Operating Officer from the STP. The strategic decisions for the ROH would be considered as part of the wider STP work, with the current thinking being that the ROH remained as a setting for orthopaedics.

The STP was now given a control total, rather than individual hospitals. The Birmingham & Solihull (BSOL) STP was now being seen as one of the more forward thinking and better functioning STPs nationally, this having previously not been the case. It was suggested that it was likely that the hospital sites within the BSOL footprint would all operate as one in future. There was some work in parallel to merge the CCGs. It was highlighted that there was a risk to the future of the ROH if the Trust could not define what a sound model needed to look like and particularly if this was not consistent with the views of the STP. There was however, not enough capacity in the system at present to undertake orthopaedics elsewhere, therefore this provided an opportunity for the ROH to demonstrate it could lead this work. It was suggested that it was the critical mass of all the experts in the organisation that kept the ROH at the forefront and this needed to be kept together where the service was provided, that being either now or in the future.

It was noted that there would be a relationship to develop with Heart of England NHS FT, now that the merger with UHB had been agreed. There would also need to be capital investment in orthopaedics in the future. The NAO Vanguard work also fed into this work and the NAO would take a role in developing benchmarking. The Trust was good on clinical outcomes for hips and knees but not for some of the other specialities. It was noted that Amplitude, the system for capturing clinical outcomes would be discussed at Audit Committee at the end of this month. Work was being done to try to attract private patients.

Media attention

It was reported that there had been some adverse press around the harm reviews and the 18 weeks RTT work. There had been a link made between data quality issues and harm. This related to only spinal deformity cases, however. The definition of harm for these patients was around what outcomes might look like in the future. A moderate harm was classed as a patient listed for an operation who then needed a bigger operation. The amount of harm was often not known until surgery was complete. The Executive Medical Director had been interviewed as part of the Health Service Journal's (HSJ) research. A statement in response to the article would be developed to be published on the website to give contact details and context. It was noted that it was hard to argue on a public forum such as the HSJ and other press the complexities of spinal deformity.

The next formal meeting of the Council of Governors is to be held at 1400h on Thursday 5 October, which would then be followed by the Annual Members Meeting.

ROHGO (10/17) 002

COUNCIL OF GOVERNORS

DOCUMENT TITLE:	**Action plans to address regulatory concerns**
SPONSOR (EXECUTIVE DIRECTOR):	**Paul Athey, Acting CEO**
AUTHOR:	**Jo Williams, Interim COO**
DATE OF MEETING:	**5 October 2017**

EXECUTIVE SUMMARY:

The attached presents the updated version of the RTT action plan (Appendix 1), developed to capture key actions needed to address the current regulatory concerns around the Trust's management of the 18 weeks pathway and referrals.

Also attached is the updated cancer action plan (Appendix 2) and updated spinal deformity action plan (Appendix 3), which are the further two key elements of the former integrated action plan.

The Board will recall that these action plans were prepared in response to the letter from regulators outlining a series of undertakings that the ROH needed to achieve to be able to remedy its licence breaches.

REPORT RECOMMENDATION:

Council of Governors is asked to:

- RECEIVE and NOTE the action plans
- CHALLENGE and CONFIRM the adequacy of the actions included

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	
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:

Safe, efficient processes

PREVIOUS CONSIDERATION:

Trust Board on 4 October 2017

18wk Referral to Treatment Recovery Plan – September 2017

Achieved
On track
Off track
Not achieved
Not started

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

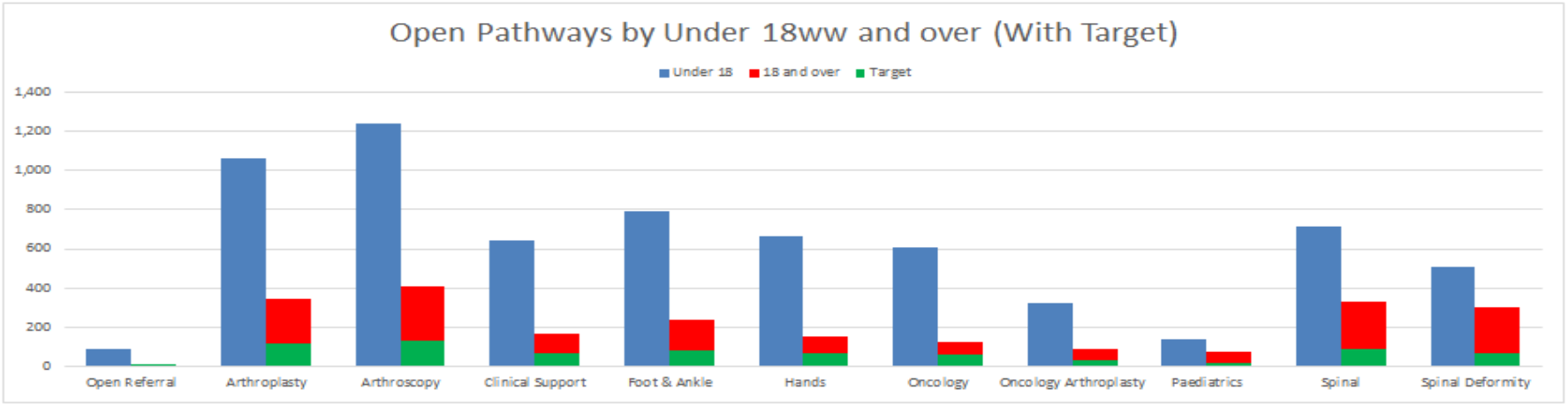
Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at: 2017-09-22

Select Pathway Type: **Both**

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
0-6	**3,109**	87	520	586	320	360	277	294	138	54	321	239
7-13	**2,549**	1	378	451	232	324	269	229	143	58	279	186
14-17	**1,029**	0	165	207	88	106	117	85	38	26	117	80
18-26	**1,307**	0	220	237	110	146	107	97	45	37	178	130
27-39	**614**	0	95	127	44	68	36	18	34	24	87	81
40-51	**185**	0	25	33	7	19	8	5	3	9	42	34
52 weeks and over	**102**	0	2	7	4	3	2	2	3	3	23	53
Total	**8,895**	88	1,405	1,648	805	1,026	816	730	404	211	1,047	803

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**6,687**	88	1,063	1,244	640	790	663	608	319	138	717	505
18 and over	**2,208**	0	342	404	165	236	153	122	85	73	330	298
Target	**712**	**7**	**112**	**132**	**64**	**82**	**65**	**58**	**32**	**17**	**84**	**64**

Performance against Target (92.0%)	75.2%	100.0%	75.7%	75.5%	79.5%	77.0%	81.3%	83.3%	79.0%	65.4%	68.5%	62.9%



Workstream		Executive Lead	Manager Lead	Issue	Action	Updates/Progress	Target Completion (RAG)
3.0	Process	Interim COO	~~J Phillips~~ M Payne	Standard operating procedures (SOP) need to be in place and reviewed to support the access policy	The access policy is to be reviewed and embedded to ensure that it meets the national RTT guidance. All supporting SOP's need to reviewed and implemented. Any changes need to be communicated to all staff and reflected in the training.	**Update 14.8.17** • SOP for planned waiting list has been drafted and out for review. Meeting held to discuss use of planned waiting list and flow chart drafted. • Adding pts to a WL, removing pts from a WL, printing admission letters and sending for patients have also been reviewed and being updated. **Update 24.08.17** • SOPs need to be Trust wide • Review from long-list of SOPs for all staff to use • JP, NL & JW to agree leads for each • On track for delivery at end of Sept 17 **Update 14.09.17** • Check status of Planned Waiting List SOP with R Matthews **Update 21.09.17** • Planned waiting list to be re-launched beginning of Oct – this is key SOP • 20 further SOP's to be reviewed and timeline for all to be agreed	**End of Sept 17 (remainder of SOP's to be refreshed by end of December 17)**

9.0	Process	Interim COO	Jo Phillips	The Trust needs to complete the validation of the records with open pathways showing inconsistencies with data quality (c100k)	Prioritisation of key patient pathways to establish an accurate RTT position and identify any patients who may have incurred harm. This number is 59,000	**Update 24.08.17** • Open pathway validation is complete • IST will be on site on 18th September to review progress against actions (such as 32s, 34s, 35s) **Update 14.09.17** • Review of clinical support pathways over past 10 years has been sampled and results of sampling for completion by end of Sept 17.	**Ongoing – Review 18th September 2017 IST review (1day)**
13.0	Ops	Interim COO	Nicky Lloyd	Develop an options appraisal and delivery plan for the booking process which includes an option for centralisation and review of listing processes.	Review the current process and scope the transfer for a centralised team	**Update 24.08.17** • The booking function has come out of a centralised model, and devolved back to secretary teams to improve ownership of service level booking • Common process established across teams • Oncology service is next step – team to be trained with spinal going live at the end of August 17. **Update 14.09.17** • All bookings now going through medical secretaries and activity has increased as a result (effective booking of patients) • Next step to review any function for centralisation potential	**End of August 17**
14.0	Ops	Interim COO	Nicky Lloyd	Review all clinic templates for OPD	To ensure that all clinic templates are reflected of current job plans and booking rules support 18wk RTT delivery	**Update 14.09.17** • Review templates with R Matthews and timings of appointments • Use Oncology templates as exemplar	**End of Sept 17**

18.0	Ops	Interim COO	Nicky Lloyd	Refresh the trajectories once validation has been completed	Once validation has been completed at the end of June 2017 all the trajectories will need to be recalculated to reflect demand and capacity and delivery of activity	**Update 24.07.17** • Validation to be completed by 31.07.17 for open pathways **Update 03.08.17** • Phase 1 validation of open pathways to be completed by 04.08.17 – update next week based on cleansed data set • Training at BCH on 16.8.17 for ops managers on Capacity & Demand this will help to develop refreshed **Update 24.08.17** • Ops team attended demand & Capacity training at BWCH • EA to review information stream to feed model **Update 14.09.17** • Informatics currently populating BWCH demand & capacity model, some data quality issues • J Davies to refresh original trajectories	**End of Sept 17**

19.0	People	Director of Strategy & Delivery	Clare Mair	Review all job descriptions to staff with RTT responsibility	To ensure that all staff involved in the management and delivery of RTT data (data & operational) have the correct skills and knowledge. To ensure that all staff as part of their objectives have this reflected in their appraisal and are managed as required. Ensure all staff have an annual refresher around 18 weeks RTT, it becomes part of the annual appraisal process and all bank and agency staff have their competence assessed prior to commencing work.	**Update 03.08.17** • Initial discussion with Professor Begg to review resources available to design, schedule and deliver PDR sessions before the end of September. • Letter to staff with RTT responsibility • Recruitment policy to be circulated for comment (referencing performance & patient outcomes) **Update 24.08.17** • Draft letter for all staff with RTT responsibility – to include refresher training, new PTL, consultant level dashboards. • Line managers trained to include within PDR process **Update 14.09.17** • Trust Priorities have now been agreed by Exec and urgency is required to roll these out to staff members. • CM & RB to put together a roll out plan which will include a one hour session for all managers and engagement from the Exec team.	**End of September 17**

20.0	Ops	Interim COO	Nicky Lloyd	Review current theatre utilisation by specialty and develop as required remedial action plans to support the delivery of 18wk RTT	Review all the work undertaken including 6-4-2 to ensure that theatres are optimised to support delivery of 18wk RTT	**Update 24.08.17** • As of w/c 21.08.17, if lists aren't populated by 3pm on a Friday, the list is formally closed for the following week • Reviewing utilisation every week in theatres at 6-4-2 chaired by Deputy COO and Associate Medical Director **Update 14.09.17** • Check with NOA re. benchmarking ourselves against other providers re. theatre utilisation target (currently 85%) – look to increase	**End Of August 17- ongoing**
21.0	Ops	Interim COO	Nicky Lloyd	Review the current process for Inpatient/OPD and planned waiting list management to include POAC'd patients ready for surgery.	Undertake a review of the current processes to include current waiting times	**Update 14.8.17** • Planned waiting list SOP has been updated and a flow chart drafted following a workshop for use of planned waiting list. **Update 24.08.17** • Speak to specialty leads for examples of planned patients • Following this, circulate SOP and flowchart to teams • Amend SOP – patients should not be added to planned waiting list where it is foreseen that their procedure is more than 12 months (with exception of Spinal Deformity) **NEW ACTION: Review of POAC process as part of Scheduled Care Improvement Process**	**End of August 17 – original action complete – see new action**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

CLOSED ACTIONS

Workstream		Executive Lead	Manager Lead	Issue	Action	Updates/Progress	Target Completion (RAG)
1.0	Process	Interim COO	J Phillips	Knowledge of 18wks RTT amongst all staff	Introduce a Trust wide education programme for 18 weeks RTT for all ROH staff. Establish how many staff need training (A&C and Clinical) and review current training programme Develop and implement annual refresher training for all staff to include 18 week RTT information in Trust induction & MT.	**Update 27.07.17** • Consultant training session held as part of Clinical Audit today – good engagement and well received. • Suggestion that this session is included as part of consultant induction – JP & CM to review • 18 weeks to be included in Junior Doctor induction – HR to confirm schedule **Update 03.08.17** • Ongoing consultant training programme • As part of corporate induction • Include in consultant on boarding programme	**End of Aug 17** **COMPLETED**

2.0	Process	Interim COO	J Phillips	The access policy needs to be reviewed to ensure that it meets national guidance including incorporating any locally agreed variation	The access policy should be reviewed and embedded, ensure that it meets with the national guidance – this should then form the basis of the training delivered. This should be reviewed annually.	**05.07.2017** • This action is complete • Policy has been approved in line with national guidance and has been communicated to all staff via Communications	**End of July 17** **COMPLETED**
4.0	Data	Director of Finance	Enderjit Aujla	The Trust does not have strategic end to end PTL and a suite of reports to support operational daily delivery	Develop a robust and accurate tracker for all patients on an 18 week pathway with a reporting suite to support patient management. (daily, weekly reports)	**Update 27.07.17** • Provisional date of 14.08.17 to go live with switchover – support for Ops team to understand the difference between systems • First drafts of new dashboards are with the Ops team **Update 03.08.17** • 14th August – all dashboards link to new PTL & process (refreshed data) **Update 24.08.17** • No longer using milestones • Summary of RTT to include 'admitted & non-admitted' language (rather than milestones) – for all consultants • This action is complete •	~~**Mid July 17**~~ **14.08.17** **COMPLETED**
5.0	Data	Director of Finance	Enderjit Aujla	The Trust has a number of standalone systems that do not "talk" to PAS	The pathways and process need to be reviewed to understand the use of the systems and the impact on RTT data - and a full appraisal undertaken with alignment to PAS.	**Update 03.08.17** • Standalone systems all identified. This action is linked to development of SOPs to ensure that staff use PAS as primary source.	**End of Sept 17**

				which records RTT data		**Update 24.08.17** • JP & JH to meet to confirm dual entry across PAS & Tiara (with PAS as master system) **Update 14.09.17** • All data is in PAS as the master system, all staff have been made aware.	
6.0	Process	Interim COO	Jo Phillips	The Trust has a number of tracker systems. These all needs identifying to understand their purpose on operational delivery and assurance	The trackers need reviewing to ensure that there is a focused based validation process to support data quality issue and improve accuracy	**Update 27.07.17** • Review of trackers complete	**Mid July 17** **COMPLETED**
7.0	Process	Interim COO	Jo Phillips	The Trust needs to have in place a weekly PTL and assurance meetings to support the delivery of RTT	A standing agenda's, terms of reference and action notes should be captured. Agenda's should include:- -RTT pathways incomplete, admitted & non admitted -planned and reviewed list -data quality -trend report -exception report for long wait waiters -monitoring recovery plans and trajectories	**05.07.2017** • E Aujla has taken over producing the weekly summaries (previously completed by J Phillips) for the last year and JP & EA will be working together to provide forecast information to develop the suite of reports (link to previous action) **11.07.17** • Currently embedding use of new weekly summaries and work continues to refine and develop further forecasting information **Update 20.07.17** • PTL meeting format is being revised. As of 26th July trialling hour slots for each	**End of June 17** **COMPLETED**

						specialty for patients waiting 51 weeks and below not currently booked. • Informatics are developing the dashboards for operational managers which are currently out for consultation and review. Informatics have now taken over all weekly summaries from Division 3 regarding waiting list summaries. **Update 27.07.17** • Revised format – each sub speciality has 1 hour slot where all patients 51 weeks and under are reviewed. A separate 52+ ww meeting is held with Interim COO on weekly basis	
10.0	Process	Interim COO	Nicky Lloyd	The Trust needs a separate assurance operational meeting to review and action all patients over 52weeks	Given the volume of long waits a separate weekly forum will be set up to drive the reduction and management of this cohort and will identify RCA requirements to be presented.	**05.07.2017** • Weekly meeting scheduled • Ongoing reporting & escalation to RTT Recovery Board (weekly) Exec Team (weekly), and to Finance & Performance Committee (monthly) • Supports weekly external reporting of 52+ww patients (assurance mechanism) • First meeting scheduled for 6.7.17 to be chaired by Associate D Ops/DGM Div 3 • Meeting with E Cullen with CSSMs to review lists of 52+ww patients (7.7.17) • Interim COO chairs weekly mtg	**End of June 17** **COMPLETED**

11.0	Process	Interim COO	Jo Phillips	The outcome form in clinic needs to be refreshed and implemented	The outcome form needs to be reviewed in line with national guidance – this needs to be supported with local training and daily monitoring	**19.06.2017** • This has gone live as of today. Corporate Team to provide update to Jo Phillips. **05.07.17** • Receiving feedback and will be making small amendments to improve its use. • Validation team will conduct sample validation the new form to determine accuracy of completion. • Review feedback received since go-live of new form • Breach date to be added on form from w/c 10/07/17 • Trust wide communications to explain additions to form, and targeted face to face engagement with key staff • Corporate validators are now validating clock stop 30s using the form **Update 20.07.17** • New outcome form is now embedded, waiting for informatics to add the breach date to the form. Corporate validation team are auditing outcome forms.	**End of June 17** **COMPLETED**

12.0	Ops	Interim COO	Nicky Lloyd	Review and revise the external performance scorecard to inform and ensure that all key metric s are monitored.	Review all operational performance documents and ensure they are consistently reported both internally and externally – imaging, RTT and Cancer	**05.07.2017** • N Lloyd to meet with J Williams & E Cullen & E Aujla – review UHB 'Report 1' deployment at ROH • Draft report 1 to be shared following this meeting for review by NL • Scope all other external returns – SGL to advise **Update 24.07.17** • Some slippage – awaiting review of 'Report 1' **Update 27.07.17** • ROH report under development will replicate elements of UHB Report 1. First draft due to be reviewed internally by Ops management 01.08.17 **Update 03.08.17** • New system on 14th August includes functionality for daily reporting • Compare with Report 1 **Update 24.08.17** • New PTL has launched today • Refreshed daily (automated by beginning September)	**End of July 17 (Revised date mid August)**

15.0	Ops	Interim COO	Nicky Lloyd	To ensure that all patients who are identified as long waits are tracked and discussed at the monthly harm review	To ensure that any patient who have are long waiters are clinically reviewed and an appropriate management plan is in place	**19.06.2017** • Harm Review chaired by Medical Director already in place until further notice. **05.07.2017** • JP to confirm that all systems are being cross-referenced (for development of timeline) before being presented to Ops managers to carry harm review with consultants **11.07.17** • JP confirmed all systems are cross referenced during the process of timelines for long wait patients **Update 03.08.17** • Any patient over 40 week wait will be reviewed and assessed through harm review process	**End of June 17** **Ongoing process in place**

16.0	Ops	Interim COO	Nicky Lloyd	Review the current process for letter turnaround and track performance	To establish a speciality based report to track and monitor weekly performance	**Update 24.07.17** • Oldest clinic letters to be typed from 20.06.17 (4 weeks behind) – affected by reduced staff capacity • From this week, increased bank staff to improve backlog position **Update 02.08.17** • This action is complete – the speciality monitoring system is in place and letter turnaround has improved dramatically, with Hands up to date • Business as usual	**End of July 17**
17.0	Ops	Interim COO	Jo Williams	Review and update actions from the RSM	Ensure that all actions and recommendations have either been implemented or are detailed in this action plan	**Update 27.07.17** • The report has been amalgamated and for completeness will be documented for review in September 2017 (Audit Committee)	**End of June 17 – review completed**

22.0	Ops	Interim COO	Nicky Lloyd	Establish a SOP for cancellation of operations on the day of surgery (including BCH)	Review current communication process for cancelled ops and embed a robust escalation process to be shared across organisations (including 28 day guarantee patients).	**05.07.17 (ongoing)** • All potential cancellations are flagged via the senior of the day by phone call to Associate Director of Operations – reduction seen in number of cancellations to date • Theatre handbook contains SOP for cancellation for all reasons • Issue extract of theatre handbook by AMD to all surgeons and anaesthetists to remind them of agreed SOP • Comms team to ensure rolling programme of comms around cancellation processes and encouraging all staff to prevent any possible cancellation occurring **Update 27.07.17** • Associate Director of Ops/Interim COO receive phone call to notify of any potential cancellations to ensure that all actions are taken to mitigate and prevent cancellations • DGM for Div 3 working with Division 2 to streamline data capture and reporting of on the day cancellations including cause & re-booking **Update 02.08.17** • On track and business as usual. Unacceptable number of cancellations due to medical reasons (review as part of POAC workstream) and patients changing their mind (review as part of consent audit)	**End of August 17 (complete ahead of schedule)**

23.0	People	Interim COO	All leads	To develop a communications strategy to deliver corporate objectives.	Develop as part of the communications strategy a patient experience scenario.	**Update 03.08.17** • Positive recognition of staff involved in improvement schemes as part of RTT recovery • Validation work complete • Scheduled Care Improvement programme in place – looking at ideal pathways (across whole patient pathway), split into OP/pre-assessment/theatres/post-op/discharge planning • Engaging broad range of teams to own improvements across patient journey • Communications to focus on streamlining processes **Update 24.08.17** • Weekly update through Friday message • To be included on theatres dashboard • Case study • Part of Scheduled Care Improvement Programme • Briefing as part of Clinical Audit /Quality Improvement monthly session	**End July 2017**
8.0	Data	Director of Finance	Enderjit Aujla	Establish a robust reporting suite to identify RTT data quality issues and potential exclusion cohorts based on audited groupings.	Agree change to business rules to facilitate a focused datasets for validation to support data quality issues and potential exclusion groups – with audit samples to support conclusions or agreement to exclude.	**Update 24.08.17** • EA to confirm with BH what has been sample validated before exclusion rules can be signed off **Update 14.09.17** • New PTL and reporting suite in place	**End of June 17** **Phase 1 completed** **Ongoing validation in place**

Achieved
On track
Off track
Not achieved
Not started

ROH CANCER ACTION PLAN			
NAME OF PROVIDER	**The Royal Orthopaedic Hospital NHS Trust**		
Key Performance Indicator	Cancer – 31 & 62 day targets		
Lead Officer	Suzanne Kelly, Clinical Service Manager	**Executive Director**	Joanne Williams Interim Chief Operating Officer

			Unreported	Reported Month (2017/2018)						
Target Name	National Standard		Indicative August *	July	Jun	May	Apr	Mar	Feb	Jan
2ww	93%		**100%**	**100%**	**95.65%**	**100%**	**97.30%**	**93.75%**	**100%**	**100%**
31 day first treatment	96%		**100%**	**100%**	**91.67%**	**100%**	**100%**	**100%**	**88.89%**	**95%**
31 day subsequent (surgery)	94%		**100%**	**100%**	**100%**	**100%**	**100.00%**	**100%**	**100%**	**90%**
31 day subsequent (drugs)	98%		**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
62 day (traditional)	85%		**100%**	**37.5%**	**71.43%**	**60%**	**66.67%**	**100%**	**66.70%**	**75%**
62 day (Cons Upgrade)	n/a		**75%**	**100%**	**100%**	**100%**	**100%**	**n/a**	**n/a**	**n/a**
No. day patients treated 104+ days			**0**	**3**	**1**					

Action		Executive Lead/ Operational Lead	Target Completion (RAG)	Status/Updates
2	Undertake a review of cancer services, including all process, systems and staffing structure (this is to include the entire pathway from referral)	Interim Chief Operating Officer	~~End of August 17~~ End of October 2017	Head of Operational Performance at HEFT to commence initial review 14th July 17. The review will now also include the requirement to agree the structure for succession planning with the consultant nurse due to retire at the end of 2017. (Additional action added – 26). New Oncology Support Manager commences 04/09/17 and will undertake the end to end process mapping.
4	All Cancer Service staff to receive training on the new access policy. In addition, ensure that all Cancer Services staff are familiar with the national cancer waiting times guidance and associated rule set, and are competent in its application.	Clinical Services Manager	End of September 17	To be completed once the policy has been reviewed. HEFT Cancer team to support training Training date tbc (w/c 18/9 or 25/9) to include competency test/quiz for all Oncology staff
5	Develop a cancer PTL with a suite of reports to monitor performance and backlog	Interim Chief Operating Officer	End of October 17	Full system review needs to be undertaken. PTL has been developed and used weekly to track patients for all targets
6	Establish a Cancer Informatics Group to provide oversight to the processes in place to collect assess and submit data relating to all aspects of Cancer services and care.	Lead Cancer Clinician & Clinical Service Manager	End of September 17	Meeting structure to be established Template Terms of Reference supplied 29/8/ as a starting point in developing ROH version

Action		Executive Lead/ Operational Lead	Target Completion (RAG)	Status/Updates
7	Establish a weekly PTL meeting for all cancer patients including both suspected and confirmed sarcoma and spinal cancer patients. Establish a mechanism for highlighting patients who are at risk of breaching 104 days to the relevant clinical and operational leads. This should be linked to the establishment of the PTL and should include defined trigger and escalation points, such as any patient reaching 80 days on a cancer pathway.	Interim Chief Operating Officer	~~End of August 17~~ End of September 2017	Refreshed meeting to be chaired by the Interim Chief Operating Officer PTL function on Onkos being reviewed and patients being validated with a view to establishing formal PTL meeting by 15/9 Updated to merge with action 13 Weekly PTL meetings commenced 4/9 and being refined. The process for including spinal patients will be in place by end September 2017.
8	Review the current patient cohort and establish any backlogs. Develop a weekly report to track backlog activity	Interim Chief Operating Officer	End of September 17	PAS data received and is currently being reviewed. All 62 day patients (except spinal patients) appear on the Onkos database live tracker.
9	Develop a performance scorecard for all targets. This should include an adjusted and unadjusted 62 day performance figure based on application of the West Midlands breach reallocation policy methodology.	Interim Chief Operating Officer	End of September 2017	Scorecard for all targets drafted. No function to record date tertiary referral received. Reviewing process to produce a report on adjusted/unadjusted and (un)reported. Report in place

Action		Executive Lead/ Operational Lead	Target Completion (RAG)	Status/Updates
10	Review of all MDT working to provide assurance to the Cancer Board that robust processes are in place. Ensure cancer MDT support structure covers all cancer patients including spinal MDT and that outcomes are reported live and approved by the relevant clinical lead.	Interim Chief Operating Officer	End of September 17	To include as part of review of service MDT Operational Policy due for review July 2017 (new action – 27, as per action 3) No spinal MDT patients have been recorded on Open Exeter in relation to cancer waiting times. PAS data and paper records obtained and retrospective review of patients to be included is underway. Scale of patients not recorded since January 2017 will be available after review. Support structure for onward recording to be defined.
11	Review the Inter-hospital referral protocol for all referrals and ensure that the WM Reallocation policy has been implemented and communicated.	Interim Chief Operating Officer	End of August 17	Overview presented to CSM 25/8. Training date tbc (w/c 18/9 or 25/9) to include competency test/quiz for all Oncology staff
14	Review the current cancer reporting system Onkos and its functionality and integration with other systems in the Trust. A full appraisal of the current use of the system is required to fully understand how it is being used for research and an electronic patient record system.	Interim Operating Officer	~~End of August 2017~~ End of October 2017	An initial review has been conducted and an option appraisal paper is required to agree the system for cancer operational reporting. Timelines and implementation plan to be agreed. Current system does provide PTL and has ability to track patients
16	Ensure that timed pathways are in place for all patients and are reviewed to ensure that they meet the national performance targets. These should take account of any demands on clinical support services and identify key milestones across the pathway and form the basis of the MDT tracking and escalation process.	Clinical Service Manager	~~End of August 17~~ End of September 2017	Discussed with Cancer Network Clinical Lead (Rob Gornall) on 30/08/2017. Work not commenced Local ideal pathway for soft tissue sarcoma to be drafted w/c 25/9, to be thereafter agreed by MDT in preparation for future discussions with the cancer network.

Action		Executive Lead/ Operational Lead	Target Completion (RAG)	Status/Updates
18	Review the oncology MDT facility and ensure that it is configured to enable a MDT to be safely and efficiently carried out	Clinical Service Manager	End of August 2017	Proposal submitted to Finance for upgrade of certain elements of the facilities.
19	In collaboration with the respective clinical teams, develop tertiary referral criteria for sarcoma (bone and soft tissue) and spinal cancers services and embed these as part of the process for accepting referrals from other providers.	Lead Cancer Clinician & Clinical Service Manager	September 2017	Established that these have not been developed or agreed via the Expert Advisory Groups (EAG) hosted by the Strategic Clinical Network (SCN). ROH proforma in use but does not mandate referrers to complete all fields. Trust is also considering bespoke referral software to enable this.
22	Undertake a review of the data submitted to Open Exeter for the previous 6 months and cross reference this against data held on the ONKOS system	Interim Chief Operating Officer/Clinical Service Manager	End of September 2017	Data from Open Exeter submissions obtained and analysed. Comparative data not available from Onkos, so data obtained from PAS. Review underway to enable cross reference (also action 10) Review of sarcoma patients from PAS revealed no 62 day patients omitted from Open Exeter submissions for Q2. Further review carried out based on 2 week wait referrals from April to August 2017, also revealed no patients omitted. Review on spinal patients underway.

Action		Executive Lead/ Operational Lead	Target Completion (RAG)	Status/Updates
23	Ensure that there are robust processes in place for the recording and submission of data to all relevant national systems, including subsequent treatments and any cancer patients discussed at the spinal MDT.	Interim Chief Operating Officer/Clinical Service Manager	~~August 2017~~ End of September 2017	Process for recording spinal MDT data currently collected by Lead Nurse and outcome letters dictated and typed. Process for recording all waiting times data to be agreed, current process being reviewed. Data obtained from PAS to review potential impact. Improved process for submitting data to be implemented upon appointment of new Oncology Support Manager in September 2017, as role currently sits with Lead Nurse.
25	Establish a clear tracking and escalation process (documented in SOPs) for the timely flow of patients along cancer pathways. This should be based on any agreed timed pathways, and clearly identify the named individuals for escalation purposes.	Clinical Service Manager	September 2017	HEFT to share examples & template for SOPs Current process being reviewed. Improved process to be defined and documented. Process being drafted for sign off
26	*NEW* Agree implementation of structure for succession planning of 'Lead Cancer Nurse' role with consultant nurse due to retire in December 2017	Clinical Service Manager	September 2017	New structure will increase the clinical nursing resource but consideration is underway regarding the Lead Cancer Nurse role and responsibilities within the Trust.
27	*NEW* Review and update MDT Operational Policy to ensure the appropriate and timely management of patients on suspected and confirmed cancer pathways	Clinical Service Manager	September 2017	Review ~~31/8~~ 21/9 and agree plan. Date changed due to annual leave and awaiting commencement of new Cancer Support Manager

Action		Executive Lead/ Operational Lead	Target Completion (RAG)	Status/Updates
28	*NEW* PTL and escalation process to be documented	Clinical Service Manager	September 2017	Test and agree new PTL process and document process/TOR PTL process in place since 4/9, next step to include spinal patients. Process being drafted for sign off
29	*NEW* Internal Peer Review process should be implemented to ensure that QST measures are assessed routinely and owned by the MDT	Clinical Service Manager	October 2017	Peer review to be set up
30	*NEW*There should be a process for shared learning of processes with local Trusts to ensure better understanding of requirements	Clinical Service Manager	End of September 2017	Date to be arranged for visit to QEH MDT to review how meeting is held and data recorded by the clinical teams/MDT Coordinator during the meeting ROH Trust representation at recent 'Learn and Share' Cancer Network event 13/9, next date 17/10

CLOSED ACTIONS		Executive Lead/ Operational Lead	Target Completion (RAG)	Status/Updates
1	Review the recent external audit report undertaken to ensure all actions and recommendations have been addressed	Interim Chief Operating Officer	End of August 17 COMPLETED	Recommendations from the 2016/17 Quality Accounts reviewed and their recommendations are included within this action plan Deloitte review undertaken to understand current 62 day process, sample records and review any outstanding recommendations. Rating – Blue Satisfactory- minor issue only. This related to no processes in place to accurately report performance against the West Midlands Breach Reallocation policy.
3	Review the Trust Cancer specific Access Policy to provide guidance for the management of patient on cancer pathways. To ensuring that it meets National Guidance	Interim Chief Operating Officer	End of August 17 COMPLETED	There is an approved Trust Access Policy which is in date and incorporates Cancer Access. There is a further MDT Operational Policy which requires review to ensure operational guidance is current (Additional action added – 27).
13	Establish a mechanism for highlighting patients who are at risk of breaching 104 days to the relevant clinical and operational leads. This should be linked to the establishment of the PTL and should include defined trigger and escalation points, such as any patient reaching 80 days on a cancer pathway.	Interim Chief Operating Officer/Clinical Service Manager	End of August 2017 **COMPLETED**	Added to action 7 (establishment of PTL process, including escalation).
15	Review the process to ensure the Root cause analysis is undertaken for all patients who breach the target	Clinical Service Manager	Mid August 2017 COMPLETED	Root cause analysis is undertaken and reviewed at Cancer Board. Format will be reviewed in line with 104 day process as action 12

CLOSED ACTIONS		Executive Lead/ Operational Lead	Target Completion (RAG)	Status/Updates
17	Review the process for consultant upgrades to ensure that this is being monitored and recorded in line with national guidance	Interim Chief Operating Officer	End of August 17 COMPLETED	Head of Operational Performance at HEFT to commence review 14th July 17 Data collated on scorecard (as in action 9). Data being reviewed (as in action 8). Potential patients for Consultant Upgrade are identified at the daily Diagnostic MDT Meeting, upgrade date is updated on the Onkos database and patients are monitored and recorded in line with national guidance.
20	Develop an interim manual cancer PTL, either using existing fields on PAS, or by developing a standalone PTL. Patients to be identified and recorded on PTL at the point of registration (Patient Liaison Officers) and updated daily.	Interim Chief Operating Officer/Clinical Service Manager	August 2017 COMPLETED	Review undertaken. Interim manual PTL implementation not required. Function exists on Onkos database. Data being validated and prepared to commence PTL meeting as per action 7 and 8
12	Establish a process for undertaking root cause analyses and clinically-led harm reviews for any patient over 104 day and ensure it is in line with national guidance	Interim Chief Operating Officer	End of August 2017 COMPLETED	Overview presented to CSM 25/8 – standardised process and format to be agreed together with action 15. Format standardised, process already in place to produce and clinically review all patients treated over 62 days.

CLOSED ACTIONS		Executive Lead/ Operational Lead	Target Completion (RAG)	Status/Updates
21	Develop a daily tertiary breach report based on the methodology contained within the West Midlands tertiary breach reallocation policy. To be available centrally and shared with operationally leads.	Clinical Service Manager	August 2017 COMPLETED	HEFT to share template. HEFT to forward template to better understand requirements. Breach reallocation adjustment figures planned to be included in scorecard (as in action 9). HEFT tertiary report reviewed and not suitable for use at ROH due to small numbers of patients. Shared patients easily identifiable by new live tracker and forward look report. Analysis to be completed manually until future cancer data system and associated automated reports are decided and implemented.
24	Establish a two-stage validation process for all external cancer data returns to ensure that there are appropriate levels of scrutiny and assurance. Responsibility for overall organisational sign-off should rest outside the oncology directorate.	Interim Chief Operating Officer	August 2017 COMPLETED	Process for validation of external cancer data returns; cancer waiting times and UNIFY returns to be scrutinised via PTL meeting. This and other processes for external cancer data returns to be implemented upon appointment of new Oncology Support Manager in September 2017, as role currently sits with Lead Nurse. Overall organisational sign-off to be Interim COO Monthly reports in place to cross reference and ensure data completion and integrity. Process being drafted for sign off. Interim COO signs off all national reporting

Spinal Deformity Action Plan August 17

Achieved
On track
Off track
Not achieved
Not started

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

	Executive Lead	Manager Lead	Action	Updates/Progress	Target Completion (RAG)
2.0	Medical Director	Nicky Lloyd	Develop a shared clinical assessment to include all clinicians (ROH & BCH) before listing any patients to the waiting list and then reviewed two months prior to surgery	Nicky Lloyd to attend July BCH MDT to discuss with Andy Tatman and Spinal Deformity Consultants An initial meeting has been held to discuss the waiting list with BCH. This should be eased with the introduction of a planned waiting list. A further meeting with Dr Morland and Andy Tatman is planned for August to review the current positon and then meet with all spinal consultants to agree the process **Planned waiting list has been created with process and scenarios to be sent out to consultants beginning of Sept 17- planned waiting list SOP to be re-launched October 17.**	~~31st July~~ 2017 – initial meeting has taken place 25th August 2017

3.0	Interim COO	Nicky Lloyd	Agree the baseline position on the shared waiting list	ROH operational team met wk commencing 19/6/17 to consolidate position. Further review and methodology required with BWCH to implement shared waiting list sign off between ROH & BWCH. Initial meeting held – full list to be shared once validation has been completed at the end of July. This will also include as required re-prioritisation of the list . List to be completed by ROH 4.08.17 and shared week commencing 07.08.17 **Shared with BWCH End of August 2017**	~~30th June 17~~ 7th August Date reflects validation completed as part of RTT action plan
5.0	Interim COO	Nicky Lloyd	Lack of PICU - PICU capacity secured at BCH until September 17 – ensure where clinically appropriate a patient is listed. Where not possible this is to communicated to BCH	The team will work to a prioritised clinical list and unless clinically appropriate will list patients for PICU. Should this not be the case ROH will inform BCH. **COMPLETED further discussion is required regarding ongoing requirements**	**23rd June 17**
9.0	Interim COO	Nicky Lloyd	Explore the capacity options for use of Theatre 8 at BCH (January 2018)	Theatre 8 is still subject to financial investment and agreement but plans should be drawn up to look at the potential opportunities and resource required to support operational delivery of the trajectory and on-going demand – **this will be discussed as part of wider piece of work re transition of services – action for BWCH.**	28th July 17

10.0	Interim COO	Nicky Lloyd	Develop an trajectory to support the backlog of patients	A trajectory for improvement has been developed and is being monitored to ensure that the backlog is addressed - this is being refreshed daily in line with changes to the waiting list, activity and capacity. This will commence once the backlog position has been confirmed at the end of July 17. **All admitted patients validated and with exception of a couple of patients all dated throughout 2018.** **Patients to be reviewed at 20-35weeks to see if they can be treated at alternative provider to create additional capacity.** **BWCH exploring additional capacity in early 2018 to support long waits.** **OPD demand/activity to be sourced & populated into capacity modelling tool (BWCH model)** **Trajectory to be submitted to NHSI by 6th October**	~~30th June 17~~ End of August 2017
12.0	Interim COO	Nicky Lloyd	Explore the option for surgery to be undertaken at UHB for children aged between 16-18	Jo Williams and Nicky Lloyd to have meeting with UHB to look at option to treat cohort of patients aged 16-18 at UHB. Identify number who would need treating and potential options to support. Initial discussion has been held with UHB and a meeting will be arranged. **This will also be picked up as part of wider discussion with Specialist Commissioners re transition of services**	~~28th July 17~~ Ongoing

13.0	Medical Director/Interim COO	Nicky Lloyd	Meet with team to explore the potential for some work to be undertaken at ROH acknowledging previous concern over regulatory requirements of paediatric support	To be discussed with Jo Williams w/c 10/7/17 in light of recent Board discussions on 5/7/17 **ON HOLD re decision to transition inpatient services**	28th July 2017
14.0	Medical Director/Interim COO	Nicky Lloyd	Recruitment of 2wte surgeons	Review of capacity requirements underway. (wk. commencing 31/7) Jo Williams to speak to Tim Atack and Bruce Morland to agree next steps re recruitment plan. Jo Williams meeting with Tim Atack 11.08.17. **Advertised and interviews wk comm 25th October 2017.**	TBC- process to commence August 2017
15.0	Interim COO/Paediatrics AMD	Jo Williams	Review potential providers who have offered additional support/capacity	Sheffield/Alder Hay/Stoke and Leeds have all approached ROH to discuss further any additional support we require. This will be explored further with Dr Morland once we have finalised the waiting list positon at the end of July. This will need to be carefully managed to ensure a smooth and efficient patient pathway supports the patients and it meet the needs of patients & families **Discussions ongoing with Stoke & Sheffield**	Ongoing discussions will commence in August 2017

CLOSED ACTIONS

	Executive Lead	Manager Lead	Action	Updates/Progress	Target Completion (RAG)
4.0	Interim COO	Nicky Lloyd	Create dedicated operational resource to manage the spinal deformity pathway	Completed – Sue Kelsall Clinical Service Manager effective from 26th June for a 3 month period	26th June 17
6.0	Interim COO	Nicky Lloyd	Establish a weekly operational catch up meeting with BCH/ROH	NL to agree with Jo Williams who else needs to be on weekly update. Operational team to catch up weekly to ensure that any issues are escalated and flagged - Sue Kelsall will meet with Annie Cheatham at BWCH. Escalation process and contact details in place with Deputy COO and COO across at BWCH & ROH	26th June 17
11.0	Interim COO	Nicky Lloyd	An internal assurance meeting should be in place to support the operational delivery	Weekly PTL meeting assures tracking and TCIing of patients A separate PTL meeting has also been established to focus on long waiters. A weekly meeting is in place Tuesday)	30 June 17
7.0	Interim COO	Nicky Lloyd	Explore the option of weekend working to delivery additional capacity	Understand clinical availability to delivery weekend list and plan ahead to ensure that all parties have been given sufficient notice. 10 weekend lists identified until the end of October and surgeons identified for all of these **COMPLETED**	Wk. ending 9th July
8.0	Interim COO	Nicky Lloyd	Cancellations- agree an escalation policy for all cancellations and communicate to all managers and stakeholders	Escalation policy to be in place. ROH currently has an escalation policy this is to be adapted to incorporate BCH patients. All cancellations are escalated to Interim COO & Deputy at ROH – links in place with BWCG	15th July 2017

1.0	Interim COO	Nicky Lloyd	Discuss with Sheffield the potential for additional capacity at Sheffield Children's	Initial conversation took place on 21/6/17- **see action 15 CLOSED**	30th June 17

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	26 September 2017
Guests	Matt Boazman, Chief Officer for Strategy & Innovation, STP representative
Presentations received and discussed	None
Major agenda items discussed	• Progress with the delivery of the 18 weeks RTT plan; cancer action plan; and spinal deformity action plan • Scheduled Care Improvement Programme update • Finance and Performance Overview • Recovery plan • Progress with the development of the Strategic Outline Case
Matters presented for information, brief update or noting	• Effectiveness of pooling waiting lists • Extract of the Corporate Risk Register was considered including additional and reframed risks based on a refresh undertaken by the Executive Team
Matters of concern, gaps in assurance or key risks to escalate to the Board	• As part of the discussion around the spinal deformity action plan, it was noted that the delivery of the trajectory for improvement of the 52 week waiting time position was predicated on continued access to PICU beds at Birmingham Children's Hospital. The plan needed to be system-owned. There was also further work underway to explore setting elsewhere to treat patients who had been waiting for a long time – every effort was being made to ensure that these would be locations convenient for patients. • Although there was good progress with addressing processes in theatres, the Committee agreed that due to the criticality of the operation of the theatres, it would seek additional assurance of improvement at a granular level and so the planned presentation on Theatreman would be rescheduled for October, rather than November. • Although every effort was being made to reach the 92% national 18 weeks RTT target by April 2018, this would be a considerable challenge from where the Trust was currently performing. • The financial deficit incurred in August was noted to be

	above the planned level and delivery of the Cost Improvement Programme was behind where it was anticipated to have been; a shortfall against the delivery of the CIP was expected by the year end, which was concerning as this was a key element of the Recovery Plan • The Committee was concerned at the high level of non-pay spend, which was mainly associated with theatres. Additional controls were being arranged around implants and other consumables, however the position was being reviewed further. Work was underway to establish average cost per procedure to identify variation between consultants and this information would be shared at the next meeting. There was also further work to do to control theatre stock usage. • Cancellations and DNAs by patients were noted to remain high. The 72 hour call before admission was being reinstated however, and information would be sent to patients to advise them of the financial impact of not turning up for appointments. • The Recovery plan was reviewed, the achievement of which was noted to carry a high degree of risk around delivery of higher activity levels and achievement of the Cost Improvement targets.
Positive assurances and highlights of note for the Board	• There was good progress with delivery of the action plans to address the regulatory concerns and in particular with the 18 weeks RTT action plan. The number of open pathways stood at 8,800, a reduction from the previous level of 59,000. New dashboards were available which helped monitor the position on daily basis and a formal weekly meeting was held to review the waiting list. • The visit by the Intensive Support Team recently had been positive and they were assured on the Trust's processes now in place to manage the 18 weeks RTT pathways. There was further work to do to address the 'clock stops', although this would be completed by the end of September. The draft report from the visit would be received shortly. The Head of Business Intelligence was congratulated for his work to support the improvement. • The move away from centralised booking was working well and good feedback had been received from the Acting Chief Executive on the revised process and better local ownership at a recent Team Brief session. Centralised booking was now confirmed to only a small number of referrals. • The management of the Oncology pathways had been amended to follow national guidance. • The Scheduled Care Improvement Programme was progressing well and included a number of improvement

	activities including: rationalisation & refining Standard Operating Procedures; more prompt letter turnaround; learning from elsewhere on best practice in relation to pre-assessment and pre-admission; changes in leadership in the theatres team; commencement of automatic starts in theatres; tracking of theatre trays to identify any issues and non-conformities; more robust theatre list lock-down; further embedding of Rapid Recovery and 'Red2Green' (discharge) initiatives; and more appropriate use of the discharge lounge • There was good progress with the development of the Strategic Outline Case. The work had good clinical engagement and a series of clinical reference groups had been set up which would feed into a set of workshops to develop the long list of options. Arrangements had been made for the Executive Medical Director to provide a lead role and strategic clinical input to the wider review of the orthopaedics pathway. The Long Term Financial Model base case would be presented for review at the October Finance & Performance Committee.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• The Interim Chief Operating Officer to issue a note outlining the result of the sample testing of 20,000 historical pathways, this being the final stage of the RTT validation work. • Circulate the report from the recent visit by the Intensive Support Team • Arrange for the Finance & Performance Committee to receive a presentation on Theatreman at the October meeting • Present average cost per procedure information at the next meeting • Provide an explanation behind the increase in non-pay costs at the next meeting • Provide a further update on measures to reduce patient instigated cancellations and DNAs at the next meeting • Revise the finance & performance overview to provide additional clarity on some performance metrics • Present the Recovery Plan to the Trust Board at its next meeting
Decisions made	• None specifically

Tim Pile
VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Council of Governors scheduled for 5 October 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	27 September 2017
Guests	Mr Matt Revell, Associate Medical Director Sandra Millward, Head of Imaging Dr Graham Caine, Head of Pathology Ms Maureen Milligan, Chief Pharmacist Rani Virk, NHS Improvement
Presentations received	None
Major agenda items discussed	• Quality & Patient Safety report • Nursing key performance indicators • Radiation Protection update • Human Tissue Authority licence compliance • Harm review update • Nurse staffing update • Infection Control update • Annual complaints report • Quality assurance walkabouts • Paediatrics update • Clinical Quality Committee upward report • Drugs & Therapeutics Committee upward report and minutes • HDU Improvement Board upward report and minutes
Matters presented for information, update or noting	• CQC Provider Information requests • Divisional governance updates • Quality & Patient safety risks on the Corporate Risk Register • RCPCH and CQC action plan status report • Update on performance against the contract quality requirements
Matters of concern, gaps in assurance or key risks to escalate to the Board	• The Committee was advised that reports on WHO checklist compliance could not be readily obtained from the Theatreman system, however manual audit and validation highlighted that compliance rates remained high. • In September to the date of the meeting, there had been seven VTEs reported, which had included inpatients as well as patients post discharge. Investigations were underway on all cases to identify any common themes. • There had been six inpatient falls and two staff falls; there

	were no apparent themes that needed to be addressed. • The development of a trajectory to address the spinal deformity waiting list was reported to be predicated on the provision of a Paediatric Intensive Care Unit (PICU) bed by the Birmingham Children's Hospital. The system wide ownership of the management of this risk would be discussed at the next joint stakeholder oversight meeting. Work was underway with BCH to secure additional paediatrician cover and a service that ensure that an on-call service was available which could review a deteriorating child within 30 minutes of a request; this was in line with national standards. There continues to be a robust risk assessment process for Paediatric patients being treated by the Trust. • There had been a 48% increase in the numbers of complaints year on year, with the increase mainly associated with the administrative systems in Oncology and spinal services; these were issues understood by the Trust and would be addressed through the Scheduled Care Improvement programme and the delivery of the 18 weeks RTT action plan. • The significant increase in PALS complaints was noted to be associated with the direction to call this department in case of a query on the appointment letters. • The quality assurance walkabouts had rated Outpatients as 'Requires Improvement'. There were plans to introduce an Outpatient Improvement Board analogous to that of the Children's Board and HDU Improvement Board. • The risk registers of the Clinical Quality Group were currently being reviewed. • A number of risks were escalated from the Clinical Quality Group to the Quality & Safety Committee, including the robustness of the PAS alert process for dementia; standardisation of resuscitation trollies; the operation of the Resuscitation Committee; the failure of the bleep named within the massive haemorrhage/ transfusion policy; histopathology consultant recruitment; the delivery of life support training; and paediatric nurse cover in HDU. • It had been identified that governance around medical gases needed was weak and needed to improve. • Following a recent exercise to respond to the CQC's Provider Information Requests, a number of areas for strengthening had been identified including: clinical supervision; patient movement for non-clinical reasons; audit for patients with complex care; bereavement surveys; and clinical audit. • The Trust had one Contract Performance Notice around the 18 weeks RTT position, although this was well

	understood and being addressed. PREVENT training levels needed to be improved and the Trust Board would be asked to participate in this training shortly.
Positive assurances and highlights of note for the Board	• A new set of nursing Key Performance Indicators had been developed as a further step from the previous overall ward dashboard. Where there were areas of concern these would result in a condition report which would be presented to the Clinical Quality Group; this would contain the actions planned to address the issues or themes. Additionally, ward notice boards would be implemented which provided a visual display as to how the ward or area was performing against a set of quality indicators. • The harm review panel was working well and had recently reviewed 76 spinal patients; no harm had been identified • There had been no radiation protection incidents during the quarter. All those reported previously had been closed and the learning from these included the introduction of a standard set of standard operating procedures which provided clarity on the standards required in Imaging more clearly. Incidents however were noted to be very rare. Waiting times for diagnostic tests were reducing. • The update on the compliance with the Human Tissue Act licence showed that there were no concerns and overall Dr Caine was commended for the improved assurance on the operation and compliance of the Pathology service overall. • A new set of Key Performance Indicators would be introduced to monitor the care of children who might deteriorate while in the care of the ROH. This would further mitigate the risks of the current Paediatric care model while it remained with the Trust. These would be monitored by the Children's Board. • The use of agency nurse staffing had reduced. • Two offers had been made to individuals to be appointed into the Infection Prevention & Control team. Interviews were planned shortly for the lead Infection Control nurse. This would address the vacancies currently carried by the Trust. There was good medical staff input to the selection process for these posts. • The quality assurance walkabouts had rated Ward 11 as 'Good'. • The new system within Pharmacy was operating well and identifying any trends of increased usage of medicines. • The Trust was the highest reporter in the region for patients with adverse reaction to medicines (higher reporting is a positive indicator) • A draft Learning Disabilities strategy had been developed • Discussions at divisional governance boards were reported to be positive and provided a productive multi-disciplinary

	forum for operations, nursing and medical staff
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Themes associated with near miss incidents would be presented at the next meeting • The complaints report to be revised to provide a greater breakdown of some categories of complaints and to better illustrate the changes that had occurred as a result of the complaints received • Details of the consultants' level of participation in Mandatory Training to be presented at the next meeting • Detail of external reporting of controlled drugs incidents to be provided to the Committee when the Drugs & Therapeutics Committee was next to report • There was concern over the level of risk that the ROH would be carrying around the continued provision of paediatric surgery in the light of the reduction in nurse staffing in paediatric HDU
Decisions made	• The Committee recommended that the OD Committee should consider information on staffing groups other than nurse staffing which was considered by the Quality & Safety committee

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

For the meeting of the Council of Governors scheduled for 5 October 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	29 September 2017
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. Mr Matt Revell, Associate Medical Director Ms Marie Raftery, Clinical Services Manager (Theatres) Mr Will Overfield, Clinical Services Support Manager (Theatres) Mrs Mandy Johal, Freedom to Speak Up Guardian
Major agenda items discussed	• Update on Amplitude implementation • Internal Audit progress report • External audit progress report and plan 2017/18 • Counterfraud progress report and annual report • Recommendation tracking update, including update on stock management and eDC Gold • Cash & Treasury Management policy • Losses and compensations register • Breaches of waivers and SFIs register • Scheme of Delegation and Standing Financial Instructions • Whistleblowing and Freedom to Speak Up progress • Board Assurance Framework
Matters of concern, gaps in assurance or key risks to escalate to the Committee	• Following concerns raised via the governors, the Committee received an update on the Amplitude System, which was designed to provide information on clinical outcomes. The system has the potential to enhance the Trust's reputation and provide a diverse range of clinical outcome data for improvement. It was suggested that further consideration is needed to deal with the delays to the project and to the support arrangements for the implementation of this system, including project management and resource to collect data in clinics. It was clear that the system needed to be owned by the clinical outcomes team. • Two of the three internal audit reports finalised since the last meeting provided only partial assurance, these being: research & development processes and e-rostering. Of these, the findings from the e-rostering audit needed considerable attention, as it was clear that staff were not closely following the e-rostering policy and there were

	delays with signing off rotas which impacted on the ability to fill gaps in rotas with bank staff. It was noted that the clinical governance team was assisting with addressing these process issues. • The external audit plan for 2017/18 would focus most closely on cash and CIP and the overall financial sustainability of the Trust. • The feedback from the Quality & Safety Committee included the need to gain assurance on the WHO checklist through the use of the Theatreman system. Paediatric nurse staffing was also raised as a risk, particularly as two substantive nurses had tendered their resignation recently.
Positive assurances and highlights of note for the Board	• The recent assessment by NHS protect had been positive: the 'prevent and deter' element was particularly positive, with the pre-employment check process being commended • The Committee were joined by Marie Raftery and Will Overfield from Theatres who provided some sound assurance on the measures being taken to implement controls around stock in theatres and to implement more robust stocktake & monitoring procedures. Of note was the measure taken to centralise the stock and to encourage the Trust's own stock to be used before consignment stock. The arrangements with the firm that undertook decontamination of theatre trays were also being made more robust and eDC Gold would be used in future for initiating automatic ordering of stock. • There was good progress noted with updating the accuracy of the recommendation trackers, with updates being received for the majority of actions. As a next step, the evidence to provide assurance that the actions were closed would be worked through. It was agreed that the actions associated with the reports relating to stock, 18 weeks RTT and consent would be separated out from the tracker in future as these were being addressed through separate action plans. • The Committee received a positive presentation from the Freedom to speak Up Guardian – she was making good progress with encouraging staff to raise patient safety concerns and as a next step would be getting behind the reasons why some individuals might still be reluctant to raise concerns. It was agreed that positive feedback to staff when things had changed as a result of them raising their concerns was crucial.
Significant follow up action commissioned including discussions needed with any other	• A further update on stock management in theatres is needed for the next meeting • The Executive were encouraged to think through the next steps for the Amplitude system and it was suggested that a

Executive Boards/Committees	status report outlining where the project was at and the measures needed to implement it more fully was needed • Consideration was needed as to the balance between R&D and clinical audit within the overall Knowledge Hub • Consider the means by which the effectiveness of the internal and external audit could be assessed
Decisions made	• The Audit Committee supported the Treasury management Policy • The Audit Committee supported the proposed changes to the Scheme of Delegation and Standing Financial Instructions • A revised schedule of meetings for the Audit Committee was agreed to ensure that they were more evenly spaced throughout the year

Rod Anthony

NON EXECUTIVE DIRECTOR AND CHAIR OF THE AUDIT COMMITTEE

For the meeting of the Council of Governors scheduled for 5 October 2017

ROHGO (10/17) 007

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY REPORT

September 2017

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Patient Services
AUTHOR:	Ash Tullett	Clinical Governance Manager

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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 and the CQC for routine engagement visits.

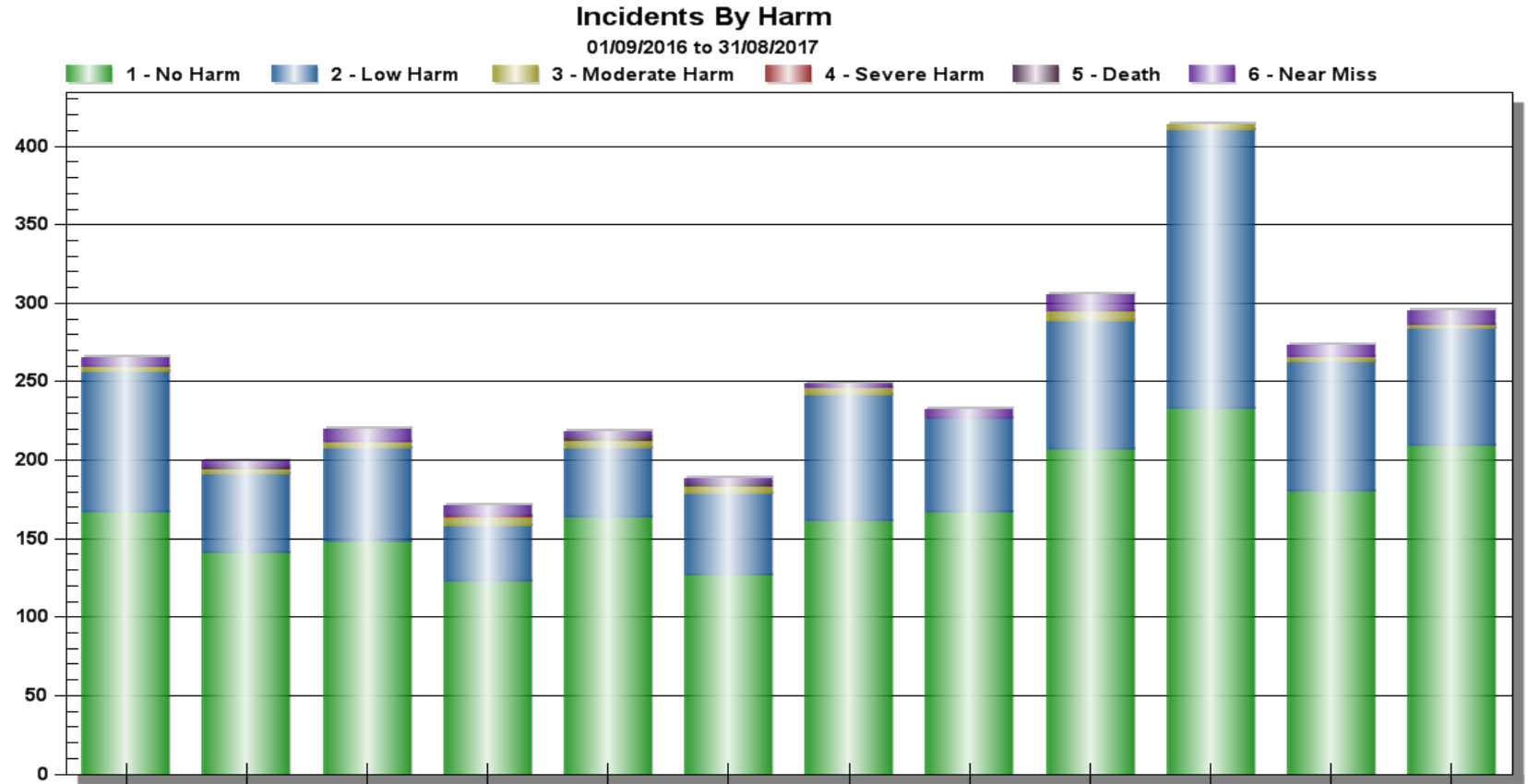
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

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.



Month and Year	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017
1 - No Harm	166	140	147	122	163	126	161	166	206	232	180	209
2 - Low Harm	90	51	60	36	44	52	80	60	82	178	82	74
3 - Moderate Harm	3	3	4	5	5	5	5	0	6	4	3	3
4 - Severe Harm	0	0	0	1	0	0	0	0	0	0	0	0
5 - Death	0	1	0	0	2	2	0	0	0	0	0	0
6 - Near Miss	6	4	9	7	4	3	3	6	11	0	8	9

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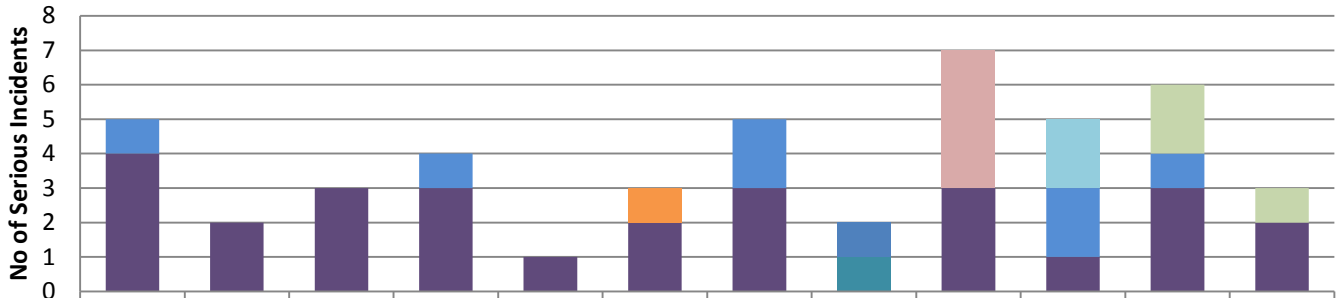
INFORMATION
In August 2017 there was a total of 295 Incidents reported on the Ulysses incident management system. The breakdown of those incidents is at follows; 209 – No Harm 74 – Low Harm 3 – Moderate Harms 9 – Near Miss
ACTIONS FOR IMPROVEMENTS / LEARNING
An ongoing Ulysses action plan continues to make changes and improvements to the Incident management system
RISKS / ISSUES
None

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 .

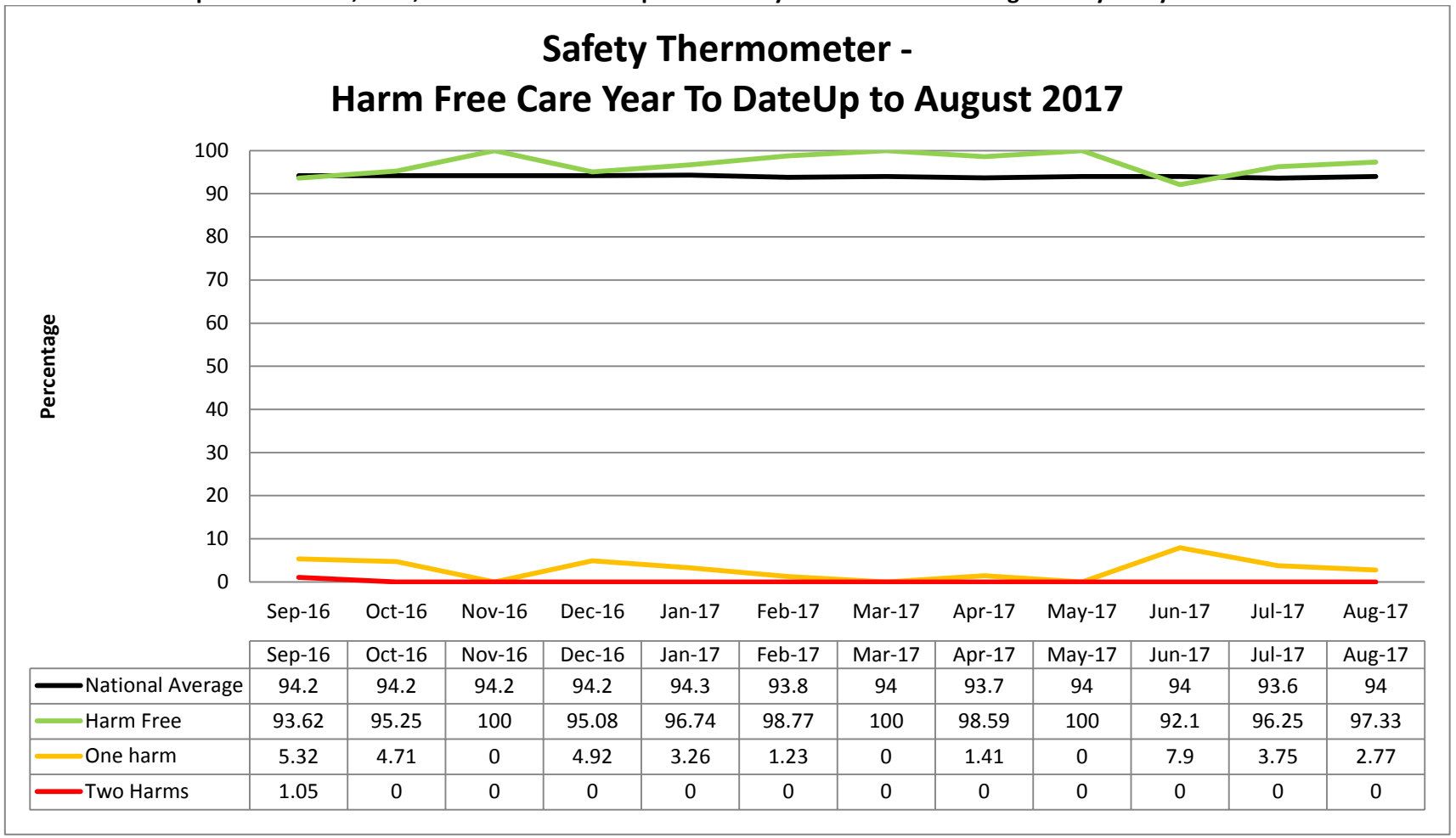
Serious Incidents Declared Year to Date to August 2017



	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	July	Aug-17
Unexpected Injury											2	1
RTT Harm review									4			
Emergency transfer to HDU												
Exposure to hazardous substance						1						
Wrong Site Incision												
Wrong Implant												
Suspension to services												
RTT Data Issue								1				
Wrong side injection										2		
Suspension of Service (BCH Spinal)								1				
Slips, trips & falls												
Pressure Ulcers	1			1			2			2	1	
VTE meeting SI criteria	4	2	3	3	1	2	3		3	1	3	2

INFORMATION
There were **3 Serious Incidents Declared in August 2017;**
ACTIONS FOR IMPROVEMENTS / LEARNING
Two serious incidents were closed by the Commissioners in August 2017. The incidents were reported in the May 2017 Quality report.
RISKS / ISSUES
None.

3. **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-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
National Average	94.2	94.2	94.2	94.2	94.3	93.8	94	93.7	94	94	93.6	94
Harm Free	93.62	95.25	100	95.08	96.74	98.77	100	98.59	100	92.1	96.25	97.33
One harm	5.32	4.71	0	4.92	3.26	1.23	0	1.41	0	7.9	3.75	2.77
Two Harms	1.05	0	0	0	0	0	0	0	0	0	0	0

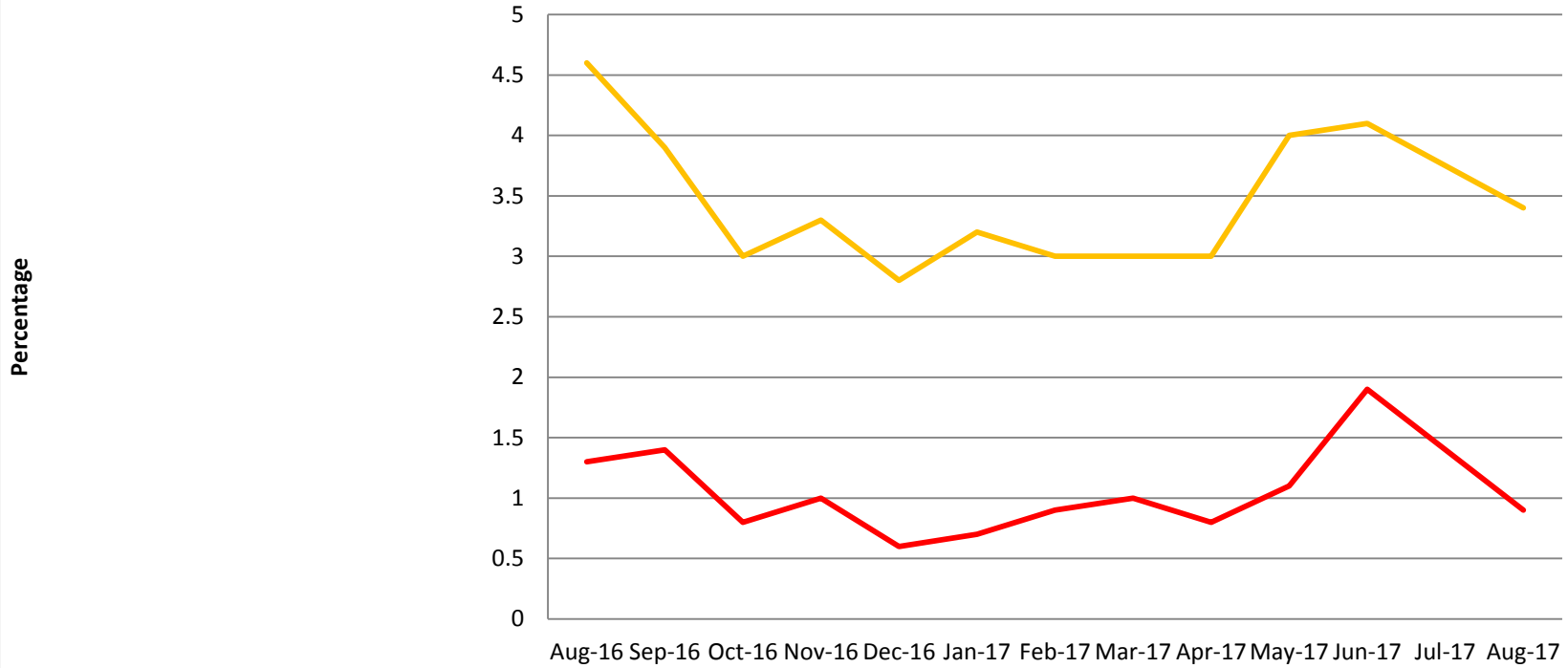
The harms highlighted on the safety thermometer were;
1 Fall with harm on ward 3 and 1 New VTE on HDU

4. 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 inAugust 2017 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-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
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794
Feb-17	52	5	0	2	59	188	6429
Mar-17	80	6	0	0	86	250	7326
Apr-17	62	0	0	0	62	232	7328
May-17	83	5	0	0	83	303	6918
Jun-17	178	4	0	0	182	414	9162
Jul-17	82	4	0	0	86	273	8743
Aug -17	74	3	0	0	77	295	8560

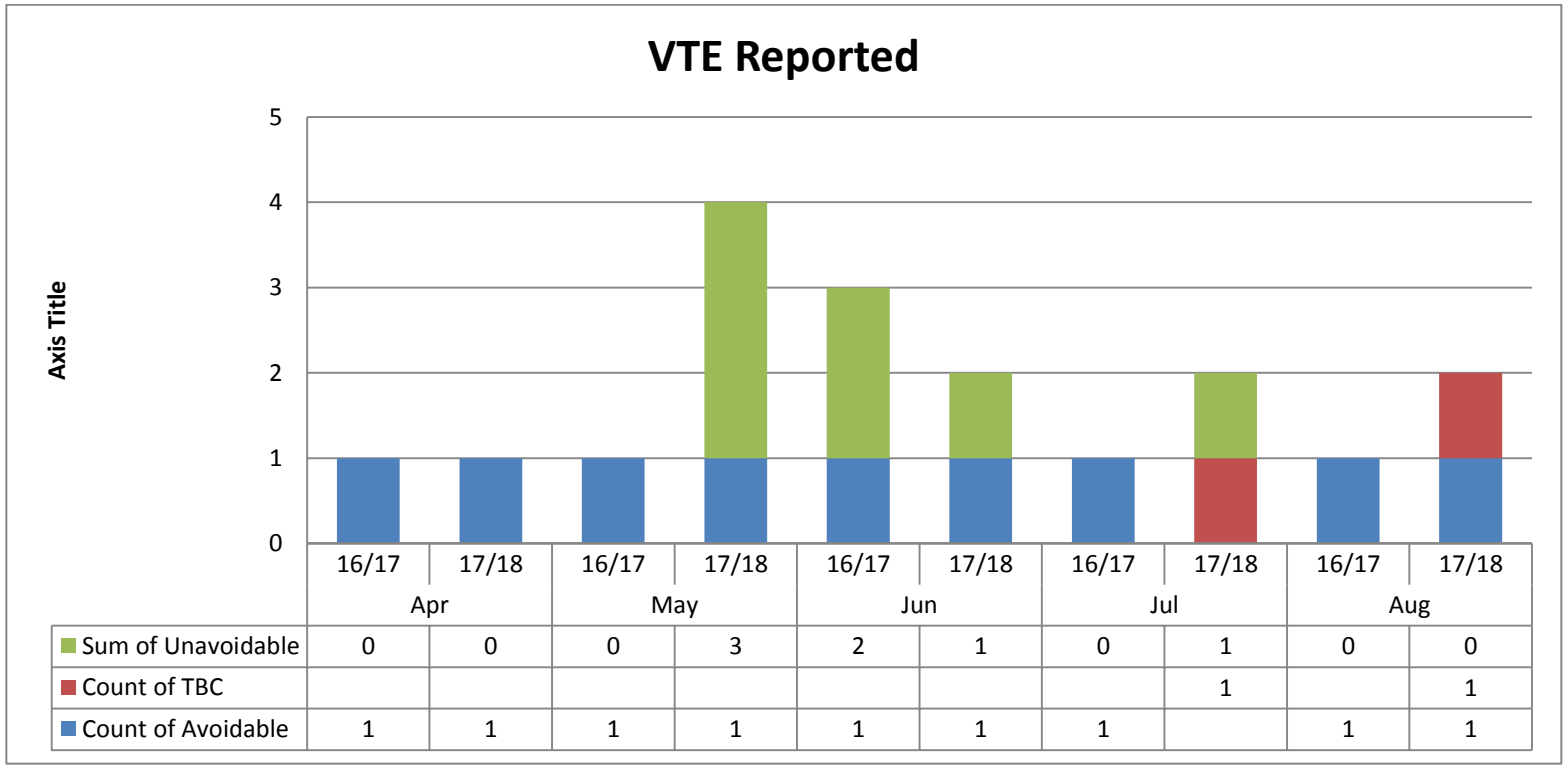
In August 2017, there were a total of 8743 patient contacts. There were 295 incidents reported which is 3.4 percent of the total patient contacts resulting in an incident. Of those 295 reported incidents, 77 incidents resulted in harm which is 0.9 percent of the total patient contact.

% of Patient Contact Compared to Number of Incidents and Incidents with Harm August 2016 to August 2017



	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Aug-17
% of Patient Contacts with Incidents Causing Harm	1.3	1.4	0.8	1	0.6	0.7	0.9	1	0.8	1.1	1.9	0.9
% of Patient Contact With All Incidents Reported	4.6	3.9	3	3.3	2.8	3.2	3	3	3	4	4.1	3.4

5. **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).**



	Apr 16/17	Apr 17/18	May 16/17	May 17/18	Jun 16/17	Jun 17/18	Jul 16/17	Jul 17/18	Aug 16/17	Aug 17/18
Sum of Unavoidable	0	0	0	3	2	1	0	1	0	0
Count of TBC								1		1
Count of Avoidable	1	1	1	1	1	1	1		1	1

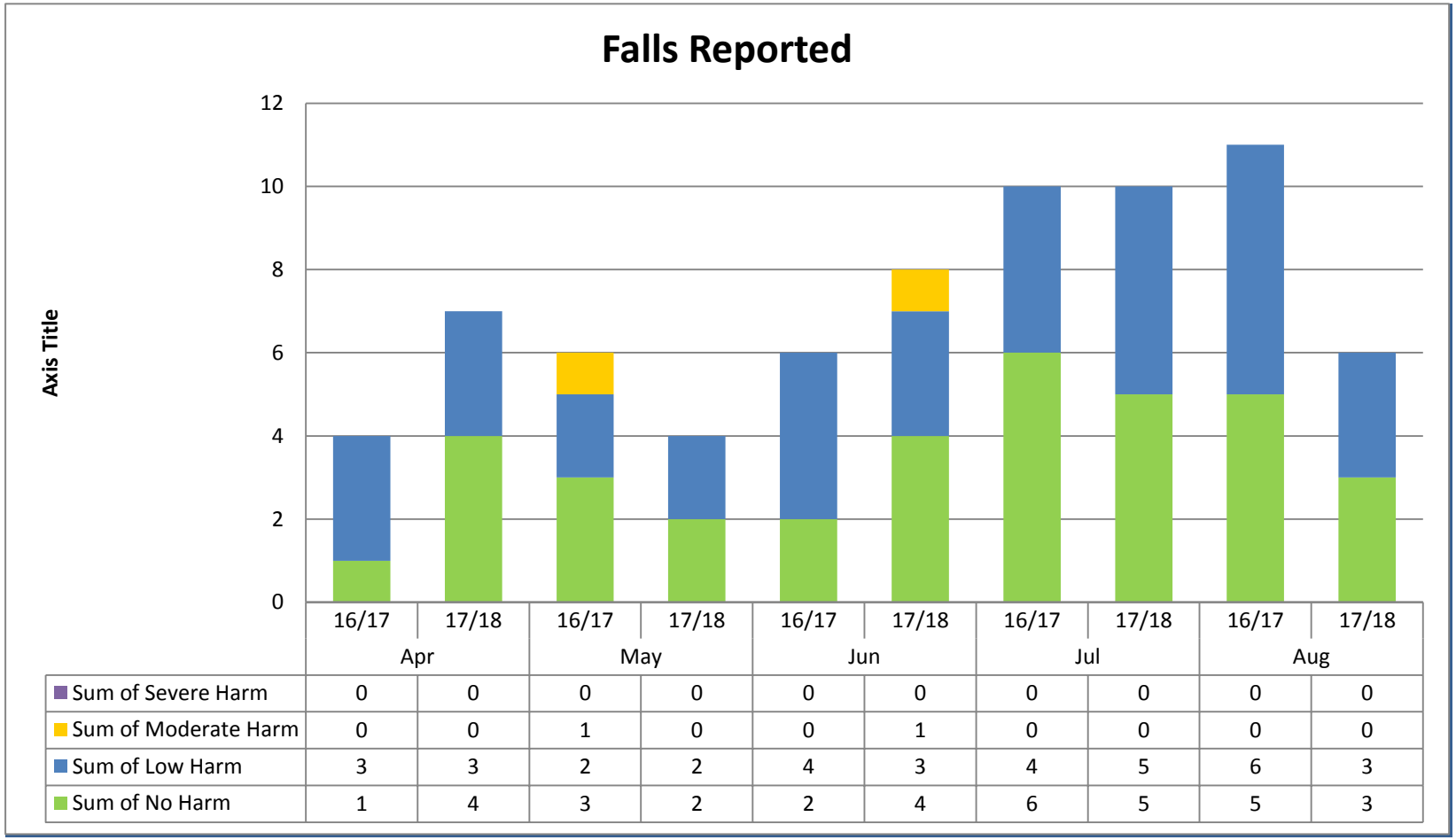
11

total		Avoidable
16/17	27	13
17/18	8	0*

***not classified**

INFORMATION
There were two VTE's declared in August 2017.
ACTIONS FOR IMPROVEMENTS / LEARNING
All commissioner KPI's /audits have been completed and continue to be consistently achieved VTE training continues for Student nurses, training for registered and non-registered staff (clinical update days) was suspended in Q4 but will re-commence in April 2017. It is mandatory for clinical staffs 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. Now that the VTE guidelines have been finalised and approved the requirements for meeting exemplar site status are met which has enabled application to be completed in Quarter 4.
RISKS / ISSUES
On-going learning and management in relation to non-compliance with 24 hour re-assessment by medical staff and Advanced Nurse Practitioners is required. Once the electronic system is implemented this will enforce completion.

6. **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.**



	16/17 Apr	17/18 Apr	16/17 May	17/18 May	16/17 Jun	17/18 Jun	16/17 Jul	17/18 Jul	16/17 Aug	17/18 Aug
Sum of Severe Harm	0	0	0	0	0	0	0	0	0	0
Sum of Moderate Harm	0	0	1	0	0	1	0	0	0	0
Sum of Low Harm	3	3	2	2	4	3	4	5	6	3
Sum of No Harm	1	4	3	2	2	4	6	5	5	3

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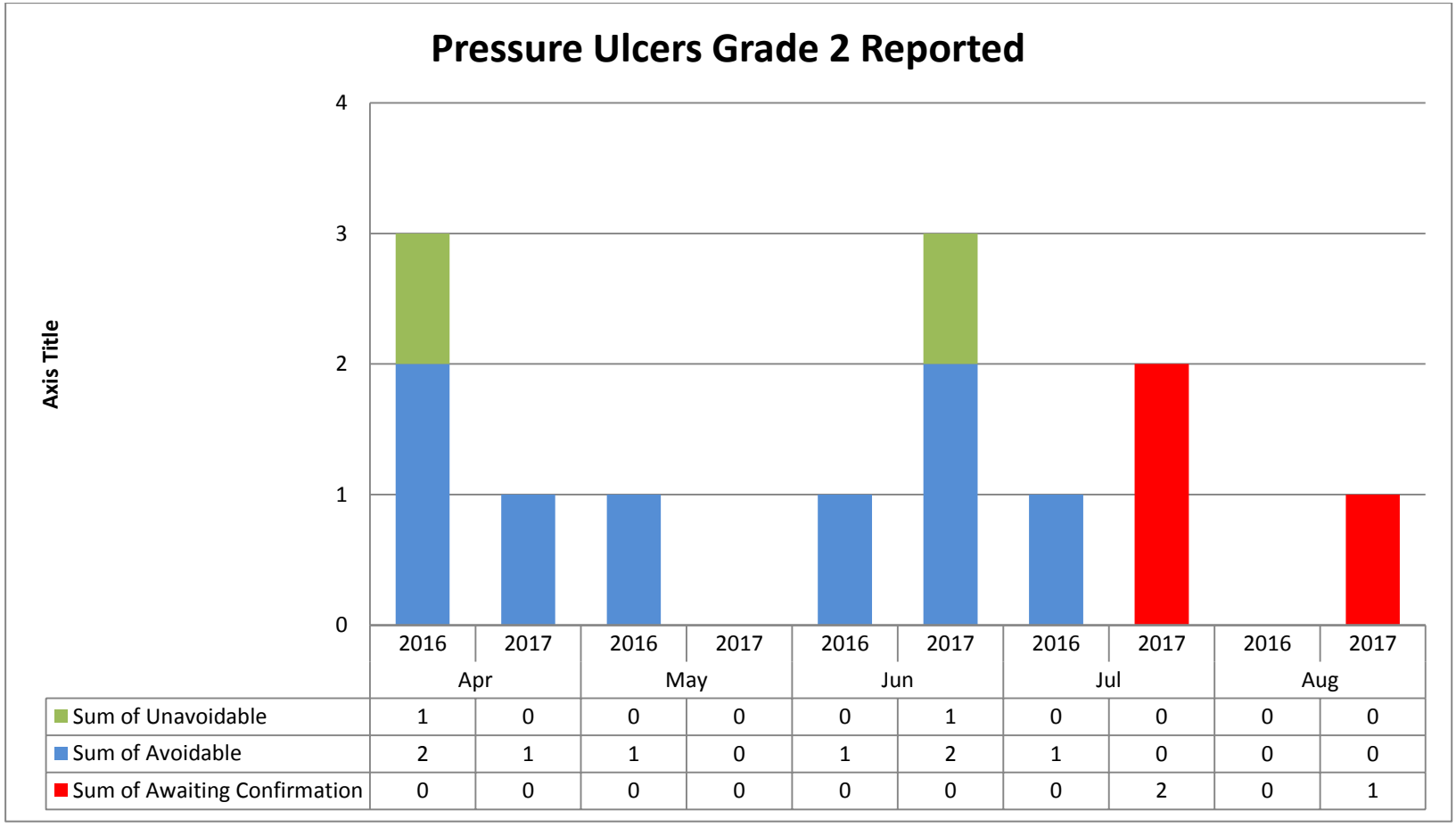
INFORMATION
Overall 8 fall related incidents were reported across the Trust in August 2017, six of these related to adult inpatient falls. All incidents have been subject to a post-fall notes review by the ward manager or deputy and a falls questionnaire has been completed for each fall. The inpatient falls are all reported to CQG via the Divisional Condition reports from the Heads of Nursing and are reported in the Monthly Quality Report.

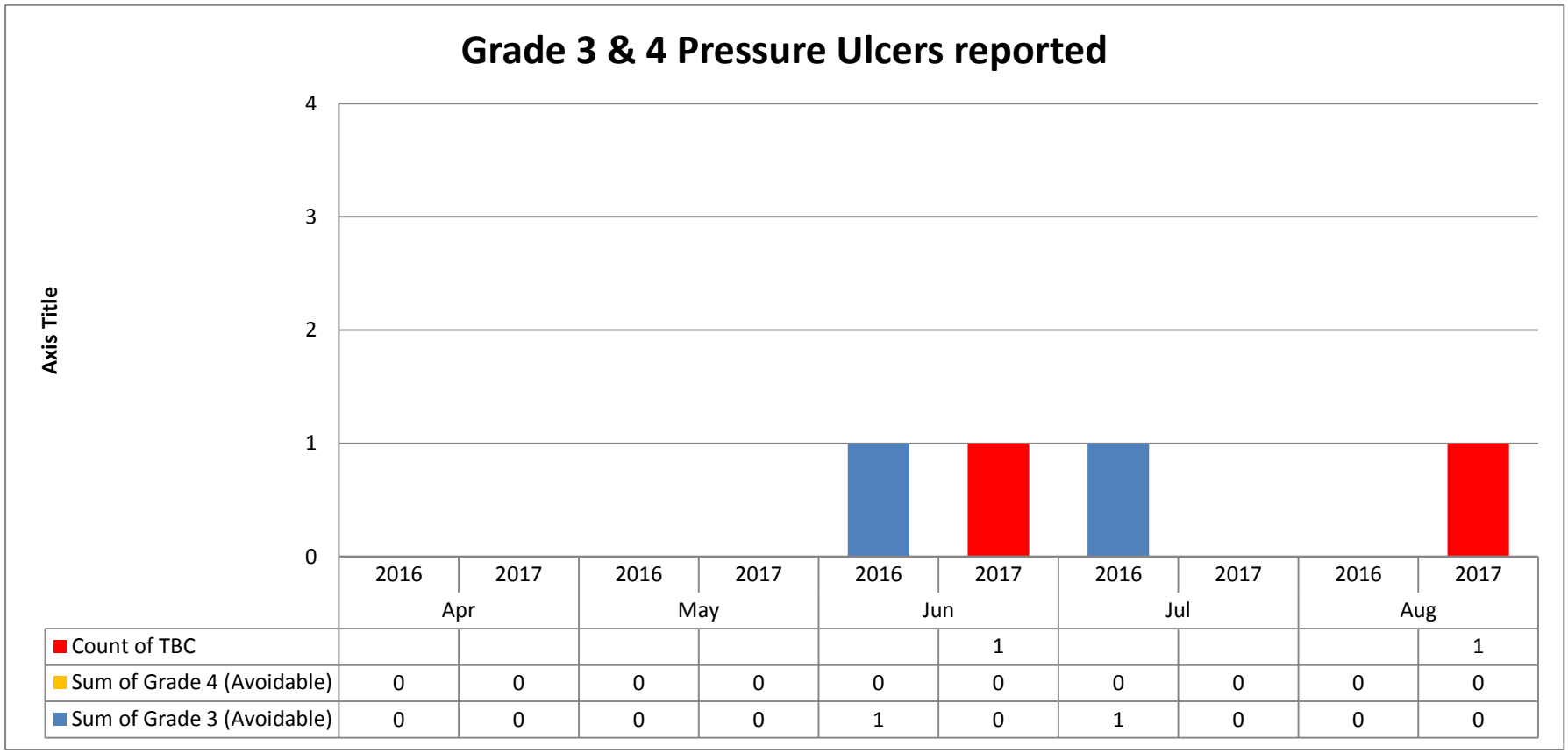
ACTIONS FOR IMPROVEMENTS / LEARNING
• The Falls Working Group (FWG) meetings recommenced in December 2016 and are scheduled bi-monthly after the January 2017 meeting. • Through the FWG the work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller is in progress. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care. • Falls information boards are to be standardised across all ward areas, with the information being agreed at the FWG meeting. 'Walking stick' visual information to be produced on a monthly basis for all ward areas for cascading of information regarding the number of falls per ward, per month to all staff. • Recommendations from the Throne Project will be overseen by the Falls Group on a Bi-monthly basis. • A review of the falls assessment and care plan documentation to take place, to include development of a post falls medical review template report, which is with the Documentation task and finish group currently. • Monthly reporting via the Ward Quality Dashboards to continue.

RISKS / ISSUES
None

7. **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 2016	Apr 2017	May 2016	May 2017	Jun 2016	Jun 2017	Jul 2016	Jul 2017	Aug 2016	Aug 2017
Sum of Unavoidable	1	0	0	0	0	1	0	0	0	0
Sum of Avoidable	2	1	1	0	1	2	1	0	0	0
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	2	0	1



	Apr 2016	Apr 2017	May 2016	May 2017	Jun 2016	Jun 2017	Jul 2016	Jul 2017	Aug 2016	Aug 2017
Count of TBC						1				1
Sum of Grade 4 (Avoidable)	0	0	0	0	0	0	0	0	0	0
Sum of Grade 3 (Avoidable)	0	0	0	0	1	0	1	0	0	0

INFORMATION

In August 2017 there has been;
1 x Grade 2 pressure ulcers and 1x Grade 3 pressure ulcer. The avoidability is to be determined

In total, from 1st April 2017 the Trust has reported the following avoidable pressure ulcers:

1 avoidable Non Device Related Grade 2 pressure Ulcers against a limit (target) of 12.

1 avoidable Device Related Grade 2 pressure Ulcers against a limit (target) of 12.

0 avoidable Grade 3 pressure Ulcers against a limit of 0. (Two Grade 3 Pressure Ulcers currently awaiting RCA's to establish avoid ability and are therefore not included in these figures)

Royal Orthopaedic Hospital and Stop the pressure campaign

The 'Stop the Pressure' campaign was launched in the UK in by NHS Midlands and East, and 19 November 2015 marked a national celebration of the campaign, aiming to raise awareness and educate about the ways that pressure ulcers can be prevented, and act as a vehicle for change to make life better for patients.

The NHS has reported that:

- 700,000 people are affected by pressure ulcers each year;
- Each pressure ulcer adds additional costs of care of over £4,000;
- 95% of pressure ulcers are preventable.

In 2016/2017 The Royal Orthopaedic Hospital had a total of 16 avoidable pressure ulcers in a total of 13989 inpatient's. This is equal to 0.11% of patients with avoidable Grade 2 or higher pressure ulcers at the Royal Orthopaedic Hospital. This is well below the national average.

Updates from June/July:

- **1 x Grade 3** and **1 x Grade 4** (relating to same patient) no 21115 device related pressure ulcers
- **1 x Grade 3** - device related pressure ulcers investigation (20769) concluded damage as result of traction prop used in theatre, lessons learnt regarding consent and skin examination. Changes required to documentation for theatres. Awaiting outcome
- **1 x 3 Grade** hospital acquired pressure ulcers under investigation (20930) report should be concluded this month and submitted to commissioners, initial outcome is this being an avoidable pressure ulcer.

ACTIONS FOR IMPROVEMENTS / LEARNING

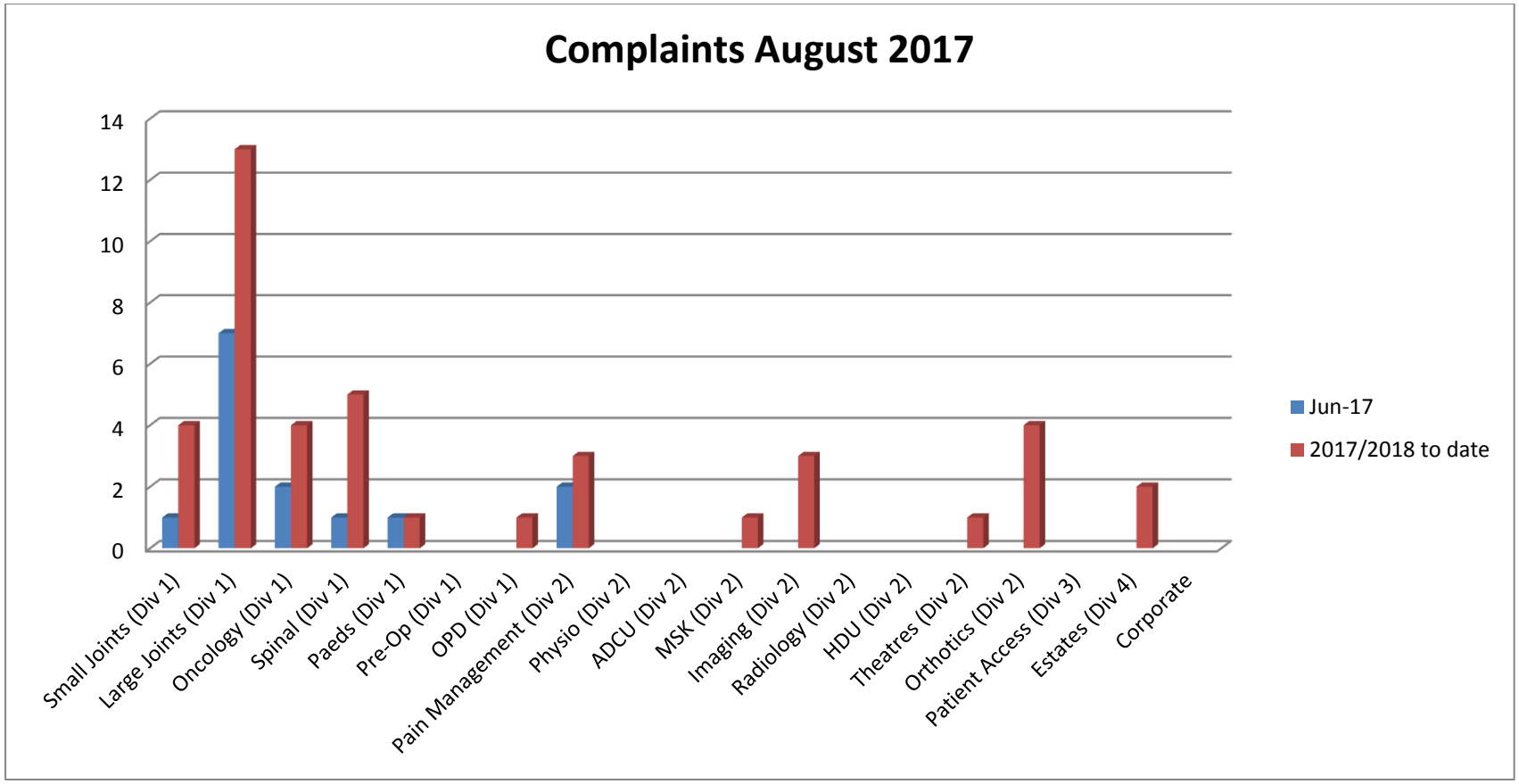
Identified from reviews and investigations /RCA's:-

- Risk of pressure damage not elucidated at time of consent this must be discussed and documented on the consent form.
- Perineum not examined pre operatively
- Tissue viability information stored separately on their database and not recorded in medical notes
- Importance of documenting discussion with patients about advises on repositioning themselves and pressure prevention information been given and understood by the patient.
- Transfers form other hospital to check and challenge documentation and care plans received and handover, ensuring skin inspection on admission to ward/area is undertaken and documented.
- GP referring back to ROH there is a possibility that further breakdown may not have occurred, importance of information sharing

RISKS / ISSUES

Currently have 2 Tissue Viability Nurse Post vacancies Lead Nurse –Band 7 and Sister Band 6. The Band 7 has been recruited to staff member should commence early December 17. Band 6 previous recruitment unsuccessful, advertised and interviews to take place 27 September 2017. Interim cover is being provided by ward managers and ward and departmental tissue viability nurse nurses and band 6's nursing from ROCS team as required for support and grading of pressure areas supporting ward staff until recruitment into the vacancies.

8. 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.



INFORMATION

PALS

The PALS department handled 375 contacts during August 2017 of which 88 were classified as concerns. This brings the total of PALS contact for the year to date to 2368 (546 concerns) This represents a much higher figure than at the same point last year (1558 PALS contacts). This increase is likely due to the changes to the Trusts appointment letters now including the PALS contact details.

Compliments

There were 424 compliments recorded in August 2017, with the most being recorded for Div 1. This is slightly higher than last month with the Pre-Operative Assessment Clinic continuing to receive a significant number of compliments. Areas have been reminded to submit their records for central recording.

All compliments are sent electronically to the Patient Experience Team who holds the records. A Compliment is recorded if there is tangible evidence such as a card, a thank you letter, a box of chocolates or an e-mail. Teams are reminded monthly to submit their compliments for central logging.

Complaints

There were a total of 11 formal complaints in August 2017. It has been noted that Large joints in Division 1 has the highest amount of complaints in the Trust. Further analysis of this will be included in the next quality report.

The subjects of this month's complaints were:

Initially Risk Rated Red:

- Wrong side procedure, under investigation (Div. 1, oncology)

Initially Risk Rated Amber:

- Wrong side injection, approach of Consultant (Div. 2, Pain Management)
- Lack of communication regarding treatment; cancelled surgery (Div. 1, Oncology)
- Clinical diagnosis provided by initial Consultant (Div. 1, Paeds)
- Delays to treatment and communication about what is happening (Div.1, Oncology)
- Treatment for spinal condition (Div. 1, Spinal)
- Information about who carried out operation on left knee (Div. 1, Oncology)

Initially Risk Rated Yellow:

- Experience in ADCU and care provided by staff on Ward 2 (Div. 2, ADCU)
- Transport not booked (Div. 4, Transport)
- Unhappy with hydrotherapy appointment (Div. 2, Therapies)
- Attitude of secretary; non-receipt of requested information; apt delay (Div.1 , Oncology)

ACTIONS FOR IMPROVEMENTS / LEARNING

Complaints closed in August 2017

There were 10 complaints closed in August 2017, all of which were closed within the agreed timescales. This gives a 100% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in August 2017 was 26.5 days which is within normal limits.

Learning/Actions from complaints

Of the 10 complaints closed in July 2017:

- 2 were upheld
- 6 were partially upheld
- 2 were not upheld

Learning identified and actions taken as a result of complaints closed in August 2017 include:

- Communication about needs of inpatients with Learning Disability is not robust
  Action: Discussion with new Learning Disability Nurse has been commenced

- The system for pre-booking x-rays for Outpatients isn't always followed
  Action: Staff have been reminded of the expected protocols for pre-booking imaging

- Communication to patient about discharge arrangement and what needs to happen before being allowed to go home is not always clear.
  Action: New patient information leaflet on the steps to discharge is being created for the bedside

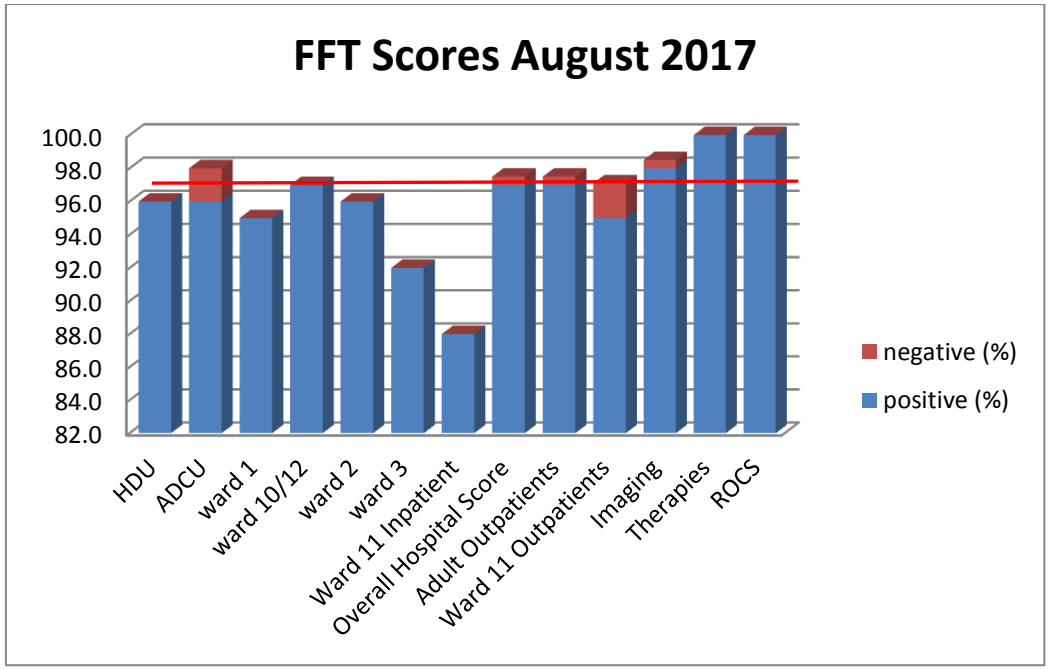
RISKS / ISSUES

None Identified.

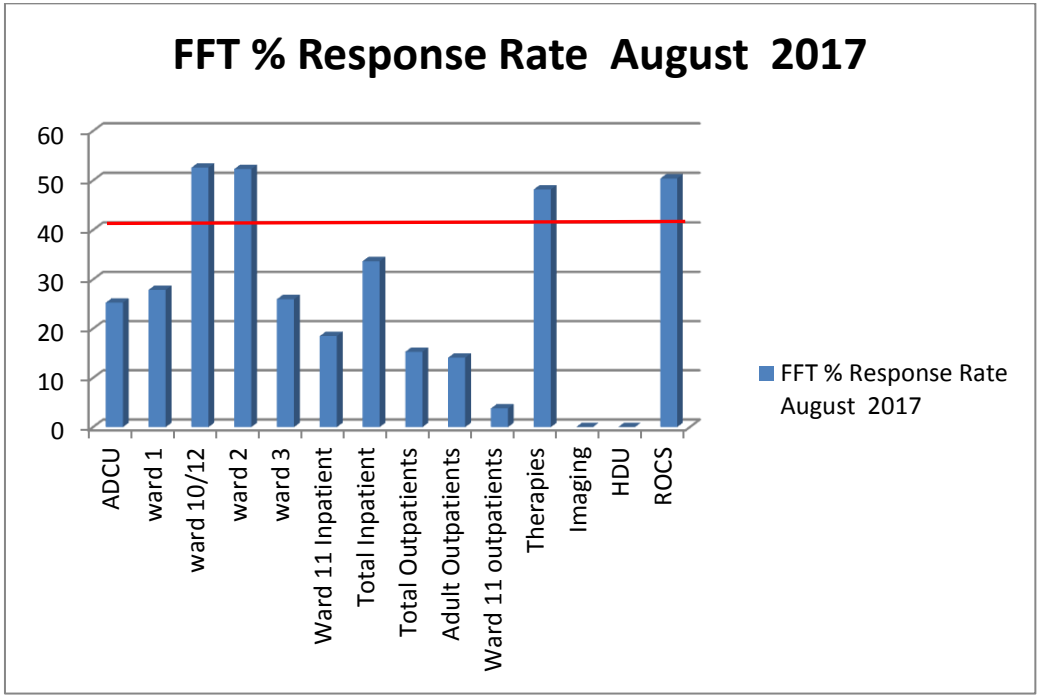
10. Friends and Family Test Results and iwantgreatcare - The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

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.



There are several areas of low response rate which have clearly affected the score received. The management of FFT has now returned to the Public and Patient Services Manager, who will be working with departmental colleagues to improve these rates over the next three months. The Trust has set an internal target to reach a 40% response rate across all areas within the first quarter of 2017/18. This has not been met and will form part of the work for improvement. In addition, it has been noted that the ipad online data collection system in place in the wards is not currently being used to collect FFT. This will also be reviewed over the next three months.

I Want Great Care - iWantGreatCare makes it simple to collect large volumes of meaningful, detailed outcomes data direct from patients on your organisation, clinical locations and whole clinical teams. It Continuously monitor and compare performance of individual services, departments and wards and Aggregated, graphical monthly reporting meets needs of both providers and commissioners for robust, patient-centric metrics to track quality and performance.

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.

12. Litigation

No new litigation to report in August 2017.

13. Coroner's

No new Coroner's inquest for August 2017.

14. **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 perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**

INFORMATION
No Data available due to theatre man
ACTIONS FOR IMPROVEMENTS / LEARNING
The Clinical Standards Lead and Theatres Manager are discussing the development of a new report to ensure that we give an accurate reporting and provide the correct assurances.
RISKS / ISSUES
The Audit Data for WHO checklist is not available for May/June/July/August 2017 due to the migration to the new theatre man software. A new report is currently being generated that will show the WHO compliance and audit. This will be included next month

Finance and Performance Report

AUGUST 2017

CONTENTS

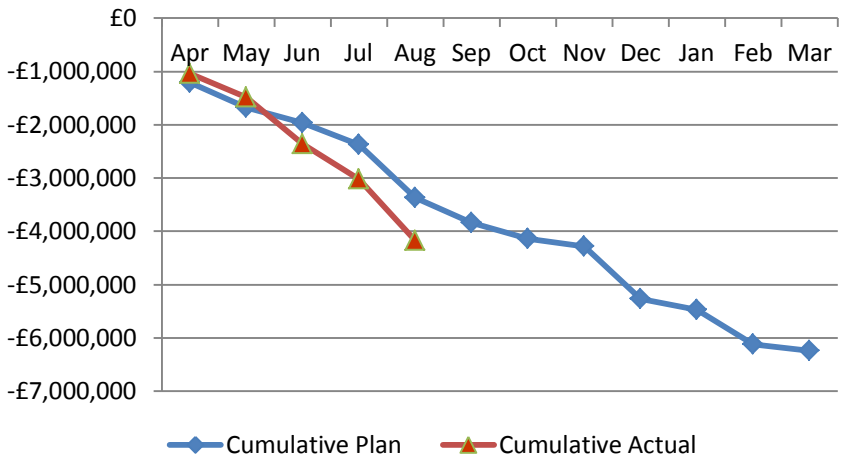
INTRODUCTION

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.

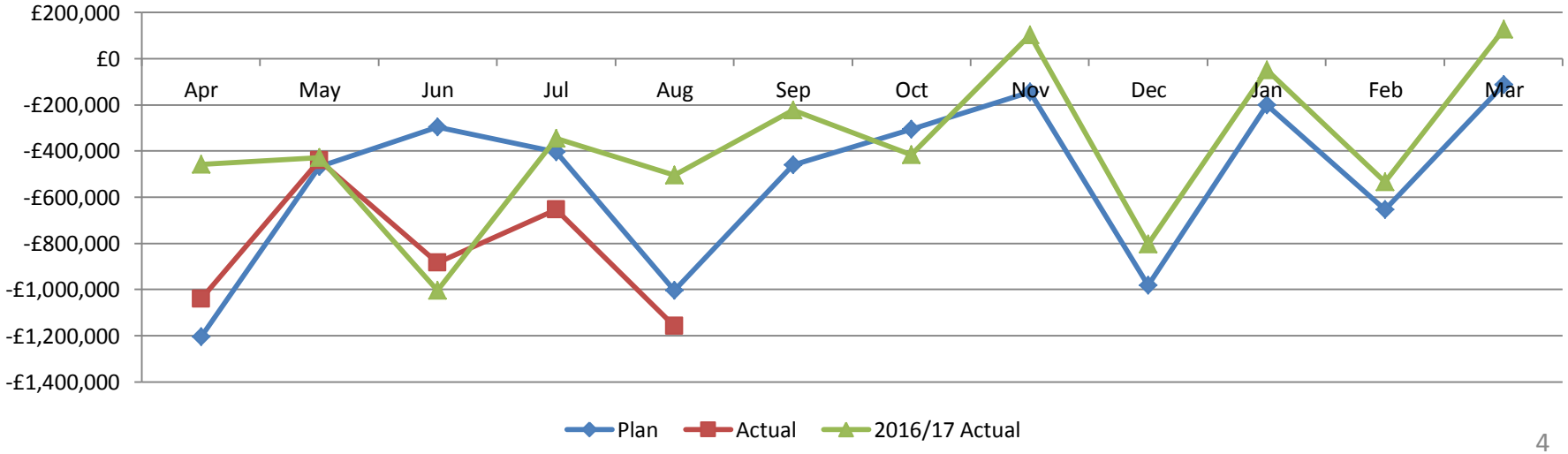
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Cumulative Deficit vs Plan



NHSI Use of Resources Rating (UOR)		
	Plan	**Actual**
Capital Service Cover	4	4
Liquidity	4	4
I&E Margin	4	4
I&E Margin – Variance against plan	1	4
Agency metric	1	2
Overall UOR	N/A	4

Monthly Surplus/Deficit Actual vs Plan



INFORMATION

The Trust has delivered a deficit of £1,157,000 in August against a planned deficit of £1,005,000, a result £152,000 behind plan. This brings the Trust's year to date position (on a control total basis) to £4,148,000 against a plan of £3,355,000, £793,000 behind plan.

The in-month position remains behind plan in August, although an improved position on the £250,000 the position was behind plan in July. Part of the variance year to date is the spend on RTT resources, including consultancy and agency. This alone results in c.£450,000 of cost pressure against the original plan. This spend is expected to reduce as the majority of the RTT validation is complete, with in-month spend being c.£50,000 in comparison to months' 1-4 average of c.£100,000 a month. RTT spend in itself does not explain the variance; as previously described, the position has benefited from £101,000 of fire insurance income. The remaining variance is as a result of two key factors – poor activity performance, particularly in June, but also a trend for increased spend on non-pay items, particularly within theatres. Indeed, in an unprecedented position for the Trust, income over-performed slightly against plan, but non-pay significantly overspent, largely driving the August position. In month performance will be discussed further in the slides to follow.

As at the end of August, the Trust has recognised £558,000 of CIP savings, against a plan of £1,089,000. £49,000 (7%) of savings to date are non-recurrent. A review of the original CIP Plans is underway and has highlighted some areas of risk but also some new areas of opportunity. As such a revised CIP Plan has been drafted with forecast CIP of £2,754,000 against an original plan of £3,191,000.

With regards to the Trust's Use of Resources Risk Rating (UOR), the deficit position against plan results in the Trust reporting ratings of 4 for Capital Service Cover, I&E Margin and I&E Margin variance. The negative variance from plan has also resulted in a 4 for I&E Margin Variance. The Trust's requirement for cash support has resulted in the Trust being a 4 for liquidity. Whilst agency spend in month was below plan, previous month's RTT spend means the agency spend is overspent year to date and remains at a 2. As a result, the overall rating for August remains at a 4.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Trust Executive are monitoring weekly progress against activity improvement and the scheduled care improvement programme. In addition, fortnightly meetings are being held with operational, clinical and finance stakeholders to improve the theatre environment and give better visibility of stock levels and spend. In addition, increased and new senior resourcing in theatres has been put in place, with a particular priority on improving theatre flow and understanding and controlling theatre spend.

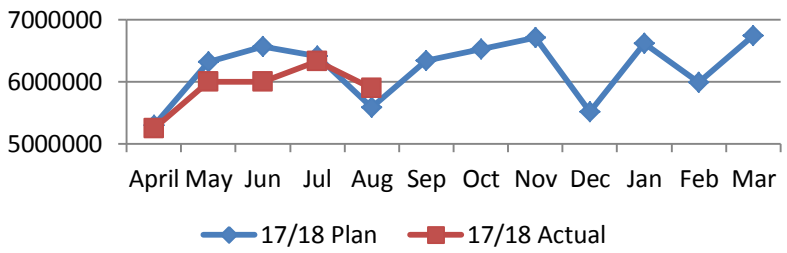
The new Assistant Director of Finance – Financial Delivery is performing a detailed review and refresh of CIPs as described further in the CIP section.

RISKS / ISSUES

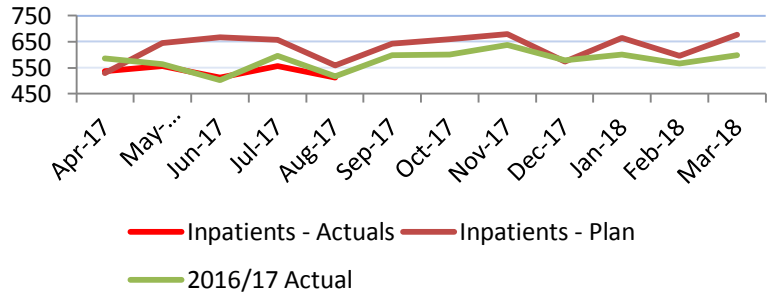
There remains a risk that the focus on RTT and operational activity delivery results in CIP schemes not being implemented in a timely enough manner to ensure the required savings for 2017/18.

2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity

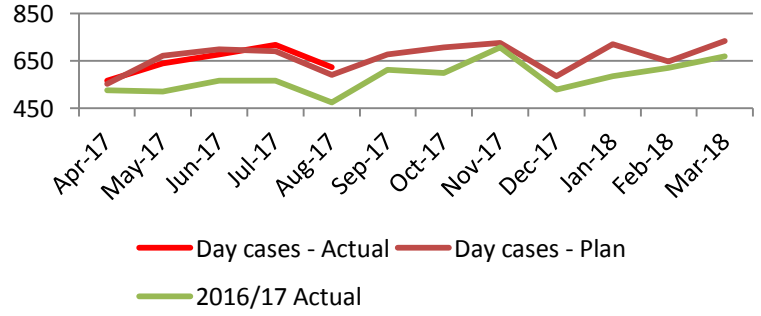
Monthly NHS Clinical Income vs Plan, £, 17/18



Inpatient Activity



Day Case Activity



NHS Clinical Income – August 2017 £'000			
	Plan	Actual	Variance
Inpatients	2,806	3,094	288
Excess Bed Days	87	62	-25
Total Inpatients	2,893	3,156	263
Day Cases	677	650	-27
Outpatients	541	637	96
Critical Care	217	138	-79
Therapies	216	219	3
Pass-through income	194	244	50
Other variable income	329	334	5
Block income	518	518	0
TOTAL	5,585	5,896	311

NHS Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	15,268	15,146	-122
Excess Bed Days	474	265	-209
Total Inpatients	15,742	15,411	-331
Day Cases	3690	3482	-208
Outpatients	2949	2992	43
Critical Care	1183	952	-231
Therapies	1175	1097	-78
Pass-through income	1055	1116	61
Other variable income	1797	1830	33
Block income	2590	2590	0
TOTAL	30,181	29,470	-711

INFORMATION

NHS Clinical income has over-performed against plan by 5.5% in August having under-performed by 1.2% in July. This is being driven largely by final activity for July being higher than was initially recorded in the draft activity position (the difference between draft and final SLAM). This accounted for c.£200k of the £311k over performance. There are always slight differences between draft and final, but this was higher than usual, and is driven by activity being entered late onto the system by individual teams throughout the hospital.

In addition, unavailability of BCH lists in the early months of the year had an impact on spinal performance, which should be recovered by the end of the year.

Cumulatively, the trust is now 2.4% behind plan. Admitted patient care performance was below target by 46 cases, but case mix was richer within these cases, explaining the over performance in income terms. Day case activity over performed against plan by 34 cases by case mix was poorer (e.g. increased injections) resulting in a small underperformance in income terms.

Outpatients continued to over-performed in month from an income point of view, driven by over performance in first and follow up appointments, despite outpatient procedures underperforming against plan.

ACTIONS FOR IMPROVEMENTS

As noted previously, the Interim Chief Operating Officer is holding weekly challenge and improvement meetings with a range of operational and other stakeholders to identify areas for efficiency improvement. Current areas of focus include an end to end pathway review and theatre efficiency.
In addition the spinal firm are following the example of large and small joints in reversing their booking processes to allow medical secretaries to TCI patients before they book the theatre sessions. This appears to be having a positive effect on the forward activity look with future activity being booked further out.

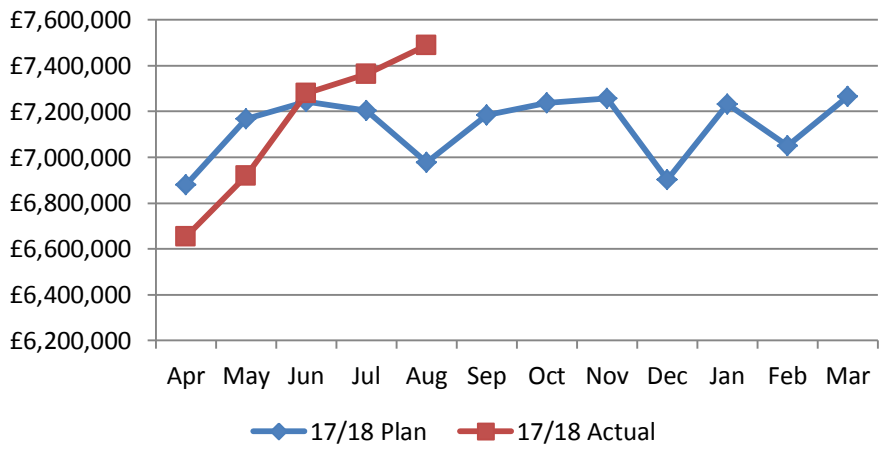
The firms are developing their activity recovery plans to assist with the process of financial recovery. There remains actions ongoing to give further assurance around the ability of the teams to deliver that activity in areas such as ensuring theatre teams are available, and patients are fit and willing to attend over the Christmas period.

RISKS / ISSUES

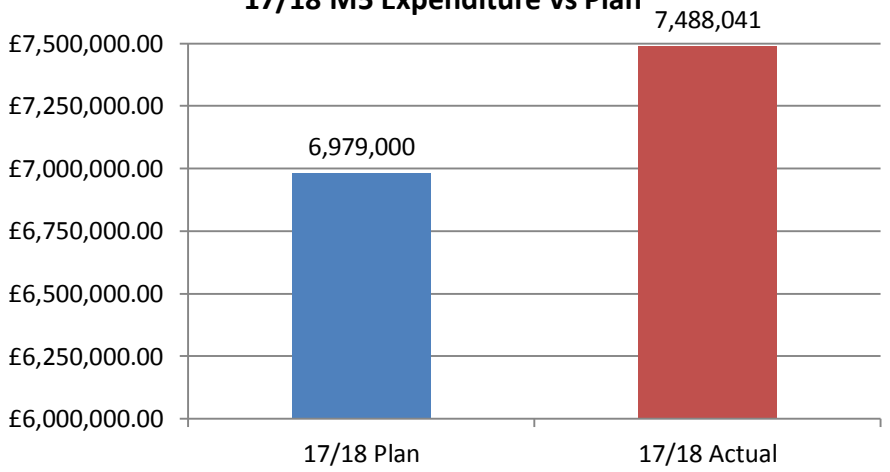
There remains good clinical engagement in developing improvements to productivity for both operations and out patients. Some consultants have very short, with others having very long, waiting lists, and work is underway to smooth out flows across firms. As noted above, a key risk will be the ability of the Trust to staff the lists offered by the consultant body in order to maintain clinical buy-in in recovery.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends

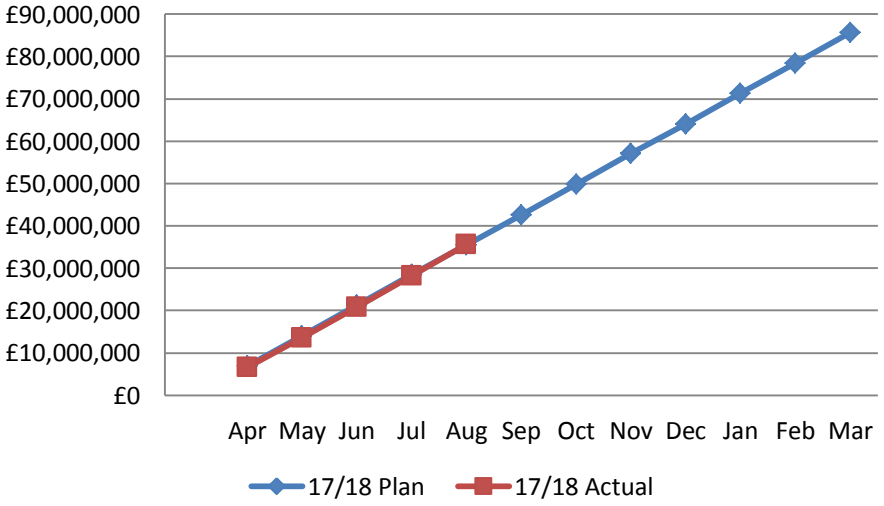
17/18 Monthly Expenditure vs Plan



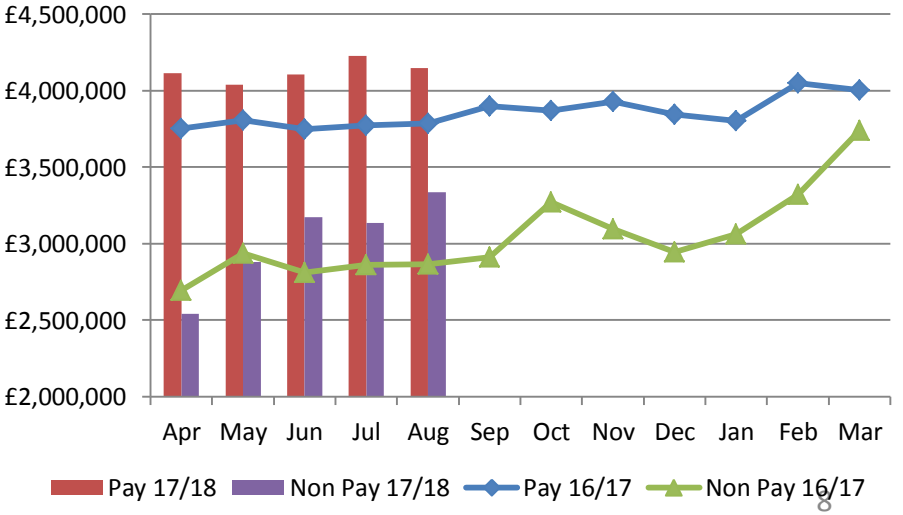
17/18 M5 Expenditure vs Plan



Cumulative Expenditure vs Plan 17/18



16/17 vs 17/18 Pay & Non Pay Spends



INFORMATION

Expenditure levels for the month were £7,488,000, which is £509,000 above the in month plan of £6,979,000.

The reason for the overspend was non-pay spend being higher than planned, particularly with regard to theatre non-pay costs. At the last executive led Division 2 performance meeting, the operational leads were challenged to urgently review non-pay costs in areas such as human bone products and dressings which seem to have increased spend with a disconnect with activity. The next divisional meeting is occurring on 22nd September, at which the executive are expecting a report on the key findings to date and actions. In addition, a new theatres group of operational, clinical and financial staff has been set up to identify the key issues within theatres, which is recognised as key to the Trust's success with recovery. Stock and non-pay spend in particular is seen as a urgent area of focus within these groups. Action plans are being developed and implemented urgently.

In addition, new theatre management is now in place, with initial objectives being particularly focussed on non-pay spend.

Pay spend was largely in line with the plan. When the pay categories are reviewed individually, substantive spend was behind plan by £28,000, bank spend ahead of plan by £229,000, and agency lower than plan by £35,000. As noted in prior month, it is clear from a review of the bank plan that this was erroneously set too low in each month, with the balance being taken from substantive pay. When the plans are corrected to what they should have been set as, the spends are much more in line with plan.

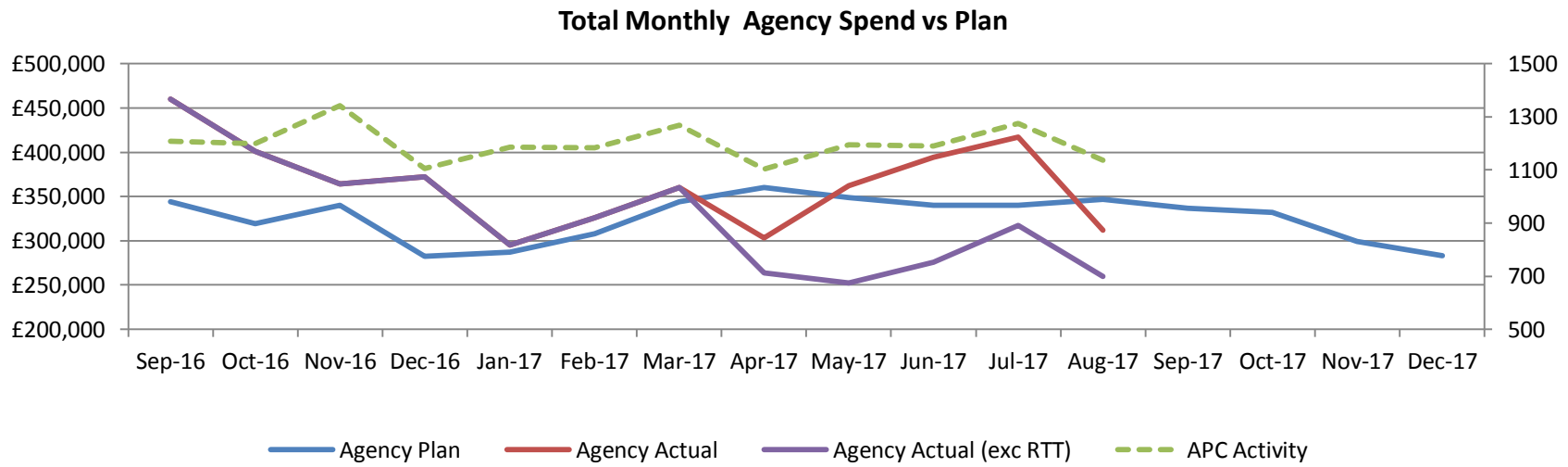
ACTIONS FOR IMPROVEMENTS / LEARNING

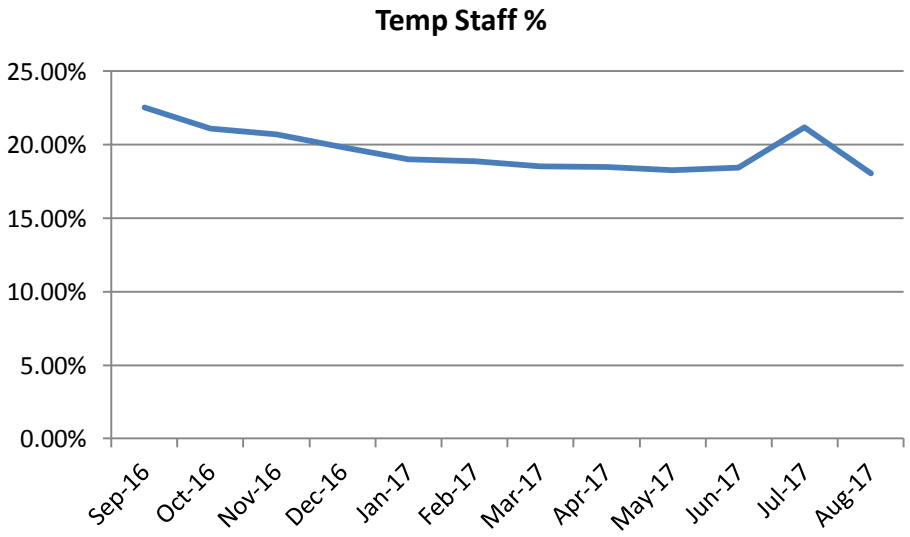
Costs will continue to be scrutinised and minimised, and the alteration of the bank spend plan will be followed up further with NHS Improvement.

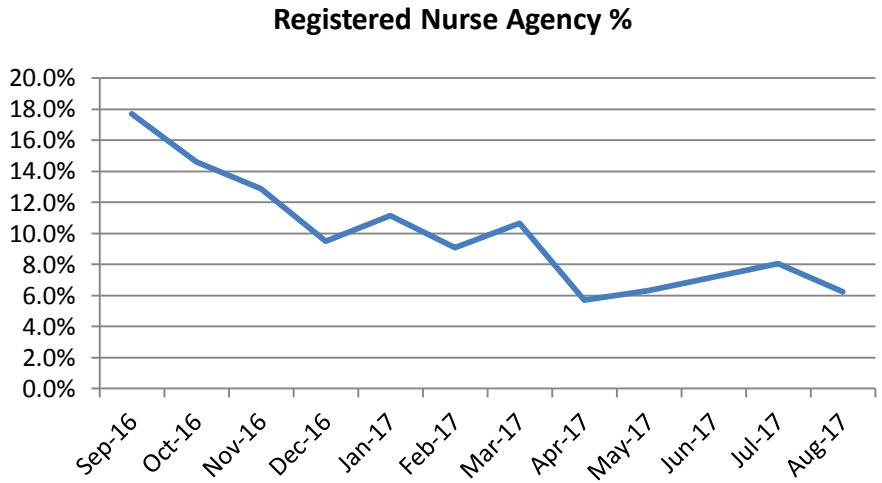
RISKS / ISSUES

Gaining a greater understanding and control of theatre spend is essential to the recovery of the financial position, and will be mitigated via the workgroups stated above.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements







INFORMATION

August showed an decrease in agency spend (£417k to £312k). Fewer RTT validators on site has resulted in RTT agency spend reducing significantly in month. Both with and without the RTT agency spend, agency spend was below in month plan, although it remains overspent year to date. Healthroster appears to be yielding some excellent savings on nursing spend, although agency spend on the wards was higher than expected in month, and is being reviewed further. There continues to be a pressure on Medical spend due to an under provision of GP trainees from the West Midlands Deanery and gaps in rotas hence needing to be covered through locums.

ACTIONS FOR IMPROVEMENTS / LEARNING

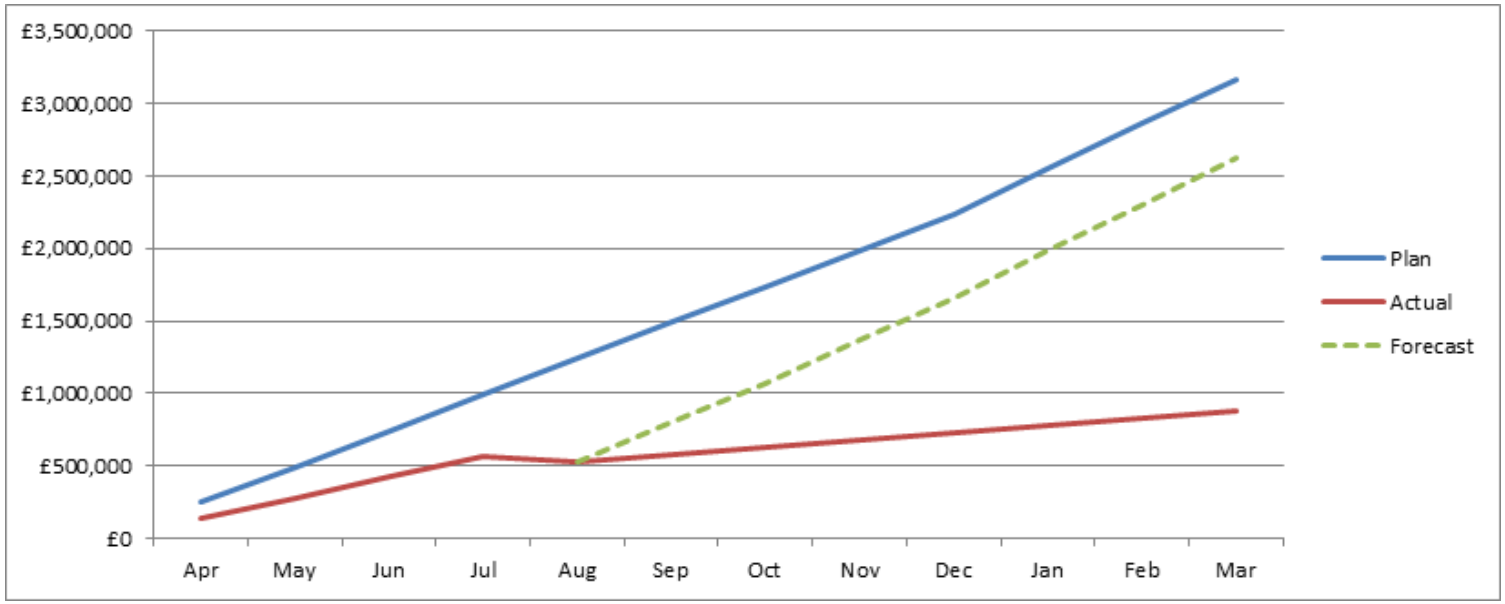
The leadership by the Nurses in addressing use of agency continues to impact positively, although as explained above, ward spend was higher than had been expected in August.

Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios. The Trust is currently consulting on a change to rota working patterns as part of this process. Further work is planned to introduce Healthroster for the medical workforce, to enable further forward planning of annual leave and rota cover.

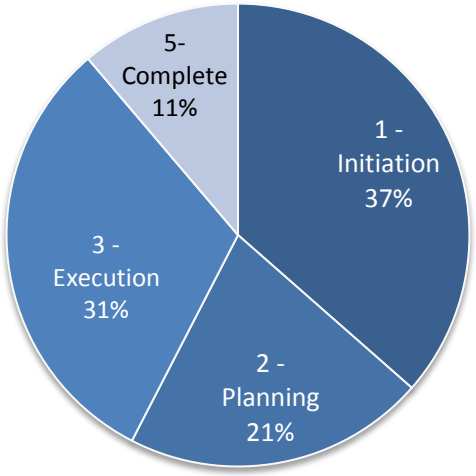
RISKS / ISSUES

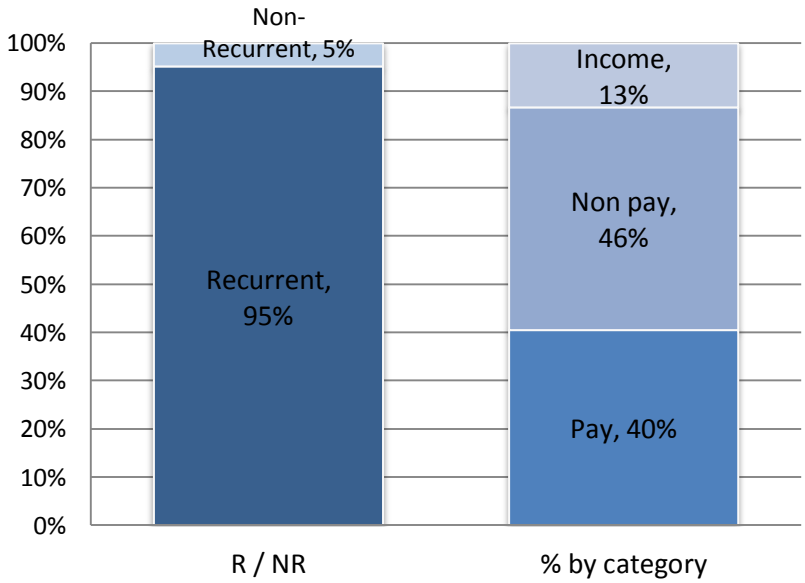
Achievement of the NHSI agency cap is seen as a key metric to measure whether Trusts have an appropriate grip on their financial controls, and agency expenditure is being built into the Single Oversight Framework. An overspend against the trajectory will have a direct impact on our regulator ratings. The Trust has remained at a 2 for agency spend, resulting in the overall UOR rating being a 4.

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2017/18



Stage of development





INFORMATION

As at the end of August, the Trust has recognised £558,000* of CIP savings, against a plan of £1,089,000. £49,000 (7%) of savings to date are non-recurrent.

A review of the original CIP Plans is underway and has highlighted some areas of risk but also some new areas of opportunity. As such a revised CIP Plan has been drafted with forecast CIP of £2,754,000 against an original plan of £3,191,000.

The current plan only contains 13% of income related schemes which is an area to explore and identify if there is more opportunity to grow both NHS and Non NHS income. The remainder of the plan is split 46% non pay and 40% pay.

The majority of the CIP is within the Initiation and Planning stage (58%) with 11% complete (i.e. fully achieved against Plan) and 31% at execution stage.

*Please note, within the NHS Improvement monthly return year to date actuals of £718,000 were reported. A detailed review exercise has been performed (since submission of the return) of achieved CIPs in addition to likely forecasts and has identified that some CIPs have been prematurely recorded as achieved.

ACTIONS FOR IMPROVEMENTS / LEARNING

Many schemes do not have robust delivery plans, and as such assurance that timescales will be met in order to deliver the savings in the time needed. Work is underway with CIP leads to develop the plans and identify other areas for CIP opportunity.

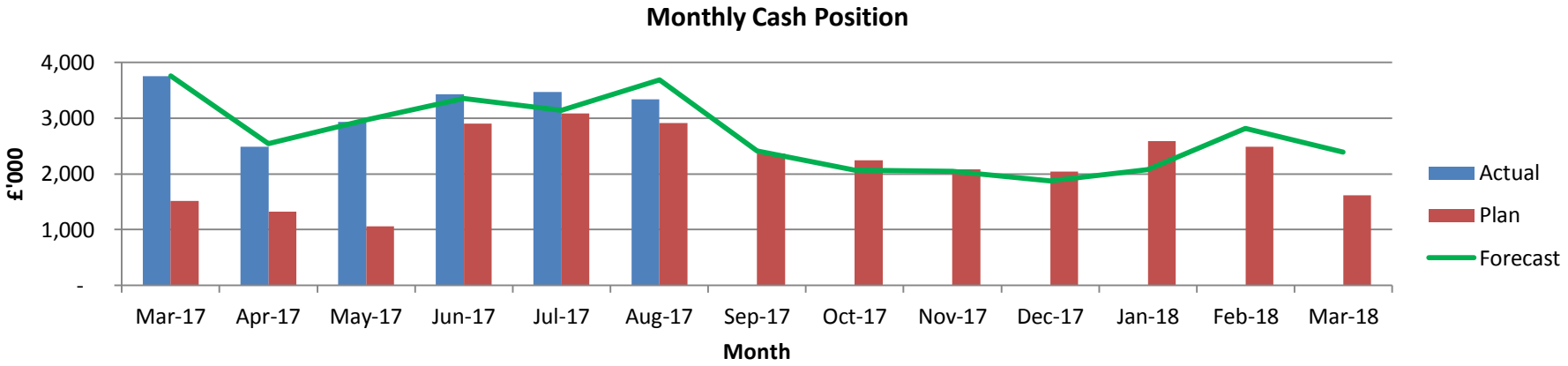
The schemes which specifically require increased focus to ensure the full CIP is delivered are;

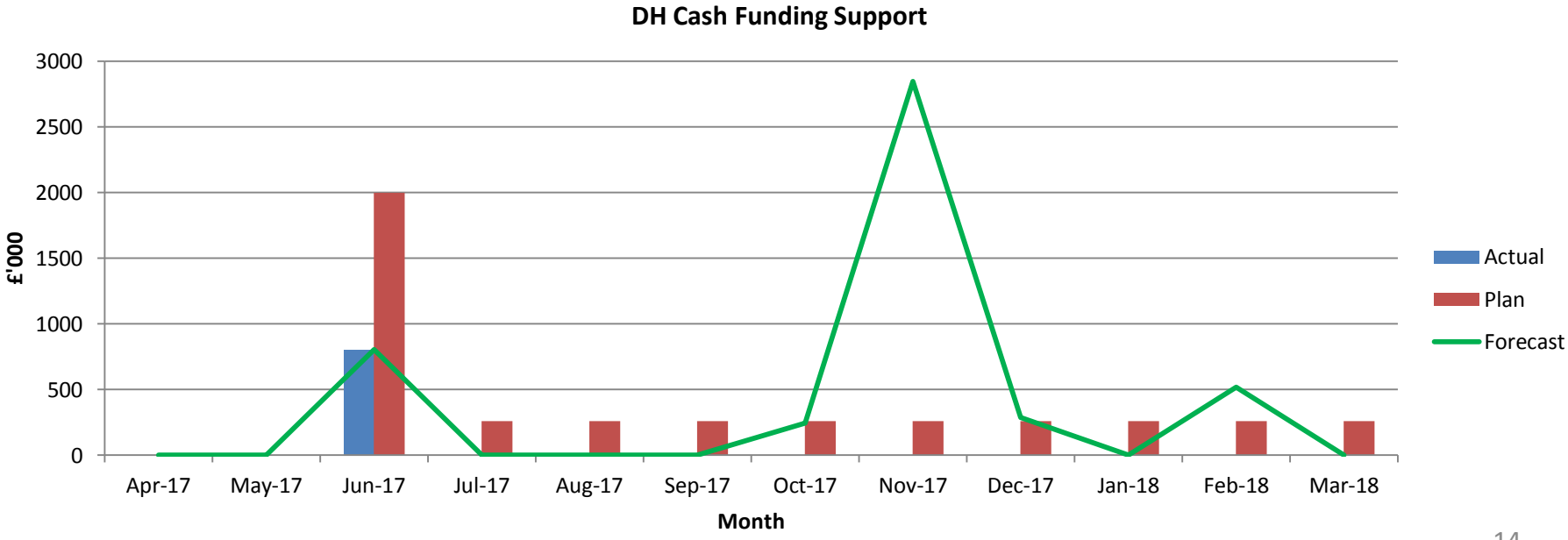
- Theatres stock management and rationalisation
- Implant rationalisation – ensure compliance against the agreed framework
- Other non pay consumables – rationalisation and product changes
- Coding improvements

RISKS / ISSUES

A review of CIP documentation has identified a risk around completeness of documentation in relation to CIP plans particularly delivery plans and Quality Impact Assessments (QIAs). To address this work has started with the CIP leads to accelerate the completion of these. A review of the CIP policy is also underway in readiness for CIP planning for 2018/19.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet in addition to expected borrowing requirements from the Department of Health





INFORMATION

Information

Cash levels are £0.4m higher than planned levels at the end of August, largely driven by cash held at the end of March being significantly higher than planned. The cash position for July is roughly in line with the Trust revised cash forecast for the month.

The Trust received its first cash loan from the DH on the 12th June for £804k as previously advised to the committee and has submitted its second request for funding required in October of £244k, this is lower than the forecast provided previously as the Q1 underperformance payments have been deferred until November.

The Trust has recently revised its Cash and Treasury Management policy and it was highlighted that it was felt necessary to consider investment, borrowing, interest rate and foreign exchange risk management strategy and policies. It was therefore agreed that this would be included within the cash section of the F&P paper to be reviewed monthly.

Given the Trust's current cash position and the need to request cash loans, the Trust is not in a position to hold any investments and at present the Trust does not hold any bank accounts other than those operated by the Government Banking Service. This means that interest and foreign exchange rate risks are determined to be low risk.

As in previous months, the requirement for borrowing has kept the Use of Resources Rating liquidity rating at a 4, the lowest level.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Head of Financial Accounting has set up a monthly cash control committee attended by the DDOF, and representatives from management accounts and the transaction team. The committee is reviewing cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications of cash from the Department of Health to be actioned.

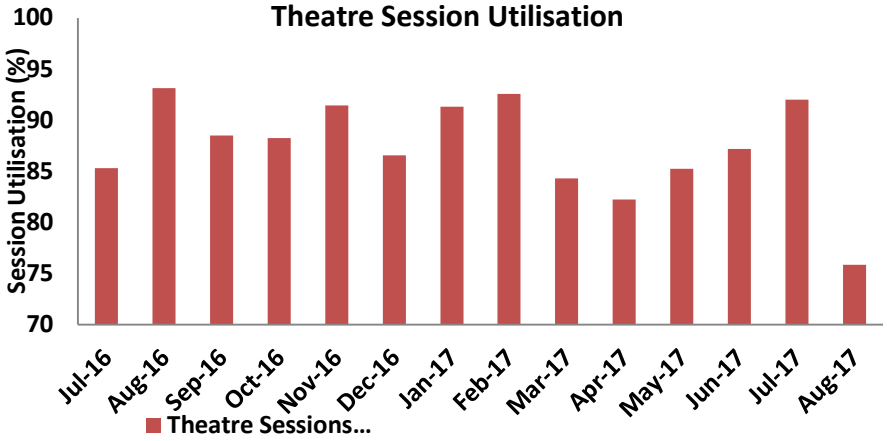
Based on the feedback from NHS Improvement the information provided to request funding was robust. The finance team are however continuing to review this and are looking to gather more information to continue to improve the Trusts management of cash.

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.

There is a risk is in relation to DH not approving a cash loan or approving a lower than requested amount, but the positive feedback to date from NHS Improvement provides assurance that this risk is relatively low.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are potentially available (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we aim to use at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis.

Due to annual leave / study leave, we typically plan that surgeons will operate over 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.

ACTIONS FOR IMPROVEMENTS / LEARNING

Further improvements have been made to the communications to surgeons of the availability of fallow lists, enabling more effective utilisation. From September there has been an additional 3 session day scheduled to facilitate the 2 x scoliosis cases on a list for spinal deformity. The large joints team are exploring a regular 3 session day list for those consultants with back log issues. In week twin theatre sessions have started in order to drive efficiency and reduce backlogs.

All reasonable efforts are made to recycle, including where it is deemed appropriate the use of sessions additional to job plan (paid ADHs). Since theatres and anaesthetic teams are not yet fully staffed, capacity is flexed up through overtime and bank working, so where lists are not recycled, and deemed 'fallow', the theatre staffing and anaesthetic shifts are removed 1 week ahead, to reduce bank and agency costs.

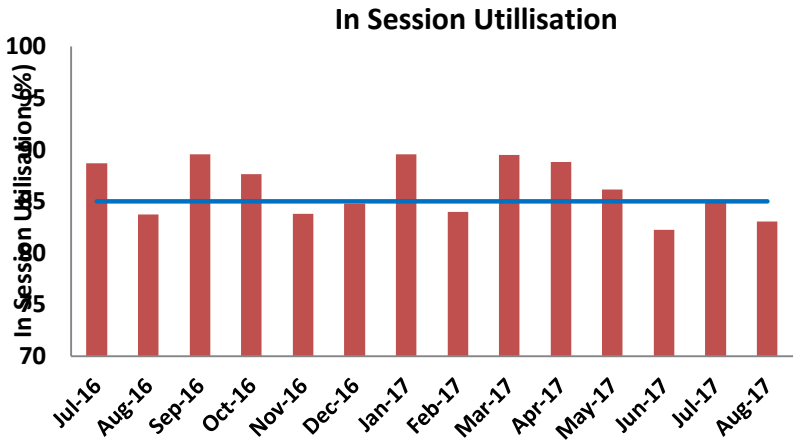
The ops team are proactively monitoring surgeon annual leave in order to manage the reduce the number of fallow lists and to offer appropriately to those services that are most challenged.

Weekend sessions are being planned throughout the remainder of the year with good uptake from consultants.

RISKS / ISSUES

Job planning is now completed for surgeons, with outstanding issues with only 2 surgeons; these are actively being progressed with the involvement of the Associate Medical Director, Clinical Service Manager and Clinical Service Lead.
The new theatre schedules and outpatient schedules started on 1st May 2017, to match the updated agreed job plans.
The next round of job planning is about to start.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained above the target 85% in the majority of months. Weekly reviews at 6-4-2 and other focus groups continue to improve the quality of listing and hence forward preparation to ensure smooth delivery of activity planned.

Several surgeons have now established a pattern of 6 primary joints on a two session list, and the learning from repeating this efficiency is being replicated across all firms and all lists to improve productivity. Starting Monday 25th September automatic call for first patients on lists commences following an engagement and training programme with all parties.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Scheduled Care Improvement work is now underway, with additional support and expertise joining in September. The Head of Nursing, Division 2, is continuing to lead work on The Productive Operating Theatre principles.

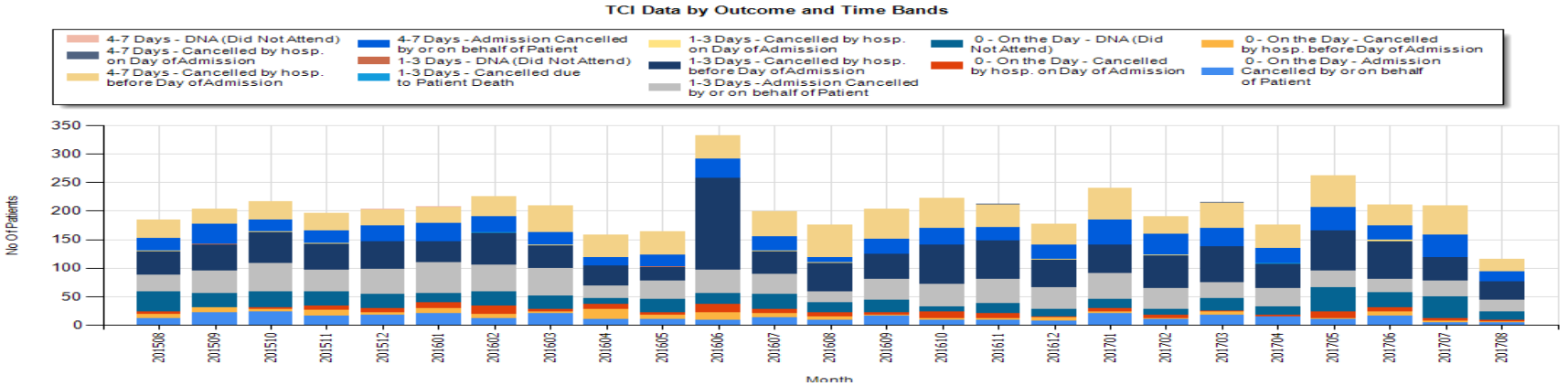
The new Theatre Management System 'Theatreman' was successfully implemented on 24th May 2017, replacing ORMIS. The reports now available are enabling further scrutiny of variation and opportunities for improvement.
Individual operation timings have now been refreshed based on actual times for surgery since May 2017. This allows the team to manage this on a daily basis with the ability to challenge the team real time.
Scrutiny and challenge is via the weekly 6-4-2 meeting, with instructions back through to the surgical teams to book lists to their maximum potential and to POAC and identify patients well in advance so that specific requirements can be planned for to reduce cancellations. From the beginning of September the ability to indicate patients who have been through POAC has been evident so that the operational team can contact those patients at short notice. A weekly review of the last 7 days in theatres now takes place every Friday morning with the Operations Team reviewing opportunities for better performance. Work also continues in the validation of the theatre data set, to ensure the accurate reporting of theatre performance, lead by the newly appointed Clinical Services Manager for theatres.
The revised PTL is now available and additional capacity delivery through use of non consultant staff is being explored. As the validation work is finalised, this has confirmed an accurate picture of the waiting list and hence the level of additional activity required.

RISKS / ISSUES

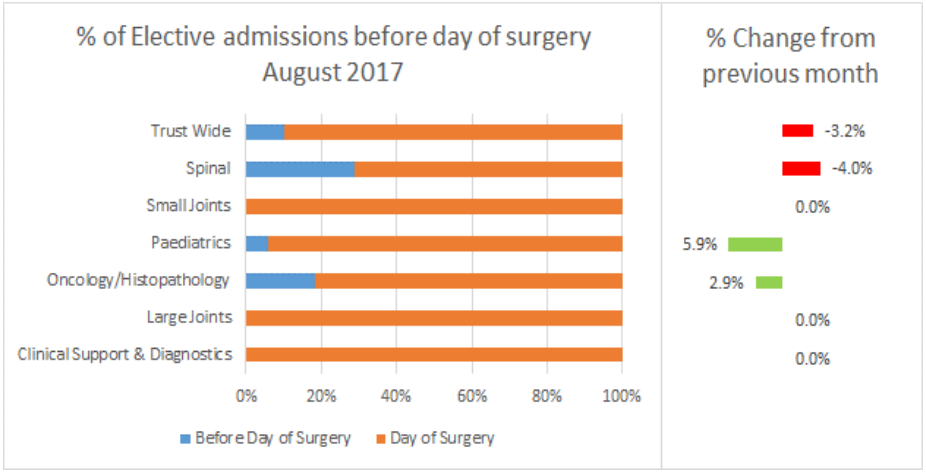
Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (e.g. experience in spinal scrub) to ensure the best possible use of available operating time. A theatres recruitment open day is scheduled for Sunday 15th October, with the aim of recruiting across all theatre vacancy types. Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit.

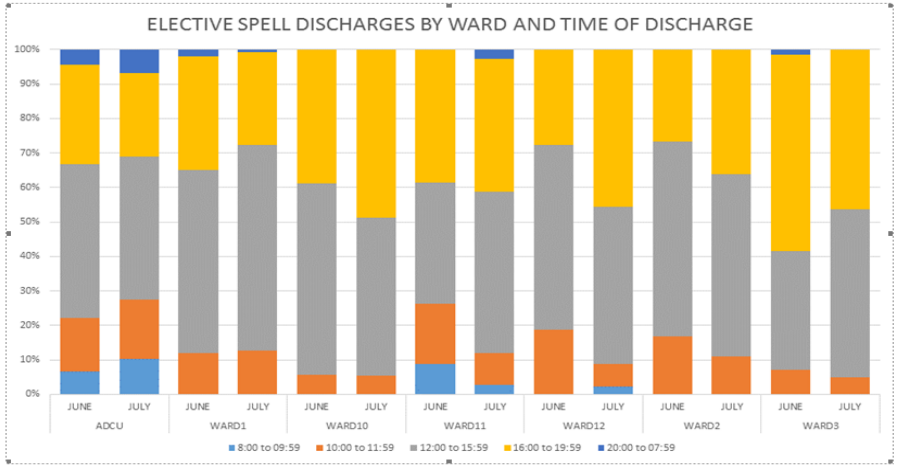
11. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner

Cancellations by patient / hospital



Admission the day before surgery





INFORMATION

Active management of the Patient Tracking List (PTL) , the planning for the establishment of a separate Oncology PTL weekly meeting to track the booking of individual patients, and a separate PTL weekly meeting for each firm to track patients is creating a new momentum, with lists being booked several weeks ahead where previously they were being booked only days ahead.

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Some of the replacement patients are then booked at short notice. We are working towards booking with 3 week's notice and 2 reasonable offers as per national guidance and our Access Policy.
Now that there are Clinical Service Leads and Clinical Service Managers for each specialty, and regular team meetings, some longstanding issues relating to disparity of waiting lists across consultants, variations in theatre productivity and listing protocols are being addressed and resolved.

Forensic analysis of cancellations continues, with a focussed analysis by the anaesthetic lead and nursing lead for POAC of the majority cause of cancellations on the day of surgery, namely those who are medically unfit, to ascertain what process changes can be made in POAC or to the 72 hour phone call to reduce this.

ACTIONS FOR IMPROVEMENTS / LEARNING

Now that the longstanding vacancies in Medical secretaries, admin support and operational management have been filled, there is now the capacity for transacting the forward booking of patients for both preoperative assessment and surgery. A pilot for medical secretaries to book patients directly is now in place across Hands and Large Joints teams which will be rolled out to spinal at the end of September 2017.

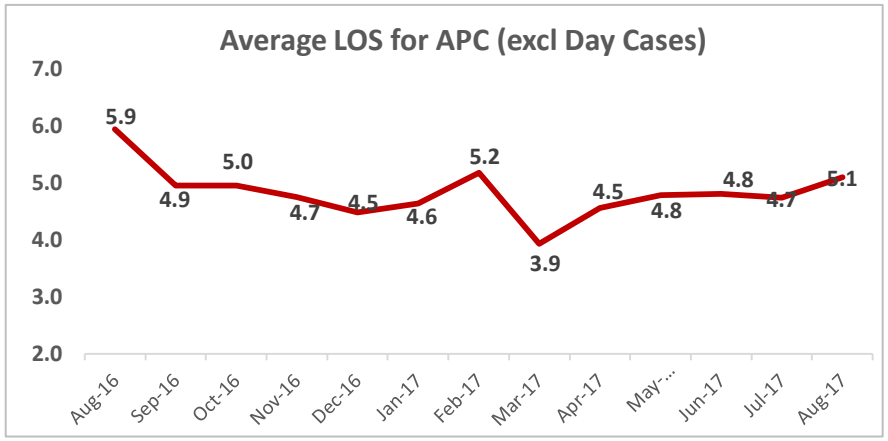
Work is still required to agree criteria for admission the day before, to use beds more effectively and reduce length of stay.
Pre-operative assessment improvements have been delivered, so that there are now 32 slots available each day.
A daily update review by operational management of forward bookings has been established and the 642 and a daily 9am Operations huddle has continued. Daily statistics on beds , admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to deliver activity and patient flow.

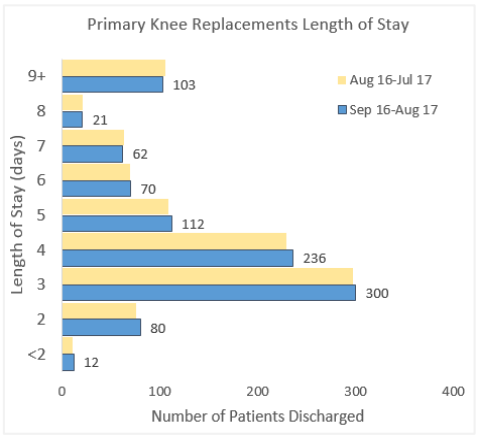
RISKS / ISSUES

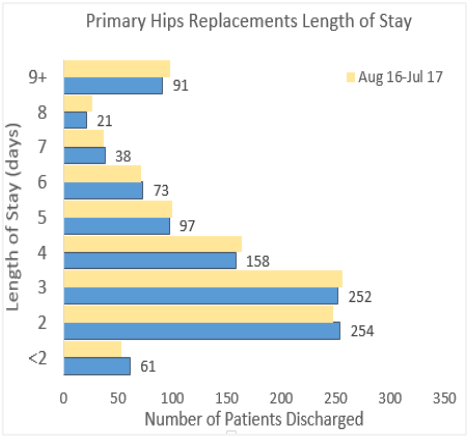
Continued focus with all staff involved to ensure that the operating lists are booked in advance, with sufficient caseloads, together with daily tracking.

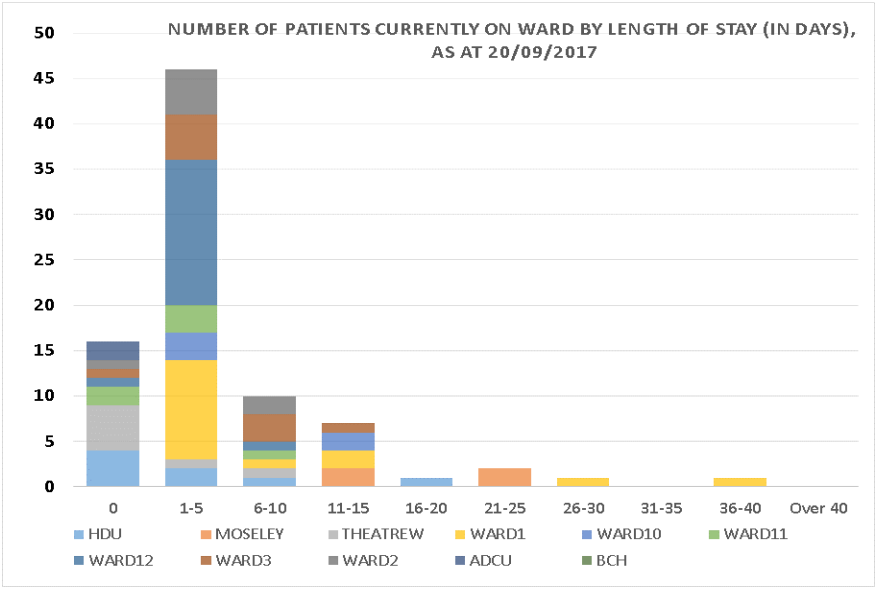
It is currently not possible to identify if the time of day patients are discharged is an accurate reflection of reality, or whether data is being entered onto the system in a delayed manner, making discharges look later in the day.

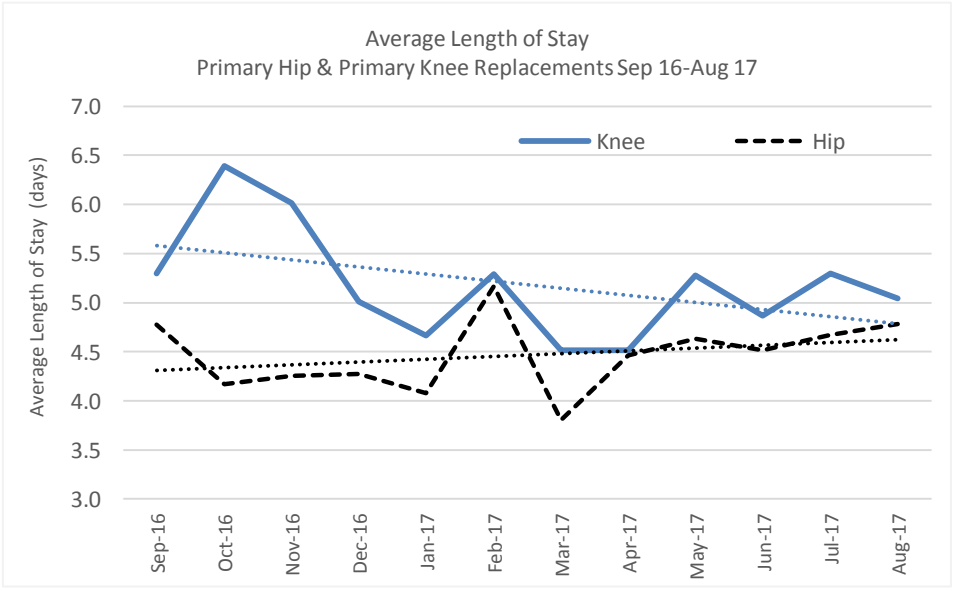
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Under the leadership of the Associate Medical Directors , Clinical Service Leads and Clinical Service Managers, work is progressing to increase activity levels to deliver 18 week compliance by creating additional capacity from within existing resources by improving flow. Length of stay reductions for primary hips and knees is key to achieving this , and an update will be brought to the next committee as to the progress of this work.

In May 2017, a 'Red2Green' process has been started to force better flow of patients hour by hour, partly to facilitate the rolling ward closures for the site infrastructure cabling installation, and mainly to improve overall patient flow. Work is ongoing to ensure that the analysis from Red2Green is highlighted and any areas which are flagging as red are explored further. Further work is underway as part of the Scheduled Care Improvement work to embed this approach across the organisation. This will also see the development of criteria led discharge to support weekend discharge planning.

ACTIONS FOR IMPROVEMENTS / LEARNING

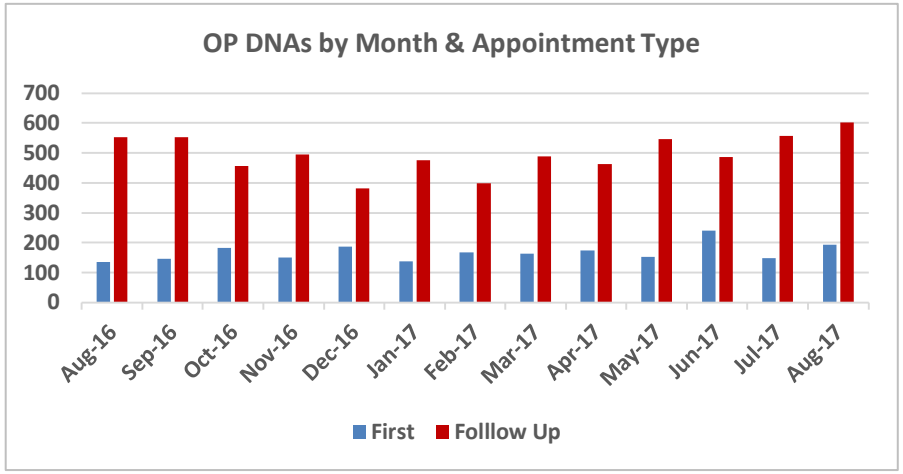
Changes have taken place as a result of an approved Occupational Therapy business case to undertake more pro-active pre-assessment for patients likely to be a complex discharge, in order to reduce length of stay.

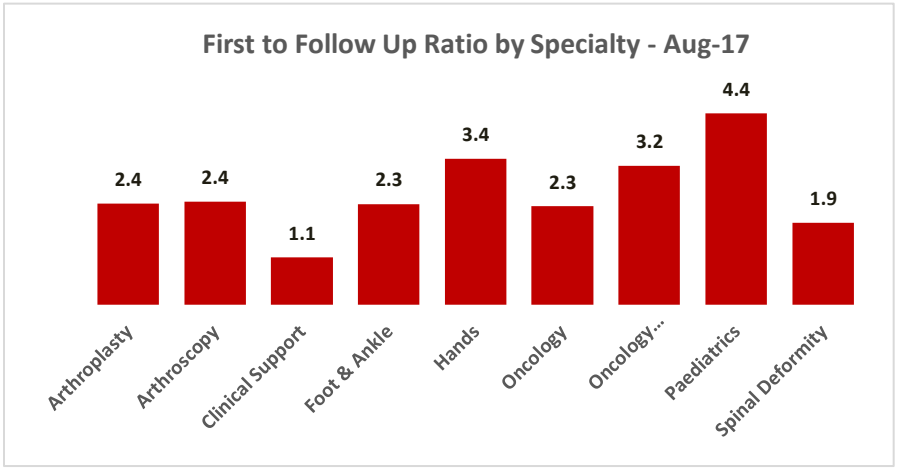
Daily senior reviews are being formalised as part of job planning, and the rising adherence to recording the Expected Date of Discharge (EDD) (now over 90%) is helping all involved in that patient's care to manage their length of stay more effectively.

RISKS / ISSUES

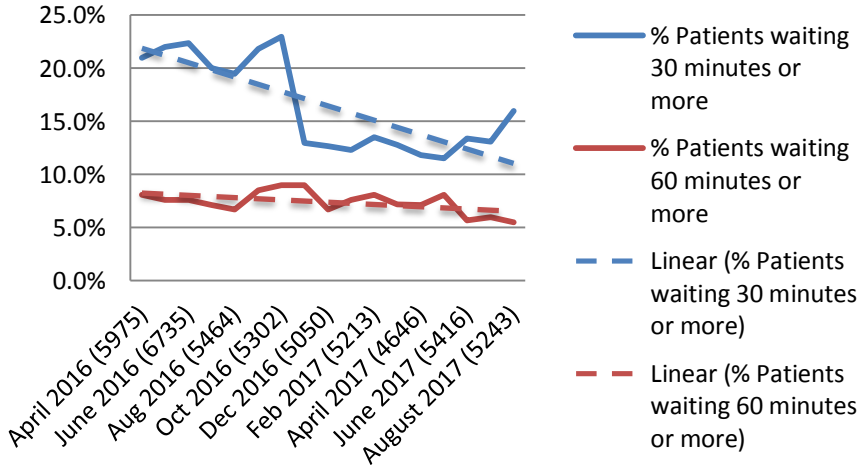
Using individual consultant information, Operational management teams and Clinical Service Leads are reviewing outlying clinical practice to help ensure that all patients are able to go home as soon as possible after their surgery.

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients

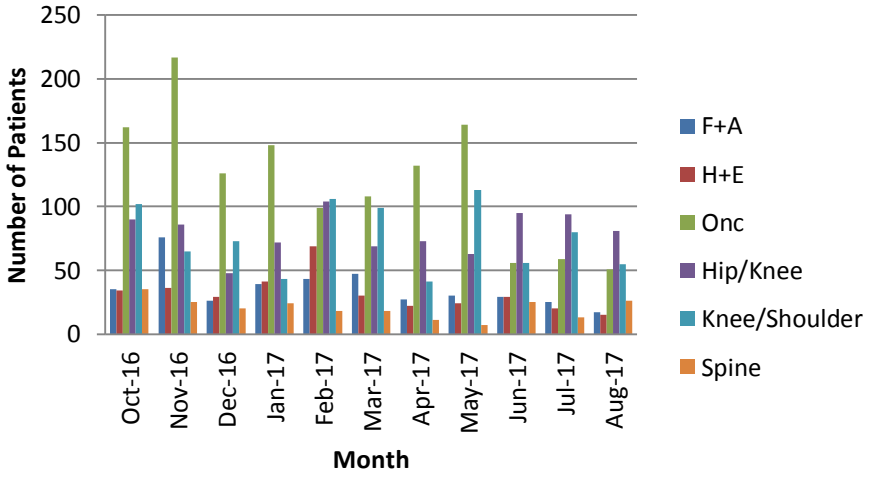




Wait times in OPD trend line April 2016 - August 2017



Wait times over 60 minutes by Specialty Oct 16-Aug 17



INFORMATION

Since the initial implementation of the new clinic templates in November there has been a reduction in the 30 minute wait times for patients. For the third month the Trust has been able to demonstrate achieving the target of no more than 6% of patients waiting over 60 minutes. The new Oncology templates, which started on the 6th June, have reduced the number of waits over 60 minutes by 60% . In July 2017 the medical notes not arriving on time to clinic was the main reason for delays. The medical notes process will be the main focus and there is an expectation this will help reduce the 30 minute wait to achieve the 11% target.

The outpatient department continue to audit its compliance against the SOP for wait time and can demonstrate 100% compliance. There is a new standard operating procedure for any clinic running over 60 minutes late. The incident reporting system , Ulysses , has been amended to make it easier for the clinic staff to complete the incident form. An incident form is completed and a new drop down analysis is selected by the staff completing the incident . The reasons documented on the incident forms now form part of a monthly action plan and this will be shared so reasons can be addressed.

In August 2017 the main 3 contributing factors for delays are: 1) delay in medical notes arriving on time to clinic. 2) Overbooked / not reduced clinic due to junior staff late notice leave. 3) Issue with Logging in to Winscribe. The 30 minute wait times have increased this month, a predicted result in the 60 minute waits reducing. The medical notes process will be the main focus again this month together with a review of the annual leave process for junior doctors.

ACTIONS FOR IMPROVEMENTS / LEARNING

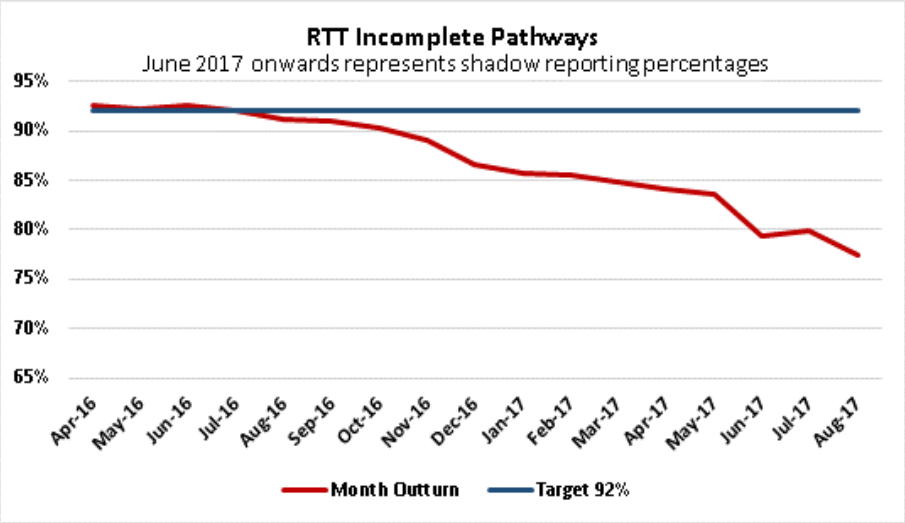
There are a range of actions as part of the CQC action plan and as part of the implementation of In Touch, to provide better granularity of information, and to focus change down to where it is required to improve the service for patients, minimise waiting times and maximise the income stream associated with outpatient activity.

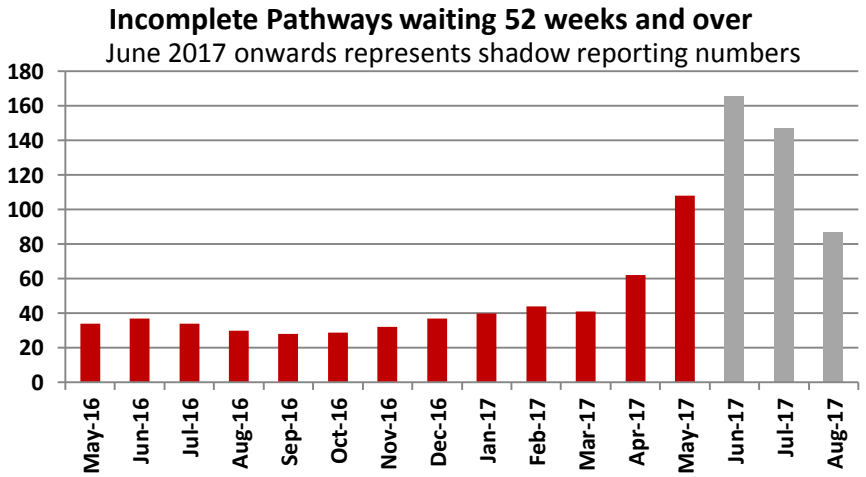
As part of the Trust's RTT recovery work, there will be a focus on out patient pathways and any patients who are in the system awaiting a follow up appointment and have become overdue, for whom a new active RTT clock should be started in line with national guidance. However, if it is found that there is a follow up appointment capacity problem, then this could worsen new to review ratios in the short term. This is being reinforced through RTT training and the clinical service managers working closely with consultants and medical secretaries to ensure that the Trust access policy is being adhered to by all involved.

RISKS / ISSUES

Feeding back patient waiting lists to consultants weekly continues, with much focus on improving data quality arising from the validation work that is ongoing .

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories





Cancer Target's	National Standard	Unreported		Reported Month							Reported Quarter					
			Indicative August *	July	Jun	May	Apr	Mar	Feb	Jan	Q1 17/18	Breaches	Total	Q4 16/17	Breaches	Total
2ww	93%		100%	100%	95.65%	100%	97.30%	93.75%	100%	100%	97.56%	3	123	98.41	2	126
31 day first treatment	96%		100%	100%	91.67%	100%	100%	100%	88.89%	95%	96.55%	1	29	100%	0	33
31 day subsequent (surgery)	94%		100%	100%	100%	100%	100%	100%	100%	90%	100%	0	22	96.30%	1	27
31 day subsequent (drugs)	98%		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
62 day (traditional)	85%		100%	37.5%	71.43%	60%	66.67%	100%	66.70%	75%	66.67%	3	9	84.21%	1.5	9.5
62 day (Cons Upgrade)	n/a		75%	100%	100%	100%	100%	n/a	n/a	n/a	100%	0	4	n/a	n/a	n/a
31 day rare (test, ac leuk, child)	n/a		n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
No. day patients treated 104+ days			0	3	1											

*Performance for August is indicative reportedin arrears submisison date 3rd October 2017

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017, and has been shadow reporting since that time. The Trust will recommence reporting in October, with first submission in November 2017. Validation of open pathways is complete and work to inform 'Business as Usual' validation is nearly complete to ensure that Data Quality standards are maintained going forwards.

Validation is now underway reviewing clock stop data, and a first draft plan for completion is being reviewed. A weekly RTT Recovery Board has been established and met for the first time on 27th April 2017- this work is progressing well and is informing the Scheduled Care Improvement work .

The new PTL went live week commencing 21st August 2017- this has established an accurate waiting list introducing nationally recognised terminology e.g. 'Admitted' and 'Non Admitted' as status points on the patient pathway. The way in which the Trust utilises and manages the planned waiting list is being updated to ensure that it adheres to national guidance, where the treatment date is determined clinically, rather than by resource i.e. a patient who requires a second surgery e.g. removal of metalwork 6 months after first surgery, would be put on the planned waiting list .

Aug-17	Total pathways	Over 18 weeks pathways	Over 52 week pathways
Admitted	830	283	12
Non-Admitted	1216	233	14
Incomplete	7997	1799	87

The above figures have been used for the shadow reporting of the ROH RTT performance for August 2017

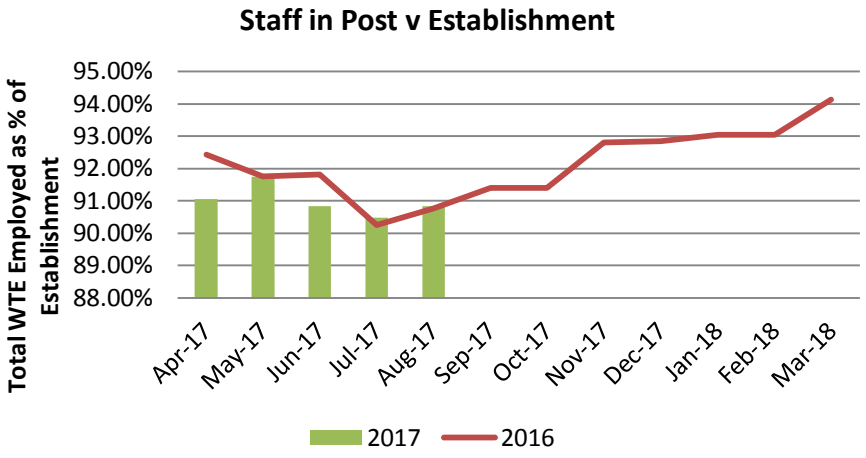
ACTIONS FOR IMPROVEMENTS / LEARNING

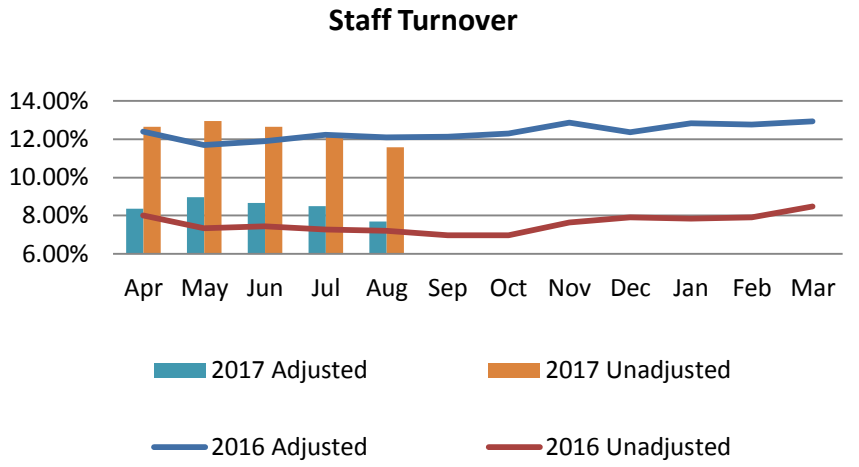
All consultants now receive an updated copy of their individual waiting list (PTL), this is sent electronically from the Operations Team every Friday to all specialities. It is expected that all medical secretaries will review their PTL with their consultant and ensure that all patients are dated in waiting time/clinical priority. The Operations team meet weekly to scrutinise all patients waiting 51 weeks and less across all specialities to ensure all patients have definitive treatment plans and ensuring all patients requiring further validation are identified. A separate review is undertaken of all patients waiting over 52 weeks.

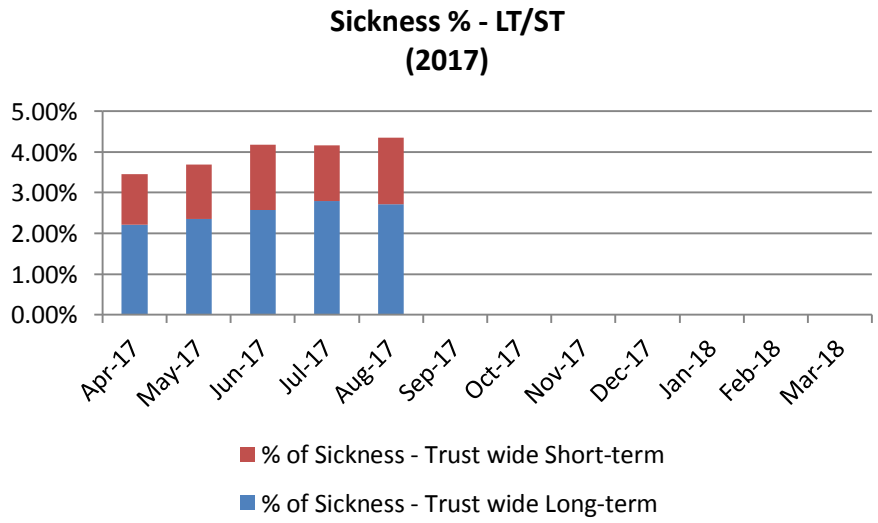
RISKS / ISSUES

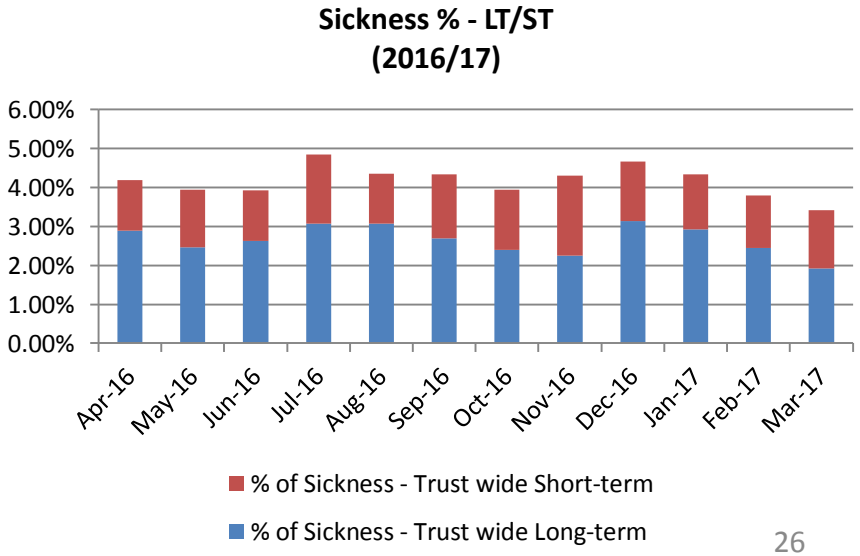
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern.

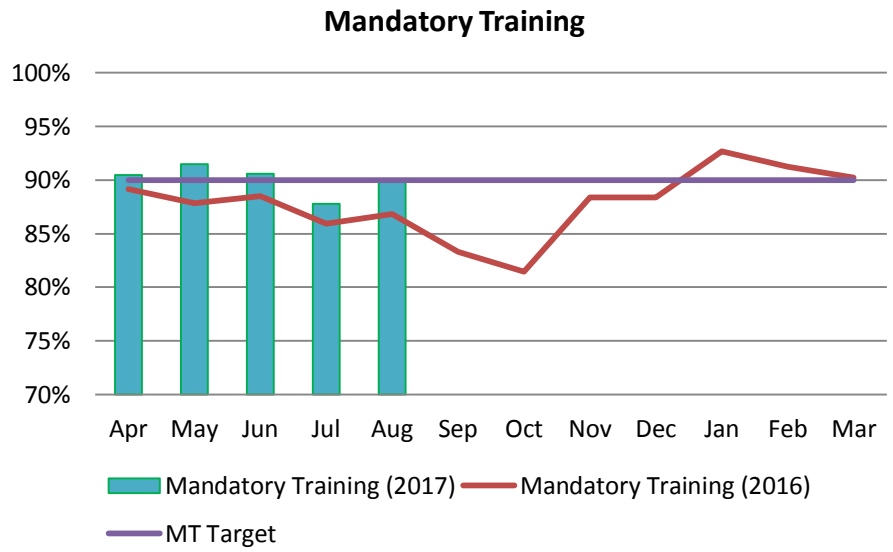
15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

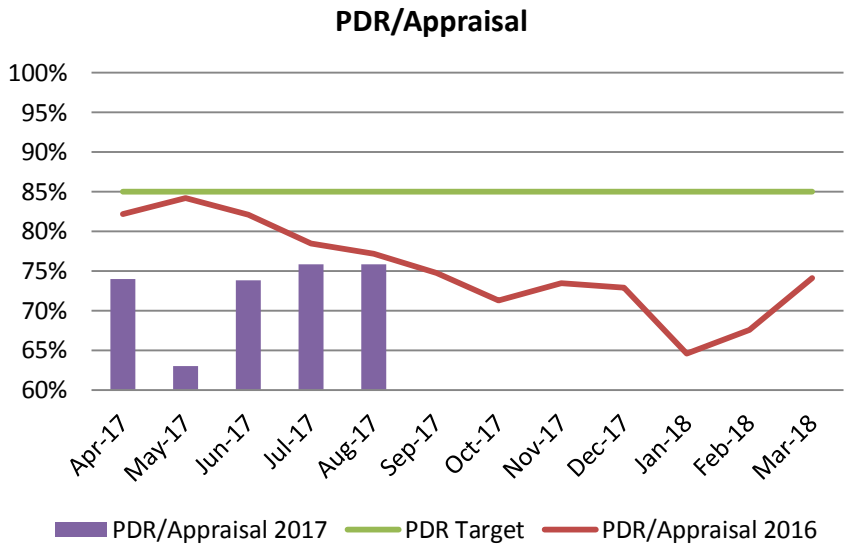









Mandatory Training
100%
95%
90%
85%
80%
75%
70%
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Mandatory Training (2017)
Mandatory Training (2016)
MT Target


PDR/Appraisal
100%
95%
90%
85%
80%
75%
70%
65%
60%
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
PDR/Appraisal 2017
PDR Target
PDR/Appraisal 2016

INFORMATION

Taken in the round, August was an encouraging month in terms of workforce performance.

Whilst sickness absence increased slightly moving the Trust into amber in month, the 12 month underlying figure remained green; staff in post increased slightly; there was a reduction in turnover and an improvement in mandatory training. Appraisal remains the area for improvement, although performance did not deteriorate in month.

The Trust's vacancy position improved very slightly on last month's figure by 0.36% to 90.84%. This is still amber for August 2017, is within the range of the last 12 months and reflects a small decrease in the funded establishment for the month.

August saw sickness absence increase to 4.35%, the highest month of the calendar year to date, with a slight decrease in long term absence being offset by an increase in short term absence. The 12 month average figure is also green at 4.18%.

Mandatory training improved back to green this month as expected (although only just), following the reinstatement of a missed training session in July. Further work is being carried out this month by the L&D Team to encourage staff to book onto or carry out their Mandatory Training via e-learning. With the new E-learning and IT Training Facilitator now in post, we expect this figure to further improve for September data.

Performance relating to PDR/appraisals in August remained steady at 75.83%. To improve the accuracy of reporting, for the last 3 months preliminary PDR data has been issued to Clinical Service Managers as an early alert, to enable them to update records in ESR where no information is recorded but PDRs have been carried out. This system will continue in order to ensure that our data are accurate. Although August's position is still red, it does appear to be holding.

There was positive movement again in August turnover figures. The unadjusted turnover figure (all leavers except doctors and retire/ returners) decreased again by over half a percent on last month to 11.57%, the lowest level since October 2015. The adjusted turnover figure ("true leavers" meaning "voluntary resignations") also greatly decreased by 0.81% and remains green in month.

The preliminary data release appears successful with operational managers. Appraisal performance in particular was a focus at the Divisional 1 performance meeting in August and will remain a feature of the current round of divisional performance reviews.

As was the case last month, the announcement of the planned transfer of paediatric surgery may cause significant uncertainty for staff, although little has actually changed in the last month. It is possible that sickness absence, turnover and vacancies may increase in the coming months.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Notice of Public Board Meeting on Wednesday 1 November 2017

The next meeting in public of the Royal Orthopaedic Hospital NHS Foundation Trust NHS Trust Board will take place on Wednesday 1 November 2017 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, Claire Kettle at the Management Offices or via email claire.kettle@nhs.net.

Dame Yve Buckland

Chairman

Public Bodies (Admissions to Meetings) Act 1960

Members of the Public and Press are entitled to attend these meetings although the Trust Board reserves the right to exclude, by Resolution, the Press and Public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the Resolution

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD (PUBLIC)

Venue Board Room, Trust Headquarters **Date** 1 November 2017: 1100h – 1315h

Members attending

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Rod Anthony	Non Executive Director	(RA)
Mr Richard Phillips	Non Executive Director	(RP)
Prof David Gourevitch	Non Executive Director	(DG)
Mr Paul Athey	Acting Chief Executive	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)

In attendance

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Jo Williams	Interim Chief Operating Officer	(JWI)	
Mr Steve Washbourne	Interim Director of Finance	(SW)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Guests

Stacie Davies	Care Quality Commission manager	(SD)	[Item 3]

TIME	ITEM	TITLE	PAPER	LEAD
1100h	1	Apologies - Prof Phil Begg	Verbal	Chair
1102h	2	Declarations of Interest *Register available on request from Company Secretary*	Verbal	Chair
1105h	3	CQC – new regulatory framework	Presentation	SD
1135h	4	Minutes of Public Board Meeting held on the 4 October 2017: *for approval*	ROHTB (10/17) 012	Chair
1140h	5	Trust Board action points: *for assurance*	ROHTB (10/17) 012 (a)	SGL
1145h	6	Chairman's and Chief Executive's update: *for information and assurance*	Verbal	YB/PA
	6.1	Voting rights for interim Board members	Verbal	YB
QUALITY & PATIENT SAFETY				
1155h	7	Patient Safety & Quality report: *for assurance*	ROHTB (11/17) 002	GM

1205h	8	Annual complaints report: *for assurance*	ROHTB (11/17) 003 ROHTB (11/17) 003 (a)	GM
1215h	9	Annual infection control report: *for assurance*	ROHTB (11/17) 004 ROHTB (11/17) 004 (a)	GM
1225h	10	CQC inspection preparation: *for information*	ROHTB (11/17) 005 ROHTB (11/17) 005 (a)	GM
1235h	11	'Perfecting Pathways' update: *for assurance*	ROHTB (11/17) 006 ROHTB (11/17) 006 (a)	JWI
FINANCE AND PERFORMANCE				
1245h	12	Finance & Performance overview including recovery: *for assurance*	ROHTB (11/17) 007 ROHTB (11/17) 007 (a)	SW
UPDATES FROM THE BOARD COMMITTEES				
1255h	13	Quality & Safety Committee: *for assurance*	ROHTB (11/17) 008	KS
1300h	14	Finance & Performance Committee: *for assurance*	ROHTB (11/17) 009	TP
MATTERS FOR INFORMATION				
1305h	15	Any Other Business	Verbal	ALL
Date of next meeting: Wednesday 10th January 2017 at 1100h in the Boardroom, Trust HQ				

Notes

Quorum

(i) No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and members (including at least one member who is also an Executive Director of the Trust and one Non-Executive Director) is present.

(ii) An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

(iii) If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see SO No.7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

MINUTES

Trust Board (Public Session) - DRAFT Version 0.3

Venue Boardroom, Trust Headquarters **Date** 4 October 2017: 1130h – 1400h

Members attending:

Dame Yve Buckland	Chairman	(YB)
Mr Tim Pile	Vice Chair	(TP)
Mrs Kathryn Sallah	Non Executive Director	(KS)
Mr Rod Anthony	Non Executive Director	(RA)
Mr Richard Phillips	Non Executive Director	(RP)
Mr Paul Athey	Acting Chief Executive and Director of Finance & Performance	(PA)
Mr Andrew Pearson	Executive Medical Director	(AP)
Mr Garry Marsh	Executive Director of Patient Services	(GM)
Prof Phil Begg	Executive Director of Strategy & Delivery	(PB)

In attendance:

Ms Simone Jordan	Associate Non Executive Director	(SJ)	
Mrs Jo Williams	Interim Chief Operating Officer	(JW)	
Mr Steve Washbourne	Interim Director of Finance	(SW)	
Mr Simon Grainger-Lloyd	Associate Director of Governance & Company Secretary	(SGL)	[Secretariat]

Guests:

Mandy Johal	Freedom to Speak Up Guardian	(MJ) [Item 12]

Minutes	**Paper Reference**
1 Apologies	**Verbal**
Apologies were received from David Gourevitch, Non Executive Director	
2 Declarations of interest	**Verbal**
There were none declared.	
3 Patient Story – Throne Project	**Presentation**
It was reported that this item would be deferred to a future meeting.	

ACTION: **SGL to reschedule the Throne Project presentation**	
4 Minutes of Public Board Meeting held on 6 September 2017	**ROHTB (9/17) 0XX**
The minutes of the previous meeting were accepted as a true and accurate record of discussions held.	
5 Trust Board action points	**ROHTB (9/17) 0XX (a)**
The Board received and accepted the action tracker which did not highlight any matters for escalation or of concern.	
6 Chairman's & Chief Executive's update, including new guidance on Data Protection and cyber security	**ROHTB (10/17) 001** **ROHTB (10/17) 001 (a)** **ROHTB (10/17) 001 (b)**
In response to a question from the Board, the Acting Chief Executive provided an update on the National Orthopaedic Alliance Vanguard. There were no plans at present for the NOA to move from standard setting to setting commissioning intentions as had been the initial aim. It was noted that there was work underway to prepare the Trust for the forthcoming General Data Protection Regulations (GDPR). The Board agreed that the summary of Trust priorities was helpful and noted that these were to be launched within the organisation shortly. It was noted that the Chief Executive's report now provided good assurance on the discussions by the Executive Team. The Chairman reported that since the last meeting a Council of Governors briefing session had been held to keep the governors up to date with the organisation's key challenges around operations and the Paediatric decision. She had met with new staff governor David Richardson and new stakeholder governor Dr Dagmar Scheel-Toellner from University of Birmingham. She was also due to meet with Hannah Abbot from Birmingham City University shortly. It was noted that this was the first time for a couple of years that the Trust had a full complement of governors. The Chairman had attended the first Schwartz Round, which was an emotional experience and centred on the experience of those presenting of their most memorable patient. The session had provided some learning around candour, opening up to scrutiny and the need to treat patients with a compassionate	

approach.	
7 Patient Safety & Quality Report	**ROHTB (10/17) 002**
The Executive Director of Patient Services reported that the Quality & Patient Safety report had been discussed in detail at recent Quality & Safety Committee. There had been three serious incidents reported in month, including VTEs and a burn from faulty equipment in theatres, which had now been replaced. It was noted that this had been actioned by the chair of the Medical Devices Committee, who was the Deputy Director of Nursing & Clinical Governance. It was reported that the types of near miss incidents would be considered at the next meeting to understand the potential gravity of these. It was agreed that it was positive that these were being reported. The number of pressure ulcers reported had increased, although data quality validation of these was needed. Disappointingly, one of the Grade 3 pressure ulcers had been identified as being avoidable and was hospital acquired. A range of professional practice issues would be addressed which would prevent any recurrence. In terms of complaints, the large joints speciality stood out as an outlier and a detailed analysis would be provided to the Quality & Safety Committee in future. It was reported that NHS Improvement had observed the Quality & Safety Committee and the Clinical Quality Group meetings, and the feedback on the operation of these was positive. This observation had been instigated on some perceived weakness in the Central Alerting System (CAS) alerts process. It was noted that it had been helpful that the NHS Improvement representative had attended and contributed to discussions.	
7.1 Patient Deaths	**Verbal**
The Executive Medical Director advised that the discussion around patient deaths was being remitted to the Quality & Safety Committee.	
8 Care Certificate update	**ROHTB (10/17) 003** **ROHTB (10/17) 003 (a)**
The Executive Director of Patient Services reported that there was a national requirement for anyone new to care to undertake the Care Certificate and the Trust's position to date was above the minimum requirement. The majority of the Healthcare Assistants had now undertaken this. Bank Healthcare Assistants would also undertake the training in future, as would housekeeping staff. A process of allowing staff to self-assess had also be introduced which had been approved by	

Health Education England. The Care Certificate training was co-ordinated by the Clinical Nurse Tutor. It was noted that there were other groups which might benefit from similar training. There had been a decision taken some time ago to cease customer care training, however this would be reintroduced shortly. It was suggested that the approach to nurse training needed to be considered more widely. The use of Band 4 nurse practitioners had not been adopted at ROH, although staff trained using the Care Certificate would assist with compensating for this. Training for apprentices and upskilling staff in Therapies needed to be considered. It was noted that there had been a cultural shift in terms of nurses embracing the concept of the Care Certificate from one of resistance to one where the training was actively sought.	
9 Scheduled Care Improvement Programme update	**ROHTB (10/17) 004** **ROHTB (10/17) 004 (a)**
It was noted that an update on the Scheduled Care Improvement Programme had been provided at the recent meeting of the Finance & Performance Committee. The Interim Chief Operating Officer delivered a presentation outlining the key elements of the Scheduled Care Improvement Programme which described progress against each of the workstreams, setting out expectations as a patient, the initiatives in progress and work planned for next month. Also discussed were the Key Performance Indicators which would be used to assess the effectiveness of the work. The Board acknowledged that there was good progress with the work and agreed that the programme was well structured. A clearer understanding of the targets needed to be worked through however. It was agreed that it was pleasing that all the ideas were being generated by staff and there was willingness to action these. The branding of the programme was agreed to be impressive.	
10 Finance & Performance overview	**ROHTB (10/17) 005**
The Interim Director of Finance reported that the August results were behind plan and behind the same position last year. The driver behind the position was reported to be costs, some of which were associated with agency staff. It was noted that in terms of theatre utilisation, there was good potential to improve, which would contribute to the recovery.	

11 Staff Survey action plan	**ROHTB (10/17) 006** **ROHTB (10/17) 006 (a)**
The Executive Director of Strategy & Delivery reported that resources and communication were key themes raised during the last staff survey. Much effort had been directed into resolving some of the issues raised and work would be undertaken to ensuring that the changes made as a result of the staff feedback were given visibility. The next version of the staff survey would be issued shortly and posters had been developed to encourage staff to complete the survey.	
12 Whistleblowing update	**Presentation**
Mandy Johal joined the Trust Board to provide an overview of her work as Freedom to Speak Up Guardian. It was noted that there needed to be a link into the Quality & Safety Committee to ensure that patient safety concerns were discussed; an update from the Freedom to Speak Up Guardian was included in the workplan of the Committee for this purpose. The Board was assured that most of the staff raising issues through the Freedom to Speak Up Guardian had been resolved to their satisfaction, particularly those issues in theatres, such as variation in practice around line care. It was agreed that some stories needed to demonstrate change using a 'You Said, We Did' concept, acknowledging that this needed to ensure that confidentiality was not compromised. It was also suggested that some of the examples could evidence an improvement journey, where sign off of the delivery of the change could be within the gift of the individual raising the initial concern. Triangulation with complaints and incidents was also needed. It was agreed that the flow chart of raising concerns would be useful as part of the forthcoming staff briefings. Ms Johal was thanked for her attendance and her good work to date with encouraging staff to raise concerns. She was encouraged to focus on being persistent and embedding the mechanisms for raising concerns further within the organisation.	
13 Quality & Safety Committee	**ROHTB (10/17) 008**
The Quality & Safety Committee assurance report was received and accepted.	
14 Finance & Performance Committee	**ROHTB (10/17) 009**

The Finance & Performance Committee assurance report was received and accepted.	
15 Audit Committee including changes to Standing Orders, Standing Orders, Standing Financial Instructions and Scheme of Delegation	**ROHTB (10/17) 010** **ROHTB (10/17) 011**
The Chair of the Audit Committee advised that the recent meeting had been positive and he described some of the key highlights from the meeting. The Audit Committee assurance report was received and accepted. The proposed changes to the Scheme of Delegation, Standing Orders and Standing Financial Instructions were approved.	
16 Any Other Business	**Verbal**
There was none.	
Details of next meeting	**Verbal**
The next meeting is planned for Wednesday 1 November 2017 at 1100h, Board Room, Trust Headquarters.	

PUBLIC SESSION

Next Meeting: 1 November 2017, Boardroom @ Trust Headquarters

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST - TRUST BOARD

4 October 2017, Boardroom @ Trust Headquarters

Reference	Item	Paper ref	Date raised	Action	Owner	Completion	Response submitted/progress update	Status
ROHTBACT. 037	Patient Safety & Quality Report	ROHTB (6/17) 003	07/06/2017	Arrange for the Throne Project to be used as a patient story at a future meeting	GM	04-Oct-17	To be rescheduled to the January 2018 meeting	
ROHTBACT. 041	Safe Nurse Staffing	ROHTB (9/17) 004 ROHTB (9/17) 004 (a)	06/09/2017	Highlight any linkage between agency nurse usage and harm as part of the report on nursing KPIs to Quality & Safety Committee	GM	30-Dec-17	ACTION NOT YET DUE. New set of nursing KPIs being developed which will provide this perspective	
ROHTBACT. 038	Staff Survey and Analysis	ROHTB (6/17) 006 ROHTB (6/17) 006 (a) ROHTB (6/17) 006 (b)	07/06/2017	Schedule a further update on the delivery of the staff survey action plan	SGL	04-Oct-17	Included on the agenda of the October 2017 meeting	

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

ROHTB (11/17) 002

QUALITY REPORT

October 2017

EXECUTIVE DIRECTOR:	Garry Marsh	Executive Director of Patient Services
AUTHOR:	Ash Tullett	Clinical Governance Manager

CONTENTS

INTRODUCTION

This integrated Quality Report aims to provide a Trust-wide overview and assurance relating to quality of care, patient safety, 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 and the CQC for routine engagement visits.

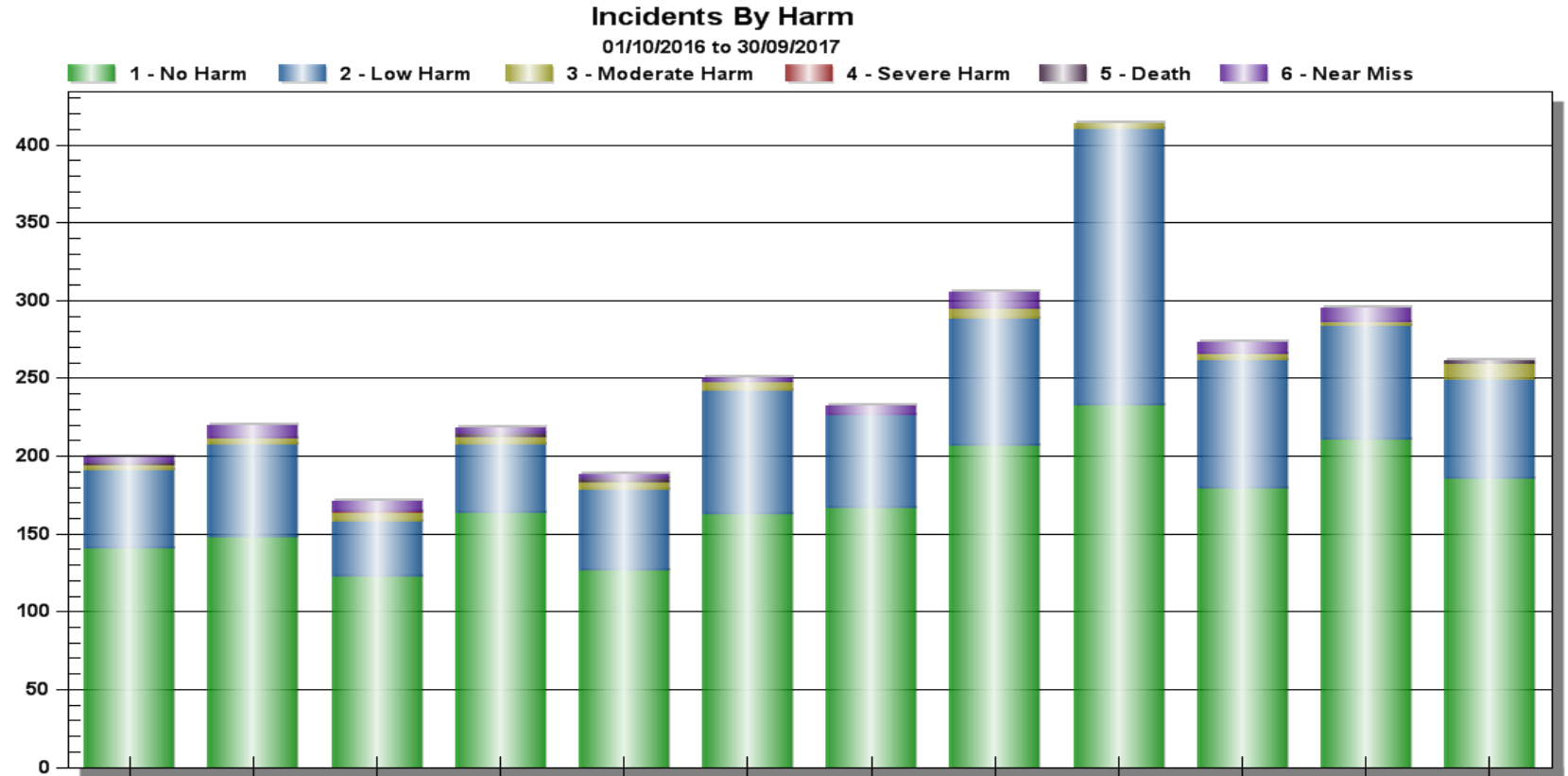
The data being used has been validated by the relevant Trust Leads and the Governance Department will be organising regular contact with members of ROH to ensure relevant information is included in this report.

Should you have any comments or queries regarding this Quality Report please contact the ROH Governance Department on;

Email: **roh-tr.governance@nhs.net**

Tel: 0121 685 4000 (ext. 55641)

1. 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.



Month and Year	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017
1 - No Harm	140	147	122	163	126	162	166	206	232	179	210	185
2 - Low Harm	51	60	36	44	52	80	60	82	178	82	73	64
3 - Moderate Harm	3	4	5	5	5	5	0	6	4	4	3	10
4 - Severe Harm	0	0	1	0	0	0	0	0	0	0	0	0
5 - Death	1	0	0	2	2	0	0	0	0	0	0	2
6 - Near Miss	4	9	7	4	3	3	6	11	0	8	9	0

RESPECT COMPASSION EXCELLENCE PRIDE OPENNESS INNOVATION

First choice for orthopaedic care

INFORMATION

In September 2017 there was a total of 252 Incidents reported on the Ulysses incident management system.
The breakdown of those incidents is at follows;

185 – No Harm
64 – Low Harm
10 – Moderate Harms
0 – Near Miss
2 – Deaths

The 10 Moderate Harms were;
21781 – VTE – Ward 1

21812 – Transfer out of the Trust – Theatre 9

21859 – VTE – HDU

21867 - VTE – Ward 2

21889 – VTE – Ward 2

21975 – Retained foreign object – Theatre 8

21980 – VTE – Ward 3

21987 - Transfer out of Trust – Theatre 5

22007 – VTE – Ward 12

22008 – VTE – Ward 1

ACTIONS FOR IMPROVEMENTS / LEARNING

Near Miss data – It has been highlighted in Quality & Safety Committee that the Trust has a high number of 'Near Miss' Incidents. It has been agreed that the Clinical Governance Manager and Directors of Patient Services will undertake a piece of work to evaluate the 'Near Miss' incidents to ensure the appropriate management of these incidents has occurred.

NRLS - The National Reporting and Learning System (NRLS) collects data on patient safety incidents (PSI) in England and Wales and uploads to national database. The primary purpose of the NRLS is to enable learning from patient safety incidents occurring in the NHS. Every six months NHS improvement publishes national statistics of the organisation patient safety incident reports.

The median reporting rate for acute hospitals is 40.02 incidents per 1,000 bed day

The median reporting rate for specialist trusts cluster is 41.68 incidents per 1,000 bed days

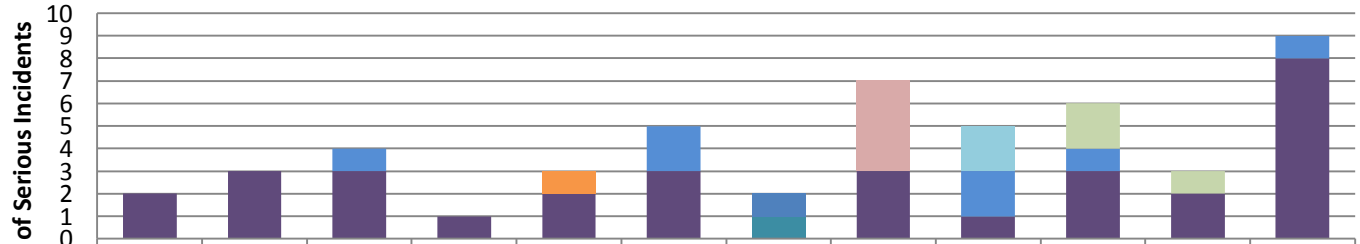
ROH reported rate of 37.84 per 1000 bed days. This is an improvement from the previous 6 month data of 19.43 per 1000 bed days
There is no 'correct' or 'safe' number of patient safety incidents
a 'low' reporting rate should not be interpreted as a 'safe' organisation, and may represent under- reporting;
a 'high' reporting rate should not be interpreted as an 'unsafe' organisation, and may actually represent a culture of greater openness.

RISKS / ISSUES

None

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 to September 2017



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	July	Aug-17	Sep-17
Unexpected Injury										2	1	
RTT Harm review								4				
Emergency transfer to HDU												
Exposure to hazardous substance					1							
Wrong Site Incision												
Wrong Implant												
Suspension to services												
RTT Data Issue							1					
Wrong side injection									2			
Suspension of Service (BCH Spinal)							1					
Slips, trips & falls												
Pressure Ulcers			1			2			2	1		1
VTE meeting SI criteria	2	3	3	1	2	3		3	1	3	2	8

INFORMATION
There were **9 Serious Incidents Declared in September 2017;** 21692 – VTE 21781 – VTE – Ward 1 21859 – VTE – HDU 21867 - VTE – Ward 2 21889 – VTE – Ward 2 21980 – VTE – Ward 3 22008 – VTE – Ward 1 21695 – Pressure Ulcer Grade 3 – Ward 3
ACTIONS FOR IMPROVEMENTS / LEARNING
Four serious incidents were **closed** by the Commissioners in September 2017. The incidents were reported in the June 2017 Quality report. These were; **Background on the 4 closed RTT Serious Incidents** Concerns were raised from the Royal Orthopaedic Hospital NHS Foundation Trust Spinal deformity Consultants around their growing concerns over the availability of Paediatric Intensive Care Unit (PICU) beds at Birmingham Women's and Children's *NHS* Foundation Trust *(BCW).* Due to the recognised

issue the Trust instigated a harm review process to review all children on the Trust waiting list that have been waiting greater than 52 weeks.

Conclusions

There is continued concern that the lack of access to this level of post-operative care will significantly impact on the Trust's ability to plan the surgical dates for the currently 29 over 52 week wait patients and consequently its ability to deliver the recovery trajectory.

Evidence of good practice:

We have kept the family up to date at all times. We have been through the complete investigative pathway and have given her the option of surgery.

Evidence of poor practice:

The lack of suitable theatre lists available for performing an operation

Recommendations

It was agreed all patients on the inpatient waiting list should be clinically reviewed to determine possible harm suffered due to the long wait for surgery.

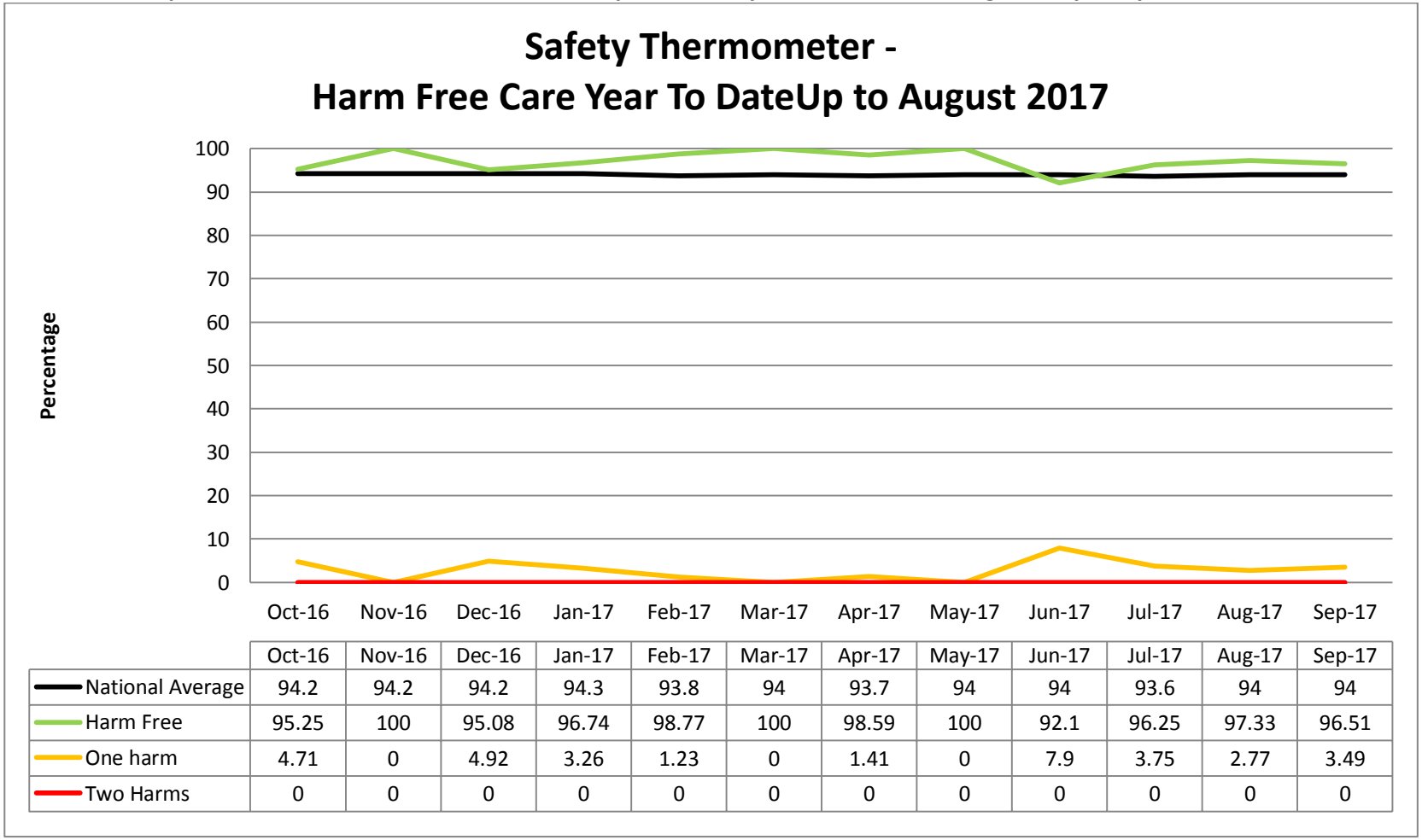
The development of the Clinical Review Group process for reviewing the underlying causes as to the delays in these pathways, recording the level of harm to patients, taking action and learning the lessons has been developed

The current priority is to review patients who breach 52 weeks RTT and 62 days cancer pathway, moving forward these parameters will be reduced. The group will record the level of harm to patients, taking action and learning the lessons or reporting internally and externally as for other patient harm incidents to assure an improvement is achieved in performance for clinical harm and supporting the equality and safety agenda.

RISKS / ISSUES

None.

3. **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-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
National Average	94.2	94.2	94.2	94.3	93.8	94	93.7	94	94	93.6	94	94
Harm Free	95.25	100	95.08	96.74	98.77	100	98.59	100	92.1	96.25	97.33	96.51
One harm	4.71	0	4.92	3.26	1.23	0	1.41	0	7.9	3.75	2.77	3.49
Two Harms	0	0	0	0	0	0	0	0	0	0	0	0

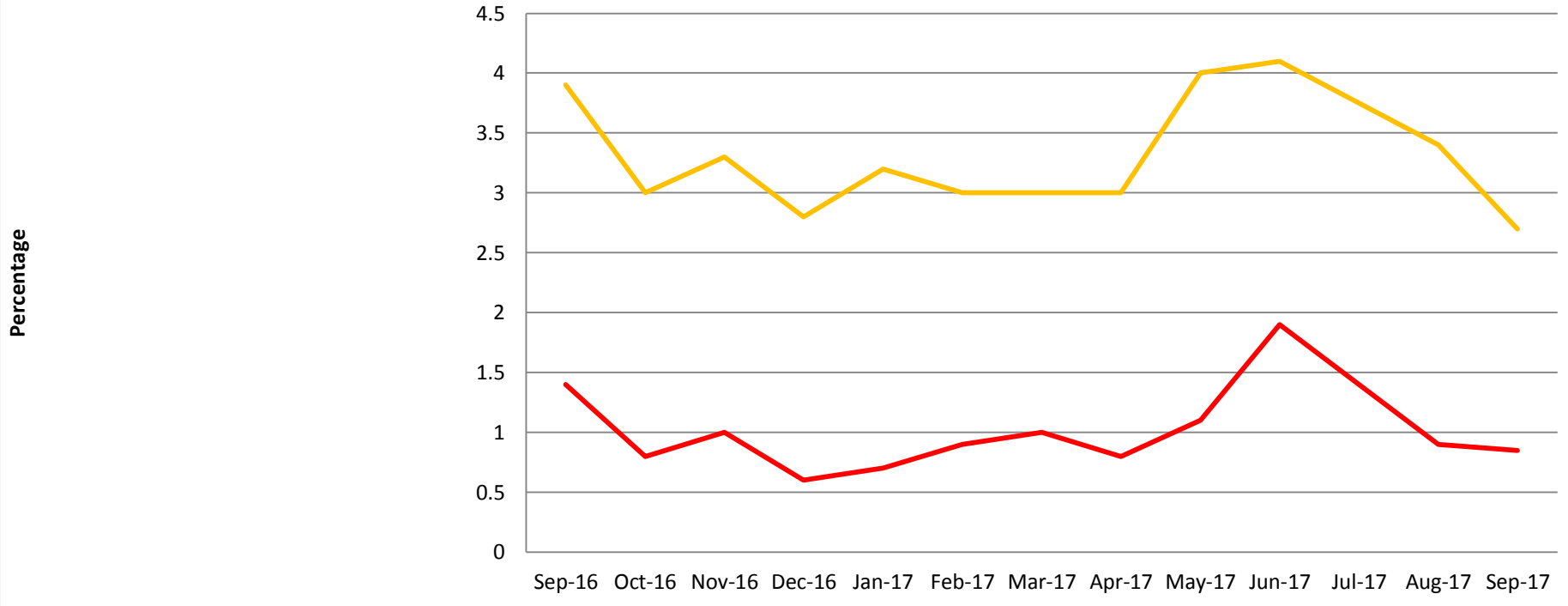
The harms highlighted on the safety thermometer were;
2 old Pressure Ulcers and 1 new pressure ulcer

4. **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 September 2017 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
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
Oct-16	50	4	0	1	55	201	6728
Nov-16	60	4	0	0	64	220	6727
Dec-16	37	5	0	0	42	169	6109
Jan- 17	42	6	0	2	50	218	6794
Feb-17	52	5	0	2	59	188	6429
Mar-17	80	6	0	0	86	250	7326
Apr-17	62	0	0	0	62	232	7328
May-17	83	5	0	0	83	303	6918
Jun-17	178	4	0	0	182	414	9162
Jul-17	82	4	0	0	86	273	8743
Aug -17	74	3	0	0	77	295	8560
Sep-17	64	10	0	2	76	252	9013

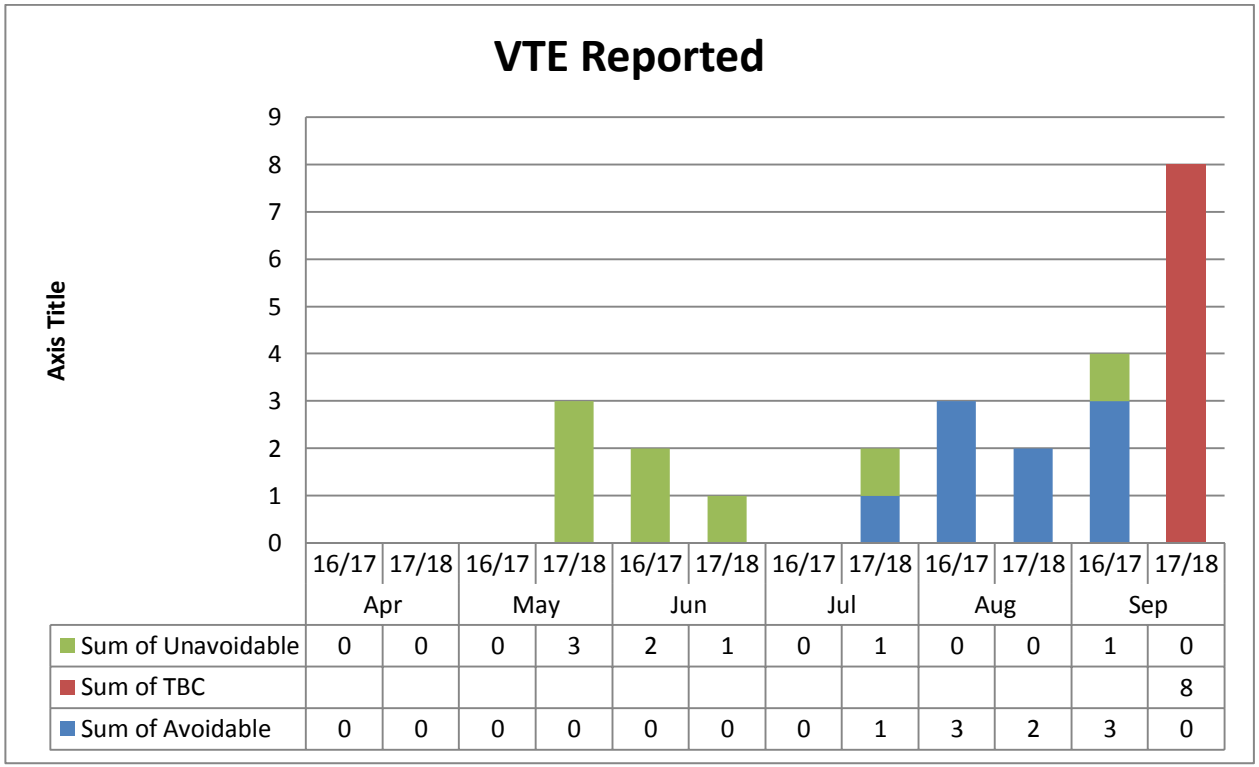
In September 2017, there were a total of 9013 patient contacts. There were 252 incidents reported which is 2.7 percent of the total patient contacts resulting in an incident. Of those 252 reported incidents, 77 incidents resulted in harm which is 0.85 percent of the total patient contact.

% of Patient Contact Compared to Number of Incidents and Incidents with September 2016 to September 2017



	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Aug-17	Sep-17
% of Patient Contacts with Incidents Causing Harm	1.4	0.8	1	0.6	0.7	0.9	1	0.8	1.1	1.9	0.9	0.85
% of Patient Contact With All Incidents Reported	3.9	3	3.3	2.8	3.2	3	3	3	4	4.1	3.4	2.7

5. **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).**



	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18	16/17	17/18
	Apr		May		Jun		Jul		Aug		Sep	
Sum of Unavoidable	0	0	0	3	2	1	0	1	0	0	1	0
Sum of TBC												8
Sum of Avoidable	0	0	0	0	0	0	0	1	3	2	3	0

13

total		Avoidable
16/17	27	13
17/18	16	3*

***not classified**

INFORMATION
There were eight VTEs declared in September 2017. 21692 – VTE 21781 – VTE – Ward 1 21859 – VTE – HDU 21867 - VTE – Ward 2 21889 – VTE – Ward 2 21980 – VTE – Ward 3 22007 – VTE – Ward 12 22008 – VTE – Ward 1
ACTIONS FOR IMPROVEMENTS / LEARNING

ROH continues to exceed expected targets set in relation to VTE risk assessment on admission

Audit of compliance with completion of risk assessments on admission and at 24 hours is part of the monthly documentation audits and area KPI's.

VTE training continues for Student nurses,
Training for registered and non-registered staff (clinical update days) recommenced in April 2017.
It is mandatory for clinical staff member's that have direct patient contact to complete a VTE e-learning module.
Training on mechanical prophylaxis has been provided by company trainers this period.

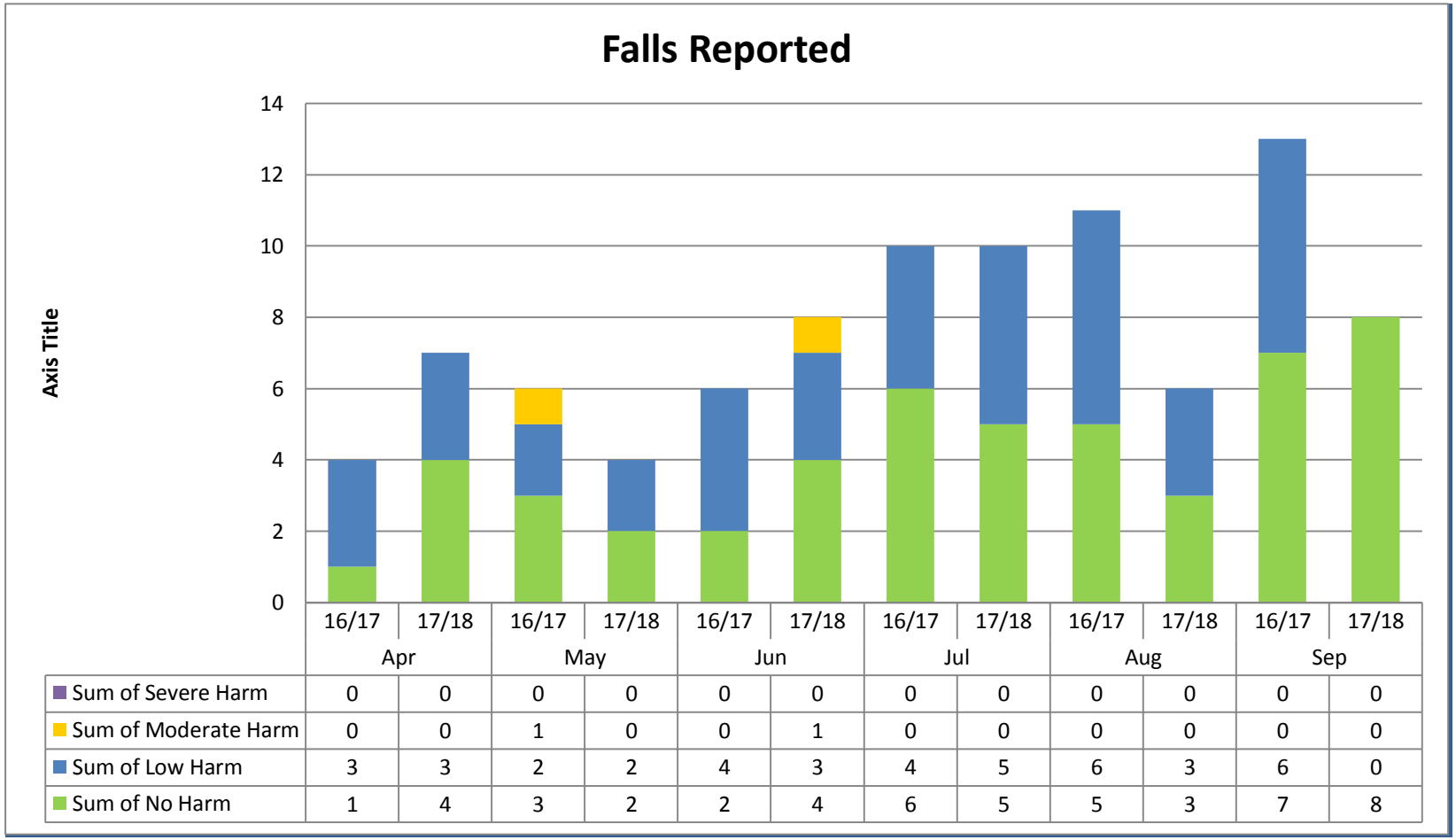
Targeted learning takes place with individuals identified within RCAs as being none compliant with expected standards.

RISKS / ISSUES

Increase in VTEs
In September there has been a significant increase in the number of VTEs (8) 6 of these were PEs and 5 occurred whilst in-patients. Initial review does not identify any themes in relation to surgeon, anaesthetist, Ward or type of surgery. Requested that shorter deadlines are given for completion of RCAs to enable closer scrutiny by VTE Advisory Group for themes/trends. Head of Clinical Governance, Medical and Nursing Director made aware.

National supply issue with Enoxaparin
There has been a national supply issue with Enoxaparin, some larger Trusts have changed to an alternative product but this is not without risk due to differences in product. Issue was reviewed by the Chief Pharmacist and VTE Advisory Group. Contingency and on-going monitoring was agreed. No issues for ROH identified up until date of report.

6. **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.**



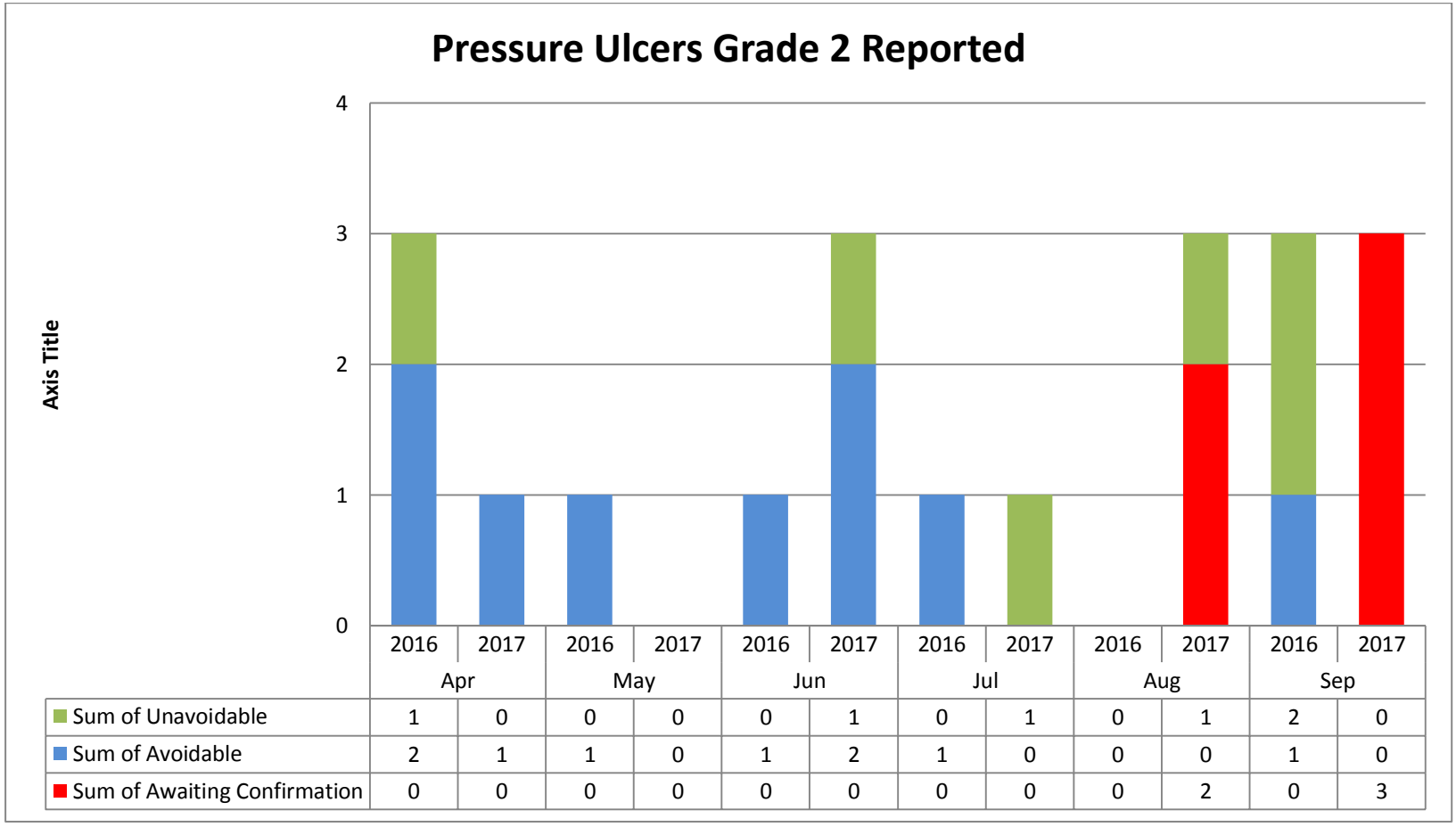
	Apr 16/17	Apr 17/18	May 16/17	May 17/18	Jun 16/17	Jun 17/18	Jul 16/17	Jul 17/18	Aug 16/17	Aug 17/18	Sep 16/17	Sep 17/18
Sum of Severe Harm	0	0	0	0	0	0	0	0	0	0	0	0
Sum of Moderate Harm	0	0	1	0	0	1	0	0	0	0	0	0
Sum of Low Harm	3	3	2	2	4	3	4	5	6	3	6	0
Sum of No Harm	1	4	3	2	2	4	6	5	5	3	7	8

INFORMATION
Overall 8 fall related incidents were reported across the Trust in September 2017, all eight were related to adult inpatient falls. All incidents have been subject to a post-fall notes review by the ward manager or deputy and a falls questionnaire has been completed for each fall. The inpatient falls are all reported to CQG via the Divisional Condition reports from the Heads of Nursing and are reported in the Monthly Quality Report.

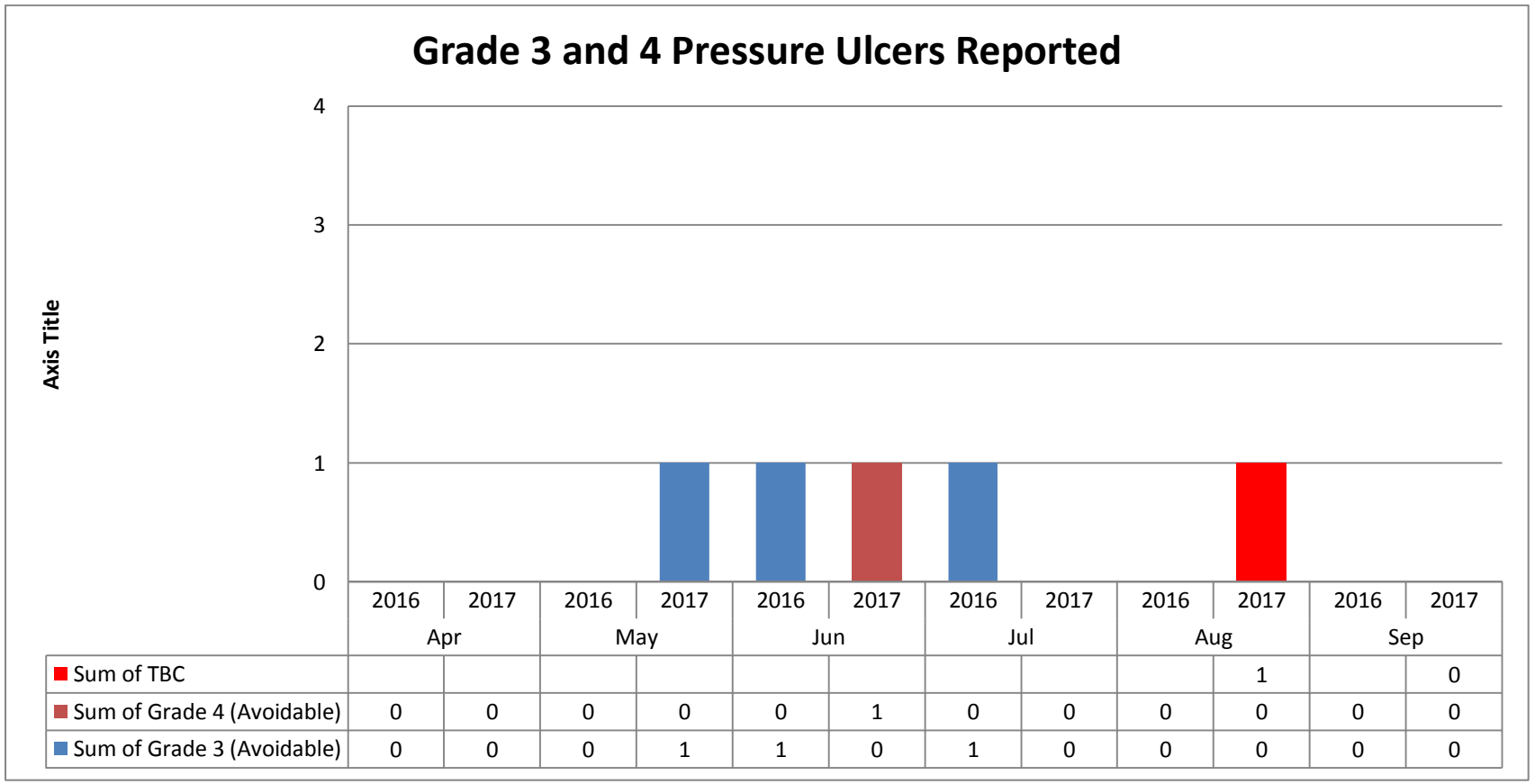
ACTIONS FOR IMPROVEMENTS / LEARNING
• The Falls Working Group (FWG) meetings recommenced in December 2016 and are scheduled bi-monthly after the January 2017 meeting. • Through the FWG the work to devise a comprehensive medical "checklist" to improve medical management of the inpatient faller is in progress. This hopes to provide a more streamlined approach to medical management and prevent inconsistencies in care. • Falls information boards are to be standardised across all ward areas, with the information being agreed at the FWG meeting. 'Walking stick' visual information to be produced on a monthly basis for all ward areas for cascading of information regarding the number of falls per ward, per month to all staff. • Recommendations from the Throne Project will be overseen by the Falls Group on a Bi-monthly basis. • A review of the falls assessment and care plan documentation to take place, to include development of a post falls medical review template report, which is with the Documentation task and finish group currently. • Monthly reporting via the Ward Quality Dashboards to continue.

RISKS / ISSUES
None

7. **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.**



	2016 Apr	2017 Apr	2016 May	2017 May	2016 Jun	2017 Jun	2016 Jul	2017 Jul	2016 Aug	2017 Aug	2016 Sep	2017 Sep
Sum of Unavoidable	1	0	0	0	0	1	0	1	0	1	2	0
Sum of Avoidable	2	1	1	0	1	2	1	0	0	0	1	0
Sum of Awaiting Confirmation	0	0	0	0	0	0	0	0	0	2	0	3


Grade 3 and 4 Pressure Ulcers Reported
Axis Title
4
3
2
1
0
2016 2017 2016 2017 2016 2017 2016 2017 2016 2017 2016 2017
Apr May Jun Jul Aug Sep
Sum of TBC 0 0
Sum of Grade 4 (Avoidable) 0 0 0 0 0 1 0 0 0 0 0 0
Sum of Grade 3 (Avoidable) 0 0 0 1 1 0 1 0 0 0 0 0

INFORMATION

In September 2017 there has been;

3 x Grade 2 pressure ulcers.

In total, from 1st April 2017 the Trust has reported the following avoidable pressure ulcers:

1 avoidable Non Device Related Grade 2 pressure Ulcers against a limit (target) of 12.

1 avoidable Device Related Grade 2 pressure Ulcers against a limit (target) of 12.

2 avoidable Grade 3 pressure Ulcers against a limit of 0. (Two Grade 3 Pressure Ulcers currently awaiting RCAs to establish avoid ability and are therefore not included in these figures)

ACTIONS FOR IMPROVEMENTS / LEARNING

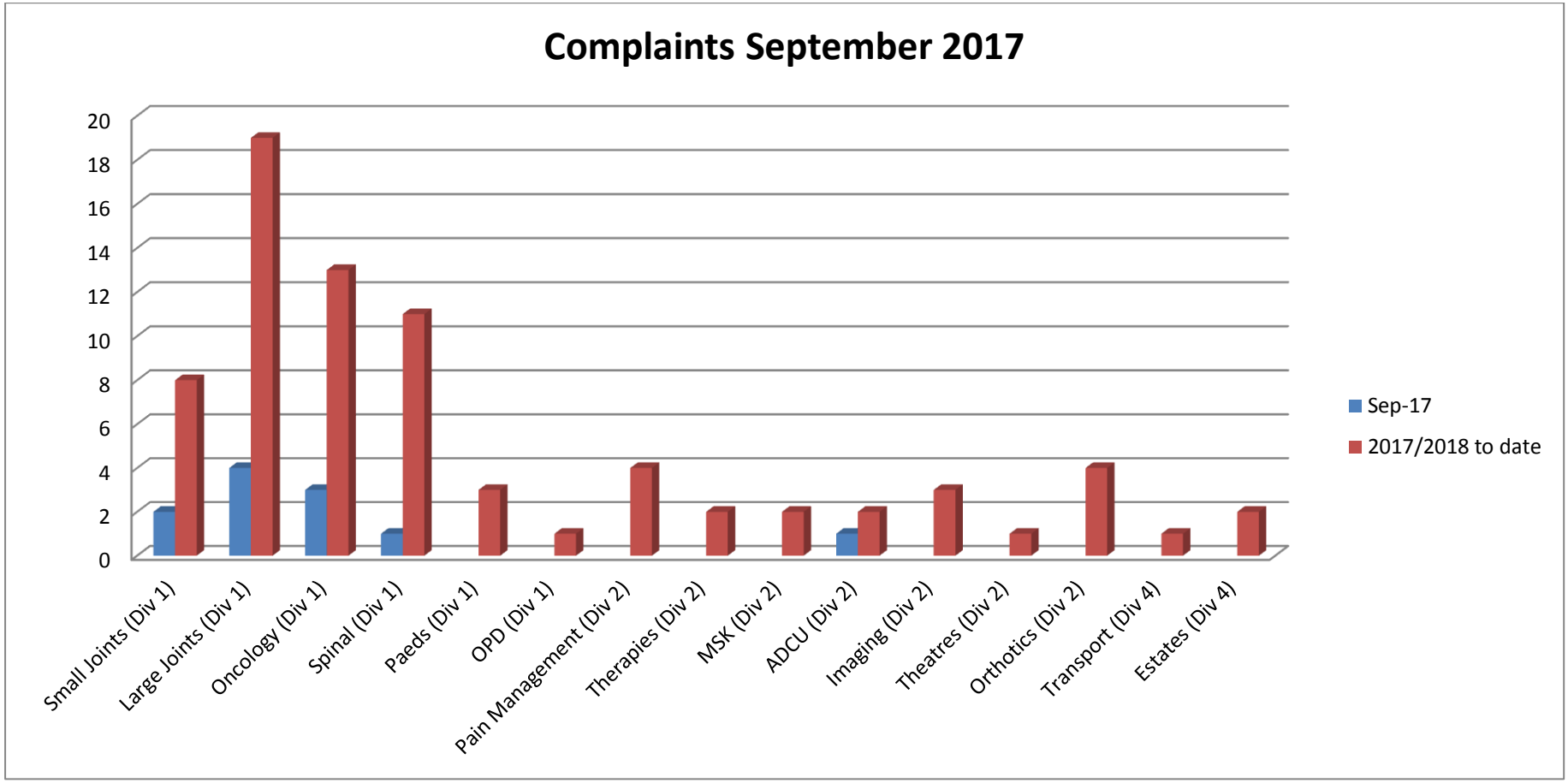
Identified from reviews and investigations /RCAs:-

- Risk of pressure damage not elucidated at time of consent this must be discussed and documented on the consent form.
- Perineum not examined pre operatively
- Tissue viability information stored separately on their database and not recorded in medical notes
- Importance of documenting discussion with patients about advises on repositioning themselves and pressure prevention information been given and understood by the patient.
- Transfers form other hospital to check and challenge documentation and care plans received and handover, ensuring skin inspection on admission to ward/area is undertaken and documented.
- GP referring back to ROH there is a possibility that further breakdown may not have occurred, importance of information sharing

RISKS / ISSUES

Currently have 2 Tissue Viability Nurse Post vacancies Lead Nurse –Band 7 and Sister Band 6. The Band 7 has been recruited to staff member should commence early December 17. Band 6 previous recruitment unsuccessful, advertised and interviews to take place 27 October 2017. Interim cover is being provided by ward managers and ward and departmental tissue viability nurse nurses and band 6s nursing from ROCS team as required for support and grading of pressure areas supporting ward staff until recruitment into the vacancies.

8. **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.**



INFORMATION

PALS

The PALS department handled 430 contacts during September 2017 of which 131 were classified as concerns. This brings the total of PALS contact for the year to date to 2798 (677 concerns). This represents a much higher figure than at the same point last year (1962 PALS contacts)

Compliments

There were 440 compliments recorded in September 2017, with the most being recorded for Div 1. This is similar to last month with the Pre-Operative Assessment Clinic continuing to receive a significant number of compliments. Areas have been reminded to submit their records for central recording.

Complaints

There were 13 complaints closed in September 2017, 11 of which were closed within the agreed timescales. This gives an 85% completion on time rate and meets the KPI for the month.

.

The subjects of this month's complaints were:

Initially Risk Rated Amber:

- Approach of Registrar (Div. 1, Oncology)
- Outcome of procedure; use of known sensitive medication (Div. 1, Spinal)
- Outcome of surgery; alleges did not give informed consent (Div. 1, Small)
- Cancellation of planned surgery (Div.1, Large Joints)
- Nursing care; unexplained bruising, housekeeping on ward (Div. 1, Oncology)
- Discharge arrangements from ward; experience of discharge lounge & transport (Div. 1, Large Joints)
- Nursing care (Div. 1, Oncology)

Initially Risk Rated Yellow: Wait in ADCU reception (Div. 2, ADCU)

- Delay to processing referral (Div. 1, Large Joints)
- Communication about cancelled surgery (Div. 1, Large Joints)
- Delay to receiving clinic letter; non-receipt of e-mail (Div. 1, Small Joints)

ACTIONS FOR IMPROVEMENTS / LEARNING

There were 13 complaints closed in September 2017, 11 of which were closed within the agreed timescales. This gives an 85% completion on time rate and meets the KPI for the month.

The average length of time to close complaints in September 2017 was 28 days which is within normal limits.

Learning/Actions from complaints

Of the 13 complaints closed in September 2017:

- 5 were upheld
- 4 were partially upheld
- 4 were not upheld

All of the partially upheld complaints were upheld for communication issues:

Learning identified and actions taken as a result of complaints closed in September 2017 include:

- Information for patients about what to expect in a hydrotherapy appointment does not currently exist
  Action: New Patient Information leaflet is being produced

- Process for cancelling appointments at short notice is not always being followed
  Action: Staff have been re-trained in the process

- Care provided by a member of the nursing team was not as expected
  Action: Professional conversation has been undertaken and a period of supervision has been applied

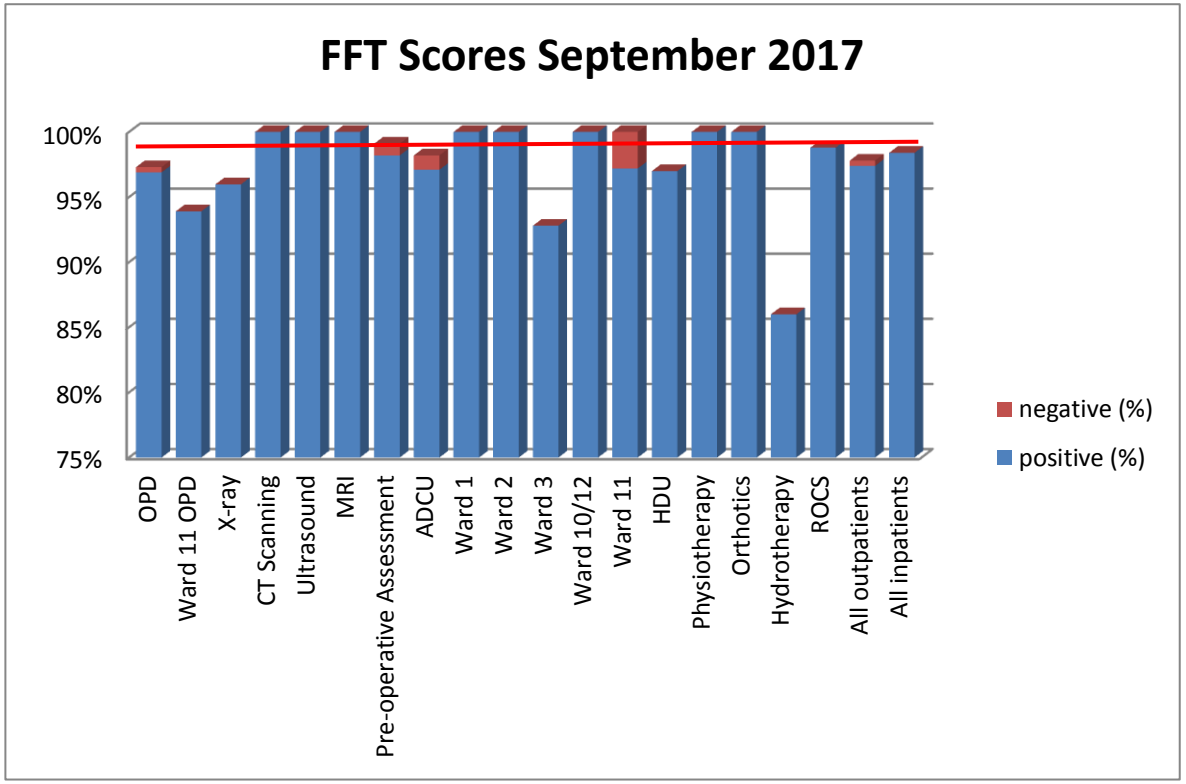
RISKS / ISSUES

None Identified.

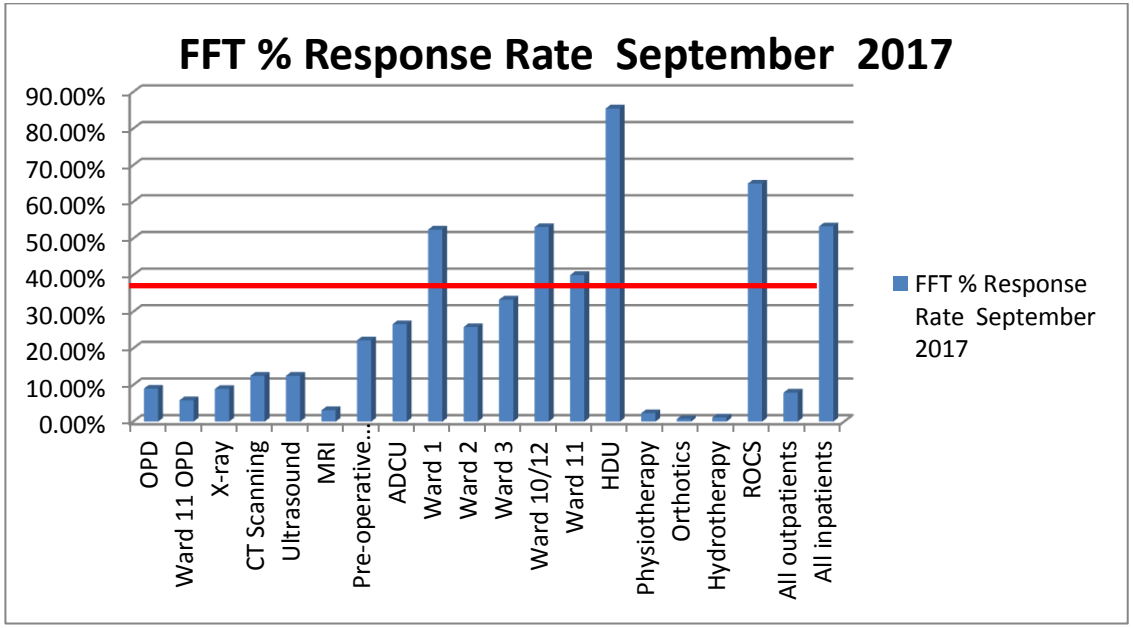
10. Friends and Family Test Results and iwantgreatcare - The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

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.



There are several areas of low response rate which have clearly affected the score received. The management of FFT has now returned to the Public and Patient Services Manager, who will be working with departmental colleagues to improve these rates over the next three months. The Trust has set an internal target to reach a 40% response rate across all areas within the first quarter of 2017/18. This has not been met and will form part of the work for improvement. In addition, it has been noted that the ipad online data collection system in place in the wards is not currently being used to collect FFT. This will also be reviewed over the next three months.

I Want Great Care - iWantGreatCare makes it simple to collect large volumes of meaningful, detailed outcomes data direct from patients on your organisation, clinical locations and whole clinical teams. It Continuously monitor and compare performance of individual services, departments and wards and Aggregated, graphical monthly reporting meets needs of both providers and commissioners for robust, patient-centric metrics to track quality and performance.

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 18 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

No new litigation to report in September 2017.

13. Coroner's

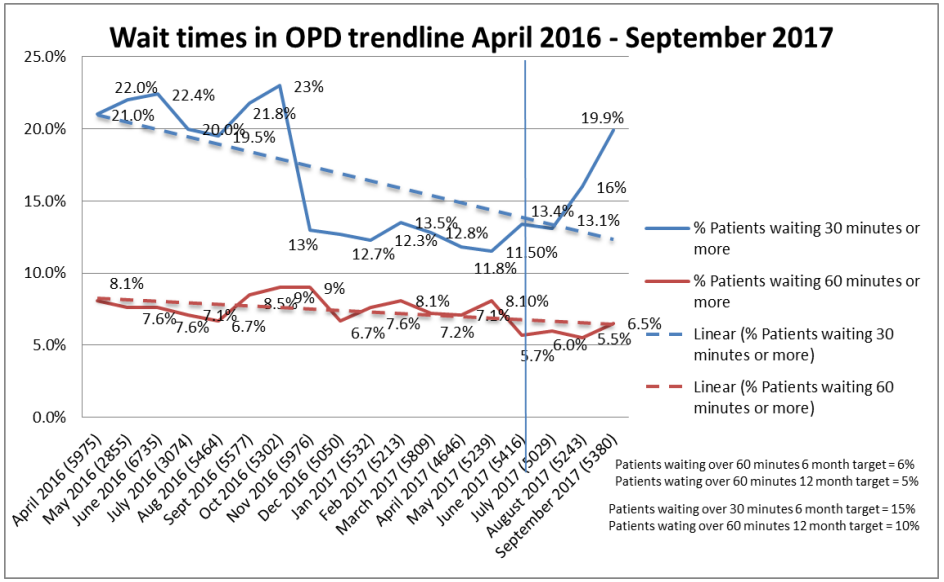
No new Coroner's inquest for September 2017.

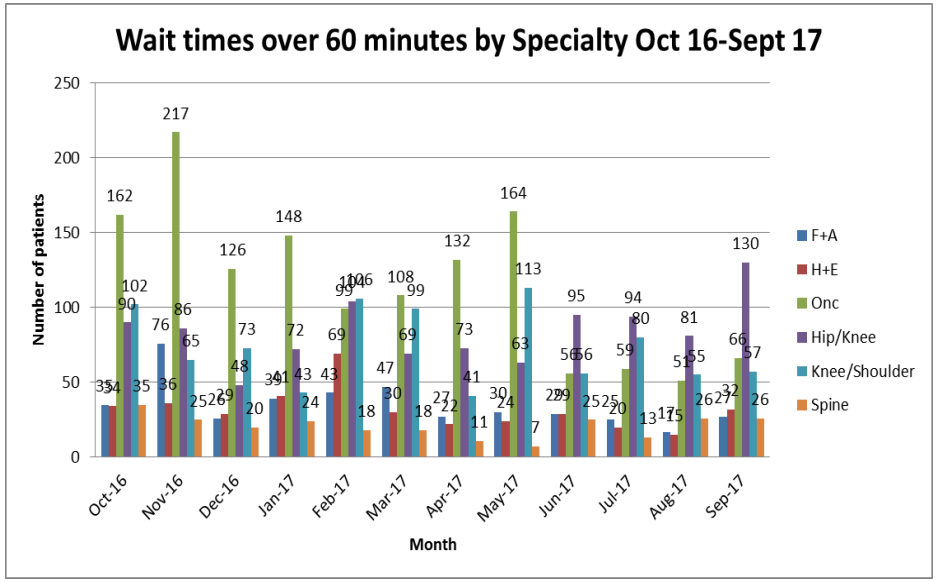
14. **WHO Surgical Safety Checklist - The WHO Surgical Safety Checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team (surgeons, anaesthesia providers and nurses) to perform key safety checks during vital phases perioperative care: prior to the induction of anaesthesia, prior to skin incision and before the team leaves the operating room.**

INFORMATION
The data is retrieved from the Theatre man program. The data collected is the non- completed patients. On review of the audit process the listed patients will have their case notes retrieved and the WHO Safety Checklist is then examined for any omission in completion. The following areas examined; • No form evident in notes • Sign in Section incomplete • Time out section incomplete • Sign out section incomplete Any non- compliance will be reported back to the relevant clinical area. **September Figures;** Total patients for month- 856 Patients manually verified as oppo sed to captured on Theatreman - 165 Total patients compliant - 856 **September WHO compliance = 100%**

ACTIONS FOR IMPROVEMENTS / LEARNING
August WHO compliance = 100% July WHO compliance = 100% June WHO compliance = 99.66%
RISKS / ISSUES
None

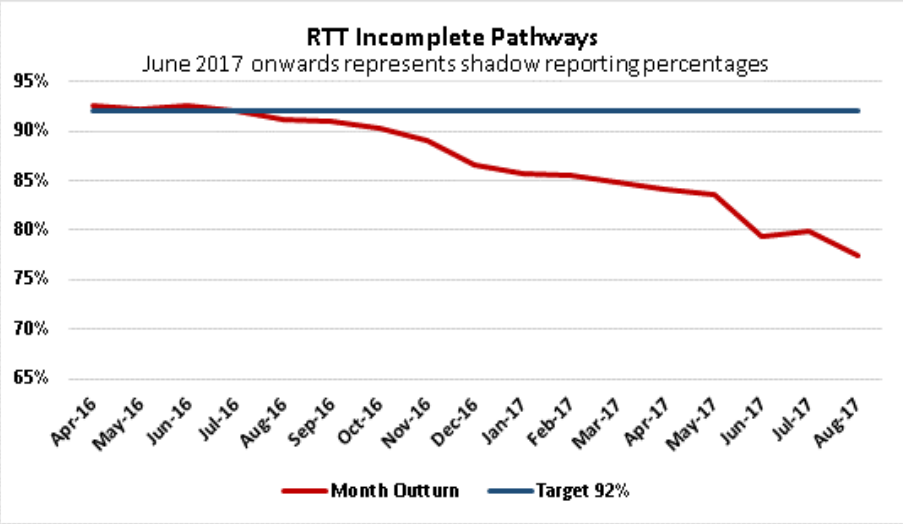
15. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients

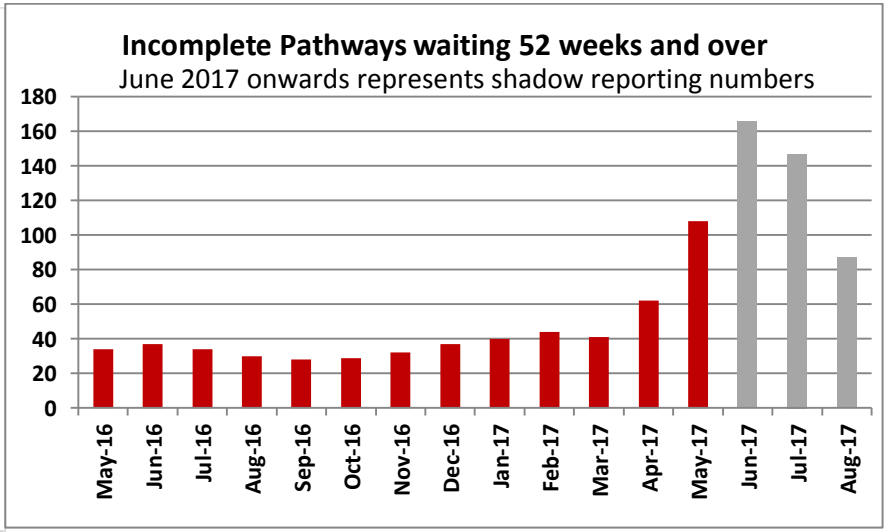


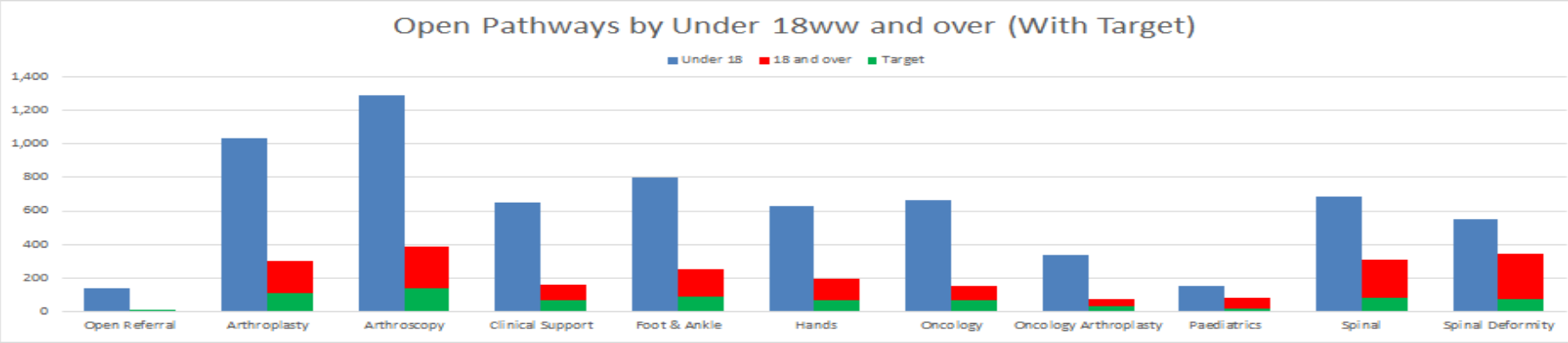


INFORMATION
Outpatient department continue to audit its compliance against the SOP for wait time and can demonstrate 100% compliance. There is a new standard operating procedure for any clinic running over 60 minutes late. The incident reporting system, Ulysses, has been amended to make it easier for the clinic staff to complete the incident form. An incident form is completed and a new drop down analysis is selected by the staff completing the incident The reasons documented on the incident forms now form part of a monthly action plan and this will be shared so reasons can be addressed. In September 2017 there was 12 incident forms completed to highlight clinics running more than 60 minutes late. The monthly audit identified 3 main contributing factors for delays: 1) delay in medical notes arriving on time to clinic. 2) Overbooked / not reduced clinic due to Consultant staff being on leave 3) Complex patients requiring more time.
ACTIONS FOR IMPROVEMENTS / LEARNING
Action from Septembers Audit • Review of current reduction in clinic rules - appointments • A review of the clinics that have not being reduced for consultant annual leave. (To check if annual leave guidance has been followed / authorisation and completion of reduction process completed) Clinical Service Manager and Secretarial Team lead for the area and the appointments team • Investigation in to Hip and Knee services wait times   • Completion of the medical notes SOP for clinics
RISKS / ISSUES
Medical Record Management

16. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories







INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017, and has been shadow reporting since that time. The Trust will recommence reporting in December 2017, with its first submission for November 2017. Validation of open pathways is complete and work to inform 'Business as Usual' validation is nearly complete to ensure that Data Quality standards are maintained going forwards.

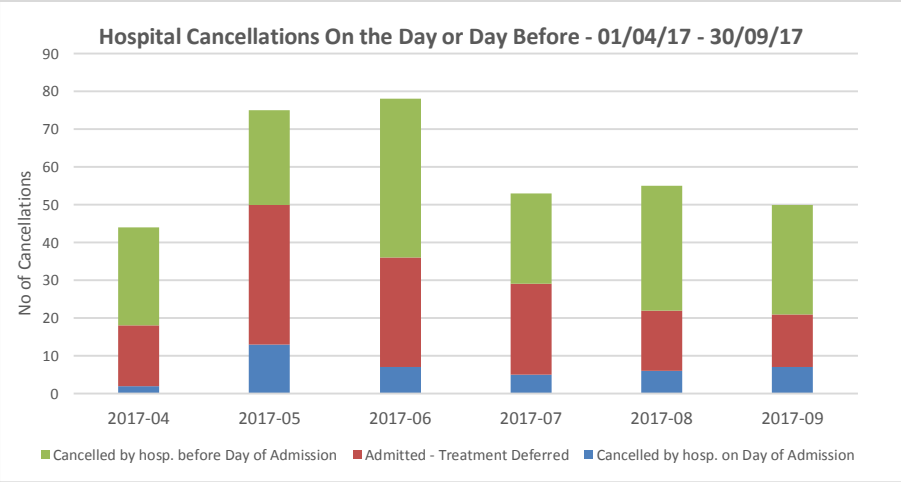
Validation has been completed reviewing clock stop data across all areas.

The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. The way in which the Trust utilises and manages the planned waiting list is being updated to ensure that it adheres to national guidance, where the treatment date is determined clinically, rather than by resource. Trajectories are currently being refreshed to recalculate the demand and capacity required to deliver 92% performance.

ACTIONS FOR IMPROVEMENTS / LEARNING

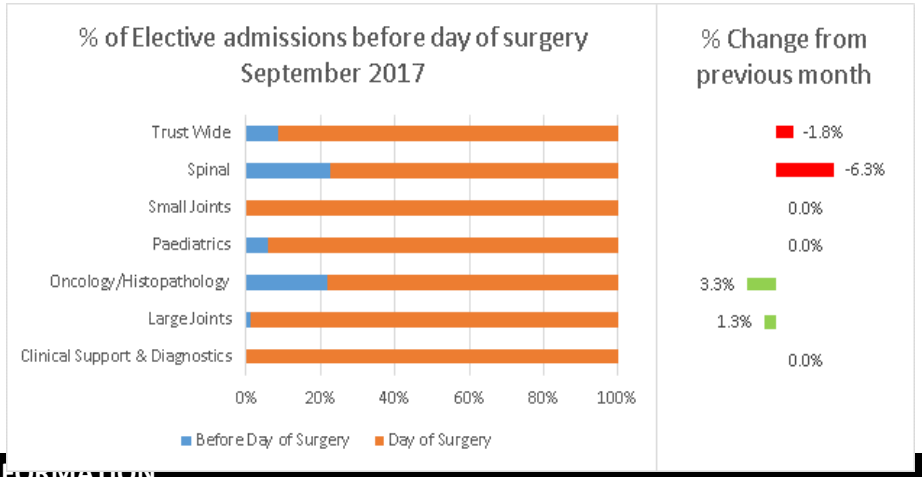
The team have concentrated over the last month on any patient over 40weeks. The focus from November 17 will now be the cohort of patients on an admitted pathway between 27-39 weeks and non-admitted over 18weeks.
RISKS / ISSUES
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is being discussed at the Stakeholder Oversight meeting on Friday 20th October 2017.

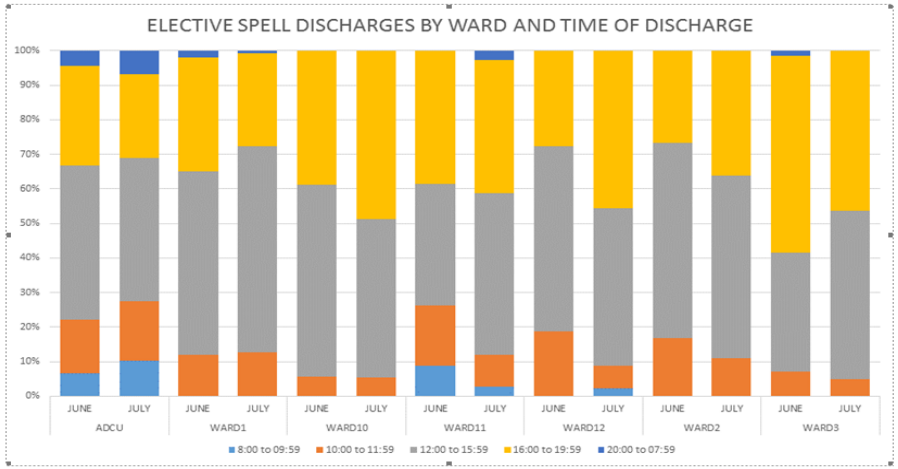
17. Process & Flow efficiencies – This illustrates how successful the Trust is being in ensuring that processes work effectively and that patients flow through the hospital in an efficient manner



Year - Month	Cancelled by hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp. before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
2017-04	2	16	26	44	1
2017-05	13	37	25	75	3
2017-06	7	29	42	78	3
2017-07	5	24	24	53	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
Grand Total	**40**	**136**	**179**	**355**	**9**

Notes:
Data taken from PAS Outcome of Offer
On the day or day before cancellation calculated by difference between TCI date and outcome of offer date
Admitted Treatment Deferred - Patients admitted with a diagnostic code Z538 (Procedure not carried out for other reasons)





INFORMATION

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Some of the replacement patients are then booked at short notice. We are now booking with 3 weeks' notice and 2 reasonable offers as per national guidance and our Access Policy.

The Clinical Service Leads and Clinical Service Managers for each specialty are discussing at regular team meetings, some longstanding issues relating to disparity of waiting lists across consultants, variations in theatre productivity and listing protocols are being addressed and resolved.

Forensic analysis of cancellations continues, with a focussed analysis by the anaesthetic lead and nursing lead for POAC of the majority cause of cancellations on the day of surgery, namely those who are medically unfit, to ascertain what process changes can be made in POAC or to the 72 hour phone call to reduce this.
On the 12th October a multi-disciplinary POAC workshop was held to understand all the issues, agree the new model and the workstreams to take the improvement programme forward. The day was well attended and 5 workstream were agreed including GP liaison, referrals & education and workforce.

ACTIONS FOR IMPROVEMENTS / LEARNING

A daily update review by operational management of forward bookings has been established and the 6-4-2 and a daily 8.30am Operations huddle has continued. Daily statistics on beds, admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to deliver activity and patient flow.
By the end of October 17 the refreshed Perfecting Pathway project team will meet with the POAC workstream leads to agree next steps and key milestones. It was agreed that the workshop would meet again in 6weeks to review the progress and ensure that all stakeholders are kept informed of any changes or new initiatives.

RISKS / ISSUES

Continued focus with all staff involved to ensure that the operating lists are booked in advance, with sufficient caseloads, together with daily tracking.
It is currently not possible to identify if the time of day patients are discharged is an accurate reflection of reality, or whether data is being entered onto the system in a delayed manner, making discharges look later in the day. This work now forms part of the Perfecting Pathways workstream (Inpatients & Discharge) and a 2week audit is currently being undertaken to identify delays with the discharge process incorporating a review of timeliness of prescribing and TTO's

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Annual complaints report**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Patient Services**
AUTHOR:	**Lisa Kealey, Patient and Public Liaison Manager**
DATE OF MEETING:	**1 November 2017**

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 Quality & Safety Committee and 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 2016/17 and outline the complaints priorities for 2017/18.

Of note, there has been a 48% increase in complaints during the year to 167, compared with 113 the previous year.

The level of satisfaction with the way we have handled complaints has increased from 76% in 2015/16 to 80% in 2016/17. This provides assurance that the changes made in the previous year have been successfully embedded.

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 Trust Board is asked to;

- Note the annual complaints report
- Agree to the improvement plans for 2017/18

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	x	Patient Experience	**x**

Clinical	**x**	Equality and Diversity		Workforce	**x**

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

With safe efficient processes that are patient centred

PREVIOUS CONSIDERATION:

The report is an annual update.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

Annual Complaints Report 2016/17

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 01/04/2016 and 31/03/2017. 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 2016/2017 were agreed as listed below:

- 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

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 Head of 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. The team are looking to change this in 2017-18 and enter data in real time. The system for recording and logging complaints and actions taken implemented in 2015 has been maintained and has enabled more accurate and responsive monitoring and allowed the team to work closely with the Divisional teams to improve the recording of actions and learning taken as a result of complaints. The changeover to recording into Ulysses was delayed until the teams were happy that the computerised system could replicate the quality of the data using the existing system.

5.0 Number of complaints

In 2016/2017, ROH received 170 formal complaints. 3 were withdrawn leaving a total of 167 to be investigated and formally responded to. 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 2016/17 with the previous year's data for comparison.

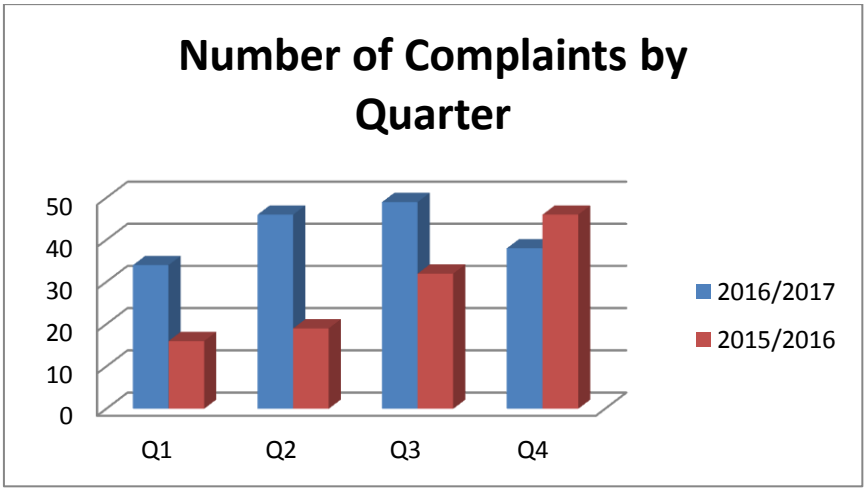
Figure 1: Numbers of complaints received 2014/2015

Formal Complaints	2014/2015	2015/2016	2016/2017
	105	113	167

Formal complaints experienced a 48% increase during the year after a steady decline over the previous 3 years. A review was undertaken to establish if this was indicative of specific concerns. The review showed an increase in 3 areas:

- Administrative concerns, particularly in Oncology and Spinal Services
- Attitude of Staff across all disciplines
- Communication, particularly with changes to appointments or surgery dates

Figure 2: Number of complaints by quarter

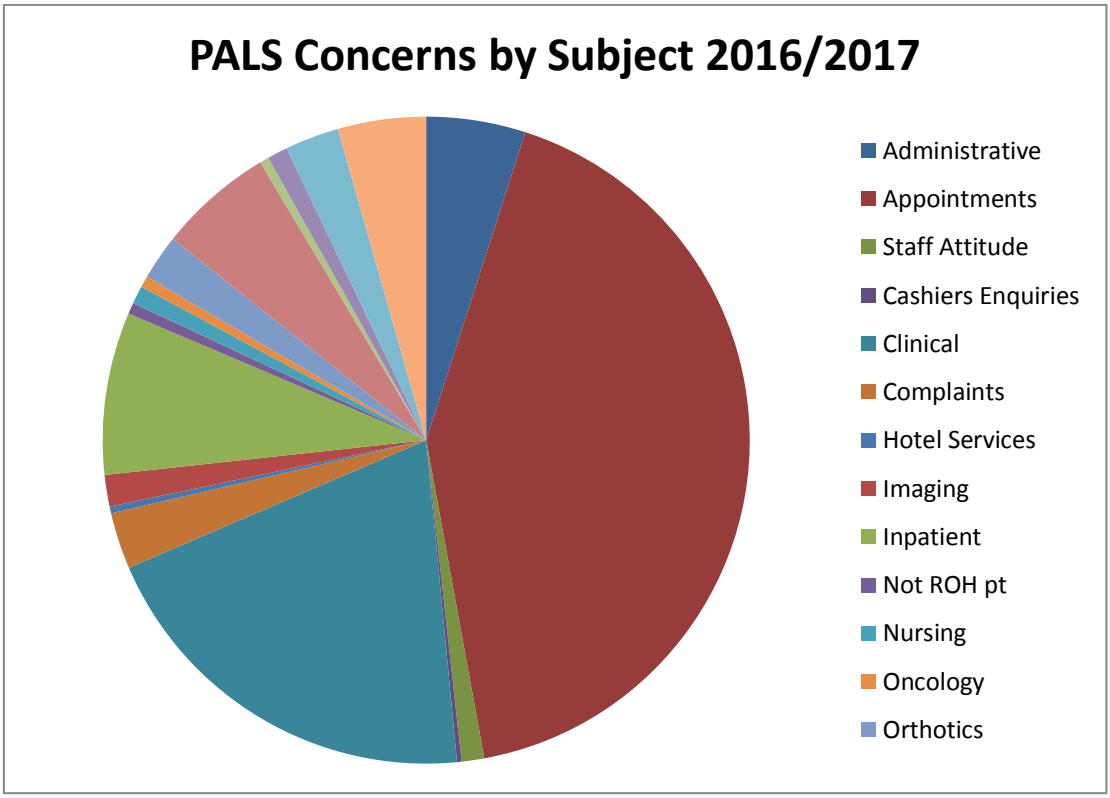


The number of complaints increased in each of the first three quarters of the year and declined in the last quarter compared with the previous year. The significant rise in complaints identifies issues that the Trust needs to improve but also offers assurance that patients and families are aware of the process and how to complain.

6.0 PALS Contacts during 2016/2017

There were 4136 contacts with the Patient Advice and Liaison Service this year of which 895 were concerns. This represents a 300% increase in the work of the PALS service and is mostly the result of an increase in visibility of the service. The number for the service is routinely included on all patient correspondence and this will now be reviewed as it has been recognised that this may not be the most effective use of the PALS resource.

Figure 3: Number of PALS Concerns by Subject



The most common concerns expressed via PALS in 2016/2017 were:

- Patients and relatives requesting a sooner appointment than currently offered
- Parents requesting a sooner paediatric spinal deformity appointment for their child after repeated rescheduling
- Failure to provide agreed or expected feedback
- Patients requesting an update on what is happening with regard to their treatment

The PALS Service has also provided support to patients with identified needs to access appointments and treatment where this has been possible. The department remains committed to supporting the work of the newly appointed Learning Disabilities Nurse in the coming year.

7.0 Formal Complaints numbers measured against Trust activity

Figure 4: Complaints against Trust Activity 2016/2017

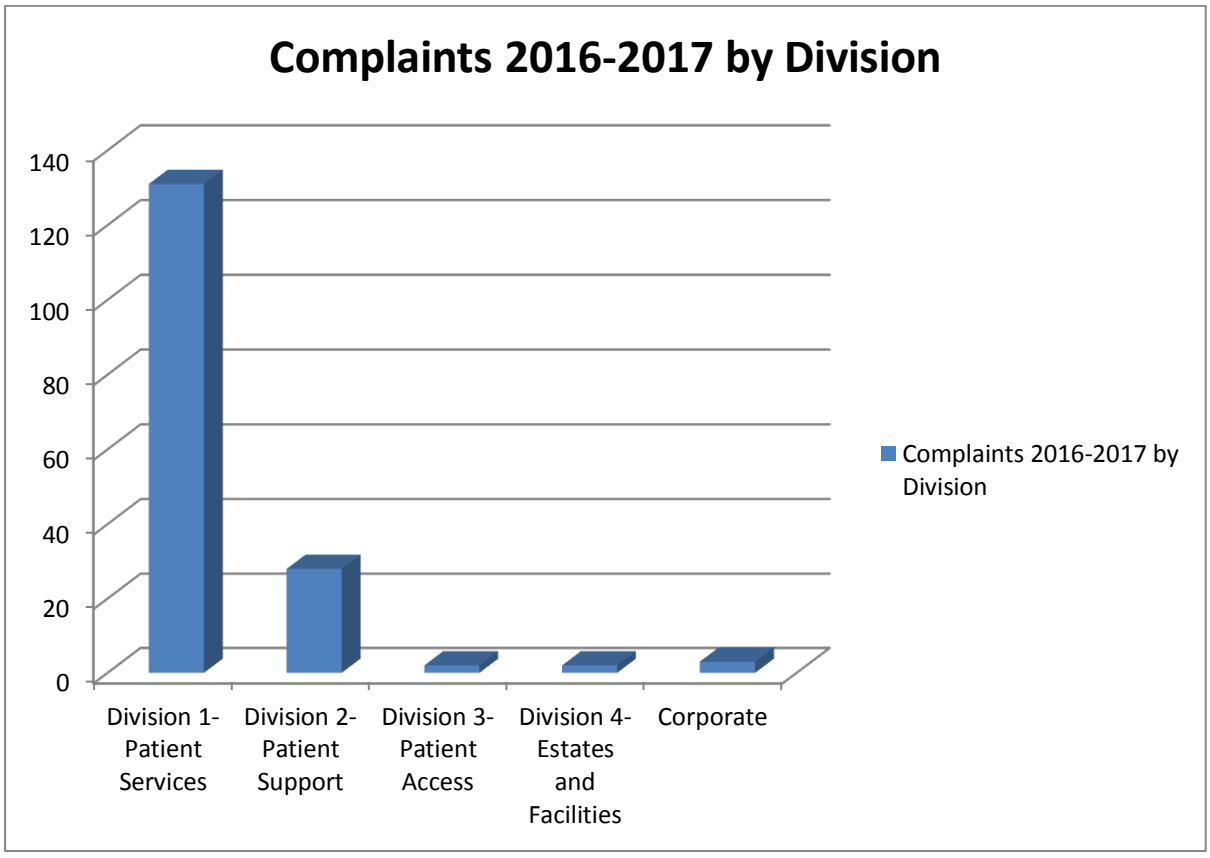
	2016/2017	2015/2016
Inpatient Attendances		
Inpatient Complaints	60	45
Inpatient Episodes	13973	14954
Complaints per 100 inpatient episodes	0.43%	0.30%
Outpatient Attendances		
Outpatient Complaints	106	68
Outpatient Episodes	67181	69253
Complaints per 1000 outpatient attendance	0.16%	0.10%

It can be seen that whilst the total number of complaints has increased over the last year, the greatest rise in complaint numbers is in out-patient areas with a 55% rise from 68 to 106 over this time period. The ratio of complaints to patient episodes has shown a slight increase but still remains low.

8.0 Number of Complaints by Division

Figure 5 below illustrates the number of formal complaints by Division in 2016/2017.

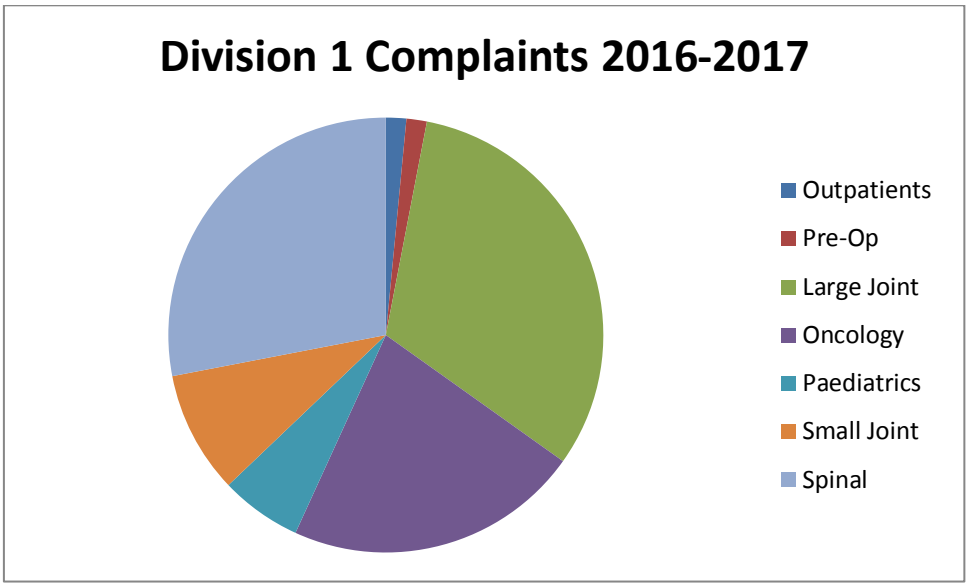
Figure 5: Number of Complaints by Division 2016/2017



The majority of complaints (79%) relate to the Patient Services Division which is to be expected since this Division oversees all inpatient and outpatient activity. This is a slight increase from 73% last year. The two areas with the highest number of complaints in 2016/17 were the Large Joint (25%) and Spinal Services (22%).

Figure 6 below provides an in-depth breakdown of complaints within Division 1

Figure 6: Number of Complaints by area in Division 1 2016/2017



8.1 Large Joints complaints

The largest numbers of complaints in Division 1 relate to concerns within the Large Joints service (25% of all complaints this year). This represents the greatest volume of surgery performed at the hospital so is perhaps not unexpected. 57% of Large Joint complaints related to aspects of care provided whilst an inpatient, with the main theme of these complaints related to Patient Care. Each of these complaints were fully investigated with action plans put in place where changes were required.

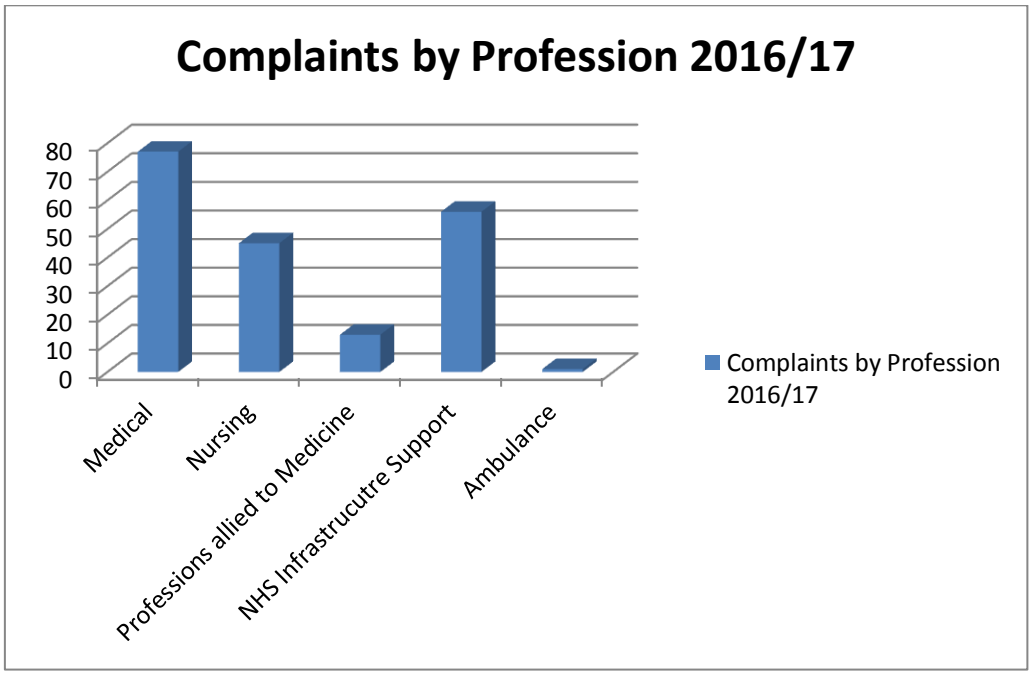
8.2 Spinal complaints

Complaints about the Spinal Service remain high in 2016-2017 (22% of all complaints this year) The spinal deformity service in Birmingham remains 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. The Senior Team continue to work with partners, NHS England and our commissioners to find solutions to increase our capacity Whilst this continues to be a challenge to the organisation, the number of spinal deformity complaints has decreased over the year. The number of complaints regarding issues relating to the Spinal Service will continue to be monitored and used as a measure of effectiveness of the new processes and systems.

For all of the information provided below, it should be noted that the total number of recorded entries may be considerably more than the number of complaints for the year. This is because there may be a number of areas of concerns in an individual complaint which are all recorded and logged.

9.0 Complaints by Profession

Figure 7: Number of Complaints by Profession 2016/2017



Whilst Medical Care remains the most significant concerns for patients, NHS Infrastructure and Support has increased again this year to be the second largest area of concern. This area includes administrative processes and support and is aligned to issues such as the capacity of the spinal service that has already been discussed.

10.0 Complaints by Subject

Figure 8: Complaints by Subject 2016/2017

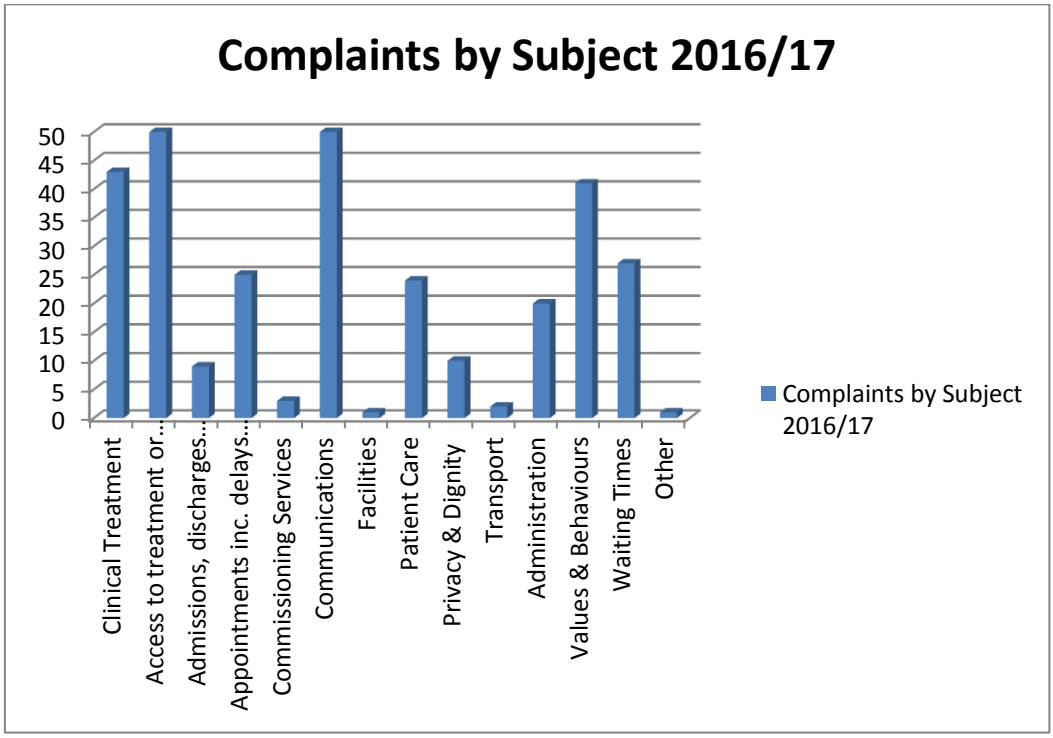
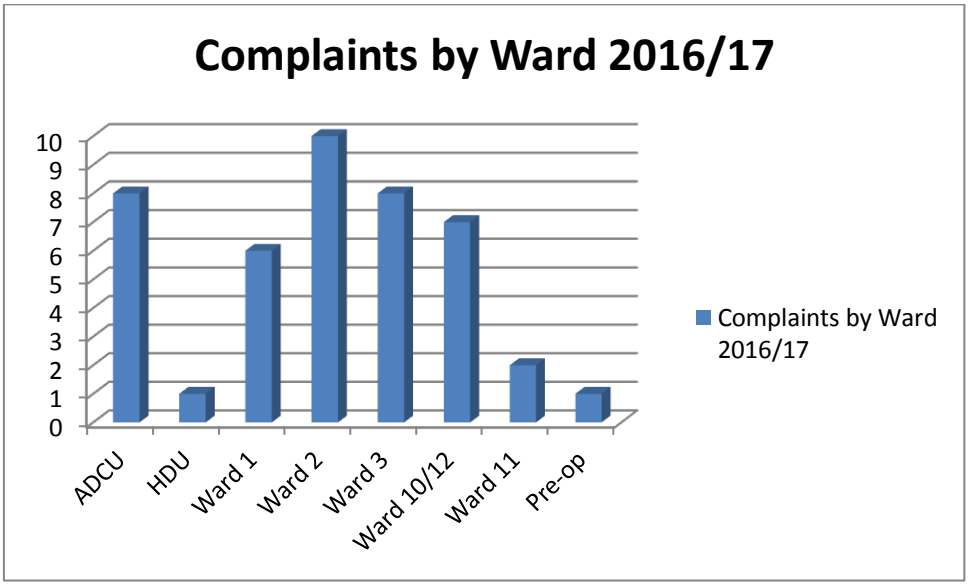


Figure 8 shows the main causes for complaints in 2016/2017, with communication with patients, access to treatment and clinical care being the highest reasons. This is a change from last year where patient care and delays in appointments together with communication were the largest concerns.

The Trust is recording outcomes of complaints in a more robust manner and aligned to the thematic codes submitted on the quarterly return to the office of National Statistics. The increase in complaints about the behaviours of staff members has been identified and action taken to address individual behaviours has been taken where necessary. In addition, the Trust has secured the services of a dedicated Staff Engagement Manager, who is working with departments and teams to identify learning and support needed to improve their overall efficiency.

11. Complaints by Ward during 2016/2017

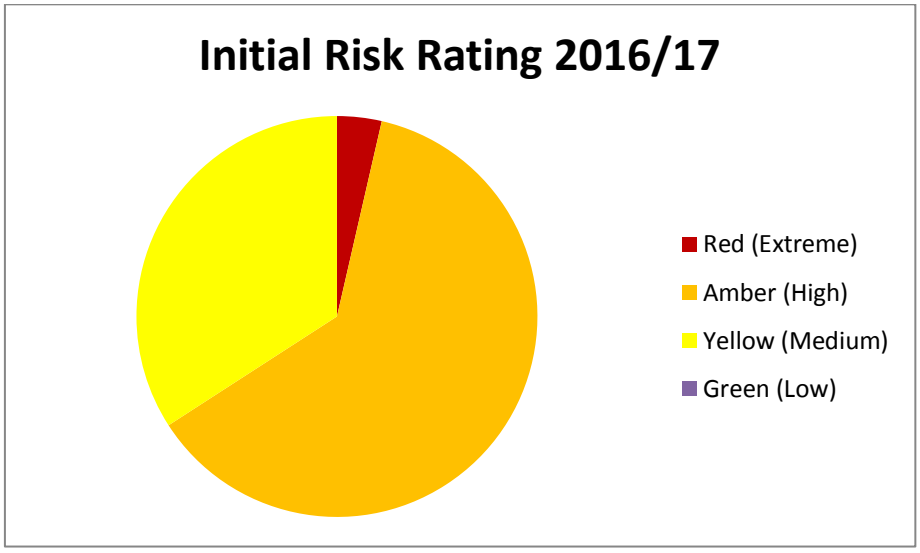
Figure 9: Complaints by Ward 2016/2017



The new recording and reporting system has enabled the analysis of ward involvement in complaints since October 2015. Although the previous year (2015/16) is not a full year's data, it can be seen that there is a reduction in the number of complaints about care on the Wards (25% this year in comparison to 45% from the previous year). The data is scrutinised monthly, with other performance metrics by the Heads of Nursing and trends are identified and addressed in Divisional Governance meetings. This has helped to identify specific performance improvements in individual wards as well as operational issues that can affect nursing care. In turn, this information is submitted to the Clinical Quality Group and escalated if appropriate to the Quality and Safety Committee. This clear progression has ensured that action as a result of complaints is taken at the right level within the organisation.

12. Risk Ratings of Complaints during 2016/2017

Figure 10: Initial Risk Rating of Complaints 2016/2017



The initial risk ratings of all complaints are reviewed by the Division Teams with all those rated red being brought to the attention of the Executive Director of Patient Services and the Head of Governance. All complaints are assessed against Duty of Candour requirements and Incidents logged. 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 as lower or medium risk 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 2016/17 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.

99% of complaint letters received during the 2016/2017 were acknowledged verbally or by e-mail within the correct timescale, thereby meeting the KPI. The two that were not acknowledged within this timescale were sent an apology and explanation for the delay.

98% of complaint letters were formally acknowledged by letter within the agreed timescale, thereby meeting the KPI. This remaining 2% were acknowledged within 5 working days. This was due to concerns and immediate actions needing to be verified and completed.

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 Patient Services, 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 90% has been met with 93.5% of complaints being completed within the timescales agreed with the complainant.

14.0 Outcome of complaints made in 2016/2017

Figure 11: outcome of complaints 2016/2017

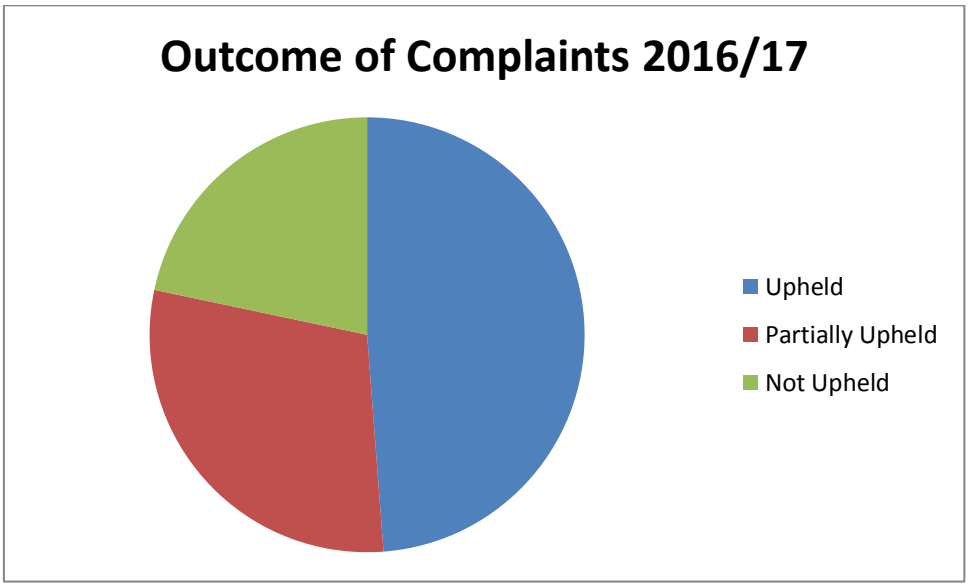
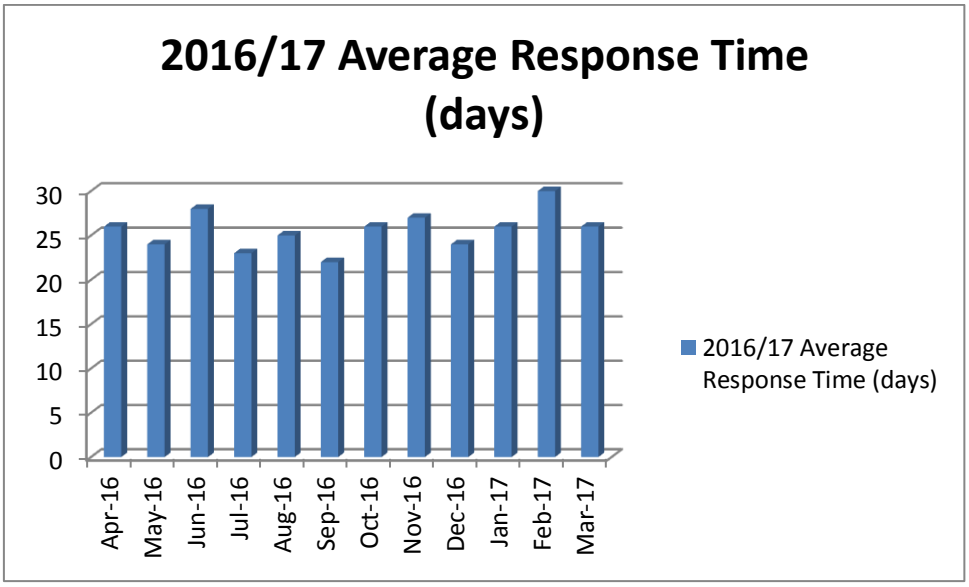


Figure 11 shows the outcome of complaints made in 2016/2017. The Trust upheld some aspects of 76% of the complaints made in this year, which is slightly lower than last year but remains significantly higher than previous years. The robust investigation and divisional involvement in quality assurance has embedded successfully into the operational structure and the increased standard of complaint investigation has been maintained.

15.0 Response times to complaints

The Trust has set internal targets for response times in the complaints policy as 25 working days for simple complaints and 40 working days for complex complaints. The complaints department provides an average response time figure monthly as part of the Quality data as additional assurance that all complaints are being handled in a timely manner. The complaint regulations stipulate that all response times are made in agreement with the complainant, which means that there are occasions where response times are much longer or shorter than would normally be expected. Narrative for the reasons for these changes is provided where necessary. (A complainant may want to resolve their concerns in a face to face meeting, but are not available to meet for 6 weeks for example).

During 2016-2017 the monthly average response time did not exceed 30 working days.



16.0 Satisfaction with the Complaints Service

During 2016/2017, a total of 62 satisfaction surveys were returned by complainants representing 37% 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 75% last year to 80% 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 from 83% to 85%. Reassuringly 98% of respondents stated that they would feel confident in using the complaints service again if it was necessary and that the complaints staff were helpful, professional and sympathetic.

The information from the full satisfaction survey will continue to be reviewed and used to inform further improvement work in 2018/2019.

17.0 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 2016/2017, the PHSO requested information about 3 complaints made to the Trust. In addition, the outcome of the remaining outstanding complaint from the previous year was received and this was not upheld with no action for the Trust.

Of the three complaints investigated this year, 2 were not upheld and the remaining case is still open awaiting a decision.

18.0 Listening and Learning from Complaints

Patient Story

Mrs X made a formal complaint that the provision for deaf patients across all areas of the Trust was not adequate. Investigation revealed that the hearing loop provision was not sufficient and staff were not aware that a portable loop was available for patients to take into consultation rooms and other departments if necessary. Upon further investigation it was discovered that the portable hearing loop could not be located. The Clinical Service Manager responded to Mrs X upholding her concerns and asking if she would be happy to assist with assessing provision for patients across all areas. Mrs X became involved with the gap analysis and met with the Clinical Service Manager to provide a detailed insight as to what would be helpful.

Mrs X is currently trialling a portable hearing loop for the hospital and if this proves to be satisfactory, a number will be purchased for loan to patients with a robust checking out process.

Mrs X is very pleased with the Trust's response to her concerns and is happy that she has been asked to provide expert advice about the proposed changes

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 themes from complaints received in 2016/2017 continue 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.

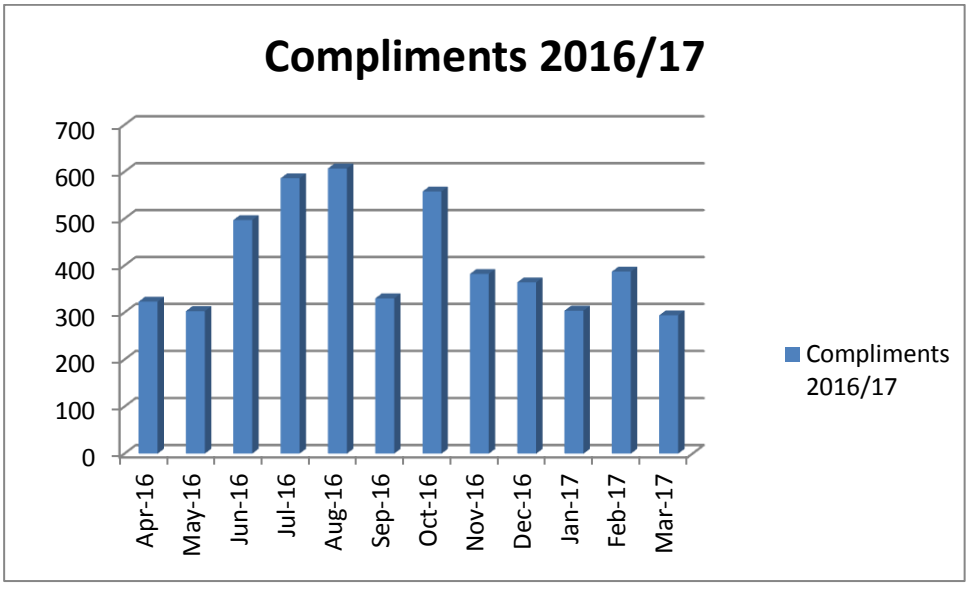
The changes to the complaints process have ensured that action plans have been created for cases that have been upheld and specific changes need to be made. These are now discussed and monitored through weekly Divisional meetings and ensure that the Trust is able to identify learning and changes that have been made directly as a result of complainant's feedback. A total of 52 individual actions plans were created in this year.

Identified Issue/ Learning	**Action taken**
Process for following up additional pre-operative tests is not robust	Processes have been reviewed and changed
PALS phone not always answered	PALS and Complaints Service brought into same office
Scheduling of patients for surgery from decision to proceed is not uniform process	Process for scheduling has been reviewed
The process for managing private patients when a patient is initially an NHS patient was not explicit	Process has been reviewed and defined
Communication to GP surgeries has not been clear re: BMI restrictions for hip and knee replacement	Information was sent to GP surgeries identified as needing it
The management of patients with phobias of hospitals was not consistent	The need has been reviewed with the Lead for Equalities and further work is in progress to produce guidelines
Admin Process for managing Oncology referrals was inconsistently applied	CSM moved to Oncology Office to work directly with teams to improve communication processes
Individual staff were identified to not be acting in line with the Trust's Core Values	Performance Management and Disciplinary Processes have been used where appropriate
Junior Doctors on-call were not always aware of escalation process of spinal emergencies	Pathway was established and provided to Junior Doctors
Patients were not always receiving notification of cancellation of appointments	Cancellation guidelines written

Identified Issue/ Learning	Action taken
Prolonged waiting in Outpatients	New outpatient booking system (In-Touch) has been implemented and is being used to improve processes
Process of Triaging new Oncology Referrals was not robust	Clinical Service Manager introduced a daily Referrals meeting with good effect
Process of informing patients of changes to clinician was not robust	Communications Team worked with Divisional Leads to implement processes
Communication of reason for delay is surgery (necessary delay) is not always communication effectively	Staff have been supported and received additional training where required
Family and Patients were not kept informed of progress in Serious Incident Investigations	Process has been reviewed and clear times for contact have been established

19.0 Compliments 2016/2017

All compliments are sent electronically to the Patient Experience Team who hold the records. A compliment is recorded if there is tangible evidence such as a card, a thank you letter, a box of chocolates or an e-mail. Teams are reminded monthly to submit their compliments for central logging.



20.0 Looking ahead to 2017/2018

The Department is continuing to review the process of handling complaints, particularly with a view to further the work of embedding complaint investigation within the new Divisional Structure.

Other improvements planned for 2017/2018:

- Complaints will be managed in real time on the Ulysses system so that all actions and learning can be recorded in a similar manner to Serious Incidents
- Complaints staff will provide ad-hoc training for any member of staff identified as needing this.
- The Trust will continue to move towards offering meetings at an earlier stage in the process where appropriate.
- The KPI's agreed for the year will be met
- The staffing of the PALS and Complaints Services will be reviewed with the Clinical Governance Department, who now manage the services. This will increase shared knowledge and upskill staff in both teams.

21.0 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.

Appendix A

Progress against 2015/2016 priorities for the Complaints Department

Priority	Status	Detail
A centralised system for monitoring and completing action plans for complaints will be developed.	Achieved	Divisions now have shared files that complaints and action plans are uploaded to. These are monitored through weekly Divisional meetings
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.	Partially Achieved – remains an objective for next year	Action Plans have started to be sent. This will be rolled out to all Divisions in the first quarter of 2017-2018
Complaint investigation and report writing training will be undertaken for all staff involved in investigating and responding to complaints where the need is identified.	Partially Achieved – remains an objective for next year	Training and support has been provided where requested
In conjunction with the Governance department, an agreed process for sharing of Trust wide learning from complaints will be created and evaluated.	Partially Achieved – remains an objective for next year	Divisional learning is now embedded but processes for Trust wide learning need to be reviewed
Achieve the KPI of 90% of complaints completed within the agreed timescale	Achieved	
A review of current staffing provision for PALS and Complaints will be undertaken	not achieved – remains an objective for next year	

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 = MEDIUM risk** **Amber = HIGH risk** **Red = EXTREME risk**

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

TRUST BOARD

DOCUMENT TITLE:	**Infection Prevention & Control Annual Report 2016/17**
SPONSOR (EXECUTIVE DIRECTOR):	**Mr Garry Marsh – Executive Director of Patient Services**
AUTHOR:	**Mustafa Ahmed – Clinical Governance Improvement Manager**
DATE OF MEETING:	**1 November 2017**

EXECUTIVE SUMMARY:

The Annual Infection Prevention & Control Annual Report 2016/17 is presented to the Board for final review prior to submission to the Commissioners and publishing on the Trust's website.

This report has been approved by the Infection Prevention & Control Committee in October 2017. Also present at the Committee were; the regional Lead for Infection Prevention & Control from NHS Improvement and the Lead for Infection Prevention & Control from the Commissioners who also approved the document.

REPORT RECOMMENDATION:

The Board is asked to receive and note the Infection Prevention & Control status at the Trust 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		

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	**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:

Safe, efficient processes that are patient centred.

PREVIOUS CONSIDERATION:

Infection Prevention & Control Committee

INFECTION PREVENTION & CONTROL

ANNUAL REPORT

1

2016 / 2017

AUTHOR	**Mustafa Ahmed – Governance Improvement Manager**
DIRECTOR OF INFECTION PREVENTION & CONTROL	**Garry Marsh – Executive Director of Patient Services**
APPROVED AT	**Infection Prevention & Control Committee**
DATE	**24 October 2017**

CONTENTS

1 Introduction

This report summarises the combined activities of the Infection Prevention & Control Team (IPC) and other staff at The Royal Orthopaedic Hospital NHS Foundation Trust (ROH) in relation to the prevention of healthcare associated infections (HCAIs).

The Trust recognises that the effective prevention and control of HCAIs is essential to ensure that patients using services at ROH receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008 (updated 2015), at the heart of this law there are two principles:

- To deliver continuous improvements of care
- And that it meets the need of the patient

With this in mind patient safety remains the number one priority for the Trust. Infection Prevention is one of the key elements to ensure ROH has a safe environment and practice which is reflected in the Trust's vision and objectives with milestones turning the vision into a reality.

COMPLIANCE CRITERIA 1
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

2 The Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) is a role (whether by that name or another) required by all registered NHS care providers under current legislation (The Health and Social Care Act 2008). The DIPC will have the executive authority and responsibility for ensuring strategies are implemented to prevent avoidable healthcare associated infections (HCAIs) at all levels in the organisation.

The DIPC will be the public face of infection prevention and control and will be responsible for the Trust's annual report, providing details on the organisations infection prevention and control programme and publication of HCAI data for the organisation.

The DIPC will offer their commitment to quality and patient safety, good communication and reporting channels and access to people with expert prevention and control advice.

At the ROH the Executive Director of Patient Services holds the role of DIPC.

The primary duties of a DIPC include;

- Have corporate responsibility for infection, prevention and control throughout the Trust as delegated by the Chief Executive
- Report directly to the Chief Executive (not through any other officer) and the Board or other senior management committee. Assures the Trust Board on Trust's HCAI performance and provides regular reports, including the Annual Report
- Responsible for the Trust's Infection Prevention and Control Team (IPCT)
- A full member of the IPCT and regularly attend the infection prevention and control meetings
- Responsible for the development and implementation of strategies and policies on infection, prevention and control
- Act on legislation, national policies and guidance and assess their impact; ensuring effective policies are in place and audited
- Provide assurance to the Board that policies are fit for purpose
- Attend Board meetings to report on infection prevention and control issues and to ensure infection prevention and control consideration in other operational and developmental decisions of the Board

- Provide leadership to the infection, prevention and control programme in order to ensure a high profile for infection prevention and control across the Trust
- Ensure that the requirements of decontamination guidance are in place and adhered to through implementation of appropriate policies
- Ensure public and patient involvement in infection, prevention and control
- Be a member of Clinical Governance Committee or equivalent

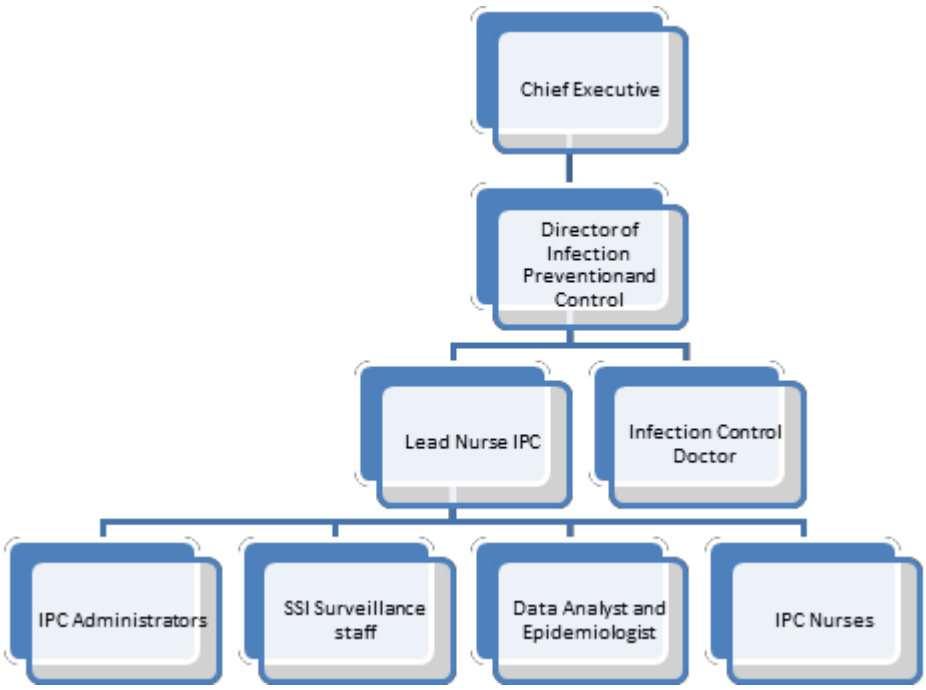
3 Infection Prevention and Control Team

The DIPC has overall responsibility for the IPC team.

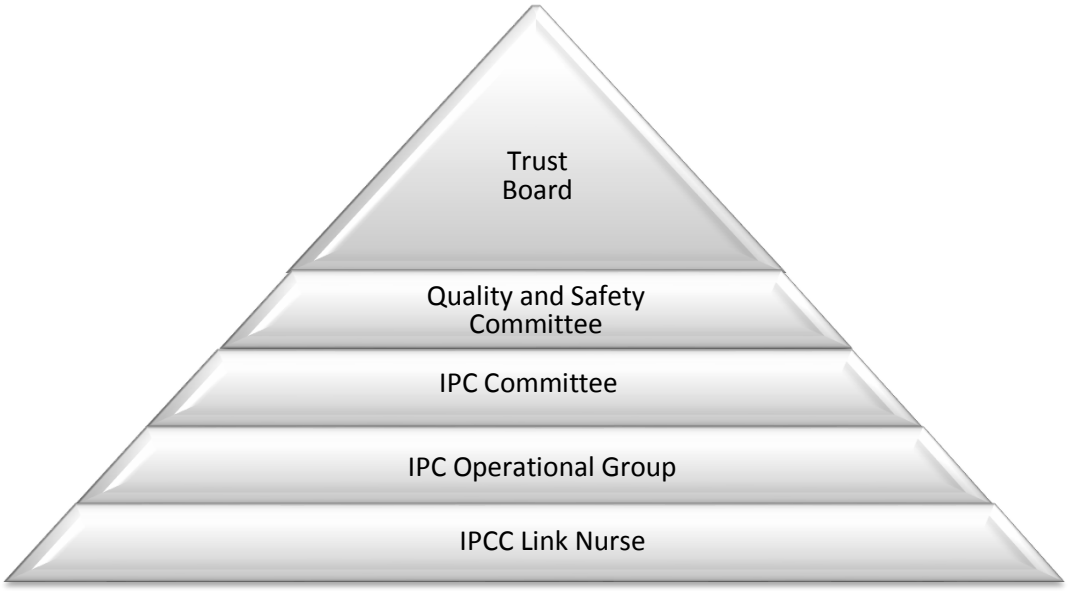
The IPC Team work collaboratively alongside the front-line clinical leaders at the Trust.

The Infection Prevention and Control service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development, and review and service development. The Trust has 24 hour access to expert advice and support via a Service Level Agreement (SLA) with the University Hospital Birmingham (UHB).

4 IPC Team Structure 2016/2017



5 Committee Structures and Assurance Processes



5.1 Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for Infection Prevention and Control. The Chief Executive has overall responsibility for the control of infection at ROH. The Director of Patient Services is the Trust designated DIPC. The DIPC attends Trust Board meetings with detailed updates on Infection Prevention and Control matters. The DIPC also meets regularly with the Chief Executive.

5.2 Quality and Safety Committee

The Quality and Safety Committee (QSC), chaired by a Non - Executive Director (NED), is a sub-committee of the Trust Board which meets monthly is responsible for ensuring that there are processes for ensuring patient safety; and continuous monitoring and improvement in relation to Infection Prevention and Control. The QSC receives assurance from the Infection Prevention and Control Committee (IPCC) that adequate and effective policies, processes and systems are in place. This assurance is provided through a regular process of reporting. The IP team provide a monthly report on surveillance and outbreaks.

5.3 Infection Prevention and Control Committee

The Infection Prevention and Control Committee (IPCC) provides direct assurance to the DIPC. The main objective of the IPCC is to provide a strategic drive in ensuring improved performance in relation to health care associated infections.

The IPCC is chaired by the DIPC; members include the Medical Director, Lead Consultant Microbiologist, Lead Infection Prevention and Control Nurse, Chief Pharmacist, Head of Estates and the Facilities Manager.

6 Surveillance of Healthcare Associated Infection (HCAI)

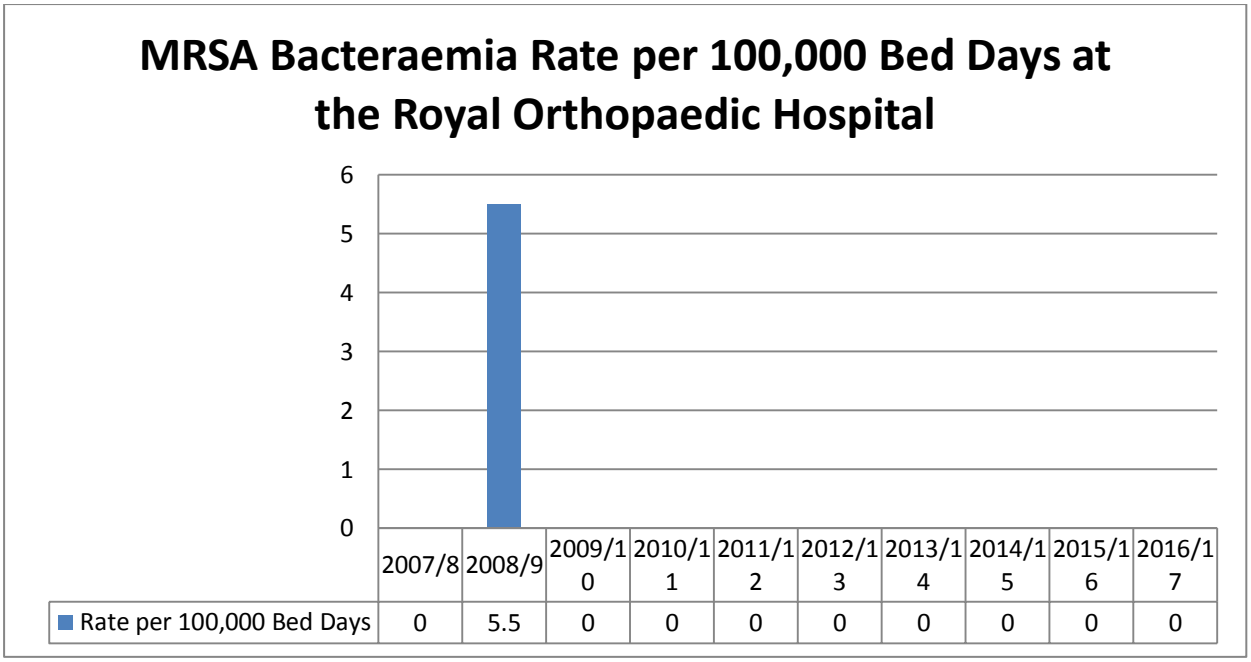
6.1 MRSA Bacteraemia

The Department of Health (DH) began mandatory surveillance of MRSA bloodstream infections (bacteraemia) in 2001. This includes all bloodstream infections with MRSA whether acquired in hospital or in the community and any that are considered to be a contaminant or not. Data is reported to the DH, via Public Health England (PHE) through the national HCAI database monthly.

There continues to be a national zero target for all MRSA bacteraemia, as part of this zero tolerance approach an in-depth Post Infection Review (PIR) is undertaken for all MRSA bloodstream infection cases which includes an external review, the purpose is to identify any possible failings in care and to identify the organisation best placed to ensure improvements are made.

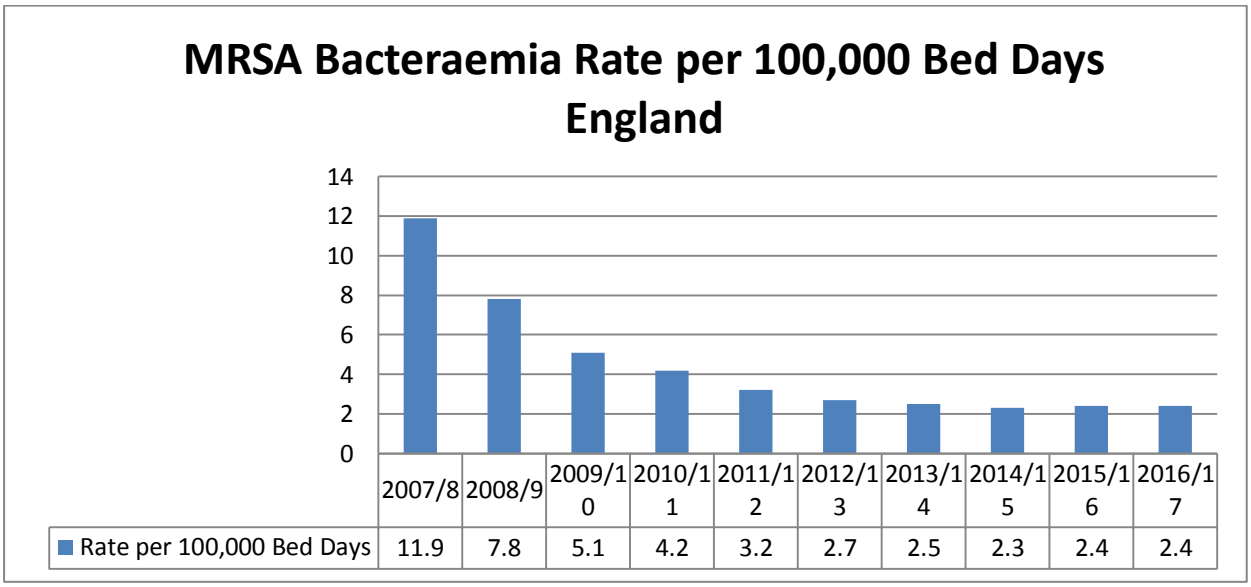
Trust apportioned cases are defined as blood culture taken “on or after the 3rd day of admission”.

For the period covered by this report there been **zero** cases of MRSA bacteraemia at ROH which is the same compared to the previous year;



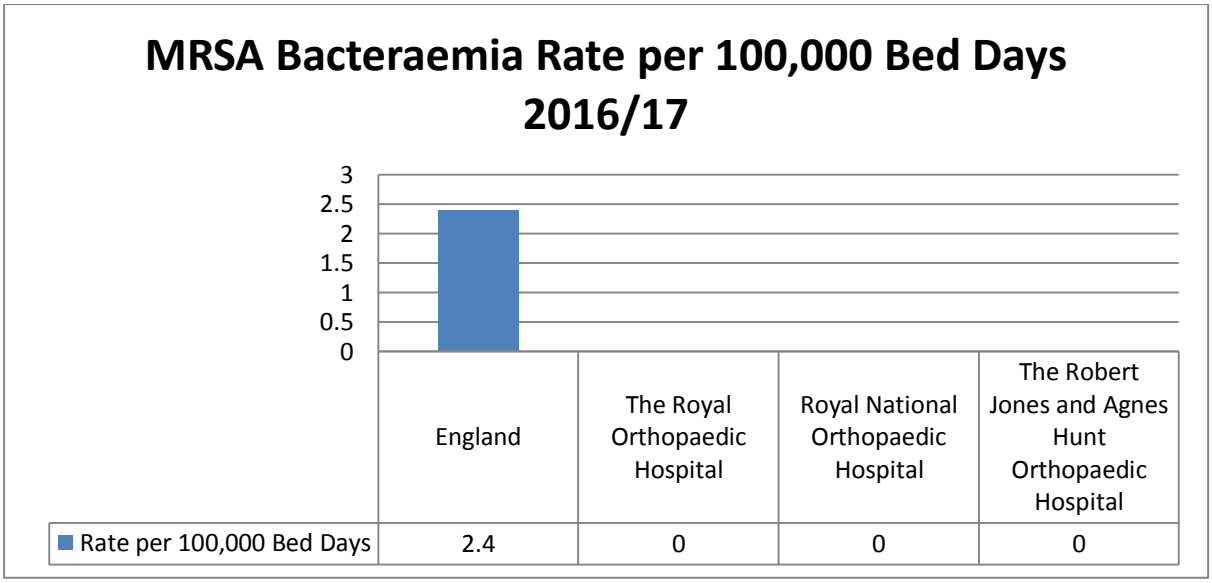
Source: https://www.gov.uk/government/organisations/public-health-england

For the period covered by this report there been **zero** cases of MRSA bacteraemia at ROH which is the same compared to the previous year;



Source: https://www.gov.uk/government/organisations/public-health-england

Since 2007/8, there has been a steady overall decrease in England.



Source: https://www.gov.uk/government/organisations/public-health-england

In comparison to other specialist Trusts in England, ROH has also had zero cases.

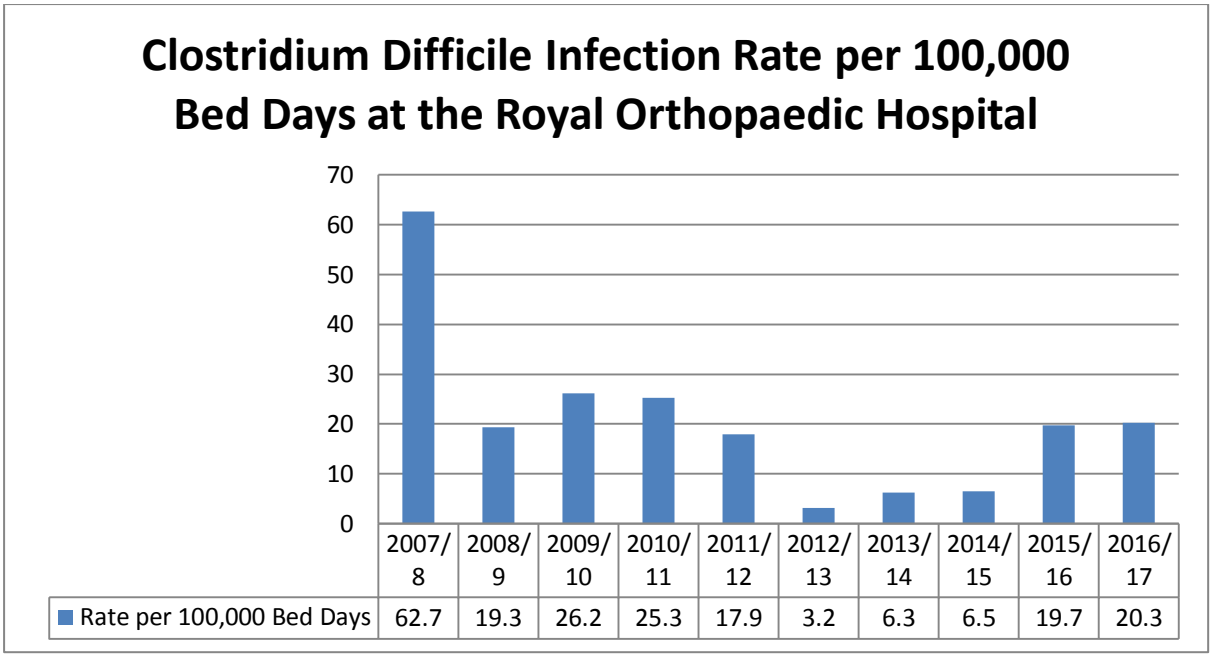
6.2 Clostridium Difficile Infection (CDI)

In March 2012 the Department of Health (DH) issued revised guidance on how to test, report and manage CDI. The new guidance aimed to provide more effective and consistent diagnosis, testing and treatment of CDI. It provided the ability to categorise patients into one of three groups:

- CDI likely
- Potential Clostridium Difficile excretors (Carriers)
- CDI unlikely

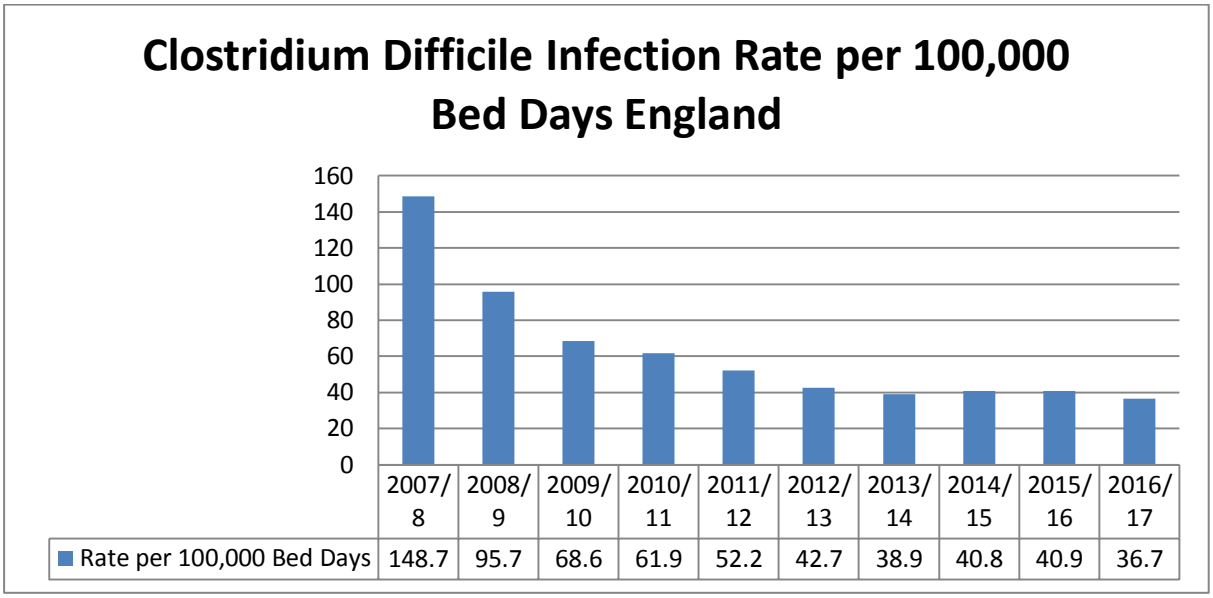
ROH is compliant with DH testing guidance for CDI.

Cases of CDI that are considered to have been acquired in that the Trust are defined as sample taken “on or after 48 hours of admission”.



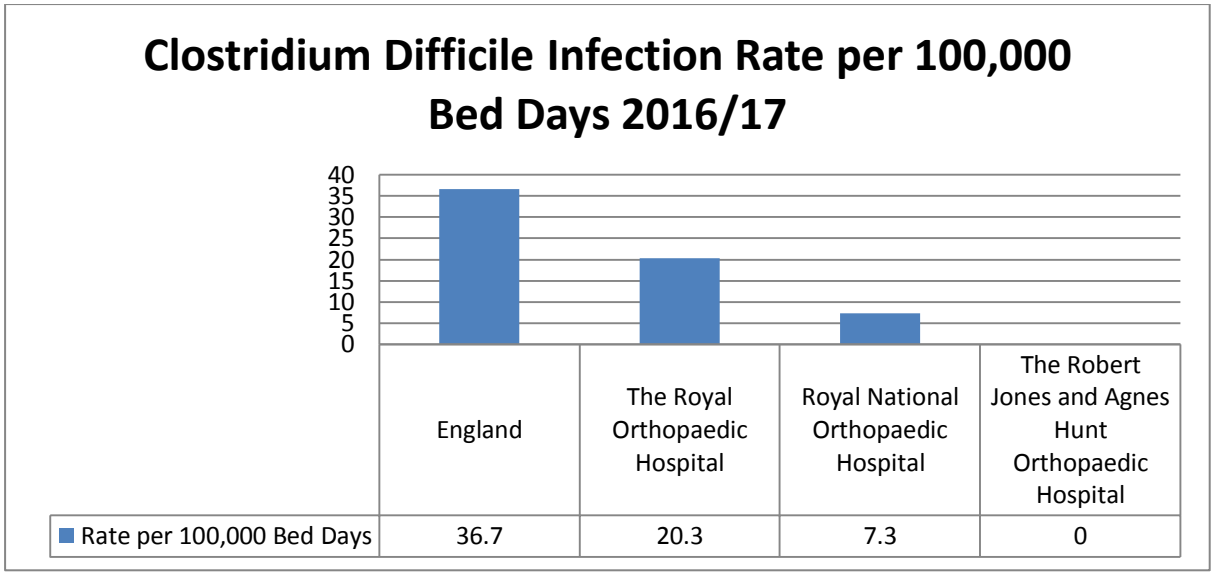
Source: https://www.gov.uk/government/organisations/public-health-england

For the period covered by this report there has been an increase in CDI rates compared to the previous year at ROH. The total number of was 4 unavoidable cases.



Source: https://www.gov.uk/government/organisations/public-health-england

There has been a steady decrease in CDI rates in England since 2007/8.



Source: https://www.gov.uk/government/organisations/public-health-england

In comparison to other specialist Trusts in England, ROH has had higher CDI rates. This is attributed to the specialist Bone Infection Unit (BIU) patients operated on at the Hospital. All cases were found to be unavoidable after investigation of each case through a Root Cause Analysis (RCA) process with Commissioner involvement from start to finish.

6.2.1 ROH CDI Action Plan

Preventing and controlling the spread of CDI is a vital part of the Trust's quality and safety agenda by a multifaceted approach and the proactive element of early recognition and isolation of CDI toxin positive cases and of those cases that are CDI carriers (PCR positive).

All Hospital acquired CDI positive samples or cases where the patient has had a recent hospital stay at ROH are submitted to Public Health England for ribotyping. Samples with the same ribotype are then examined further variable number tandem repeat (VNTR). This helps to identify wards or areas where patient to patient transmission is likely to have occurred, with enhanced focus on control measures, with decanting and deep-cleaning of the patient areas if necessary.

In all cases control measures are instigated immediately, and RCA's are reviewed. Each inpatient is reviewed by the IPC nurse regularly. In cases of Bone Infection Unit (BIU) patients, they form part of the weekly multi-disciplinary review where the patients' case is discussed including antibiotics and where necessary feedback to ward doctors. All HCAI CDI cases are subjected to root cause analysis and each case discussed with Lead IPC Nurse at Birmingham Cross City Clinical Commissioning Group (BCCCG) to decide relation to their avoidability (lapses in care) with feedback to Infection Prevention and Control Committee and Divisions. The Divisions action Duty of Candour where necessary.

ROH closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic Clostridium Difficile in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic Clostridium Difficile within a period of 28 days and associated with stay in the same ward or area.

In such instances, a full terminal clean is undertaken with detergent and hot water. Curtains are changed and all equipment is cleaned with Sporacidal wiped or disposed of. The room / bay is then decontaminated using the hydrogen peroxide machine (Bioquell). Equipment is also decontaminated in the room / bay with hydrogen peroxide.

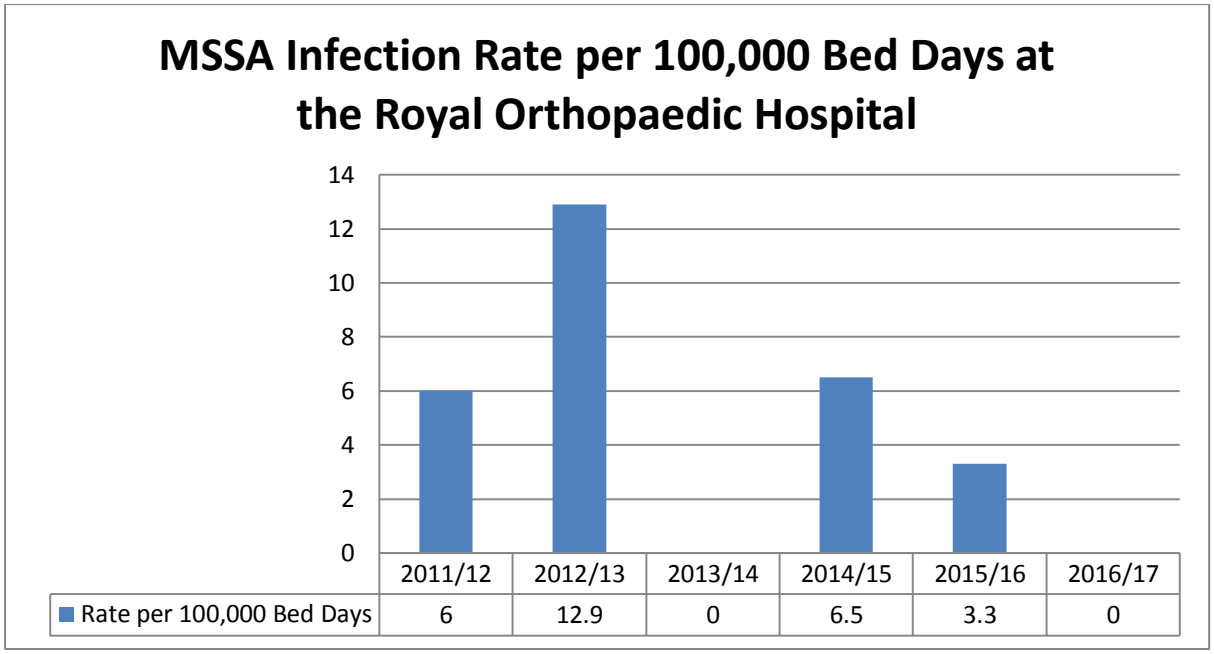
Bioquell disinfect is used for cleaning of the general environment and non- invasive equipment used in wards. In other areas, Clinell disinfectant and detergents are used.

6.3 Meticillin-Susceptible Staphylococcus Aureus (MSSA)

Meticillin-sensitive Staphylococcus aureus is a type of bacteria (germ) which lives harmlessly on the skin and in the noses, in about one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

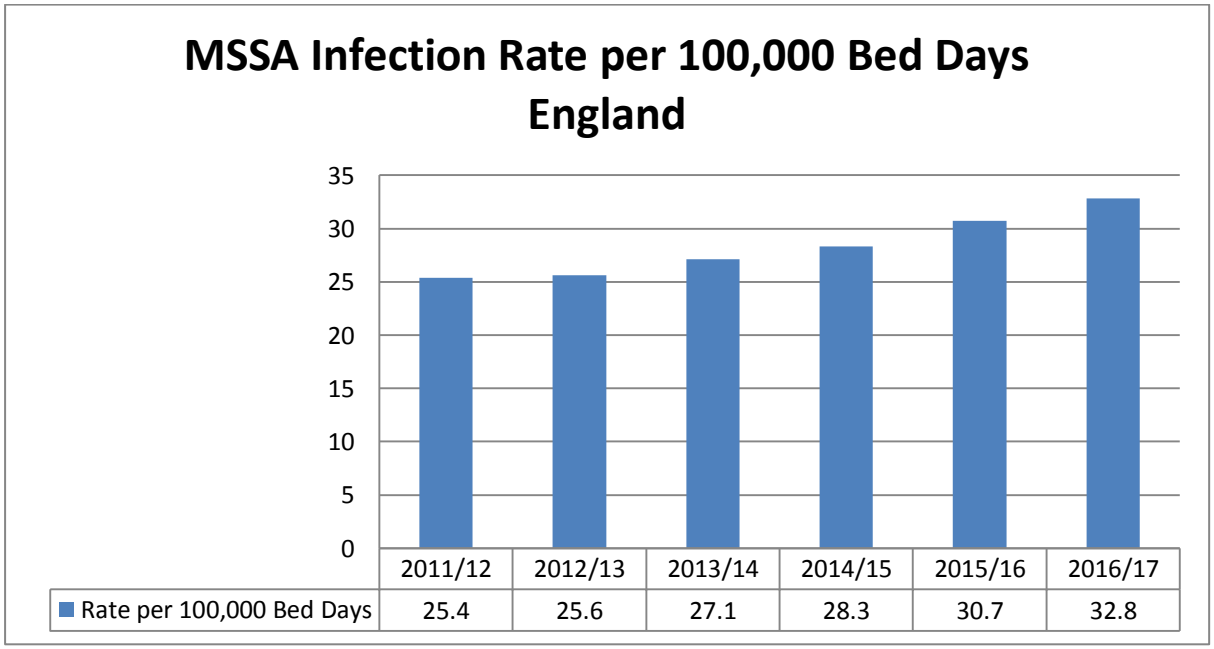
However MSSA colonisation usually causes them no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds.

MSSA can cause serious infections called septicaemia (blood poisoning) where it gets into the bloodstream.



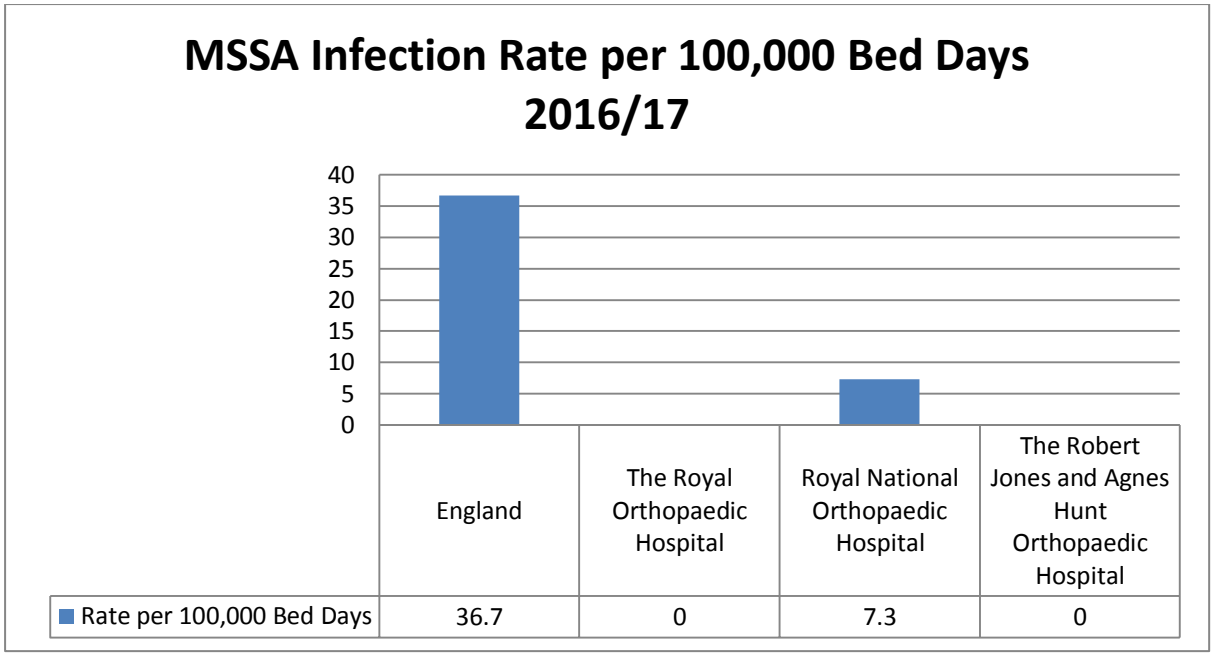
Source: https://www.gov.uk/government/organisations/public-health-england

There has been a decrease in MSSA infection rates since 2014/15. In the period for this report there have been **zero** cases at ROH.



Source: https://www.gov.uk/government/organisations/public-health-england

There has been an overall increase in MSSA infection rates on the whole in England.



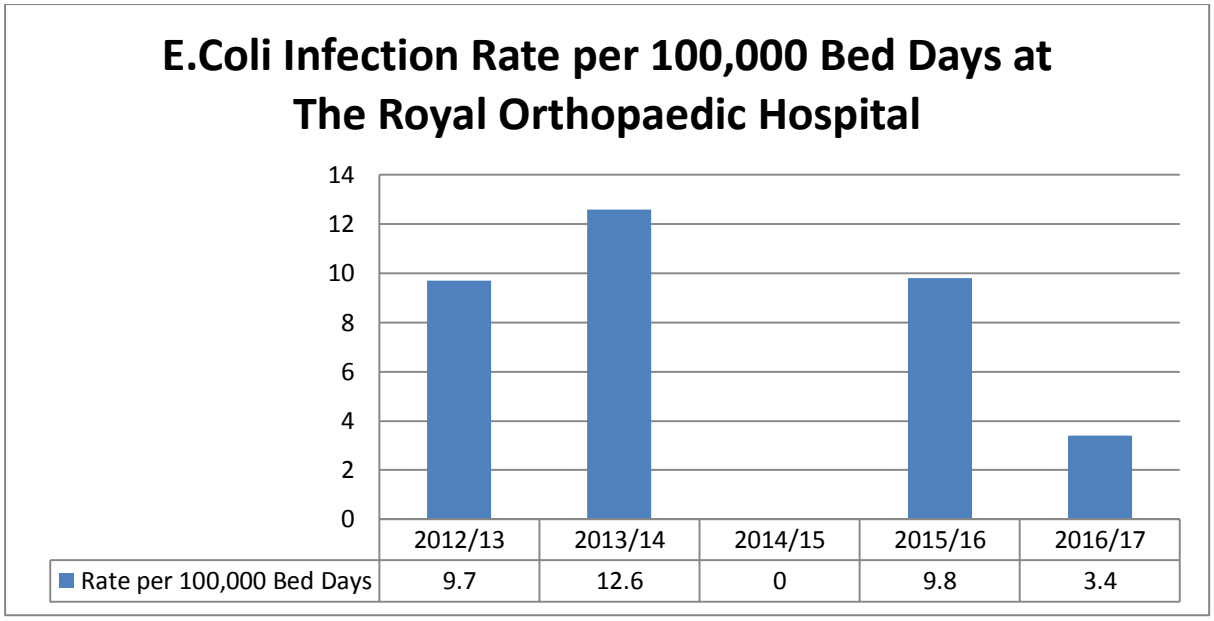
Source: https://www.gov.uk/government/organisations/public-health-england

In comparison to other specialist Trusts in England, ROH had zero cases.

6.4 Escherichia Coli (E.Coli)

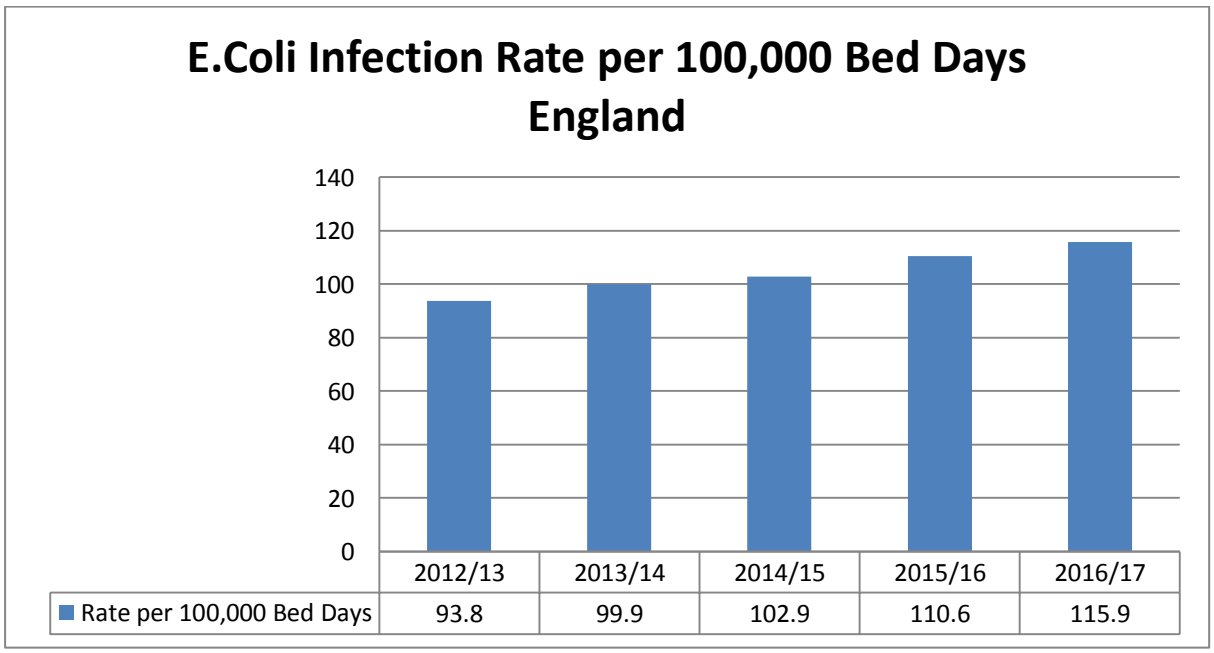
E. coli is a type of bacteria common in human and animal intestines, and forms part of the normal gut flora (the bacteria that exist in the bowel). There are a number of different types of E. coli and while the majority are harmless some can cause serious food poisoning and serious infection. For example, E. coli bacteria are a common cause of cystitis, an infection of the bladder that occurs when there is a spread of the bacteria from the gut to the urinary system. Women are more susceptible to urinary tract infection by E. coli because of the close proximity of the urethra and the anus.

Some types of E. coli can cause gastrointestinal infections. As the bacteria can survive outside of the body, its levels serve as a measure of general hygiene and faecal contamination of an environment. A common mode of infection is by eating food that is contaminated with the bacteria.



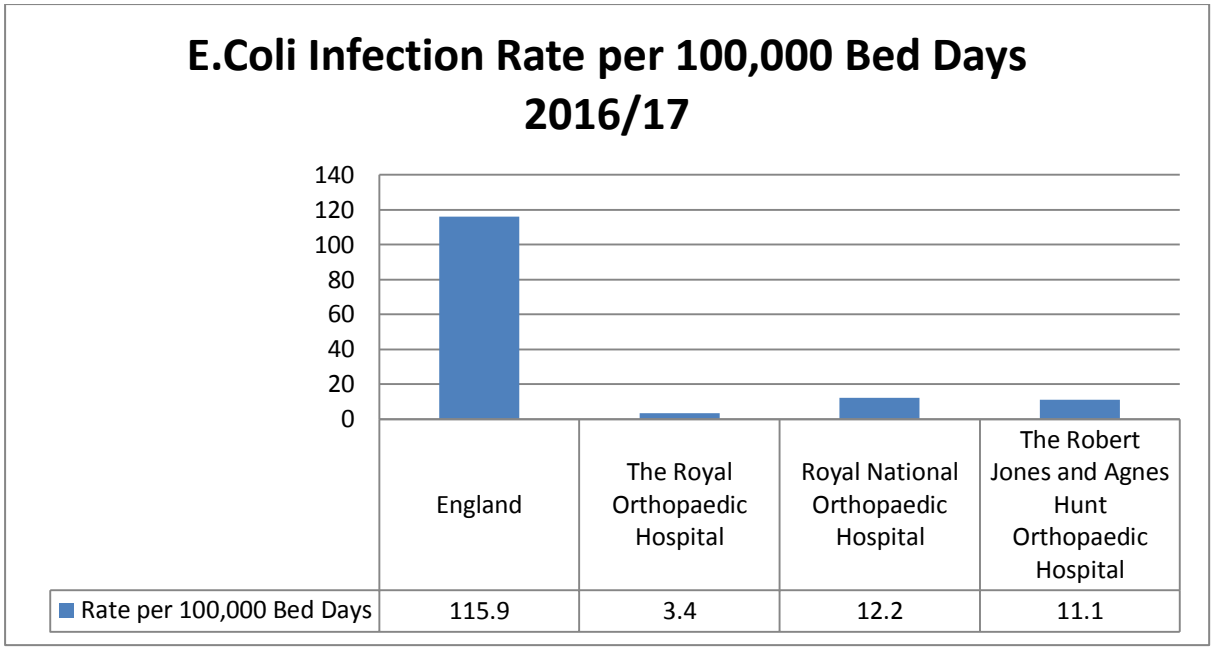
Source: https://www.gov.uk/government/organisations/public-health-england

There has been a decrease in E.Coli infection rates since 2015/16. In the period for this report there has been one case at ROH.



Source: https://www.gov.uk/government/organisations/public-health-england

There has been an increase in E.Coli infection rates in England since 2012/13.



Source: https://www.gov.uk/government/organisations/public-health-england

In comparison to other specialist Trusts in England, ROH had less reported cases of E.Coli.

6.5 Glycopeptide Resistant Enterococcus (GRE) Bacteraemia

Enterococci are bacteria commonly found in the bowel and GRE are enterococci that have become resistant to glycopeptides (for example vancomycin). Reporting of bacteraemia caused by GRE has been mandatory for NHS acute Trusts in England since September 2003.

For the period covered by this report there have not been any cases of GRE at ROH which is the same compared to the previous year;

6.6 Carbapenemase – Producing Enterobacteriacea (CPE)

Public Health England published a toolkit for the early detection, management and control of CPE in December 2013. The toolkit provides expert advice on the management of CPE to prevent or reduce spread of these bacteria into (and within) health care settings, and between health and residential care settings.

ROH adheres to the national guidance and toolkit and perform three screening episodes 48 hours apart.

7 Audit programme to ensure key policies are implemented

ROH has a programme of audits in place undertaken by both clinical areas and the IPC Team to provide assurance around practice and ensuring that they consistently complying with evidence based practice and policies. Action plans are devised by areas where issues are highlighted and fed back to the IPCC via the Matron for the area.

The IPC Team also completed additional audits where infection numbers are highest or where there appears to be an identified risk concern so improvements in the care process can be identified quickly and put into action.

8 Audits of hand hygiene practice

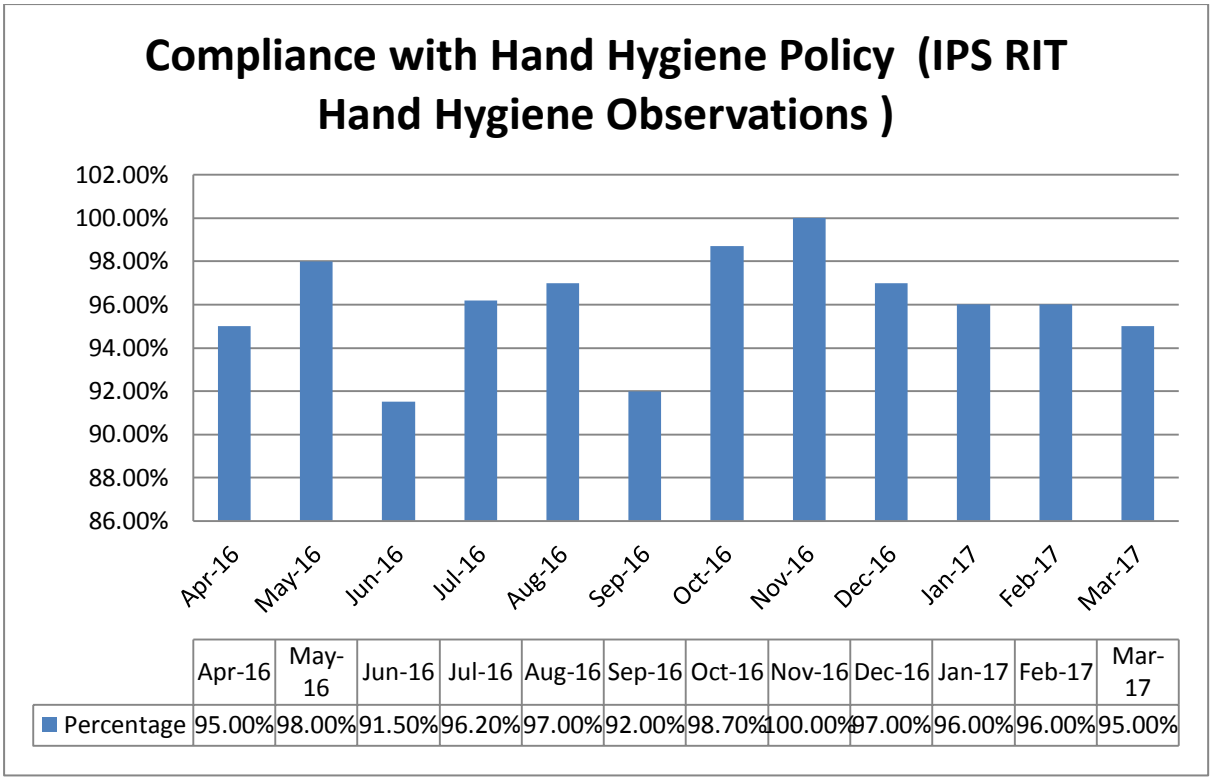
Hand hygiene remains central to the audit programme. The IPC Link Nurses perform 'Glow & Tell' training and assessments on hand hygiene within their areas.

The Link Nurses audit hand hygiene monthly by peer review. Other audits include;

1. Environment
2. Technique
3. Observation

The Trust continues to focus on four main components:

- Alcohol hand rubs at point of care prominently positioned by each patient so that hands can be cleaned before and after care within the patient's view.
- Audit of hand washing practice at least monthly. Wards that do not achieve 95% repeat the audit after 2 weeks.
- Patients are encouraged to challenge staff if they have any doubts about hand hygiene and in cases of repeated non-compliance, escalation of concerns.
- Raised awareness of hand hygiene and the 'Bare below the elbow' dress code



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Percentage	95.00%	98.00%	91.50%	96.20%	97.00%	92.00%	98.70%	100.00%	97.00%	96.00%	96.00%	95.00%

ROH has been exceeding the threshold of 90% set by the Commissioners in 2016/17.

9 Staff information and training

9.1 Staff information

- Alert Organism surveillance is reported to the Trust by the IPC Nurses daily
- Monthly ward based / Divisional surveillance data is produced, including surveillance information on MRSA and Clostridium Difficile
- The IPC Team have held promotional activities throughout the year promoting infection prevention with good practice being targeted at both staff and visitors to the Trust
- Intranet: The IPC Team continues to make use of the intranet for providing staff with an easy access portal for information, policy guidance and team contact details. This information is regularly updated
- Norovirus and other toolkits are available for all ward areas. This toolkit includes everything that staff requires to help them manage infections, such as posters, information for relatives / visitors etc.
- Posters and information leaflets are displayed throughout the Trust. These provide key infection prevention messages and actions for staff, public and visitors
- Occupational Health have been invited to attend the Infection Prevention and Control Committee

9.2 Staff Training

The IPC Team continue to have a strong training role within ROH. Educational sessions have been delivered throughout the year as part of Mandatory Training, which included programme of mandatory training sessions and induction days. All staff receive IPC training in mandatory training in addition to Sepsis, MRSA, screening and CPE screening decolonisation, Norovirus and Clostridium Difficile.

10 Seasonal Staff Influenza Vaccination Campaign

The seasonal influenza staff vaccination campaign is well established at ROH. The campaign officially commenced on 1st October 2016 with a wealth of information / videos available to staff on the Trust intranet, as well as the locally based influenza champions. The uptake for 2016/17 was 54%.

11 Sepsis

In 2015/16 a deteriorating / septic patient policy was developed. This involved the introduction of a sepsis six tool. The purpose of which is to ensure that any patients who trigger for suspected sepsis are recognised, diagnosed and treated promptly, recommending antibiotics are given within 1 hour of recognition.

In 2016/17 the Trust did not contribute to a sepsis CQUIN. Audits of PEWS, MEWS, fluid balance and sepsis were undertaken monthly by the Matron who leads on Sepsis.

12 IPC Presence

IPC Link Nurses cover all areas due to reduced staffing. They link in with ward staff to provide relevant training and expert advice to staff as well as monitoring compliance. In this way, the work of staff at the Trust was subject to scrutiny and supervision but more importantly clinical staff felt supported and knew who their point of contact was.

13 Bed Management and movement of patients

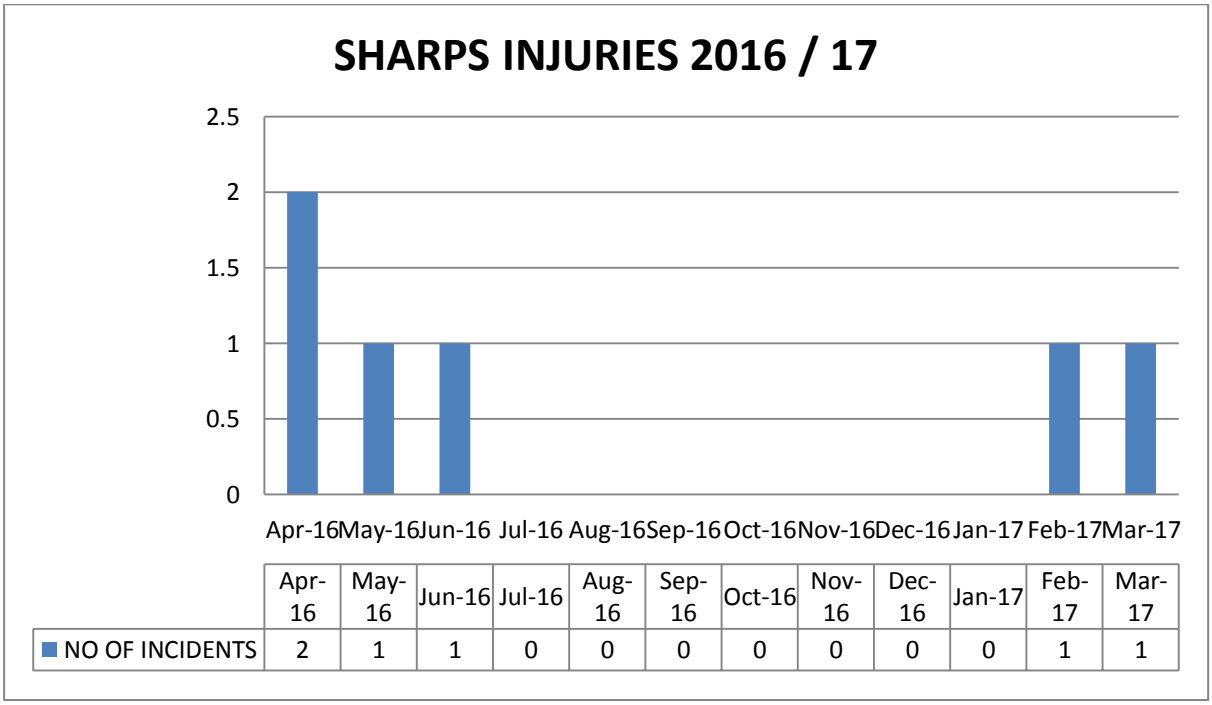
The IPC Nurses work closely with the Bed Management team especially during the winter period, providing timely and expert advice on the management and movement of potentially infected patients. There is a RAG rating system for the use of side room/

isolation facilities available for staff to use to ensure that as far as possible informed decisions are made when considering patient placement.

14 Sharps Injuries

Significant work has been undertaken and an action plan developed as a result of the EU Directive to prevent injuries and infections to healthcare workers from sharp objects such as needle sticks. Sharps used across the Trust have been reviewed and where reasonably practicable either remove or replace with a safer sharp design. In 2016/17 the decision to review the action plan and any risk assessments was taken by the Clinical Nurse Tutor and Health and Safety Advisor. The rationale for this was that new safer sharp products may now be available. This piece of work is ongoing, particularly in theatres where most reported sharps incidents occur.

The sharps policy has been updated and approved. Training relating to sharps injuries is included in all relevant clinical skill training and also on the mandatory training sessions. Sharps safety was also included within a bespoke Infection Prevention training programme delivered Trust wide, 218 clinical staff attended these sessions in 2016/17.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
NO OF INCIDENTS	2	1	1	0	0	0	0	0	0	0	1	1

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

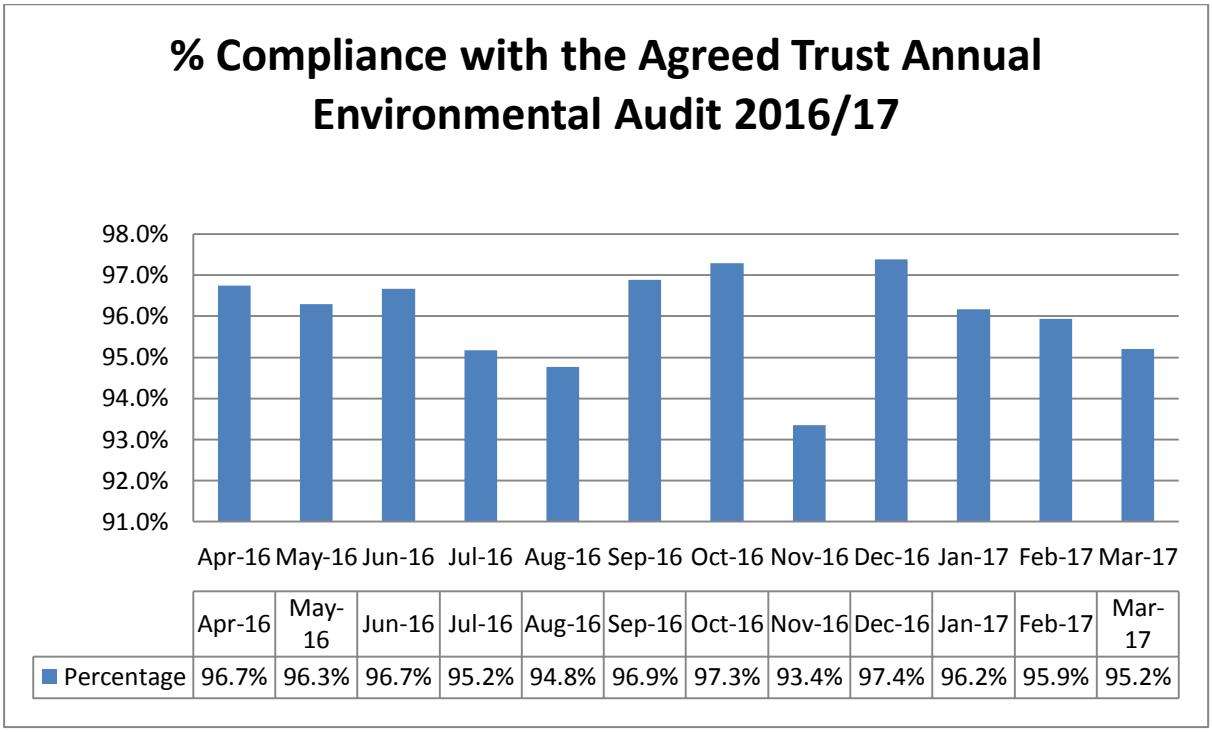
15 Monitoring Processes

There is a designated Facilities Manager for cleaning services that are managed in house. They are committed to providing an outstanding service which is reflected in our Patient-Led assessments of the care environment (PLACE).

15.1 Infection Prevention Meetings

Monthly meetings are held between IPC Team and Facilities to review cleaning scores and discuss any areas of concern.

15.2 PLACE Inspection



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Percentage	96.7%	96.3%	96.7%	95.2%	94.8%	96.9%	97.3%	93.4%	97.4%	96.2%	95.9%	95.2%

Apart from August and November, ROH has been exceeding the threshold of 95% set by the Commissioners in 2016/17.

15.3 The Water Safety Group

The Water Safety group is a sub group of IPCC, reporting directly to IPCC. The Water Safety Group is chaired by the Head of Estates.

15.4 Management of Decontamination

The management and compliance currently falls into three distinct areas;

- Estates – for medical device reprocessing equipment
- Infection Prevention – for monitoring / audit of compliance of medical devices with Trust Policies
- User – to comply with Trust Policies and to ensure all decontamination equipment within their area is fit for use and subject to periodic testing and maintenance

An external peer review was commissioned in May 2016 to review the Decontamination facilities at ROH. An action plan was subsequently developed with work undertaken as a result and almost completed by March 2017.

15.5 Refurbishment Projects

The IPC Team provided advice on number of refurbishment projects throughout the Trust. Facilities also provide an upward report to IPCC.

15.6 Theatres Closure

On 6 June 2016 a decision was taken to suspend all elective surgery on 6 June and 7 June 2016 as a result of blood / bone contamination being visible beyond the perforated casing of the Ultra Clean Air (UCA) canopies in the theatre complex.

On 6 June 2016 after further examination of the HEPA filters in Theatres 2 and 6 a decision was taken to suspend all elective surgery in all ten theatres for a further five days where an extensive cleaning programme was scheduled an undeertaken, from 8 June to 12 June 2016.

All ten theatres were closed at ROH for a period of 7 days from 6 June, elective surgery re-commenced on 13 June 2016.

The blood contamination on the HEPA filters was confirmed by leading expert Peter Hoffman at Public Health England not to be a hygiene issue.

COMPLIANCE CRITERIA 3
Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

16 Sepsis Team

Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with around 32,000 deaths in England attributed to Sepsis annually. Of these it is estimated that 11,000 could have been prevented (NHS England, 2016).

There is a National Sepsis CQUIN: Systematic screening for Sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review.

A sepsis team is in place, the team provide training, support and raising awareness about sepsis Trust wide. Emergency portals now have sepsis champions and provide sepsis training and education to staff.

Sepsis champions continue to be identified in clinical areas to continually drive the process forward.

The Sepsis Team and Antimicrobial Team work closely together. The CQUIN for 2017-18 will be joint sepsis and Antimicrobial.

17 Antimicrobial Stewardship (AMS)

For the period 2016 / 17, ROH participated in a CQUIN for reducing total consumption of antimicrobials. Antimicrobial prescriptions have been audited quarterly to ensure Doctors have been reviewing and documenting the indication and duration of antibiotics. 95% of prescriptions audited as part of the CQUIN on antimicrobial review met the required standards of documentation in all 4 quarters. Therefore this aspect of the CQUIN was achieved. All drug charts are screened by pharmacists who will challenge prescribers who do not document the details required. Antibiotic prophylaxis is also being audited.

Consumption of antibiotics is monitored by the chief pharmacist and analysed for trends. This is reported to the Drugs and Therapeutics Committee (DTC) and IPCC and any areas of concern addressed with microbiologists.

For period 2017/18, there are plans to develop a new AMS committee with a new dedicated Lead Antimicrobial Pharmacist to review all patients on antimicrobials.
The new EPMA system will allow the Trust to monitor prescribing patterns and improve documentation standards for audits. There will be work on the CQUINs as they span 2 years and will target reduction in broad spectrum antibiotics. The antibiotic guidelines are due for review and will be amended and disseminated with targeted education delivered to prescribers, nurses and pharmacists on the new guidelines.

There have been limitations due to not having a specialist antibiotic pharmacist in post at the Trust and several pressures such a national stock shortages of Tazocin which has led to reviewing septic patients more closely. There are plans for Pharmacy to increase their input into the management of Sepsis and Bacteraemias with the IPC Team.

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

18 Communication Programme

The Trust has a dedicated communication team. In cases of outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is sought. The IPC Team ensures that Communications team are involved in the following:

- Advertising infection prevention events
- Communication campaign to inform the public around the management of Influenza and Norovirus, as well as for the staff Flu vaccination campaign and Sepsis
- Updating the Trust website
- Press statements during outbreaks

19 Trust website and information leaflets

The Trust website promotes infection prevention issues and guides users to information on MRSA, Clostridium Difficile and other organisms.

The IPC Team have produced a range of information leaflets on various organisms.

The Trust has a policy on transfer of patients between wards and departments.

COMPLIANCE CRITERIA 5
Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

20 Surgical Site Infection (SSI)

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 ROH with further additional adjustments made that go above and beyond the National Guidance; the wound care helpline is a good example of this.

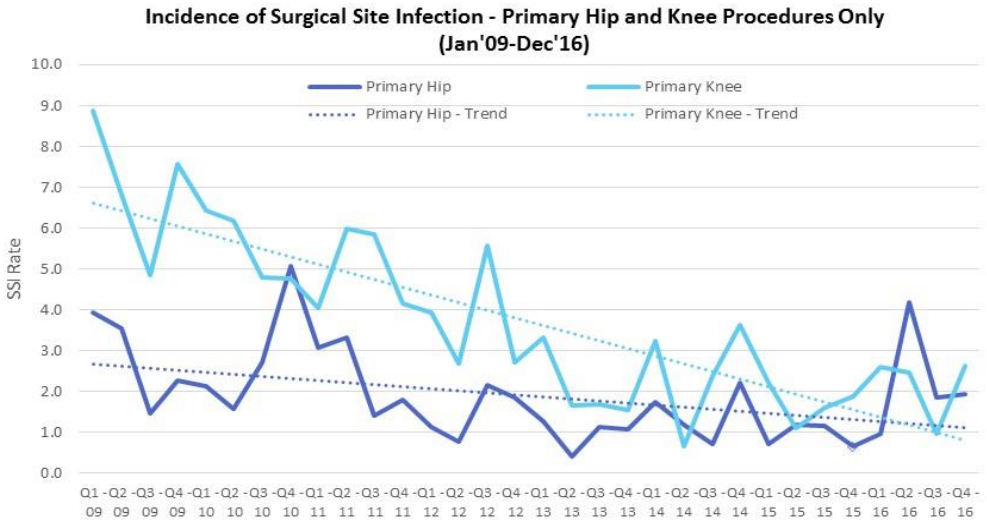
SSI clinics are offered where the patients are usually seen on the same day as the concern is raised. This allows the review of patients by specialist nurses allowing rapid treatment / admission where required avoiding the unnecessary prescribing of antibiotics by GPs.

Period	Action	Evidence	Introduced at ROHFT
Pre-operative	Showering	+ / -	x
	S.aureus decolonisation	+ / -	x
Peri-operative	Antibiotic prophylaxis	+	✓
	Skin preparation	+	✓
	No shaving with razors	+	✓
	Theatre environment/procedures	+	In part - ongoing
	Surgical technique	+	✓
	Normothermia	+	In part - ongoing
	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 ROH. 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.

In addition to this, a 90 day questionnaire is offered enabling the IPC Team to identify further infections outside of the 30 days.

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 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 IPC Team, which looks at a number of other areas of interest. This enables the team to gain an informed understanding of SSI across all divisions and the potential for them to have longstanding implications for patients and significant financial implications for the Trust.



Source: ROH SSI Databases

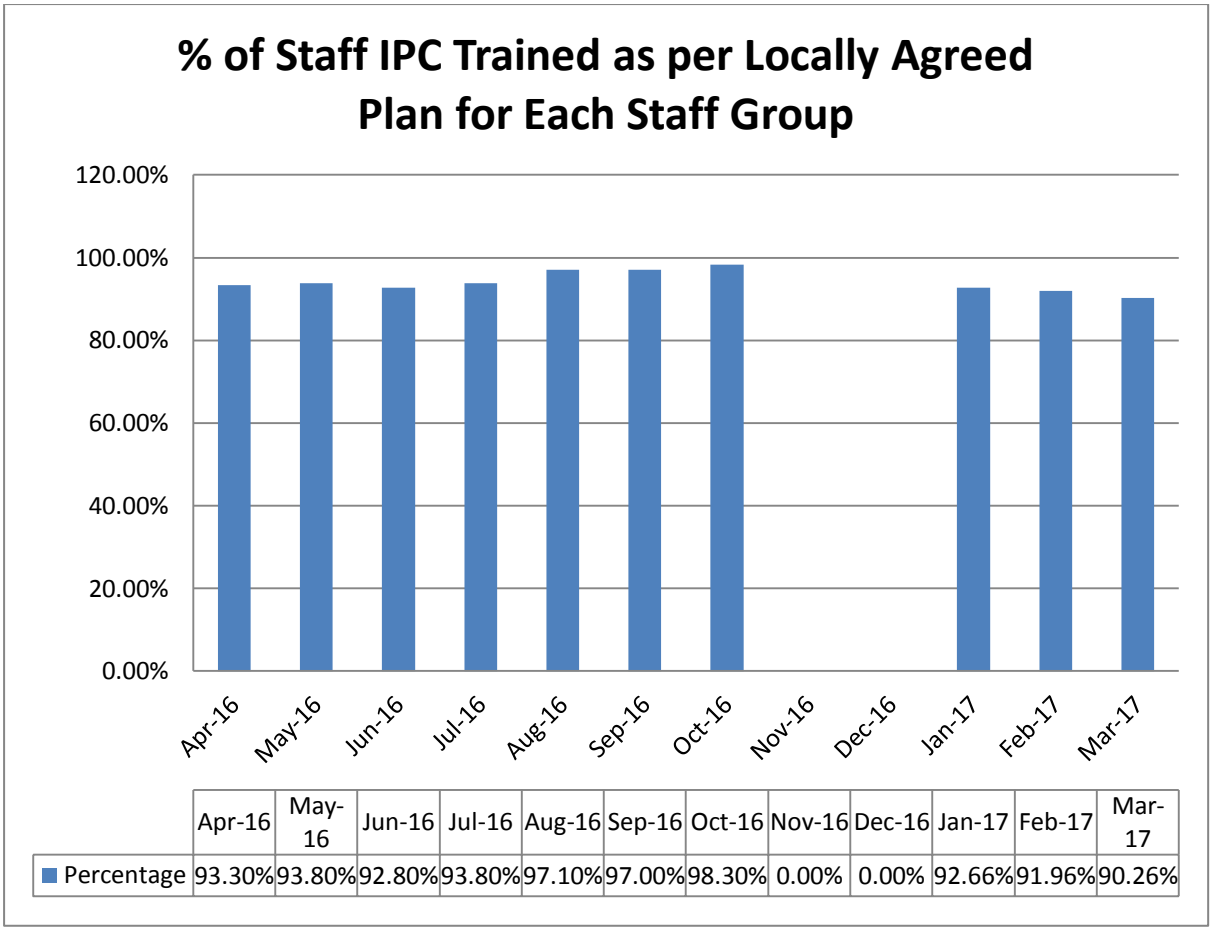
(The data is collated by calendar year as opposed to financial year due to the relevant database being set up and reporting in this method. This will be modified in next year's report to provide data by financial year)

The 30-day post op SSI rate in Q2 2016 was 4.2% for Primary Hip Replacements, 3.5% for Primary Knee Replacements following the cluster of SSIs in during April and May. Preliminary data shows that in Q4 2016 the 30 day SSI rate was 1.9% for Primary Hip Replacements and 2.6% for Primary Knee Replacements. There was a decrease in infections during Q3 2016, however, in Q4 There was an increase in SSIs.

COMPLIANCE CRITERIA 6
Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharge of and discharge their responsibilities in the process of preventing and controlling infection

At ROH infection prevention is everyone's responsibility and is included in all job descriptions**.**

All clinical staff receive training and education in optimum infection prevention practices during mandatory training and Link Nurse teaching sessions.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Percentage	93.30%	93.80%	92.80%	93.80%	97.10%	97.00%	98.30%	0.00%	0.00%	92.66%	91.96%	90.26%

A target of 90% set by the Commissioners was exceeded every month apart from November and December 2016 where training did not take place.

COMPLIANCE CRITERIA 7
Provide or secure adequate isolation facilities

The Trust has;

Wards

36 Side Rooms with en-suites.

3 Side Rooms without en-suite.

HDU

2 Adult Side Rooms without en-suites.

2 Children Side Rooms with en-suite.

Isolation audits were undertaken in May 2016 with 97.14% compliance, October 2017 with 100% compliance and March 2017 with 97.14% compliance with the Trust's Isolation Precaution Tool.

COMPLIANCE CRITERIA 8
Secure adequate access to laboratory support as appropriate

Laboratory services for ROH are outsourced, located in the purpose built Pathology Laboratory at University Hospitals Birmingham. The Microbiology Laboratory has full Clinical Pathology Accreditation (CPA) and has been recommended for UKAS Accreditation to ISO Standard 15189.

COMPLIANCE CRITERIA 9
Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

All policies and manuals are available for staff to view on the Trust intranet. Clinical Governance has produced a directory of policies alerting when policies are due for update. Policies are also updated prior to review date if guidance is updated.

Policies available on the intranet include;

1. ANTT Policy
2. BIU Referral Proforma for Clinical Information
3. Blood and Body Fluid Spillages Policy
4. Clostridium Difficile Policy
5. Hand Hygiene Policy
6. Influenza Policy
7. IPCT guidance Transfer of infected patients
8. IPCT Policy - Communicable Diseases and Notification Policy
9. Major Outbreak Policy
10. MRSA Policy
11. Procedure for the Control of Varicella Zoster Virus (Chickenpox Shingles)
12. Season Flu PGD Oct 2015.doc Season Flu PGD Oct 2015
13. SOP - Use of Ice Machine

14. Standard Precautions and Personal Protective Equipment Policy
15. When to contact Infection Control

A gap analysis will be undertaken on the policies available at the Trust compared to the policies recommended by the Hygiene Code (Health & Social Care Act 2008).

COMPLIANCE CRITERIA 10
Providers have a system in place to manage the occupational health needs of staff in relation to infection

All job descriptions include infection prevention responsibility and this message is reiterated during mandatory training. The IPC Team participate in mandatory updates for all staff groups (clinical and non-clinical). The IPC Team regularly meet with representatives of the Occupational Health service to ensure compliance with Criteria 10.

Occupational Health services are provided to staff via an SLA with the Heart of England Foundation Trust.

21 Staff Training

The IPC Team continue to have a strong training role within ROH. Educational sessions have been delivered throughout the year, which included programme of mandatory training sessions and induction days in addition to Sepsis, MRSA, CPE, screening and decolonisation, influenza, Norovirus, Clostridium Difficile, winter planning, water safety / flushing, Tuberculosis and Link Nurse bi-monthly sessions.

Clostridium Difficile training was refreshed during 2016/17 and work commenced to extend this session to be available to staff online.

22 Conclusion

Infection Prevention and Control is a key marker of patient safety at ROH, as it encompasses a broad range of factors, from the state of the environment through to the effect of antibiotic use on the selection of organisms such as Clostridium Difficile and MRSA. This requires the involvement of all staff, on an ongoing basis, and the IPC Team are central to this.

The Trust has a number of challenges:

- Reducing the incidence of CDI avoidability;
- Sustainability of Infection Prevention practices across the Trust;
- Monitoring of pharmacy / prescribing data;
- Monitoring of Surgical Site Infections
- National / International threats, e.g. multi-resistant Gram Negative Bacilli; emerging respiratory viruses;
- Reduction of Gram negative blood stream infections by 50% by 2021;

ROHTB (11/17) 005

TRUST BOARD

DOCUMENT TITLE:	**CQC Preparation**
SPONSOR (EXECUTIVE DIRECTOR):	**Garry Marsh, Executive Director of Patient Services**
AUTHOR:	**Ashleigh Tullett, Clinical Governance Manager**
DATE OF MEETING:	**1 November 2017**

EXECUTIVE SUMMARY:

The attached summaries the recent activity with providing the care Quality Commission with information as part of its routine data collection.

It also highlights the recent focus groups that have been organised by the CQC and outlines the plans for strengthening the ROH's position against the various elements of the regulatory framework ahead of the anticipated inspection of the Trust later this year or early next year.

REPORT RECOMMENDATION:

Trust Board is asked to:

- RECEIVE and NOTE for assurance

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		Workforce	X

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

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

Safe, efficient processes

PREVIOUS CONSIDERATION:

Executive Team

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PREPARATION FOR THE CQC INSPECTIONS

REPORT TO THE TRUST BOARD ON 1 NOVEMBER 2017

1. Background

Our regulators, the Care Quality Commission (CQC), have recently instructed the Trust to provide a set of information as part of its routine data request process. It has also notified the Trust of some scheduled engagement & feedback sessions and requested the Trust delivers a series of presentations from identified specialities. The Trust has been informed it will be notified of a date for the announced Well Led inspection to take place, with an associated unannounced inspection of one or more of the Trust's core services, before this date.

This paper details both these and the Trusts' preparation plans in readiness for our CQC inspection.

2. The CQC Data Request (Routine Provider Information)

The request will be sent annually. However, the date the Trust receives the request may not be the same every year, but it will be limited to one annually.

The data request contained a mixture of quantitative and qualitative questions that the CQC asked the Trust to answer, as well as a list of documents that the CQC required the Trust to submit.

The **qualitative** questions, asked the Trust to provide an answer within a stipulated word limit.

The **quantitative** questions covered among other things, information about the services the Trust provided, performance and activity data.

The Trust submitted this data request, meeting the CQC deadline of Monday 25th September 2017.

The key issues identified in this submission which needed clarification or strengthening were:

1. Medical Locums collection system;
2. Suspensions of staff and supervised practice database;
3. Clinical Audit: Key successes and concerns evidence;
4. Clinical Supervision for all staff groups process and policy;
5. Patient movement for non-clinical reasons;
6. Audit of the care with patients with complex needs;
7. Lost to follow up figures;
8. Non-executive director lead for complaints;
9. Lack of Innovative practice examples;
10. Lack of a bereavement survey;

11. Call answering rates from call centres.

3. CQC drop-in feedback sessions

The CQC visited the Trust on Thursday 26th October 2017 to facilitate a series of drop-in feedback sessions with our staff. The CQC use this methodology to gain the opinion of our staff about the 'good' and 'bad' aspects of working at The Royal Orthopaedic Hospital. Each session focussed on a particular staff group, these being:

- Healthcare Assistants, Students &Administration Staff
- Band 7 +
- Junior doctors
- Band 5 and 6
- Consultants

The intelligence gained from these sessions will potentially be used to inform and tailor the CQC's future inspection of the Trust.

4. Speciality Presentations

On the 2nd November 2017, several department/unit leads will present to CQC representatives. They will each give a 15 minute presentation describing an overview of the speciality. The Communications Department has issued a standard presentation pack for use.

The specialities identified to present are;

Division 1

Oncology
Arthroplasty
Spinal
OPD

Division 2

Day case
HDU
Theatres

5 CQC Inspection

In preparation for our CQC inspection, the Trust has developed a CQC improvement action plan that will support and highlight any immediate actions and help develop a better understanding of the compliance against the CQC key lines of enquiry (KLOE). This action plan is being led by the Executive Director of Patient Services.

The actions include:

- Each Executive Director will oversee the CQC key lines of enquiry (KLOE) and ensure there is the development of a robust action plan for the areas that fall short of the CQC KLOE;

- All the internal and external assurance visits that have been undertaken will be reviewed from the last 12 months to ensure actions & learning has been implemented and the frequency of visits reviewed;

- The previous CQC report and action plans will be reviewed to ensure the improvements have been made and ongoing sustainability is evident;

- Review the Trusts internal governance structures;

- The Trust will review self-assessments from the West Midlands Quality Review Service for
  - Quality and Governance;
  - Theatres & Anaesthesia;
  - Dementia;
  - Musculoskeletal Pathway;
  - Falls & Fragility;
  - Conclude the closure and monitoring of the WMQRS action plan for Care of the Critically Sick Child.

- Improvements are to be made to the Trusts Risk management system with conclusion of the ULYSSES action plan;

- The Trust will review the current status of all training and the status of policies within the Trust;

- The shortfalls in the recent data submission to the CQC as detailed earlier will be addressed;

6 Recommendation

The Trust Board is recommended to receive and note this update.

Garry Marsh
Executive Director of Patient Services

27 October 2017

ROHTB (11/17) 006

TRUST BOARD

DOCUMENT TITLE:	**Perfecting Pathways**
SPONSOR (EXECUTIVE DIRECTOR):	**Jo Williams, Interim Chief Operating Officer**
AUTHOR:	**Jo Williams, Interim Chief Operating Officer**
DATE OF MEETING:	**1 November 2017**

EXECUTIVE SUMMARY:

Perfecting Pathways (previously 'Scheduled Care Improvement Programme') is the means by which the Trust will deliver its six key priorities by March 2018.

Four work streams have been developed, and a set of standards for teams to implement in each area:

1. Referral to Outpatients
2. Pre-admission & Pre-assessment
3. Theatres
4. Outpatients & Discharge

The paper describes the programme and governance structure, the communication plan and how progress will be monitored.

REPORT RECOMMENDATION:

Trust Board is asked to:

- RECEIVE and NOTE for assurance

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		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:

Safe, efficient processes

PREVIOUS CONSIDERATION:

The Board received an update at its meeting on 4 October 2017.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

PERFECTING PATHWAYS

Perfecting Pathways - Proposed project structure

REPORT TO THE TRUST BOARD – 1 NOVEMBER 2017

Context

Perfecting Pathways (previously 'Scheduled Care Improvement Programme') is the means by which the Trust will deliver its six key priorities by March 2018. This is not a typical, standalone project with pre-defined milestones, deadlines & outcomes. Rather, it is a framework to enable staff to change how they work, delivering real-time efficiencies and ultimately resulting in improved patient outcomes & experience.

The King's Fund (2017) state that the key principles common to all quality improvement:

- Training staff in the nature of systems
- Using data to understand variation
- Giving all staff the opportunity to contribute and act on ideas for improvement
- Using many small-scale trials and tests as a way to learn & improve
- Ensuring a continuous focus on the needs and experiences of the people served by the system

Lessons from The King's Fund (2017)

10 key lessons for NHS leaders	Example of proposed action at ROH
1. Make quality improvement a leadership priority for boards	• Perfecting Pathways will be reported monthly via Finance & Performance, and Trust Board
2. Share responsibility for quality improvement with leaders at all levels	• Engagement will be at all levels, with support from line managers to enable their staff to enact change
3. Don't look for magic bullets or quick fixes	• Weekly reporting will demonstrate small, incremental change
4. Develop the skills & capabilities for improvement	• Currently sourcing medium-term solution for improvement training programme
5. Have a consistent & coherent approach to quality improvement	• Central management through Project Team
6. Use data effectively	• Consistent reporting of data to map trends
7. Focus on relationships and culture	• Corporate messaging – 'working together'

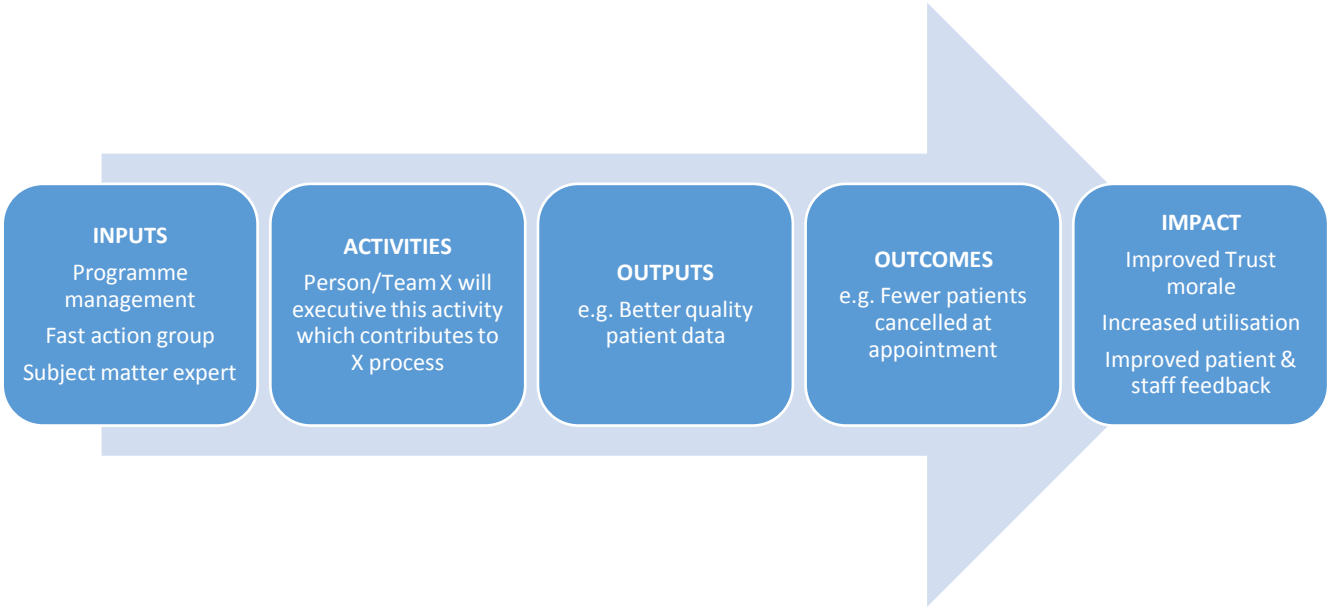
8. Enable & support frontline staff to engage in quality improvement	• Project 'facilitators' deployed to support frontline staff with change initiatives
9. Involve patients, service users and their carers	• Patient involvement in redesign of ADCU pathway
10. Work as a system	• Working with colleagues in primary care to deliver Functional Restoration Programme in the community

The workstreams

The key goals associated with each workstream are as follows:

Key aim	How will we do this?	What are the benefits for patients and the hospital?
Increase outpatient appointments and reduce waits	• Text reminders • Improved clinic utilisation • Access to notes for clinics • Increase clinic availability	• Reduced waiting times (RTT) • Reduced waiting times (in OPD) • Reduction in DNAs • Reduced cancellations
Increase in patients fit for surgery & reduction in theatre cancellations due to patient fitness	• 72 hour calls • Review of POAC & ADCU pathways • Increase utilisation of POAC	• Reduced pre-admission length of stay • No late cancellations due to patient fitness • Reduced time waiting in ADCU on day of surgery
Increase in theatre utilisation & activity throughput	• Increased list & in session utilisation • Reduced turnaround delays • Increased cases per session	• Reduced cancellations
Reduced length of stay	• Increase patients on Rapid Recovery (opt out) • Discharges before 11am	• Patients mobilised earlier • Reduced time in hospital

Project structure: what will be tracked?

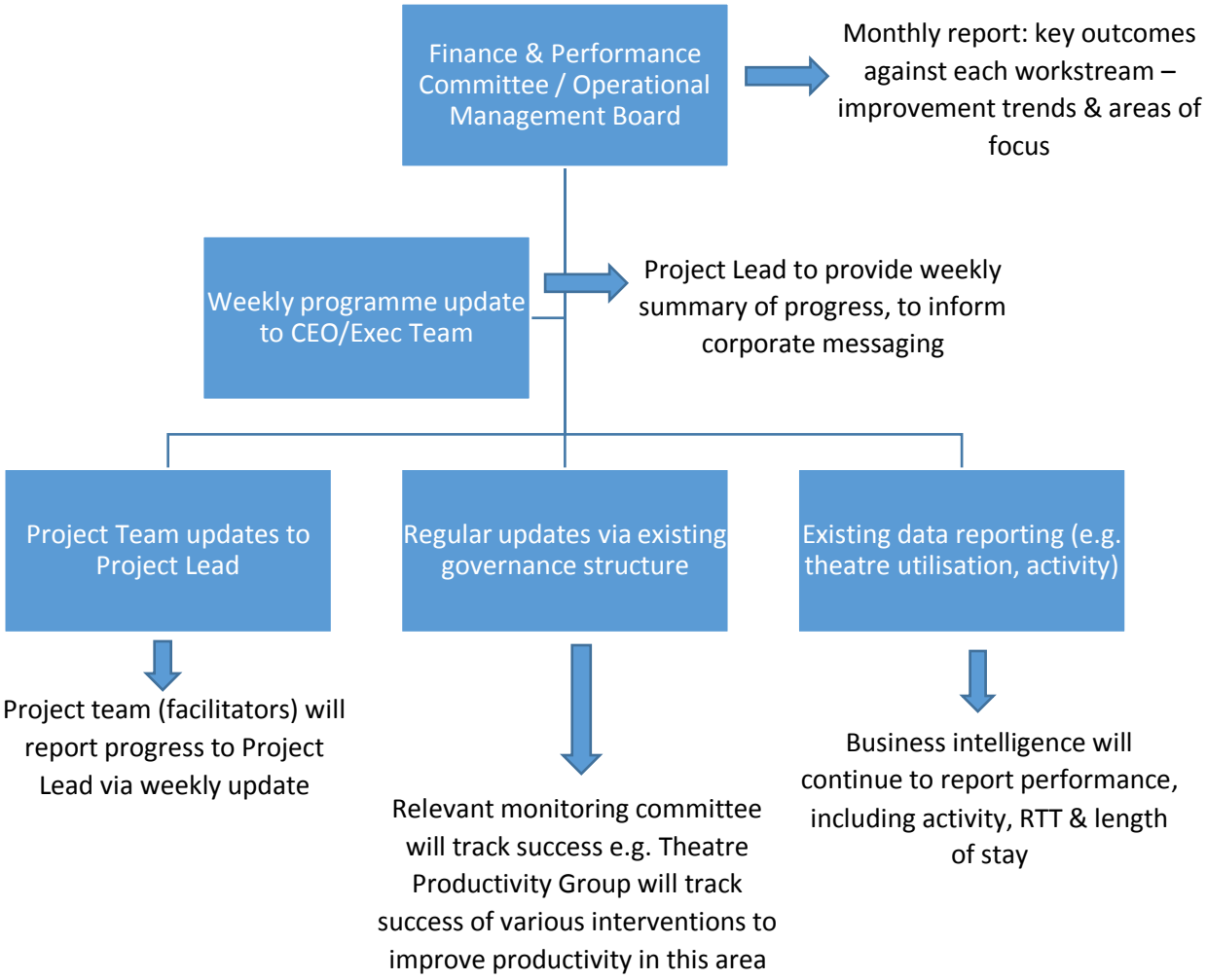


Corporate change

It is recognised that the four workstreams described above are predominantly clinically based. Therefore, corporate services will also play a part in delivering improvements, with a focus on:

- Communications – improving how we share success, demonstrating impact of working together and evidencing measurable impact of staff-initiated improvement
- Competency – focusing on staff competencies to deliver their role, managing this through the PDR process and address issues in performance
- Recruitment – ensuring that recruitment processes are as efficient as possible to reduce vacancies and expedite improvements
- Data insight – working with teams to ensure that the right data is being entered onto the right systems, and improving transparency of data across the organisation
- Coding efficiency – continuing with clinical coding project to maximise income potential

Governance – reporting through existing meeting structure



Project team responsibilities

The Project Team (led by Rebecca Buswell & Jonathan Bamford) will be responsible for developing and maintaining a project plan to include all improvement schemes (no matter how 'small'). There will be no requirement for staff to complete regular reports – updates will be provided through face to face engagement, and via existing governance routes.

Improvement workstream	Improvement scheme	Lead	Impact on existing role	Short/Medium/ Long Term	Key metrics
e.g. Inpatients & Discharge Planning	Training session for all nursing staff on complex discharge	S Smith	Reduced weekly meeting commitment (+5hrs)	Short	Length of stay

The extended Project Team will include a **dedicated resource team** who are deployed to support staff with specific improvements that require their skill set, for example:

- How to develop a cost improvement plan and quality impact assess it
- How to write a business case
- How to approve a new way of working
- How to develop a new operational model
- How to realise non pay savings
- How to communicate change with patients / staff
- How to share learning with other teams

Communications will be sent out to promote this resource to all teams, and this was reiterated at Operational Management Board on 25 October 2017.

Process for enacting change

Steps	Action
Step 1	Staff member makes a recommendation to change something in their area
Step 2	Project Lead validates the proposal and adds to project plan
Step 3	Project Team provides improvement support to make it happen
Step 4	Relevant group requested to monitor progress
Step 5	Outcomes are recorded by Project Team

The Project Team will use the pro forma at **Appendix A** to capture the key information for the improvement initiative.

Measuring & reporting outcomes

A set of key outcomes will be aligned against each workstream. These metrics are already reported through Finance & Performance Committee on a monthly basis, and therefore the Project Team will coordinate a report that shows either upward or downward trends that will demonstrate where the change initiatives are having a real and measurable impact.

Communications plan

Each Monday, there will be an email from the CEO to all line managers in the Trust sharing the realtime progress that has been made against each workstream. This is intended to be a motivating message to our leaders, and demonstrating improvements as a result of their teams working differently. This will commence from 30 October 2017.

The Trust will be using the new branding for Perfecting Pathways on all corporate messaging, and 'flooding' the organisation with posters promoting progress that has been made against each of the workstreams. The example format of these posters is as follows:

What needed to be improved?
We were not booking patients far enough in advance, and sometimes only had half the number of patients booked that we needed two weeks in advance

What did we do about it?
We changed the way that we book patients. The medical secretary team now make sure that patients have been pre-assessed and check they are available for surgery, before booking them in to a theatre slot directly.

What is the outcome/ impact
The number of patients booked in for surgery has increased by: 1 week out - 15% 2 weeks out - 43% 3 weeks out - 53%

In addition, NHS Fab Change Week takes place from 13 – 17 November, and the Trust will maximise this opportunity to engage staff at all levels (ahead of this week) to commit to making a small change in their area.

Continuous improvement – short & medium term plan

The intention is for this programme to commence immediately, and therefore there is an expectation that existing staff will be deployed with service improvement skills to coach and facilitate change. The medium-term plan is for external expert training to be sourced to train more of our staff in the skills required to lead service transformation.

Summary

The Perfecting Pathways programme aims to empower and enable staff to make real-time improvements in their areas. The impact of these changes will be closely monitored by the project team and reported via existing committee routes, as well as promoted through a variety of communication channels to ensure that every team can see where they are having an impact on achieving the Trust's priorities for 2017-18.

Recommendation

The Trust Board is asked to receive and accept this update.

Joanne Williams
Interim Chief Operating Officer

27 October 2017

Appendix A

Perfecting Pathways
Data Gathering Form

Name	Location	Function

Intervention.....
Description.....
.....
.....

Inputs
1
2
3

Activities
1
2
3

Outputs
1
2
3

Outcomes
1
2
3

Impact
1
2
3

Commencement Date.....

Additional Information

Finance and Performance Report

SEPTEMBER 2017

CONTENTS

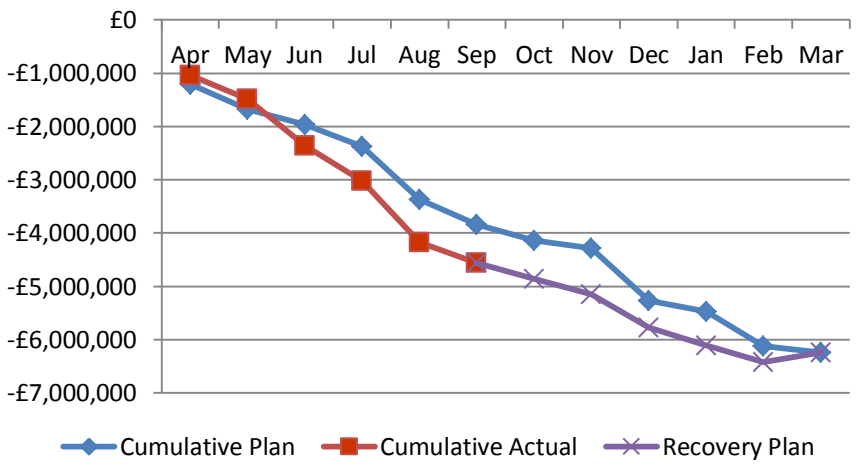
INTRODUCTION

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.

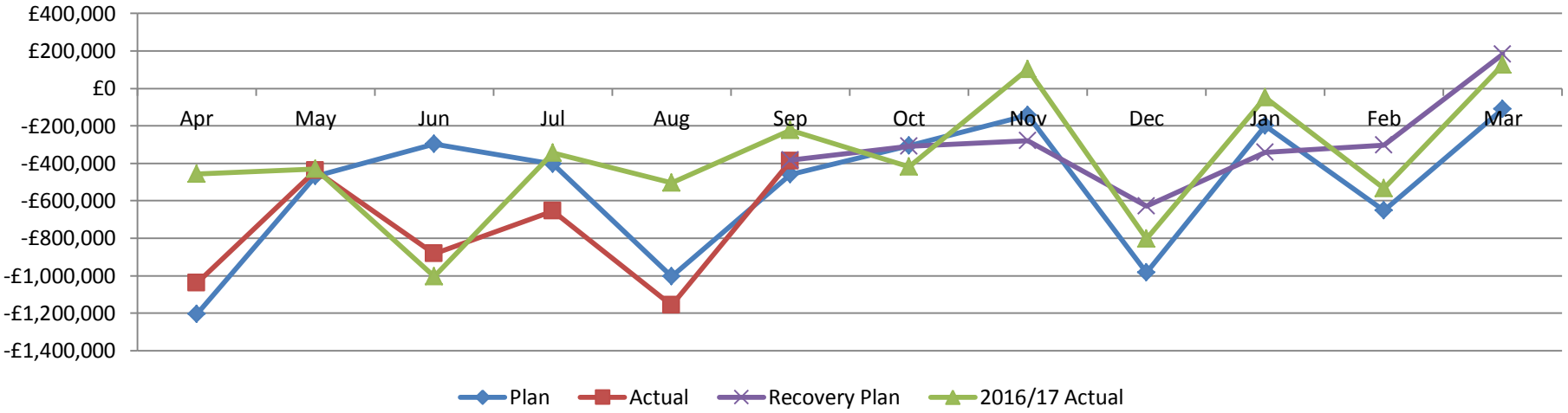
1. Overall Financial Performance – This illustrates the total I&E surplus vs plan, and how this relates to the NHSI Use of Resources Rating (UOR)

Cumulative Deficit vs Plan



NHSI Use of Resources Rating (UOR)		
	Plan	**Actual**
Capital Service Cover	4	4
Liquidity	4	4
I&E Margin	4	4
I&E Margin – Variance against plan	1	4
Agency metric	1	2
Overall UOR	N/A	4

Monthly Surplus/Deficit Actual vs Plan



INFORMATION

The Trust has delivered a deficit of £389,000 in September against a planned deficit of £461,000, a result £72,000 ahead of plan. This brings the Trust's year to date position (on a control total basis) to £4,532,000 against a plan of £3,965,000, being £567,000 behind plan.

The Trust has developed a recovery plan, which was submitted to NHS Improvement in October. This demonstrates how, through a combination of increased activity and reduced cost, the Trust expects to meet its control total by the end of the financial year. The first month of the recovery plan was the September financial position, and forecast a deficit of £382,000. The Trust was therefore £7,000 behind recovery plan in month.

Drivers for the year to date underperformance against plan include spend on improving RTT reporting (just over £500,000 year to date), poor activity performance in the earlier months of the year (partially due to the inability to operate at Birmingham Children's Hospital in April and May, and also the hard down of the MRI for a period of nearly 2 weeks). The RTT validators are expected to be finished on site at the end of October as the Trust moves further into business as usual validation. The unexpected factors resulting in an underperformance against plan have been partially offset however with £101,000 of fire insurance income not expected to be received.

Whilst the in-month position is almost in line with the recovery plan at a deficit level, the expected position against income and costs is significantly different to expectation as is described further in the forthcoming slides.

As at the end of September, the Trust has recognised £845,000 of CIP savings, against a plan of £1,570,000. £144,000 (5%) of savings to date are non-recurrent. A review of the original CIP Plans is underway and has highlighted some areas of risk but also some new areas of opportunity. As such a revised CIP Plan has been drafted with forecast CIP of £2,758,000 against an original plan of £3,191,000. The revised forecast has been assumed within the recovery plan.

With regards to the Trust's Use of Resources Risk Rating (UOR), the deficit position against plan results in the Trust reporting ratings of 4 for Capital Service Cover, I&E Margin and I&E Margin variance. The negative variance from plan has also resulted in a 4 for I&E Margin Variance. The Trust's requirement for cash support has resulted in the Trust being a 4 for liquidity. Year to date agency spend is higher than year to date agency cap and as a result the agency rating remains at a 2. As a result, the overall rating for September remains at a 4.

ACTIONS FOR IMPROVEMENTS / LEARNING

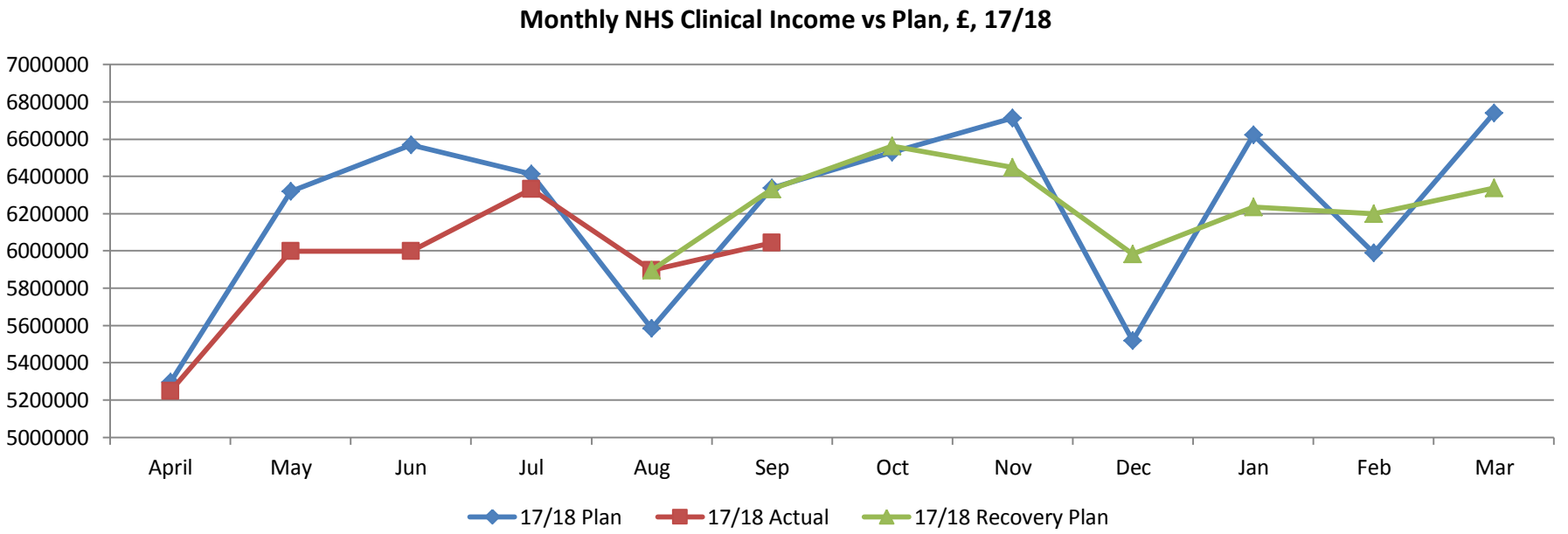
The Trust Executive are monitoring weekly progress against activity improvement and the Perfecting Pathways Project. In addition, fortnightly meetings are being held with operational, clinical and finance stakeholders to improve the theatre environment and give better visibility of stock levels and spend.

A review of the robustness of CIP plans has been undertaken which has highlighted a renewed focus is needed on delivery the current CIP plans.

RISKS / ISSUES

There remains a risk that the focus on RTT and operational activity delivery results in CIP schemes not being implemented in a timely enough manner to ensure the required savings for 2017/18.

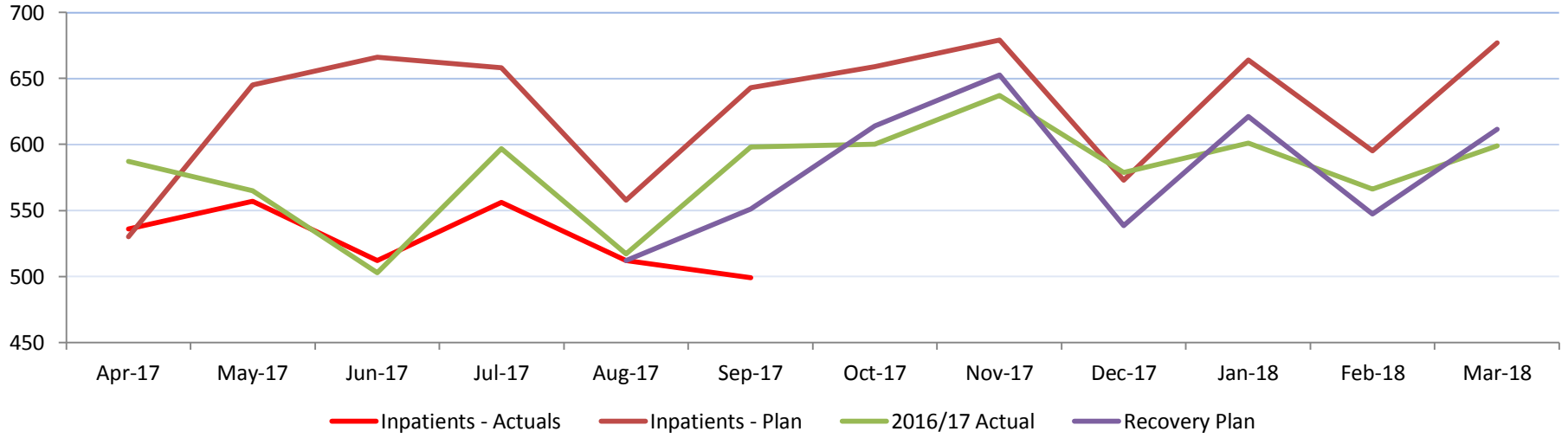
2. Income and Activity– This illustrates the total income generated by the Trust in 2017/18, including the split of income by category, in addition to the month's activity



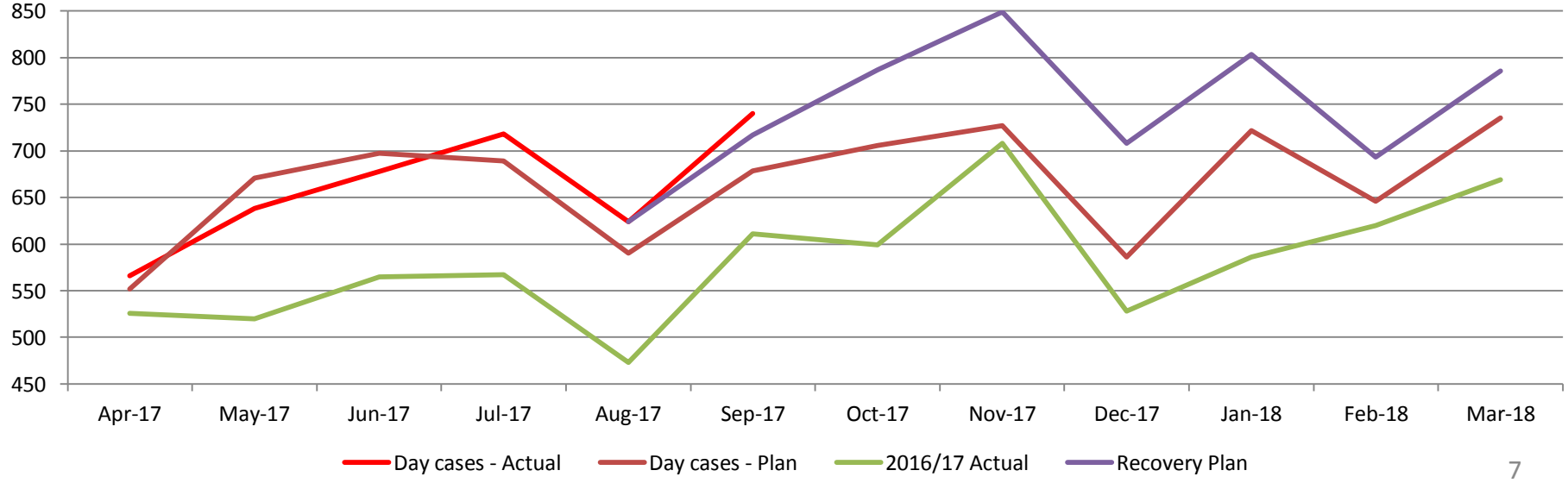
NHS Clinical Income – September 2017 £'000			
	Plan	Actual	Variance
Inpatients	3,220	3,192	-28
Excess Bed Days	100	62	-38
Total Inpatients	3,320	3,254	-66
Day Cases	779	870	91
Outpatients	622	615	-7
Critical Care	250	113	-137
Therapies	248	224	-24
Pass-through income	223	187	-36
Other variable income	378	260	-118
Block income	518	518	0
TOTAL	6,338	6,041	-297

NHS Clinical Income – Year To Date 2017/18 £'000			
	Plan	Actual	Variance
Inpatients	18,488	18,366	-122
Excess Bed Days	574	300	-274
Total Inpatients	19,062	18,666	-396
Day Cases	4469	4352	-117
Outpatients	3572	3606	34
Critical Care	1432	1065	-367
Therapies	1424	1321	-103
Pass-through income	1278	1301	23
Other variable income	2174	2092	-82
Block income	3108	3108	0
TOTAL	36,519	35,511	-1,008

Inpatient Activity



Day Case Activity



INFORMATION

NHS Clinical income has under-performed against plan by £297,000 (4.9%) in September against plan, and a similar value behind recovery plan. This result is being driven both by overall activity levels, and by the mix of the activity delivered. Elective and Day case activity against plan has been shown below.

	Elective	Day Case
Actual Activity	499	740
Original Plan	643	678
Variance	(144)	62
Actual Activity	499	740
Recovery Plan	551	716
Variance	(52)	24

Day case activity therefore overperformed against both recovery and original plan, but not to the extent required to offset the elective underperformance and deliver the income target.

Elective underperformance has also driven the Critical Care underperformance identified.

ACTIONS FOR IMPROVEMENTS

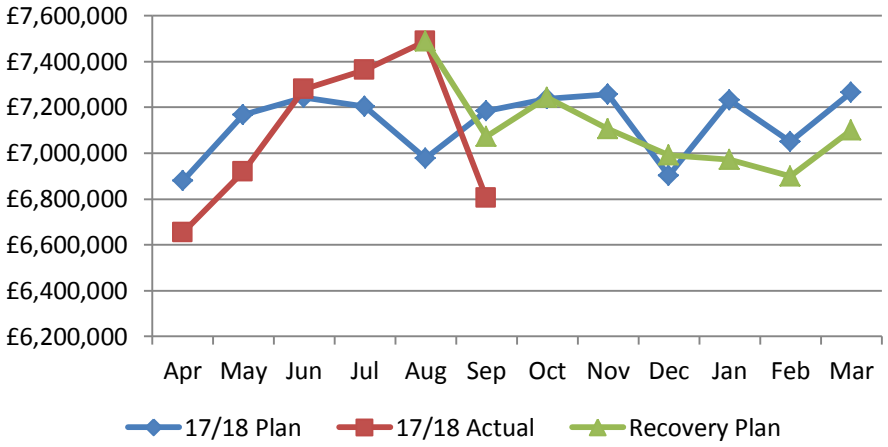
The firms have developed their recovery activity plans and are taking the actions through the Perfecting Pathway project to improve efficency and deliver additional activity. In addition they are working with key stakeholders around the Trust to ensure additional lists are performed where possible, through either additional 3 session days or weekend working. Some of the specifics of the Perfecting Pathways project are explained in further detail later on within this report.

RISKS / ISSUES

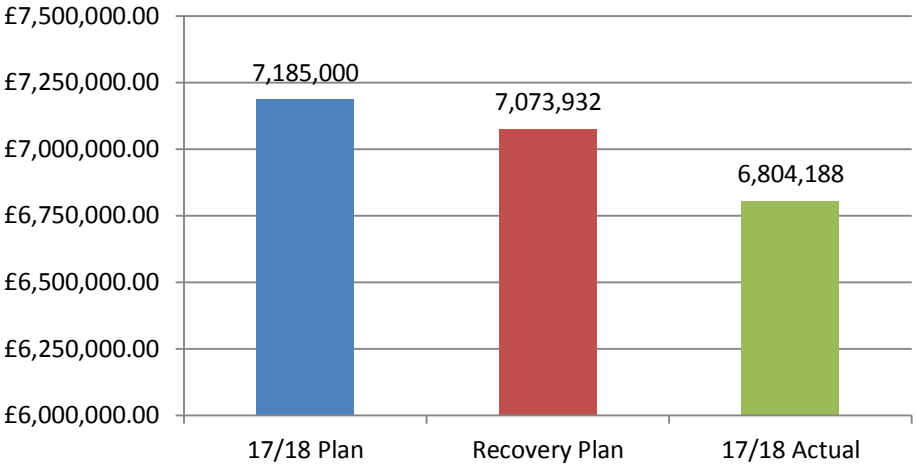
As in previous months, there remains good clinical engagement in developing improvements to productivity for both operations and out patients. Some consultants have very short, with others having very long, waiting lists, and work is underway to smooth out flows across firms. As noted above, a key risk will be the ability of the Trust to staff the lists offered by the consultant body in order to maintain clinical buy-in in recovery. There are also key times over the next few months, such as the Christmas period, where additional activity is being planned for. It will be vital to ensure that actions are taken sufficiently early to make patients aware of Christmas operating and ensure they are fit and willing to attend.

3. Expenditure – This illustrates the total expenditure incurred by the Trust in 2017/18, compared to historic trends

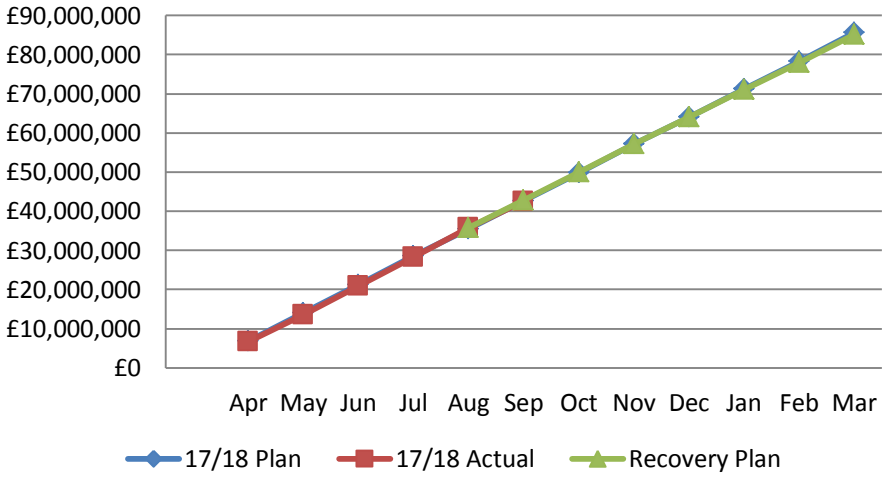
17/18 Monthly Expenditure vs Plan



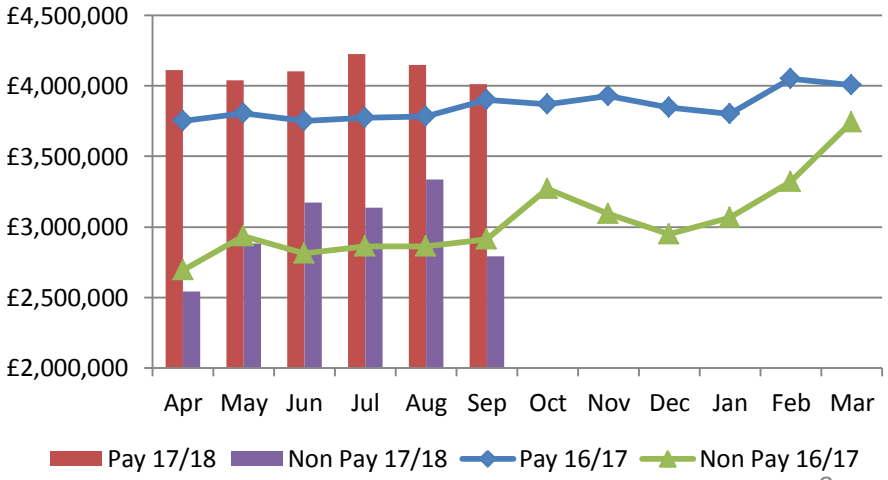
17/18 M6 Expenditure vs Plan



Cumulative Expenditure vs Plan 17/18



16/17 vs 17/18 Pay & Non Pay Spends



INFORMATION

Expenditure levels for the month were £6,804,000, which is £381,000 lower than the in month plan of £7,185,000 and £270,000 lower than the recovery plan of £7,074,000.

The reason for the overspend was non-pay spend being significantly lower than planned, and this has been driven by a significant reduction in theatre non-pay costs. Early indications as to the reasons for this reduction from discussions with the new theatre management team are that there was bulk buying of consumables occurring, which has now been stopped. As described at the last meeting, a new theatres group of operational, clinical and financial staff has been set up to identify the key issues within theatres, which is recognised as key to the Trust's success with recovery. One of the urgent actions from this group is that a full stock count is being planned for early November which will give further assurance over the stock costs.

Pay spend was largely in line with the plan. When the pay categories are reviewed individually, substantive spend was behind plan by £131,000, bank spend ahead of plan by £123,000, and agency spend higher than plan by £51,000. As noted in the year to date reports, it is clear from a review of the bank plan that this was erroneously set too low in each month, with the balance being taken from substantive pay. When the plans are corrected to what they should have been set as, the spends are much more in line with plan.

ACTIONS FOR IMPROVEMENTS / LEARNING

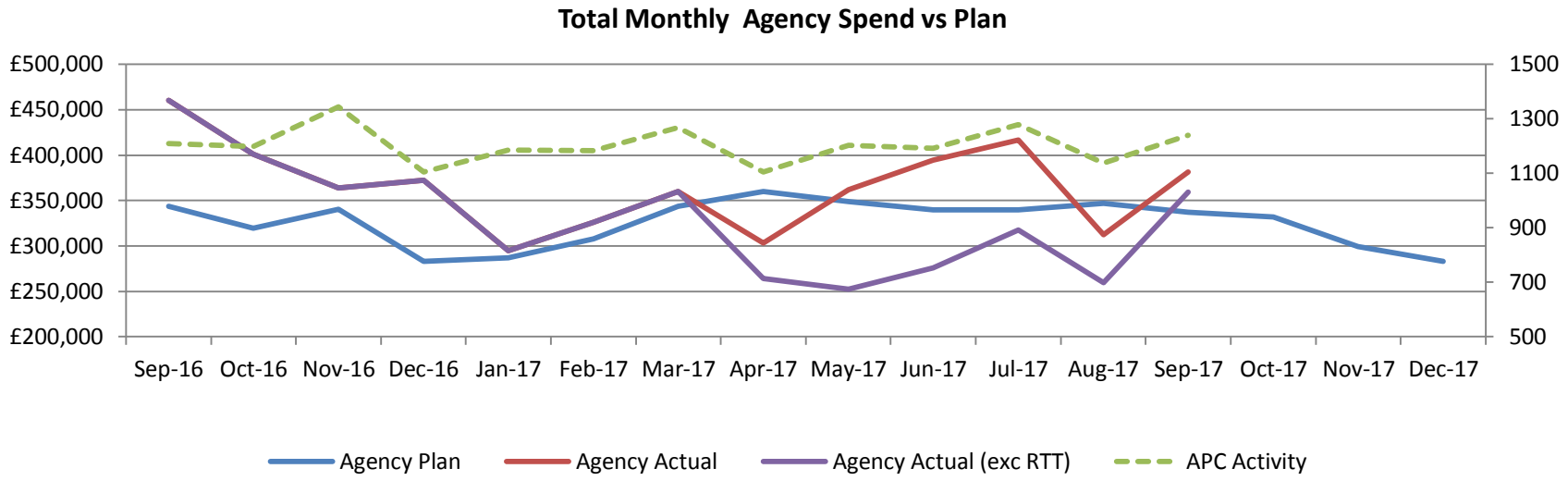
Costs will continue to be scrutinised and minimised, and the alteration of the bank spend plan will be followed up further with NHS Improvement.

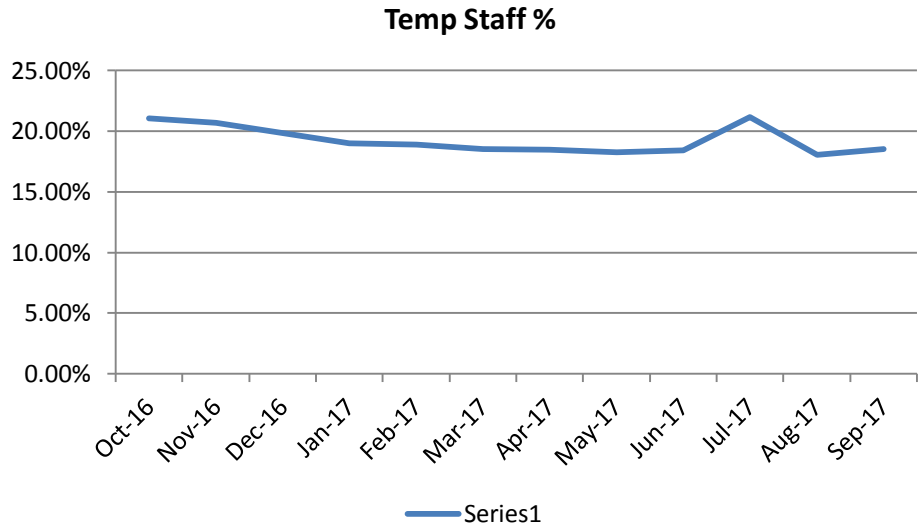
The Interim Director of Finance has been performing line by line reviews of non-pay spend with both senior finance and operational colleagues to both gain a deeper understanding of the year to date spend and ensure individuals are clear that individual budget underspends are maintained wherever possible. A similar review of pay spend is being planned over the coming month.

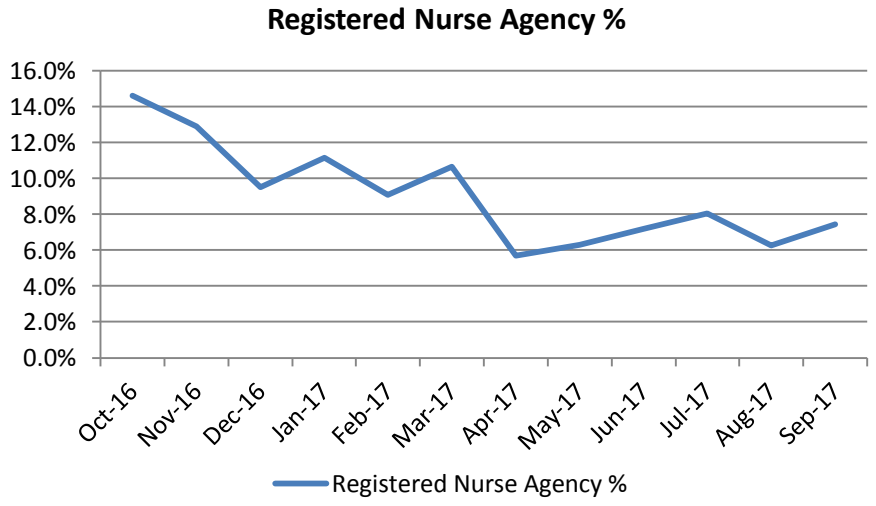
RISKS / ISSUES

Gaining a greater understanding and control of theatre spend is essential to the recovery of the financial position, and will be mitigated via the workgroups stated above.

4. Agency Expenditure – This illustrates expenditure on agency staffing in 2017/18, and performance against the NHSI agency requirements







INFORMATION

September showed an increase in agency spend (£312k to £382k). RTT validator is lower in month, and therefore this is a true increase in underlying agency spend. Presently (due to the RTT spend), year to date agency spend remains above cap, but this is expected to reduce below cap in the remaining months of the year as long as rostering control remains strong. As explained previously Healthroster appears to be yielding some excellent savings on nursing spend. There continues to be a pressure on Medical spend due to an under provision of GP trainees from the West Midlands Deanery and gaps in rotas hence needing to be covered through locums, and locum spend is driving the increase in agency spend in month.

ACTIONS FOR IMPROVEMENTS / LEARNING

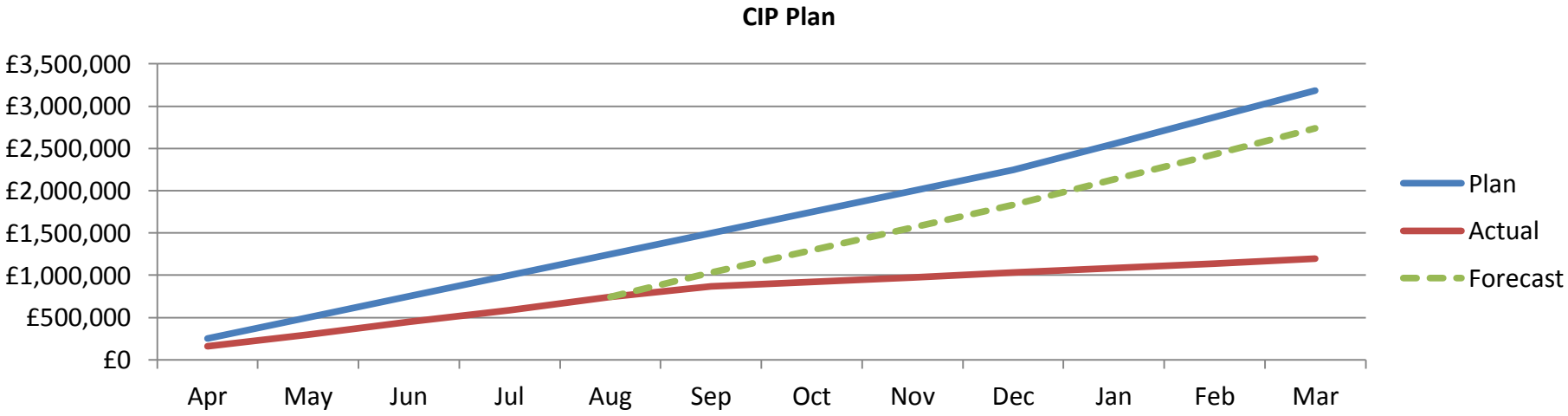
The leadership by the Nurses in addressing use of agency continues to impact positively.

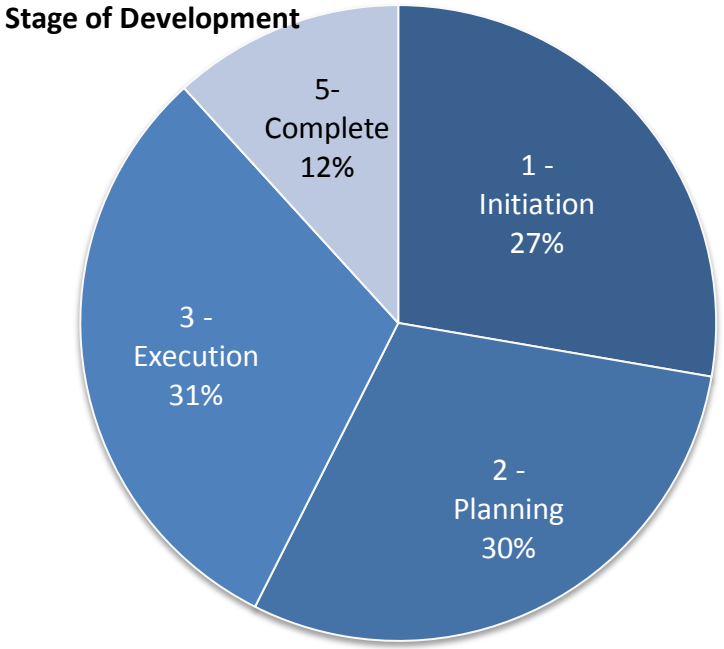
Healthroster in particular is proving to allow excellent visibility of rota requirements, and thus allowing much closer visibility of the need to use agency spend only when necessary to avoid inappropriate nursing ratios. The Trust is currently consulting on a change to rota working patterns as part of this process. Further work is planned to introduce Healthroster for the medical workforce, to enable further forward planning of annual leave and rota cover.

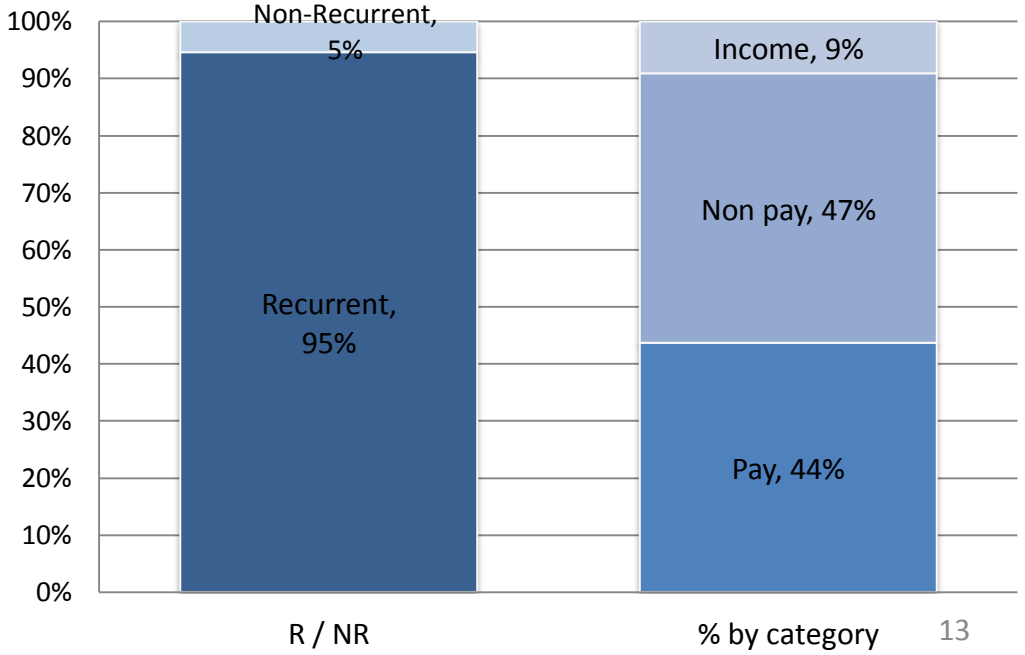
RISKS / ISSUES

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 being built into the Single Oversight Framework. An overspend against the trajectory will have a direct impact on our regulator ratings. The Trust has remained at a 2 for agency spend, resulting in the overall UOR rating being a 4.

6. Cost Improvement Programme – This illustrates the performance against the cost improvement programme for 2017/18







INFORMATION

As at the end of September, the Trust has recognised £845,000 of CIP savings, against a plan of £1,570,000. £144,000 (5%) of savings to date are non-recurrent.

A review of the original CIP Plans is underway and has highlighted some areas of risk but also some new areas of opportunity. As such a revised forecast CIP of £2,702,000 against an original plan of £3,191,000.

The current plan only contains 9% of income related schemes which is an area to explore and identify if there is more opportunity to grow both NHS and Non NHS income. The remainder of the plan is split 47% non pay and 44% pay.

The majority of the CIP is within the Initiation and Planning stage (57%) with 12% complete (i.e. fully achieved against Plan) and 31% at execution stage.

ACTIONS FOR IMPROVEMENTS / LEARNING

Many schemes do not have robust delivery plans, and as such assurance that timescales will be met in order to deliver the savings in the time needed. Work is underway with CIP leads to develop the plans and identify other areas for CIP opportunity.

The schemes which specifically require increased focus to ensure the full CIP is delivered are;

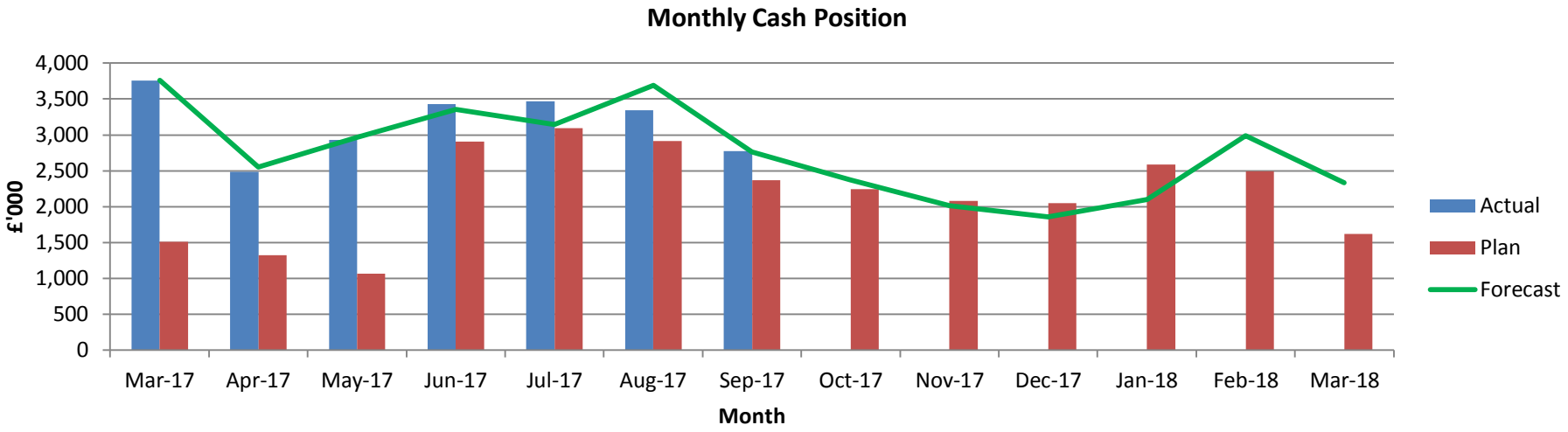
- Theatres stock management and rationalisation
- Implant rationalisation – ensure compliance against the agreed framework
- Other non pay consumables – rationalisation and product changes
- Coding improvements

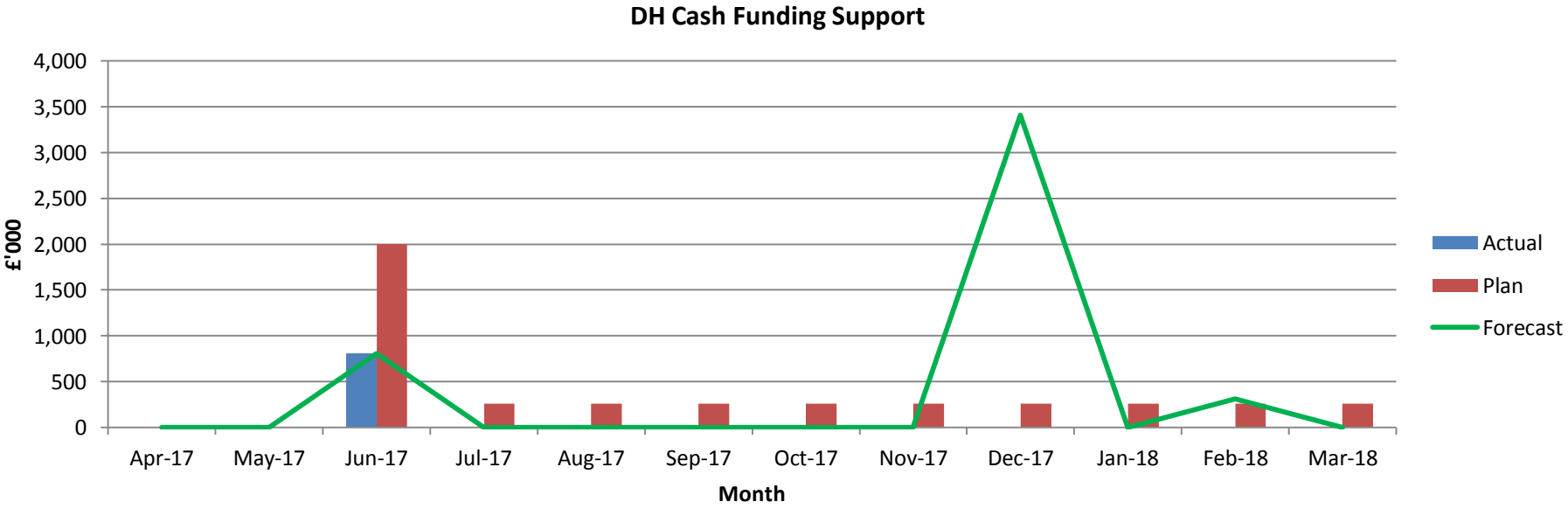
More robust divisional reporting of CIPs is also being developed for the monthly Executive Divisional Performance challenge sessions to give greater visibility of achievement and forecasts.

RISKS / ISSUES

A review of CIP documentation has identified a risk around completeness of documentation in relation to CIP plans particularly delivery plans and Quality Impact Assessments (QIAs). To address this work has started with the CIP leads to accelerate the completion of these. A review of the CIP policy is also underway in readiness for CIP planning for 2018/19.

7. Liquidity & Balance Sheet Analysis – This illustrates the Trust's current cash position, and any material movements on the Trust's balance sheet in addition to expected borrowing requirements from the Department of Health





INFORMATION

Information

Cash levels are £0.4m higher than planned levels at the end of September, largely driven by cash held at the end of March being significantly higher than planned. The cash position for September is roughly in line with the Trust revised cash forecast for the month.

The Trust received its first cash loan from the DH on the 12th June for £804k as previously advised to the Committee, but has now been able to cancel previously planned further DH loans in October and November, as both the Q1 underperformance payments, and an expected payment to NHS England, have been deferred until at least December. However, the Trust expects to require further loans from DH in December and February, due to the present financial position, and levels of activity.

The Trust has recently revised its Cash and Treasury Management policy and it was highlighted that it was felt necessary to consider investment, borrowing, interest rate and foreign exchange risk management strategy and policies. It was therefore agreed that this would be included within the cash section of the F&P paper to be reviewed monthly.

Given the Trust's current cash position and the need to request cash loans, the Trust is not in a position to hold any investments and at present the Trust does not hold any bank accounts other than those operated by the Government Banking Service. This means that interest and foreign exchange rate risks are determined to be low risk.

As in previous months, the requirement for borrowing has kept the Use of Resources Rating liquidity rating at a 4, the lowest level.

ACTIONS FOR IMPROVEMENTS / LEARNING

The Head of Financial Accounting has set up a monthly cash control committee attended by the DDOF, and representatives from management accounts and the transaction team. These will continue under the leadership of the Interim Head of Financial Accounting. The committee is reviewing cash management controls to ensure they are robust, and has set up arrangements to allow monthly applications of cash from the Department of Health to be actioned.

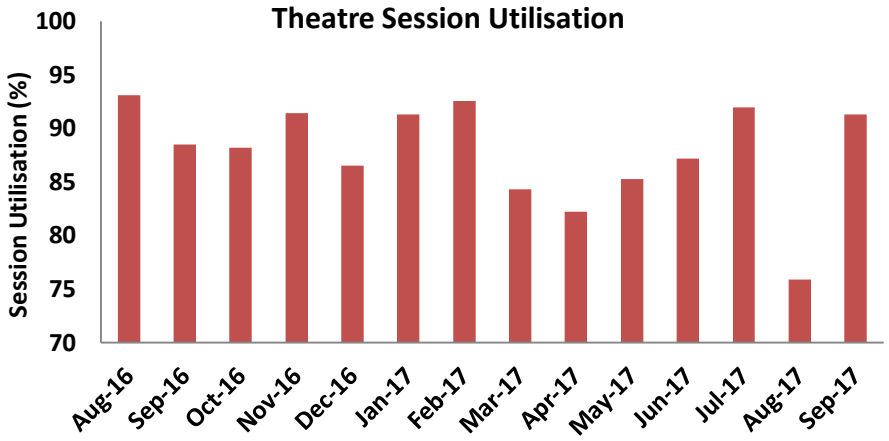
Based on the feedback from NHS Improvement the information provided to request funding was robust. The finance team are however continuing to review this and are looking to gather more information to continue to improve the Trusts management of cash.

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.

There is a risk is in relation to DH not approving a cash loan or approving a lower than requested amount, but the positive feedback to date from NHS Improvement provides assurance that this risk is relatively low.

9. Theatre Sessional Usage – This illustrates how effectively the available theatre sessions have been used



INFORMATION

Across the 114 sessions per week that are potentially available (100 weekday sessions across 10 theatres, 10 evening sessions and 2 all day Saturdays) we aim to use at least 90% of them. As part of the recovery plan, we now aim to use 95% of the lists (that is 108 of the 114 lists) on a weekly basis.

Due to annual leave / study leave, we typically plan that surgeons will operate over 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.

ACTIONS FOR IMPROVEMENTS / LEARNING

September saw an improvement in list utilisation of 91.29% compared to the previous month. Work continues to validate data within TheatreMan to ensure accurate reporting of utilisation figures continues.

Available lists continue to be offered out as part of the '6-4-2' group to ensure full maximisation of funded lists.

The ops team are proactively monitoring surgeon annual leave in order to manage and reduce the number of fallow lists and to offer appropriately to those services that are most challenged.

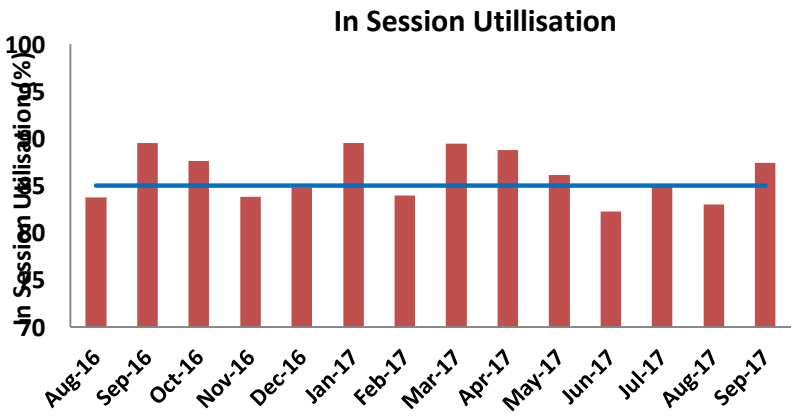
Weekend sessions are being planned throughout the remainder of the year with good uptake from consultants.

RISKS / ISSUES

Job planning is now completed for surgeons, with outstanding issues with only 2 surgeons; these are actively being progressed with the involvement of the Associate Medical Director, Clinical Service Manager and Clinical Service Lead.

The new theatre schedules and outpatient schedules started on 1st May 2017, to match the updated agreed job plans.

10. Theatre In-Session Usage – This illustrates how effectively the time within used theatre sessions is utilised



INFORMATION

Utilisation against this measure had remained above the target 85% in the majority of months. Weekly reviews at 6-4-2 and other focus groups continue to improve the quality of listing and hence forward preparation to ensure smooth delivery of activity planned.

Several surgeons have now established a pattern of 6 primary joints on a two session list, and the learning from repeating this efficiency is being replicated across all firms and all lists to improve productivity.

ACTIONS FOR IMPROVEMENTS / LEARNING

In session utilisation rose to 87.41% in September, an improvement on the previous month's performance and above the target of 85%.

The process of 'automatic sends' commenced w/c 25th September with patients first on the theatre list being sent for at 08:20. Early indications suggest that 36% of lists are achieving this target and work continues on a daily basis for those that experience problems on the day such as staffing issues, problems with equipment or theatre trays etc. to improve the overall performance going forward.

Rigorous list scheduling via the '6-4-2' weekly planning meetings, ensures that lists are booked appropriately based on the average procedure times by Consultant allowing full maximisation of the available theatre time.

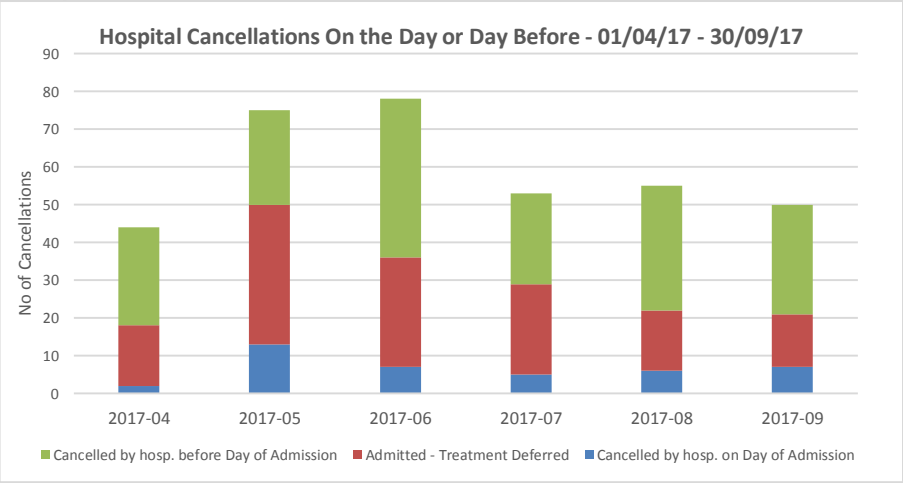
Also improvements in ensuring that tasks such as 'Group and Save' requests are not left until the day of surgery which can cause delays, and improvements in list ordering to ensure that those that require imaging support for example, are evenly distributed across all theatres that require it, further helping to improve the efficient running of the theatre lists.

RISKS / ISSUES

Staff vacancies within theatres – to be able to provide the appropriate staffing skill mix (e.g. experience in spinal scrub) to ensure the best possible use of available operating time. A theatres recruitment open day is scheduled for Sunday 15th October, with the aim of recruiting across all theatre vacancy types. Variability of anaesthetic time, custom and practice in theatre flow management, availability of patients to backfill last minute cancellations due to being medically unfit.

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

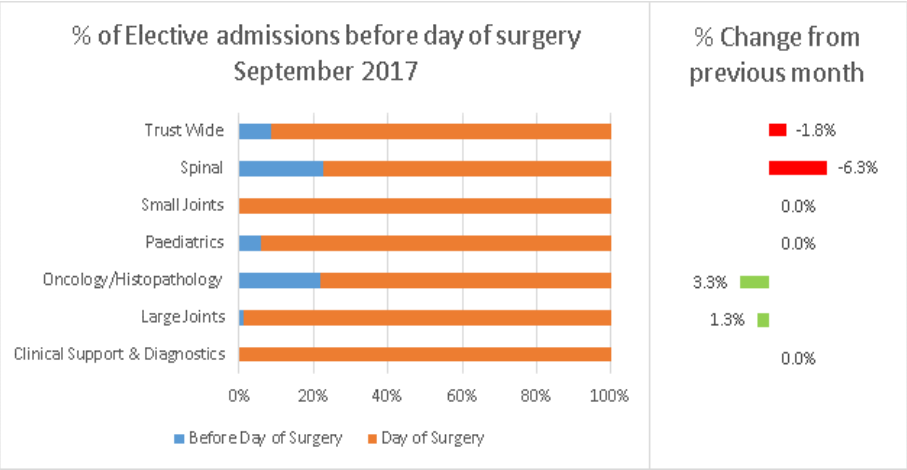
Hospital Cancellations

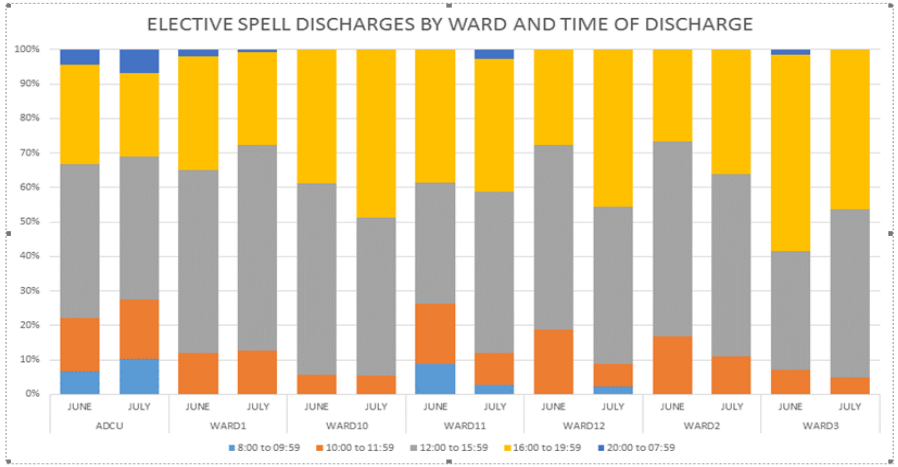


Year - Month	Cancelled by hosp. on Day of Admission	Admitted - Treatment Deferred	Cancelled by hosp. before Day of Admission	Grand Total	Cancelled Ops Not Seen Within 28 Days
2017-04	2	16	26	44	1
2017-05	13	37	25	75	3
2017-06	7	29	42	78	3
2017-07	5	24	24	53	2
2017-08	6	16	33	55	0
2017-09	7	14	29	50	0
Grand Total	**40**	**136**	**179**	**355**	**9**

Notes:
Data taken from PAS Outcome of Offer
On the day or day before cancellation calculated by difference between TCI date and outcome of offer date
Admitted Treatment Deferred - Patients admitted with a diagnostic code Z538 (Procedure not carried out for other reasons)

Admission the day before surgery





INFORMATION

There continues to be a high proportion of patients who are self-cancelling before the day of surgery. Some of the replacement patients are then booked at short notice. We are now booking with 3 week's notice and 2 reasonable offers as per national guidance and our Access Policy.

The Clinical Service Leads and Clinical Service Managers for each specialty are discussing at regular team meetings, some longstanding issues relating to disparity of waiting lists across consultants, variations in theatre productivity and listing protocols are being addressed and resolved.

Forensic analysis of cancellations continues, with a focussed analysis by the anaesthetic lead and nursing lead for POAC of the majority cause of cancellations on the day of surgery, namely those who are medically unfit, to ascertain what process changes can be made in POAC or to the 72 hour phone call to reduce this.

On the 12th October a multi-disciplinary POAC workshop was held to understand all the issues, agree the new model and the workstreams to take the improvement programme forward. The day was well attended and 5 workstream were agreed including GP liaison, referrals & education and workforce.

ACTIONS FOR IMPROVEMENTS / LEARNING

A daily update review by operational management of forward bookings has been established and the 6-4-2 and a daily 8.30am Operations huddle has continued. Daily statistics on beds, admissions and discharges are being transmitted electronically twice daily to operational managers to ensure consistent and timely actions to deliver activity and patient flow.

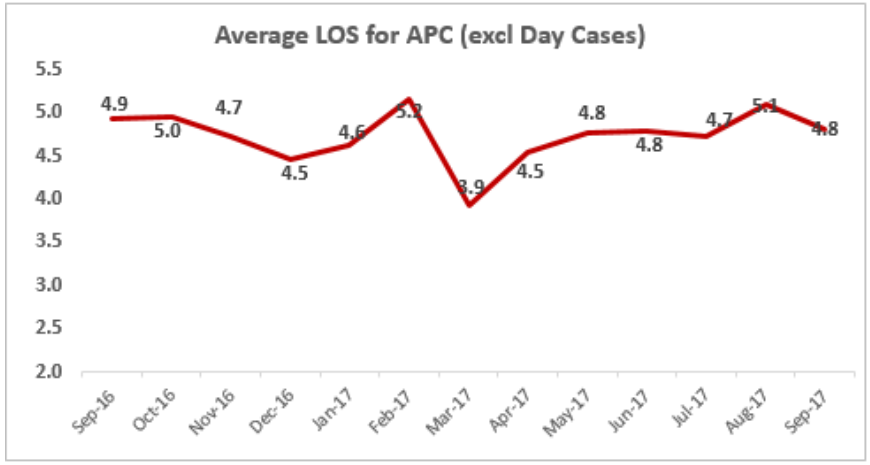
By the end of October 17 the refreshed Perfecting Pathway project team will meet with the POAC workstream leads to agree next steps and key milestones. It was agreed that the workshop would meet again in 6weeks to review the progress and ensure that all stakeholders are kept informed of any changes or new initiatives.

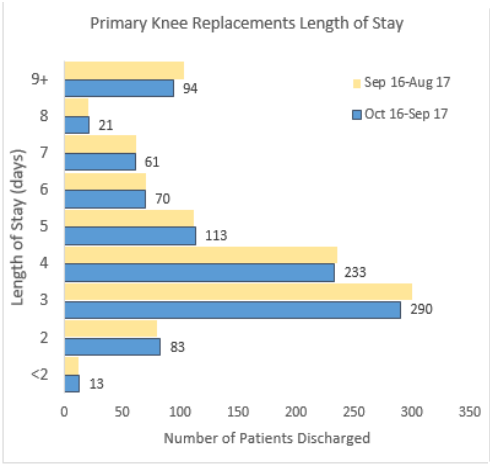
RISKS / ISSUES

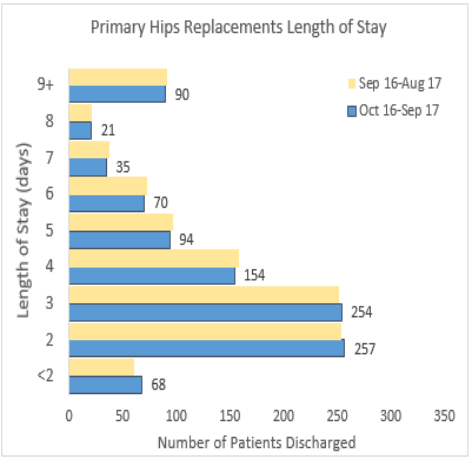
Continued focus with all staff involved to ensure that the operating lists are booked in advance, with sufficient caseloads, together with daily tracking.

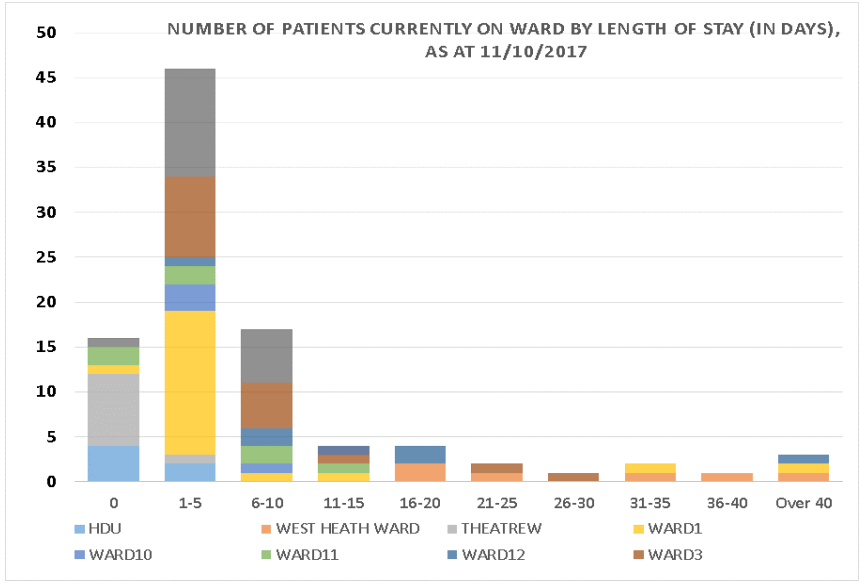
It is currently not possible to identify if the time of day patients are discharged is an accurate reflection of reality, or whether data is being entered onto the system in a delayed manner, making discharges look later in the day. This work now forms part of the Perfecting Pathways workstream (Inpatients & Discharge) and a 2week audit is currently being undertaken to identify delays with the discharge process incorporating a review of timeliness of prescribing and TTO's

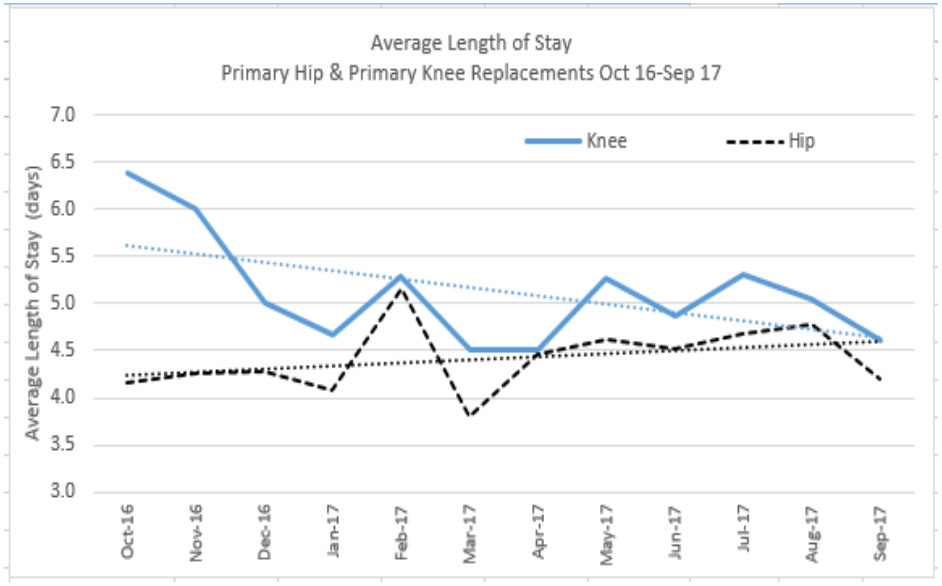
12. Length of Stay – This illustrates the performance of the Trust in discharging patients in a timely fashion, in line with planned pathways











INFORMATION

Under the leadership of the Associate Medical Directors, Clinical Service Leads and Clinical Service Managers, work is progressing to increase activity levels to deliver 18 week compliance by creating additional capacity from within existing resources by improving flow. Length of stay reductions for primary hips and knees is key to achieving this.

Work has commenced in the last two weeks with the Arthroplasty team to co-located patients to Ward 2 and this will be further developed with a structured daily consultant led, multi-disciplinary ward rounds.

The'Red2Green' process is being relaunched at the being of November alongside a workstream established to look at improving the process for TTO's and x-ray forms being completed earlier in the pathway.

ACTIONS FOR IMPROVEMENTS / LEARNING

Following a meeting with the Arthroplasty team (20.10.17) there will now be a urgent refocus around Rapid Recovery with the aim being to ensure that it is an opt out system.

A more structured programme of work will commence in November with the Arthroplasty Team which will also take into account improvement in pre-op and referrals.

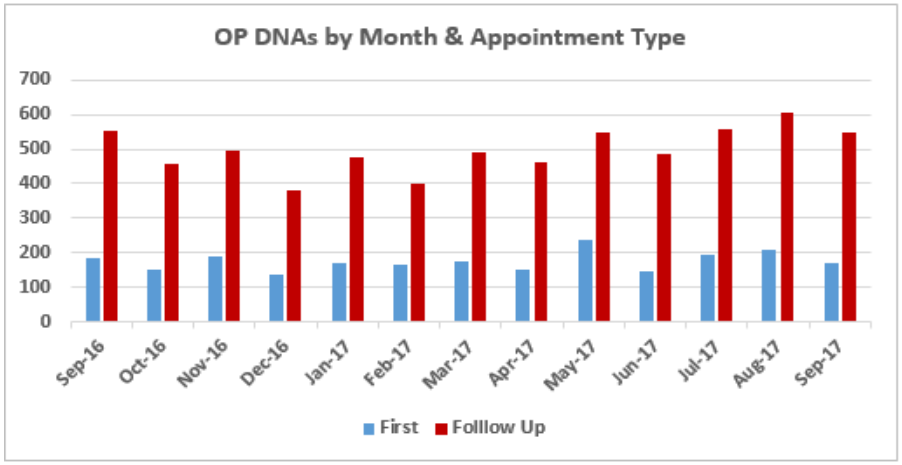
RISKS / ISSUES

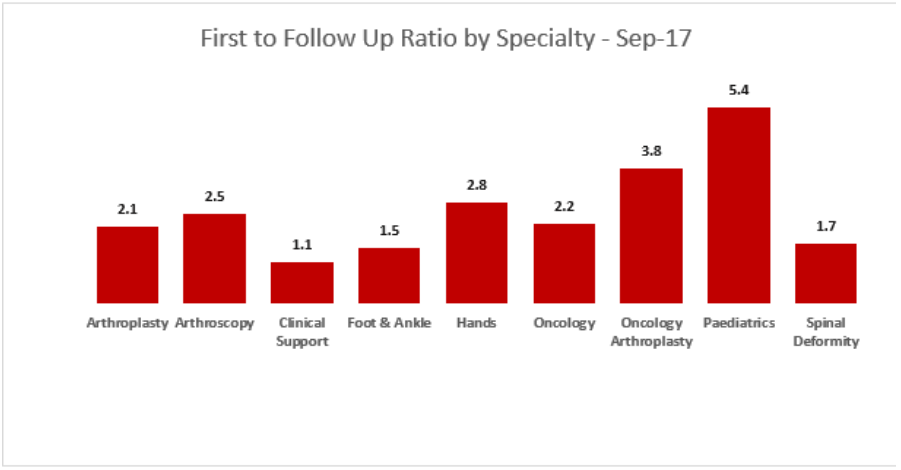
Operational management teams and Clinical Service Leads are reviewing outlying clinical practice to help ensure that all patients are able to go home as soon as possible after their surgery.

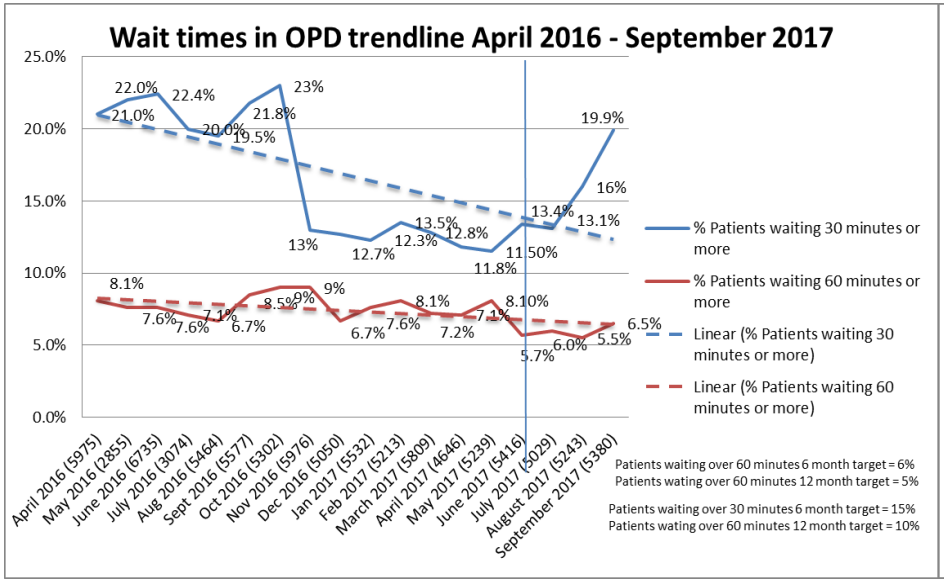
This work will be a key workstream in Perfecting Pathway which should drive a reduction in length of stay and reduce the number of patients over 14 day LOS.

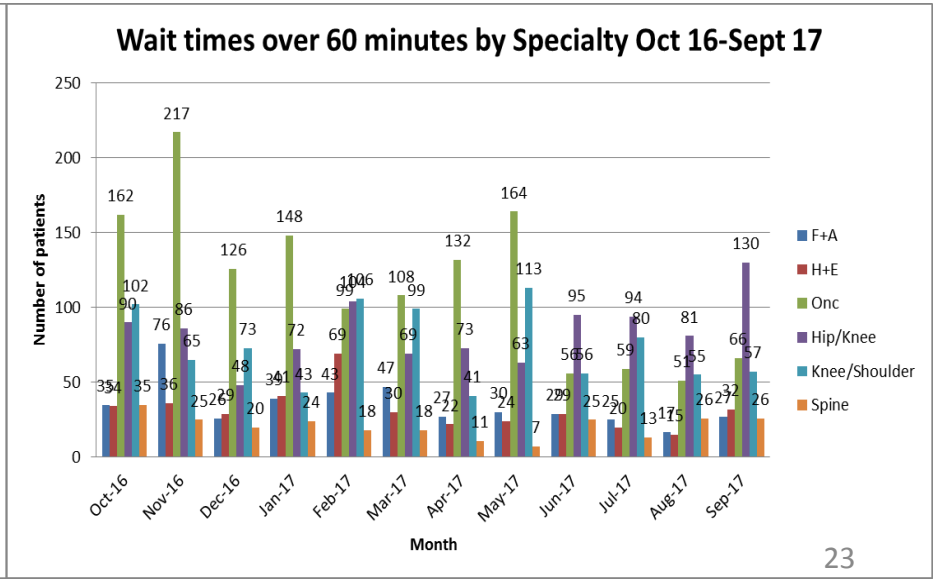
"Train the trainers" sessions are in place wk comm 23.10 to support the roll out of "Red2Green".

13. Outpatient efficiency – This illustrates how effectively the Trust is utilising outpatient resources, and how smoothly the pathway works for patients









INFORMATION

Outpatient department continue to audit its compliance against the SOP for wait time and can demonstrate 100% compliance. There is a new standard operating procedure for any clinic running over 60 minutes late. The incident reporting system, Ulysses, has been amended to make it easier for the clinic staff to complete the incident form. An incident form is completed and a new drop down analysis is selected by the staff completing the incident The reasons documented on the incident forms now form part of a monthly action plan and this will be shared so reasons can be addressed.

In September 2017 there was 12 incident forms completed to highlight clinics running more than 60 minutes late.
The monthly audit identified 3 main contributing factors for delays: 1) delay in medical notes arriving on time to clinic. 2) Overbooked / not reduced clinic due to Consultant staff being on leave 3) Complex patients requiring more time.

ACTIONS FOR IMPROVEMENTS / LEARNING

Actions from September's Audit include;

- Review of current reduction in clinic rules - appointments
- A review of the clinics that have not being reduced for consultant annual leave (to check if annual leave guidance has been followed / authorisation and completion of reduction process completed) Clinical Service Manager and Secretarial Team lead for the area and the appointments team
- Investigation into Hip and Knee services wait times
- Completion of the medical notes SOP for clinics

RISKS / ISSUES

Medical Record Management – there is a action plan to support improvements in Medical Records. The team are currently preparing notes/records 3 days ahead of clinics which is a significant improvement, this continues to be actively monitored.

An OPD operational group is being established to supplement the Divisional Boards and to ensure that all the improvement work is being captured and monitored. This team will also play a key part on the Perfecting Pathways improvements programme.

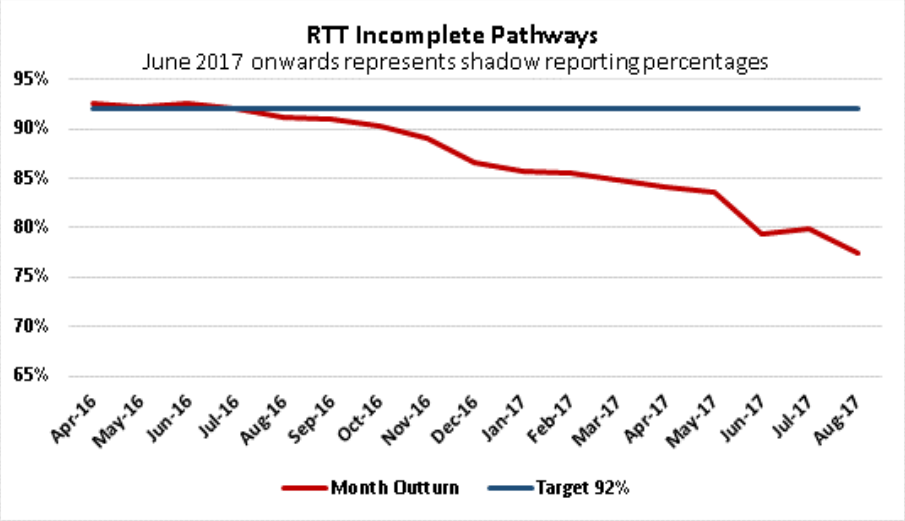
14. Treatment targets – This illustrates how the Trust is performing against national treatment target –

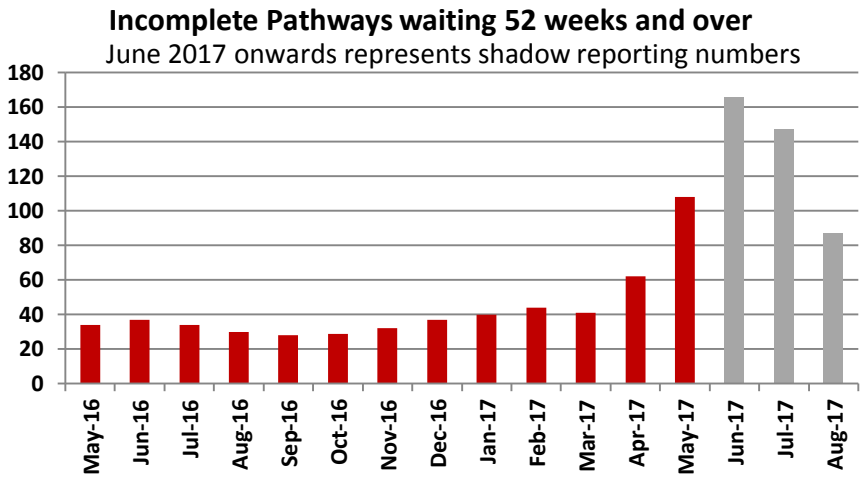
% of patients waiting <6weeks for Diagnostic test.

National Standard is 99%

	Pending				Activity							
	MRI	CT	US	total	MRI	CT	US	total	over 6 weeks	under six weeks	total	% under six weeks
Jan-17	620	81	310	1011	843	251	412	1506	3	1008	1011	**99.7%**
Feb-17	740	57	344	1141	766	196	356	1318	1	1140	1141	**99.9%**
Mar-17	865	101	364	1330	893	239	417	1549	0	1330	1330	**100%**
Apr-17	784	79	296	1159	781	176	326	1283	4	1155	1159	**99.6%**
May-17	784	79	296	1159	781	176	326	1283	4	1155	1159	**99.6%**
Jun-17	830	101	402	1333	877	217	354	1448	5	1328	1333	**99.6%**
Jul-17	785	94	404	1283	737	177	316	1230	7	1276	1283	**99.4%**
Aug-17	871	85	386	1342	749	202	395	1346	4	1338	1342	**99.7%**
Sep-17	915	103	390	1408	838	225	379	1442	1	1407	1408	**99.9%**

14. Treatment targets – This illustrates how the Trust is performing against national treatment targets and agreed trajectories





		Unreported	Reported Month					Reported Quarter					
Cancer Target	National Standard	Indicative Sept *	August	July	Jun	May	Apr	Q2	Breaches	Total	Q1	Breaches	Total
2ww	93%	100%	100%	100%	95.65%	100%	97.30%	99.20%	1	120	97.60%	3	123
31 day first treatment	96%	75%	100%	100%	91.67%	100%	100%	96.60%	1	29	96.60%	1	29
31 day subsequent (surgery)	94%	100%	100%	100%	100%	100%	100.00%	97.4%	1	38	100.00%	0	22
31 day subsequent (drugs)	98%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a
62 day (traditional)	85%	100%	100%	37.50%	71.43%	60.00%	66.67%	72.20%	2.5	9	66.70%	3	9
62 day (Cons Upgrade)	n/a	83%	75%	100%	100%	100%	100%	88.9%	1	9	100%		1
31 day rare (test, ac leuk, child)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a		n/a
No. day patients treated 104+ days		0	0	3	1								

*Performance for September is indicative, national submission date 1st November

14. Referral to Treatment snapshot as at 19th October (Combined)

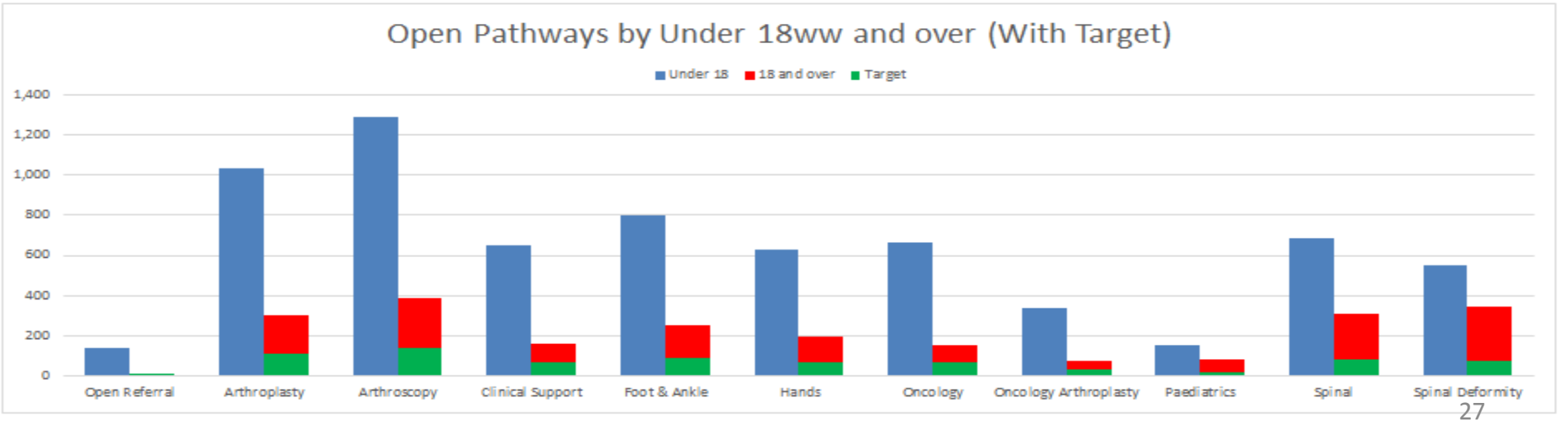
Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at: 2017-10-19

Select Pathway Type: **Both**

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
0-6	**3,601**	137	535	714	361	388	302	320	149	76	351	268
7-13	**2,304**	2	352	397	216	271	231	224	135	48	239	189
14-17	**1,026**	1	146	182	74	142	93	122	53	24	95	94
18-26	**1,337**	0	181	255	83	154	137	140	40	41	163	143
27-39	**651**	0	97	110	62	78	48	9	24	26	90	107
40-51	**137**	0	13	14	9	15	6	2	5	8	30	35
52 weeks and over	**114**	0	7	10	3	4	2	0	3	4	25	56
Total	**9,170**	140	1,331	1,682	808	1,052	819	817	409	227	993	892

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**6,931**	140	1,033	1,293	651	801	626	666	337	148	685	551
18 and over	**2,239**	0	298	389	157	251	193	151	72	79	308	341
Target	**734**	**11**	**106**	**135**	**65**	**84**	**66**	**65**	**33**	**18**	**79**	**71**

Performance against Target (92.0%)	75.6%	100.0%	77.6%	76.9%	80.6%	76.1%	76.4%	81.5%	82.4%	65.2%	69.0%	61.8%



14. Referral to Treatment snapshot as at 19th October

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at: 2017-10-19

Select Pathway Type: Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
0-6	**654**	0	138	166	30	30	55	54	51	28	81	21
7-13	**644**	0	125	155	35	38	47	43	69	21	76	35
14-17	**307**	0	60	83	15	21	33	16	30	9	25	15
18-26	**451**	0	89	136	21	23	57	12	13	21	58	21
27-39	**292**	0	50	83	17	17	22	3	11	13	36	40
40-51	**79**	0	10	8	3	6	2	1	5	6	19	19
52 weeks and over	**84**	0	4	7	2	2	0	0	3	3	15	48
Total	**2,511**	0	476	638	123	137	216	129	182	101	310	199

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**1,605**	0	323	404	80	89	135	113	150	58	182	71
18 and over	**906**	0	153	234	43	48	81	16	32	43	128	128
Target	**201**	**0**	**38**	**51**	**10**	**11**	**17**	**10**	**15**	**8**	**25**	**16**

Performance against Target (92.0%)	63.9%	n/a	67.9%	63.3%	65.0%	65.0%	62.5%	87.6%	82.4%	57.4%	58.7%	35.7%

Royal Orthopaedic Hospital NHS Foundation Trust
Consultant Led Open Pathways as at: 2017-10-19

Select Pathway Type: Non Admitted

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
0-6	**2,947**	137	397	548	331	358	247	266	98	48	270	247
7-13	**1,660**	2	227	242	181	233	184	181	66	27	163	154
14-17	**719**	1	86	99	59	121	60	106	23	15	70	79
18-26	**886**	0	92	119	62	131	80	128	27	20	105	122
27-39	**359**	0	47	27	45	61	26	6	13	13	54	67
40-51	**58**	0	3	6	6	9	4	1	0	2	11	16
52 weeks and over	**30**	0	3	3	1	2	2	0	0	1	10	8
Total	**6,659**	140	855	1,044	685	915	603	688	227	126	683	693

Weeks Waiting	Total	Open Referral	Arthroplasty	Arthroscopy	Clinical Support	Foot & Ankle	Hands	Oncology	Oncology Arthroplasty	Paediatrics	Spinal	Spinal Deformity
Under 18	**5,326**	140	710	889	571	712	491	553	187	90	503	480
18 and over	**1,333**	0	145	155	114	203	112	135	40	36	180	213
Target	**533**	**11**	**68**	**84**	**55**	**73**	**48**	**55**	**18**	**10**	**55**	**55**

Performance against Target (92.0%)	80.0%	100.0%	83.0%	85.2%	83.4%	77.8%	81.4%	80.4%	82.4%	71.4%	73.6%	69.3%

INFORMATION

The Trust ceased formal reporting of its RTT position in June 2017, and has been shadow reporting since that time. The Trust will recommence reporting in December 2017, with its first submission for November 2017. Validation of open pathways is complete and work to inform 'Business as Usual' validation is nearly complete to ensure that Data Quality standards are maintained going forwards.
Validation has been completed reviewing clock stop data across all areas.

The new PTL is actively being monitored on a daily basis with a formal weekly tracking meeting chaired by the Interim Chief Operating Officer. The way in which the Trust utilises and manages the planned waiting list is being updated to ensure that it adheres to national guidance, where the treatment date is determined clinically, rather than by resource. Trajectories are currently being refreshed to recalculate the demand and capacity required to deliver 92% performance.

	Total pathways	Over 18 weeks pathways	Over 52 week pathways
Admitted	938	381	16
Non-Admitted	1209	261	12
Incomplete	7935	1835	101

The above figures have been used for the shadow reporting of the ROH RTT performance for September 2017 – 76.87%

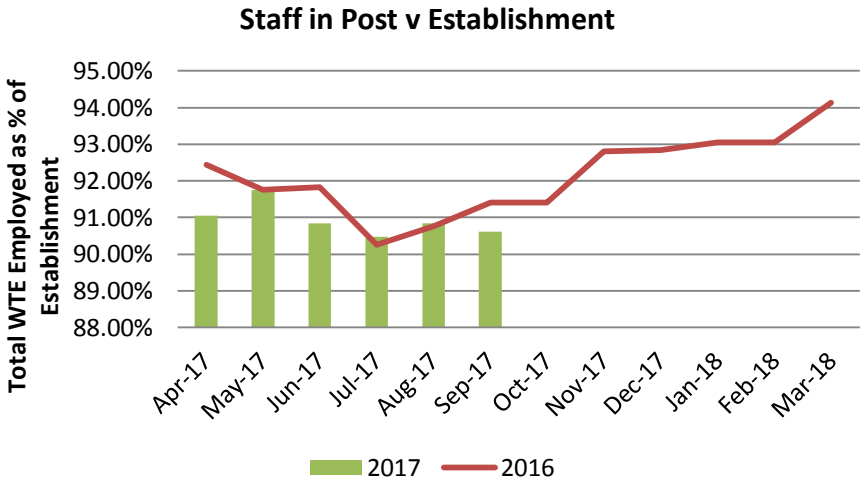
ACTIONS FOR IMPROVEMENTS / LEARNING

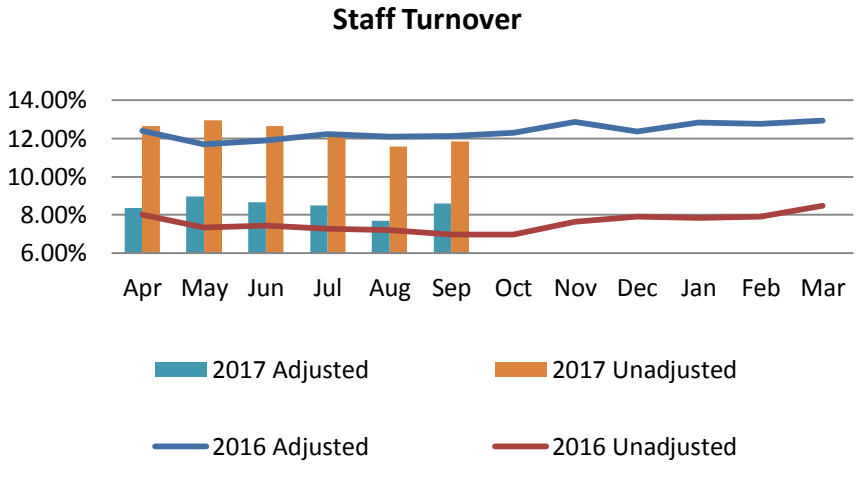
The team have concentrated over the last month on any patient over 40weeks. The focus from November 17 will now be the cohort of patients on a admitted pathway between 27-39 weeks and non admitted over 18weeks.

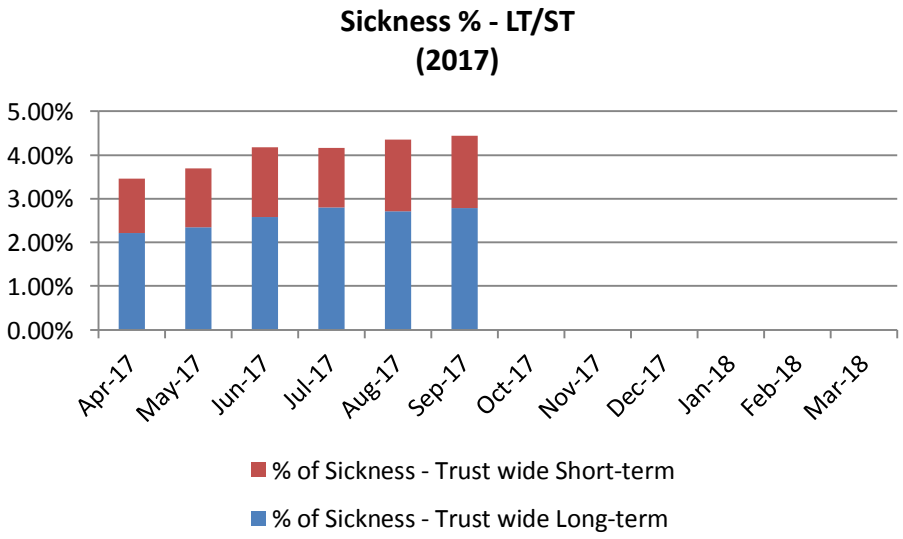
RISKS / ISSUES

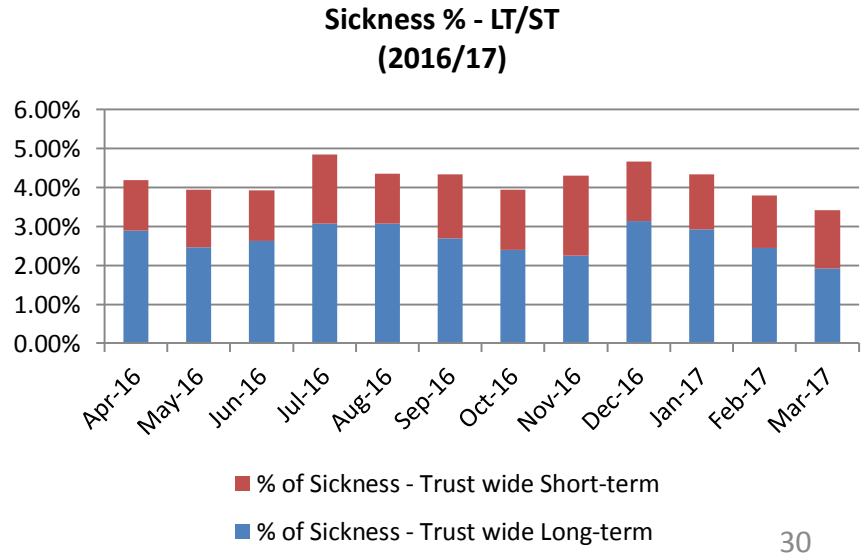
52 weeks: Spinal deformity remains a risk with regard to overall Trust performance, with the number of 52 week breaches likely to increase further. Discussions continue with BWCH to ensure that additional capacity is in place, as well as a range of other solutions to mitigate any worsening of the position, but availability of PICU beds over the winter months remains a significant concern. A trajectory has been developed to support performance and is being discussed at the Stakeholder Oversight meeting on Friday 20th October 2017.

15. Workforce – This illustrates how the Trust is performing against a range of indicators linked to workforce numbers, sickness, appraisal and training

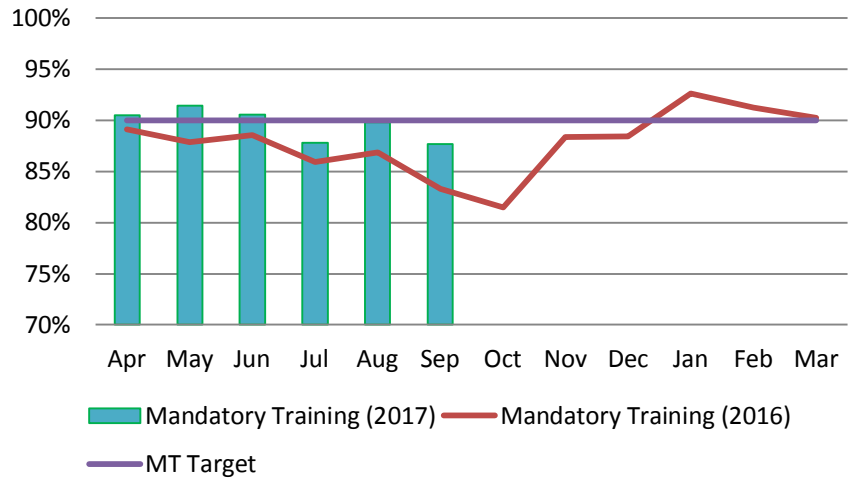




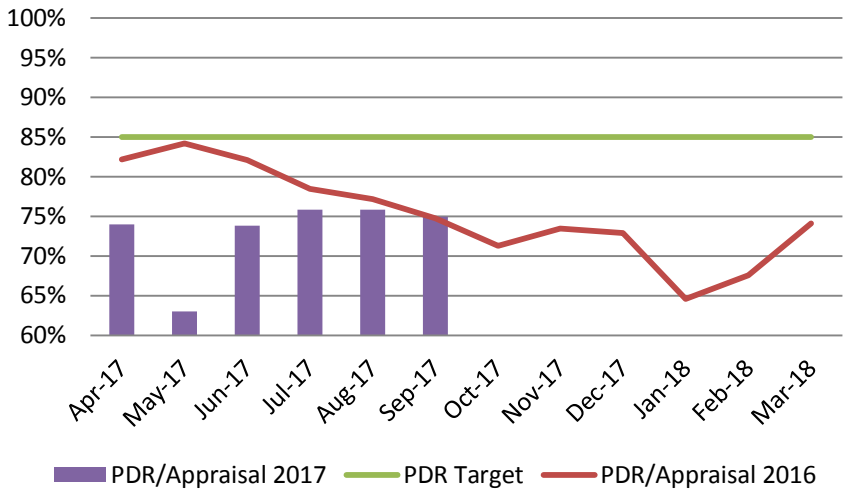




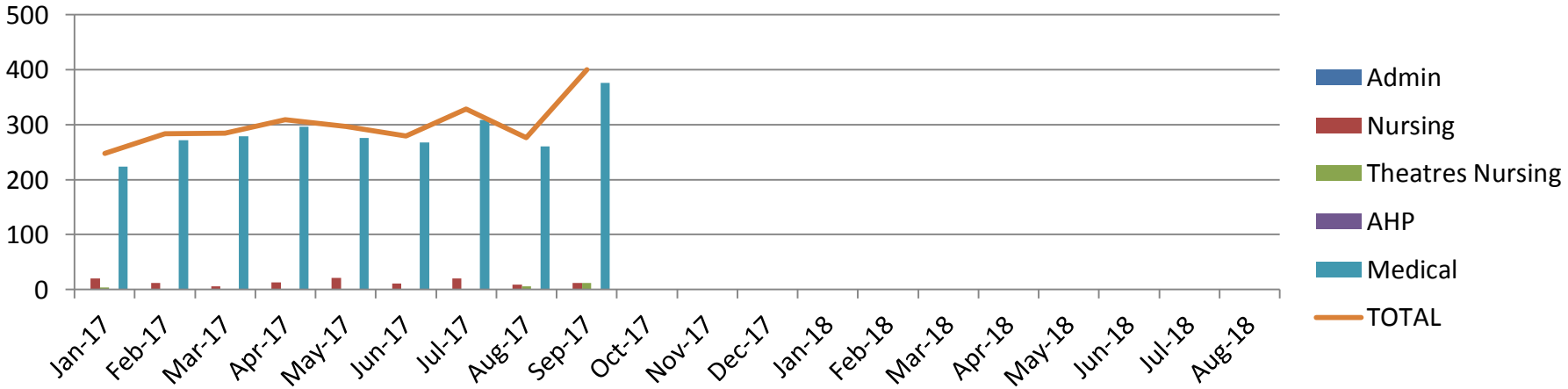
Mandatory Training



PDR/Appraisal



Agency Breaches



INFORMATION

September saw a marginal deterioration in terms of workforce performance across the full range of indicators, which is disappointing, even though the movements were generally small. Sickness absence increased slightly, keeping the Trust in amber in month, and the 12 month underlying figure also moved into the lower end of amber at 4.2%. Staff in post decreased, turnover increased, and mandatory training and appraisal both fell.
September saw sickness absence increase to 4.44%, the highest figure for the calendar year to date, with slight increases both in long and short term absence. The 12 month average figure has also tipped into amber at 4.20%, having been green (= under 4.20%) for the last 4 months.
The Trust's vacancy position dipped very slightly on last month's figure by 0.23% to 90.61%. This is still amber for September 2017, and is typical of the vacancy position since June. In context, there is a drop of just 0.88 WTE from the ledger staff in post, so this in itself is not a cause for concern.
Mandatory training took a downward turn of 2% in September and fell into amber at 88%. Further work is being carried out this month by the L&D Team to encourage staff to book onto or carry out their Mandatory Training via e-learning. With the new E-learning and IT Training Facilitator now in post, improvement in this position is expected in October data.

Performance relating to appraisals in September remained steady at 74.94%, a drop of 1% since August. The release of provisional data to Clinical Service Managers early in the month is felt to be helpful in improving the accuracy of reporting: this system will therefore continue in order to ensure that our data are accurate. Although September's position is still red, it does appear to be holding.
The September turnover figures both increased, although neither is a cause for concern. The unadjusted turnover figure (all leavers except doctors and retire/ returners) increased by 0.19% on last month to 11.86%., although in context this is the second lowest figure in the last 15 months, and the adjusted turnover figure ("true leavers" meaning "voluntary resignations") increased by 0.9% to 8.59%, up from an unusually low August position but remains green in month.
Data are included this month for the committee on agency breaches for the first time. It can be seen that the vast majority of these breaches come from medical staff (and of these, most are junior medical staff in non-deanery posts, where long term locums are in post). This is not likely to ease markedly in the foreseeable future due to market supply issues - although to attempt to mitigate the longevity there is a rolling open advertisement to seek to fill these posts, agencies have been approached to find doctors for introductory fees and there are controls on internal short term locums. The position will however improve slightly in October and November due to the arrival of middle grade doctors in spines and paediatrics.

ACTIONS FOR IMPROVEMENTS / LEARNING

The introduction of the e-learning facilitator will assist in the proliferation of online mandatory training, which will offer more flexible access.

With effect from November's divisional workforce information, compliance with return to work interviews will be included for Divisional Boards to seek assurance about the timely management of sickness absence.
Appraisal remains a challenge and the need for improved performance in this area will be reinforced at divisional performance reviews in October.

RISKS/ISSUES

The planned transfer of paediatric surgery may continue to cause uncertainty for staff. It is possible that sickness absence, turnover and vacancies may increase in the coming months.

Finance and Performance Report: Additional Analysis

SEPTEMBER 2017

INTRODUCTION

This addendum presents additional analysis that has been undertaken relating to monthly trend and performance data relating to activity, income and non-pay.

1. Table 1 below illustrates the monthly performance relating to inpatient and day case income, and main areas of non-pay spend

	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Inpatient Elective Income	3,265,771	3,503,258	3,103,724	3,453,176	3,295,371	3,510,869
Daycase income	683,792	662,060	592,568	729,604	538,566	730,329
Total Treatment Income	**3,949,563**	**4,165,318**	**3,696,292**	**4,182,780**	**3,833,937**	**4,241,198**
Prosthesis	725,375	789,967	803,200	914,858	760,188	772,227
Theatres Non Pay	800,473	652,310	645,394	814,162	798,613	742,863
Day Case	599	704	528	588	622	666
Elective	579	609	546	581	548	579
Total Activity	**1,178**	**1,313**	**1,074**	**1,169**	**1,170**	**1,245**
Ave Income per spell (Inpatient)	5,680	5,858	5,716	6,112	6,325	6,247
Ave Income per spell (Daycase)	1,258	1,205	1,366	1,408	1,482	1,407

Oct-Mar 17	Apr-Sep 17	variance
20,132,169	17,639,390	(2,492,779)
3,936,919	4,326,955	390,035
24,069,088	**21,966,345**	**(2,102,743)**
4,765,815	4,784,271	18,455
4,453,815	4,449,297	(4,518)
3,707	3,966	259
3,442	3,186	(256)
7,149	**7,152**	**3**
5,990	6,076	86
1,293	1,146	(147)

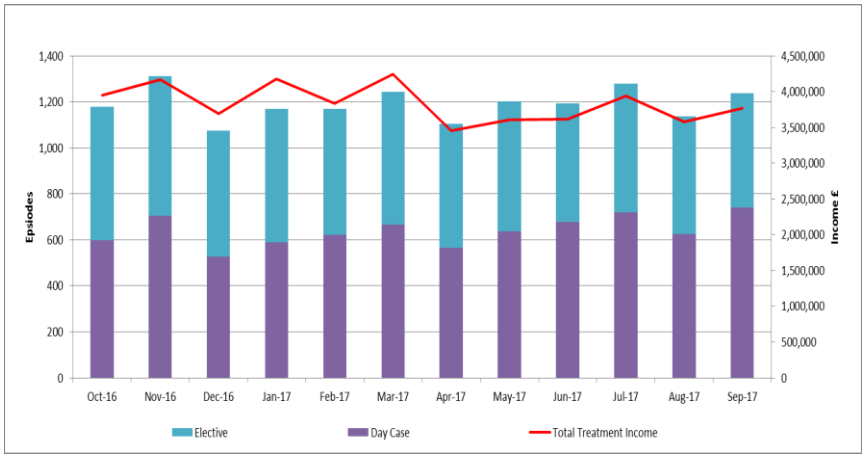
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Inpatient Elective Income	2,817,995	2,938,599	2,873,852	3,174,672	2,930,278	2,903,994
Daycase income	637,588	667,795	742,795	764,877	645,368	868,531
Total Treatment Income	**3,455,583**	**3,606,394**	**3,616,647**	**3,939,549**	**3,575,646**	**3,772,525**
Prosthesis	702,297	765,166	841,715	861,052	924,948	689,092
Theatres Non Pay	607,962	757,986	894,542	766,468	832,386	589,953
Day Case	567	636	678	720	625	740
Elective	537	566	514	558	512	499
Total Activity	**1,104**	**1,202**	**1,192**	**1,278**	**1,137**	**1,239**
Ave Income per spell (Inpatient)	0	0	0	0	0	0
Ave Income per spell (Daycase)	1,124	1,050	1,096	1,062	1,033	1,174

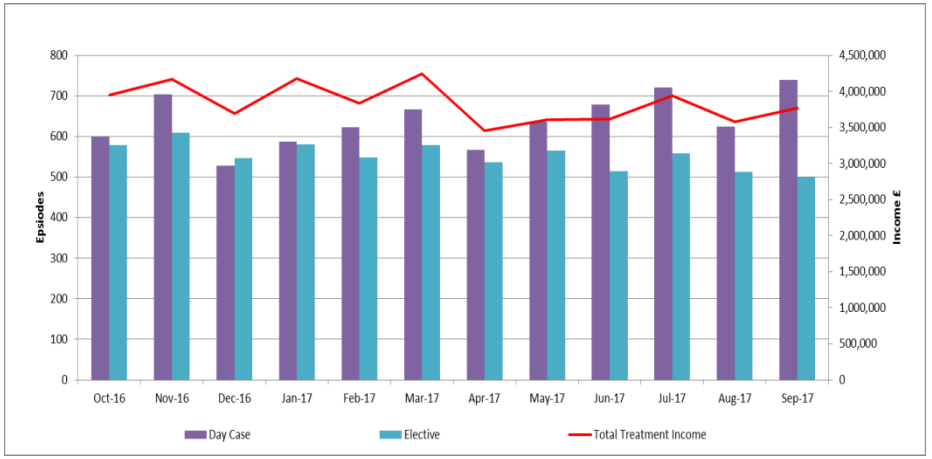
INFORMATION

This shows that:-

- Inpatient income for the first 6 months of 17/18 is significantly below the last 6 months of 16/17 (£2.5m), which is being driven by a reduction in inpatient activity (circa 256 spells);
- Income per spell has been maintained, which suggest that the income reduction is being driven by the activity underperformance, and not case mix change;
- Daycase activity has increased by 259 spells, which is, coincidently, a similar amount to the inpatient reduction;
- This generates of circa £390k;
- There is small reduction in income per spell, suggesting case mix has changed. This is explored further below;
- Expenditure on theatre non-pay and prosthesis has remained constant, which is concerning given the reduction in inpatient activity identified.

2. The graphs below reflect the data in Table 1, comparing activity, income and non pay (theatres and prosthetics)





INFORMATION

This shows that:-

- When presented graphically, there does seem to be a trend between activity and income, and although total activity remains relatively constant, it shows a step change in income levels from April reflective of the reduction in inpatient income.
- More concerning is the continuing levels of non-pay expenditure which has not reduced in line with activity, and the monthly variation in spend (which seems independent of activity).
- Further investigation is required to identify the scope and scale of any price inflation within non-pay expenditure, or whether more hardware and consumable are being used per patient.

3. Divisional Split: The tables below display the same data but presented by point of delivery, and by divisional team

Income (£)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Total	M1-6 (16/17)	M7-12 (1617)
Large Joints	1,178,185	1,117,324	1,095,031	1,266,277	1,086,087	1,137,115	6,880,020	6,780,576	7,832,902
Oncology	497,028	621,057	619,367	512,995	693,572	544,476	3,488,496	4,183,115	4,406,299
Paediatrics	122,454	223,770	234,562	200,516	157,095	216,271	1,154,669	1,177,134	1,362,561
Small Joints	164,303	122,085	76,975	168,439	98,485	159,523	789,811	676,151	758,510
Spinal Services	850,815	853,832	847,353	1,024,853	894,509	846,077	5,317,439	4,471,876	5,761,711
Clinical Support and Diagnostics	5,209	531	563	1,591	530	531	8,955	13,308	10,186
Inpatient Income	**2,817,995**	**2,938,599**	**2,873,852**	**3,174,672**	**2,930,278**	**2,903,994**	**17,639,390**	**17,302,160**	**20,132,169**
Inpatient Plan	2,591,000	3,152,000	3,288,000	3,203,000	2,750,000	3,162,000	18,146,000	18,843,621	19,465,379
Variance	227	(213)	(414)	(28)	180	(258)	(506)	(1,541,461)	666,790
Activity	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Total**	**M1-6 (16/17)**	**M7-12 (1617)**
Large Joints	215	230	200	241	189	208	1,283	1,170	1,382
Oncology	148	145	142	135	142	113	825	1,135	971
Paediatrics	34	57	60	48	42	55	296	309	361
Small Joints	43	32	20	36	30	40	201	201	213
Spinal Services	95	100	91	95	108	82	571	574	662
Clinical Support and Diagnostics	2	2	1	3	1	1	10	6	11
Inpatient Activity	**537**	**566**	**514**	**558**	**512**	**499**	**3,186**	**3,395**	**3,600**
Inpatient Plan	530	645	666	658	558	643	3,701	3,730	4,019
Variance	7	(79)	(152)	(100)	(46)	(144)	(515)	(335)	(419)
Average Per Spell (£)	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Total**	**M1-6 (16/17)**	**M7-12 (1617)**
								-	-
Large Joints	5,480	4,879	5,530	5,298	5,777	5,467	5,414	5,826	5,699
Oncology	5,288	6,149	6,385	4,981	6,800	7,071	6,112	4,737	5,825
Paediatrics	3,602	3,926	3,909	4,177	3,832	4,005	3,908	3,797	3,826
Small Joints	4,007	3,815	3,849	4,813	3,283	3,988	3,959	3,387	3,551
Spinal Services	9,051	8,538	9,521	11,140	9,416	10,318	9,664	7,864	8,840
Clinical Support and Diagnostics	2,605	531	563	530	530	531	882	1,048	584
								-	-
Average Per Spell	5,895	5,651	6,180	6,105	6,412	6,286	6,076	5,527	5,990

* - Average Spell does not include PMBTS and PP Activity

INFORMATION

Elective Activity

- The data compares the first 6 months of 17/18, with both the first and last 6 months of 16/17. Whilst activity level are consistent with the first 6 months of 16/17, it should be noted that 16/17 included a significant reduction in capacity due to theatre closure;
- Income and activity levels are short of the plan, and reduced from the activity and income levels in the last 6 months of 16/17;
- There is reduced elective activity across large joints, oncology, paediatrics and spinal;
- The average income per spell has increased in spinal suggesting an increase in complexity of the workload. It is this spinal work that is also maintaining the overall average income per spell.

Daycase Activity

- Although daycase activity has increased from 16/17 and is above plan, there is a case mix change driving this resulting in a deterioration of the income position. This can also be seen by a reduction in the average income received per day case spell;
- The main factor for the increased level of activity is clinical support and diagnostics, although unfortunately this is relatively low value activity.
- There are reduced levels of activity and income in large joints and small joints;
- There is an increased level of activity in Oncology but reduced income – suggesting a case mix change;
- Spinal has also had increased level of activity, but again there has been a significant reduction in income suggesting there has been a case mix change to less complex work being undertaken.

3. Divisional Split: The tables below display the same data but presented by point of delivery, and by divisional team

Elective Daycase Activity

Income (£)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Total	M1-6 (16/17)	M7-12 (1617)
Large Joints	210,502	168,144	195,986	192,898	188,833	187,770	1,144,133	1,267,003	1,482,070
Oncology	69,416	77,164	80,356	86,166	80,722	78,012	471,838	309,685	526,612
Paediatrics	69,430	86,537	85,295	104,079	53,351	88,032	486,726	436,522	506,451
Small Joints	134,456	184,405	215,584	200,541	159,033	269,099	1,163,117	1,149,964	1,370,023
Spinal Services	76,705	79,140	85,428	89,095	72,283	165,587	568,237	419,441	632,585
Clinical Support and Diagnostics	77,079	72,406	80,145	92,098	91,146	80,031	492,905	354,304	354,973
Inpatient Income	**637,588**	**667,795**	**742,795**	**764,877**	**645,368**	**868,531**	**4,326,955**	**3,936,919**	**4,872,714**
DaycasePlan	638,122	776,248	809,879	788,900	677,243	778,871	4,469,263	4,426,473	4,572,527
Variance	(534)	(108,453)	(67,084)	(24,022)	(31,875)	89,660	(142,308)	(489,554)	300,187
Activity	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Total**	**M1-6 (16/17)**	**M7-12 (1617)**
Large Joints	117	113	109	115	105	115	674	642	731
Oncology	89	100	97	109	116	119	630	329	560
Paediatrics	84	92	80	104	60	88	508	449	515
Small Joints	90	122	144	143	104	176	779	827	850
Spinal Services	85	93	116	99	96	109	598	468	485
Clinical Support and Diagnostics	102	116	132	150	144	133	777	555	570
Daycase Activity	**567**	**636**	**678**	**720**	**625**	**740**	**3,966**	**3,270**	**3,711**
Daycase Plan	552	671	698	689	590	678	3,878	3,525	3,769
Variance	15	(35)	(20)	31	35	62	88	(255)	(58)
Average Per Spell (£)	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Total**	**M1-6 (16/17)**	**M7-12 (1617)**
Large Joints	1,815	1,488	1,798	1,677	1,798	1,633	1,702	1,959	2,030
Oncology	1,240	1,057	1,071	1,077	897	1,000	1,057	1,059	1,127
Paediatrics	827	941	1,066	1,001	904	1,000	956	972	989
Small Joints	1,494	1,524	1,497	1,402	1,544	1,529	1,498	1,394	1,619
Spinal Services	902	860	736	900	794	1,519	952	900	1,368
Clinical Support and Diagnostics	756	635	607	614	637	602	642	641	624
Average Per Spell	**1,196**	**1,104**	**1,132**	**1,107**	**1,092**	**1,243**	**1,146**	**1,221**	**1,354**

Actions

- Further analysis and evaluation of activity need to be undertaken, discussed and understood at a divisional and team level on a monthly basis;
- Formal demand and capacity analysis will be introduced to inform current work but also the 18/19 financial planning process. Put simply this will assess the level of activity each team needs to undertake to hit RTT compliant pathways, and the non-recurrent backlog that also needs to be met. This will then be assessed against the physical capacity available to delivery activity (theatre capacity, HDU/ward beds) and the human resource required to deliver it (inclusive of consultant, nursing and theatre staffing). The impact on support services will also be assessed;
- The DoF has met with Division 1 and gone through each non pay budget line by line. An initial meeting with Division 2 has also been held and further meeting are being scheduled to repeat for other Divisions, and to also repeat for pay budgets across all divisions. These meeting are also being used to give clear messaging in terms of expected behaviour for the remainder of the year, and the importance of not just maintaining the current position but to also improve upon it;
- A new management team is now working in theatres and additional controls and processes are being put in place. A full stock check is being planned for the second week in November;
- Exploring further option to use bar scanners with Theatreman to record prosthesis, consumables and even staff;
- Compliance against agreed product rationalisation will be audited, and further procurement opportunities will be reviewed where we can possibly use exiting contract frameworks from other providers;
- A medium-longer term plan to improve procurement input needs to be developed.

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

QUALITY & SAFETY COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	25 October 2017
Guests	Talitha Carding, Matron Lisa Kealey, Public and patient Engagement Manager Carl Measey, Head of Health & Safety Carolyn Langford, Head of Research, Audit and Development
Presentations received	Sepsis
Major agenda items discussed	• Quality & Patient Safety report • Patient death review • PROMs update • Harm review update • Nurse staffing update • Annual complaints report • Quality assurance walkabouts • Health & Safety update • Research & Development update • Childrens and Young People's Board upward report • Clinical Quality Committee upward report • Infection Control Committee upward report • Divisional governance updates
Matters presented for information, update or noting	• Children's Patient Safety & Quality report • Divisional governance updates • Quality & Patient safety risks on the Corporate Risk Register • RCPCH and CQC action plan status report • Compliance against CQC fundamental standards
Matters of concern, gaps in assurance or key risks to escalate to the Board	• There have been an increase in the number of VTEs reported, with eight reported during the last month; the instance of pulmonary embolisms has also increased. There is much work to investigate any contributory factors behind the position, however it was highlighted that the level of VTEs remains low when reviewed against the position set out in NICE guidance. Consideration is being given to instigating an external review of position. • There had been two deaths reported during the month and the reviews of these were underway in line with the new national guidance and policy. • There had been one Grade 3 pressure ulcer reported, although it was likely that this would be classified as non-

	avoidable • Ward 11 had received the highest number of complaints during the month and this was being revieweerd to understand whether there was any linkage to the Board's decision to give notice that it would cease paediatric surgery • The Committee noted that there were various improvements required in Outpatients, including plans to reduce clinic waiting times; this would be considered by a new operational group • The Committee received an analysis of the 41 complains received during the year which related to large joints. Additional information was needed to provide some context around these in terms of to what they related. • During a recent Quality Assurance walkabout, the Radiology area had been rated 'Requires Improvement' on the basis of outstanding estates work needed in the area and concerns over general cleanliness. It was agreed that there was a wider issue that needed to be considered about the oversight of the estates works programme. This would be picked up with the relevant Executive Lead. • The process for dissemination, review and acting on CAS alerts was agreed to need strengthening. This would be picked up with the relevant Executive Lead. • Work was underway to strengthen compliance against the hygiene code and water safety regulations. There remained vacancies in the Infection Control Team and surveillance of Surgical Site Infections was a challenge as a result • The exceptions report on the delivery of the CQC and RCPCH action plans highlighted that medical cover for Paediatric care and Outpatient waiting times remained key issues which needed to be addressed • There was much work underway through the Children's and Young People's Board to address some of the recommendations arising from the West Midlands Quality Review Service inspection report, including ensuring that the 'Was Not Brought' policy was better embedded, separating policies into child and adult versions and improving pain control for paediatric patients
Positive assurances and highlights of note for the Board	• The Committee was advised that the bleep cited in the massive haemorrhage policy was now functioning • Overall consultant mandatory training compliance was good, although there was further work needed to improve compliance with attendance at some courses such as moving & handling. The Committee urged that the use of electronic training solutions be investigated and implemented as soon as possible, cost permitting

	• The Committee received a positive report on the Trust's sepsis process and it was noted that the ROH was performing well against national standards and against the CQUIN for screening patients for sepsis; the CEO of the UK Sepsis Trust had visited and was complimentary about the Trust's management of sepsis. The Committee debated the involvement of medical staff in the sepsis process and it was agreed that although the process was nurse-driven, medical staff also had a role to play in the identification of patients potentially experiencing sepsis and to the management of deteriorating patients • There was good compliance with the submission of incidents to the National Reporting & Learning System • 100% compliance with the WHO checklist was reported to have been achieved during the month • The Trust had received some positive feedback on its harm review process • The Trust's position on Patient Reported Outcome Measures (PROMS) was reported to be good in comparsion to local providers and peer organisations. A new company was being used to capture the information. • This was the sixth consecutive month when agency nurse staffing costs were below the 10% target • The Committee received a positive presentation on the work being undertaken to strengthen the research and development function. There had been much progress and development under the new leadership of the area. It was suggested that the aduit function needed to capture all audits undertaken across the Trust and to quantify the benefits of this work on patient care • It was agreed that the discussions at Divisional Governance meetings were robust and comprehensive
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• Further information on near miss incidents and classification is to be presented at the next meeting • An update on consultant mandtoary training is to be scheduled for May 2018 • Present the complaints report to the Board at its November meeting • A risk assessment is to be undertaken on anti-barricade devices for the doors in the hospital • Review whether relevant individuals have the required health & safety qualifications • Timetable an upwards report on clinical audit for a future meeting. • A further discussion on the sustainability of the pathology service is to be scheduled for the next meeting
Decisions made	• None specifically

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

For the meeting of the Trust Board scheduled for 1 November 2017

The Royal Orthopaedic Hospital NHS
NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT	
Date of meetings since last Board meeting	24 October 2017
Guests	Steve Allen, Programme Director, Birmingham Women's & Children's NHSFT
Presentations received and discussed	Modelling update – High level assumptions
Major agenda items discussed	• Finance and Performance Overview and recovery • Progress with action plans to address regulatory concerns • 'Perfecting Pathways Update'
Matters presented for information, brief update or noting	• An extract of the summary Corporate Risk Register was considered including additional and reframed risks based on a refresh undertaken by the Executive Team
Matters of concern, gaps in assurance or key risks to escalate to the Board	• It was reported that the Trust's performance in month was slightly behind plan, with income being lower than expected. Case mix was a key factor in this. • There was noted to be further work to do to improve ownership at a clinical level of the activity targets and this would be a discussion for the committee more fully at the next meeting, including incentivisation and a consequences framework • Agency spend had risen and a breakdown of the reasons behind this was needed for the next meeting • Delivery of the Cost Improvement programme was behind plan and work was underway to understand the feasibility of the delivery of the current schemes identified, as well as any further opportunity to deliver savings • Although the outpatient waiting times were improving overall, those 60 minutes or more were increasing; it was noted that this had been previously a point of challenge by the CQC. The reasons concerned notes not being provided in time for clinics and overbooking practice. An operational group had been established to oversee required improvements in Outpatients which would pick this up. • The Committee was advised that there had been some resignations from staff in Paediatric nursing positions, which would create a risk with the ability of the Trust to meet national guidance with the care of children • Mandatory training and PDR rates were poor; work was

	underway to cleanse the data and an improvement plan would be developed
Positive assurances and highlights of note for the Board	• The Committee received a helpful presentation on the work undertaken to develop the various models that would inform the strategic outline case. A number of analyses had been undertaken, these being based on the ROH catchment, population, market share and clustering to identify opportunities in the STP. It was noted that the forecast changes in the population demographics would present an opportunity for the Trust as this would drive demand for services offered by the ROH. • Non pay expenditure was reported to have reduced, most notably in theatres, although it would take time to understand whether this was to be a sustained position or as a consequence of the immediate controls put into place around stock • The cash positon had improved and therefore the planned draw down of the Department of Heath loan facility had been delayed • Theatre utilisation had improved, both overall and for in-session. Variation between consultants needed to be addressed however. • The Committee reviewed diagnostic waiting times and noted that the Trust's performance was good. • Cancer targets had been met in month, including the 62 day target which was the subject of much press interest at present. • External reporting against the 18 weeks RTT target would recommence in December. It was highlighted that the Trust, at the recent joint oversight meeting, had been de-escalated in terms of regulatory concern over the management of the 18 weeks RTT process. • It was noted that the previously named 'Scheduled Care Improvement Programme' had been rebranded as the 'Perfecting Pathways' initiative. A very positive workshop had been held concerning improving Pre-Operative assessment processes.
Significant follow up action commissioned including discussions needed with any other Executive Boards/Committees	• A data pack is to be developed which would set out the assumptions underpinning the market analysis work as well as the actual information being used to inform the options in the Strategic Outline Case • Breakdown of agency expenditure is to be provided at the next meeting • A focussed discussion on Cost Improvement Programme is to be planned into the agenda for the November meeting • The theatre improvement action plan is to be presented at a future meeting • Consideration of an analysis concerning casemix and the

	impact on income is to be considered at the next meeting
Decisions made	• None specifically

Tim Pile
VICE CHAIR AND CHAIR OF THE FINANCE & PERFORMANCE COMMITTEE

For the meeting of the Trust Board scheduled for 1 November 2017